IHS SELF-GOVERNANCE ADVISORY COMMITTEE (TSGAC)

QUARTERLY MEETING

JULY 20-21, 2016

Embassy Suites DC Convention Center

900 10th Street Northwest, Washington, DC 20001

Phone: (202) 739-2001

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

Wednesday, July 20, 2016
Thursday, July 21, 2016

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

Table of Contents

8. Contract Support Costs

- TSGAC Letter to Principal Deputy Director RE: IHS Contract Support Costs Policy
- CSC Update from Roselyn Tso

9. Community Health Aide Program (CHAP)

- DTLL: CHAP Expansion
- CHAP Background and Policy Statement
- NIHB Background on National Indian Health Service Community Health Aide Program

10. Other Documents

- DTLL: IHS Update on Proposed Rule for the Catastrophic Health Emergency Fund
- DTLL: IHS Purchased/Referred Care Rates Announcement
- DTLL: Tribal Consultation on the Great Plains Area Office organization and structure
- IHS Prescription Drug Monitoring Program Policy

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, July 20, 2016 (1:00 pm to 5:00 pm)
Thursday, July 21, 2016 (8:30 am to 4:30 pm)

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

AGENDA

Wednesday, July 20, 2016 (1:00 pm to 5:00 pm)
Meeting of IHS Tribal Self-Governance Advisory Committee (TSGAC) and Technical Workgroup with Principal Deputy Director Mary Smith

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

Legislative Update
- S. 2417: Tribal Veterans Health Care Enhancement Act
- S. 2953: IHS Accountability Act of 2016
- H.R. 5406: Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare Act (HEALTTH ACT)

Legislative Advocacy Coordination
- Coordination of response to health-related legislation
- Communication between organizations

Stacy Bohlen, Executive Director, National Indian Health Board
Denise Desiderio, Policy Director, National Congress of American Indians

Tribal Discussion

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

2:10 pm **TSGAC Opening Remarks**
Chief Marilynn (Lynn) Malerba, Mohegan Tribe of Indians of Connecticut and Chairwoman, IHS TSGAC
Mary Smith, Principal Deputy Director, Indian Health Service

2:25 PM **TSGAC Committee Business**
- Approval of Meeting Summary (March 2016)
- Planning for 2016 Tribal Strategy Session (Ocean Shores, WA - September 7-8)

- Recognition of new Self-Governance Tribes

3:00 pm **Office of Tribal Self-Governance Update**
P. Benjamin Smith, Director, Office of Tribal Self-Governance, IHS

3:30 pm **Tribal Self-Governance Program Review Workgroup**
- Office update regarding Agency Lead Negotiator (ALN) overview, role, current personnel, and pipeline
- Summary of June Meeting
- Recommendations for TSGAC Consideration

Melanie Fourkiller, Policy Analyst, Choctaw Nation and TSGAC Tribal Co-Chair
P. Benjamin Smith, Director, Office of Tribal Self-Governance, IHS

4:15 pm **IHS Strategy for Quality of Care Improvement in Great Plains and Across the Country**
- Concerns for future Opportunities to contract for federal programs, services, functions or activities (or portions thereof) as authorized by Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA)
- IHS Transparency in non-ISDEAA federal procurement contract assignments
- Consultation with Tribes
    - Workforce issues as identified in June 15 IHS letter to Tribal Leaders
    - Program description and identification of Tribal shares associated with the establishment of an Office of Quality Management at IHS HQ (per HHS March 4, 2016 Memo included in GAO Report GAO-16-333 *Actions Needed to Improve Oversight of Patient Wait Times)*

Mickey Peercy, Executive Director of Self-Governance, Choctaw Nation
Mary Smith, Principal Deputy Director, IHS

5:00 pm **Recess until July 21, 2016**

Thursday, July 21, 2016 (8:30 am – 4:30 pm)

Meeting of IHS Tribal Self-Governance Advisory Committee (TSGAC) and Technical Workgroup with IHS Principal Deputy Director Mary Smith

8:30 am **Welcome and Introductions**
Mary Smith, Principal Deputy Director, IHS
Marilynn (Lynn) Malerba, Chief, Mohegan Tribe of Indians of Connecticut and Chairwoman, IHS TSGAC
W. Ron Allen, Tribal Chairman/CEO, Jamestown S'Klallam Tribe, and Co-Chair IHS TSGAC

8:45 am **Indian Health Service Budget Update**
- FY 2018 Budget Formulation

Elizabeth Fowler, Deputy Director for Management Operations, IHS
Melanie Fourkiller, Policy Analyst, Choctaw Nation and TSGAC Tribal Co-Chair

9:05 am **Coordination Between VA-IHS Reimbursement**
- CHOICE Act coordination under current VA-IHS MOU
- Review of payments provided to IHS and Tribal Health Programs
- Coordination of care concerns

Dr. Baligh Yehia, Assistant Deputy Under Secretary for Health – Community Care, Department of Veterans Affairs (Invited)
Stephanie E. Birdwell, Director, Office of Tribal Government Relations, Department of Veterans Affairs (Invited)

10:00 am **Break**

10:15 am **Patient Protection and Affordable Care Act Implementation Update**
Cyndi Ferguson, Self-Governance Specialist/Policy Analyst, SENSE Incorporated
Doneg McDonough, Consultant, Tribal Self-Governance Advisory Committee

10:45 am **Contract Support Cost Workgroup Update and Discussion**
- IHS Contract Support Costs Policy Tribal Comments and Implementation Plan
- Outstanding issues related to exhibits
- Follow Up CSC Workgroup Meeting Date

Marilynn (Lynn) Malerba, Chief, Mohegan Tribe of Indians of Connecticut
Mickey Peercy and Rhonda Butcher, IHS Contract Support Costs Workgroup Members

11:00 am **Draft Policy to Expand Community Health Aide Program**
- Certification of Tribal Community Health Aide Programs (CHAP)
- Purpose and Goal of Expansion of CHAP oversight described in IHS June 1 letter to Tribal Leaders

Mickey Peercy, Executive Director of Self-Governance, Choctaw Nation
Alec Thundercloud, Director, Office of Clinical and Preventive Services, IHS

11:30 am **Joint TSGAC and IHS Principal Deputy Director Discussion**
- Proposed Action on the CHEF Rule
- New Regulation: Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Programs and medical Charges Associated with Non-Hospital-Based Care – Option to opt-in described in IHS May 24 letter to Tribal Leaders – ISDEAA Funding Agreement Language
- IHS Strategy to Improve Quality Health Care Delivery

12:00 pm **Lunch**

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

1:30 pm **Joint TSGAC and IHS Principal Deputy Director Discussion (Continued)**

3:30 pm **Closing Remarks**
Chief Marilynn (Lynn) Malerba, Mohegan Tribe of Indians of Connecticut and Chairwoman, IHS TSGAC
Mary Smith, Principal Deputy Director, Indian Health Service

3:45 pm **TSGAC Technical Workgroup Meeting**

4:30 pm **Adjourn TSGAC Meeting**

2016 Self-Governance National Calendar

Date	Meeting	Location
July 19-20	DOI SGAC Quarterly Meeting	Embassy Suites-DC Convention Center
July 20-21	IHS TSGAC Quarterly Meeting	
August 2-3	CDC 15th Biannual Tribal Consultation	Valley Center, CA
August 9-11	National AI/AN Behavioral Health Conference	Portland, OR
September 7-8	2016 Tribal Self-Governance Annual Strategy Session	Ocean Shores, WA
September 13-15	National Intertribal Tax Alliance's 18th Annual Tax Conference	Agua Caliente Casino Resort
September 18-20	NAFOA 2016 Fall Finance & Tribal Economies Conference	Charlotte, NC
September 19-23	NIHB Annual Consumer Conference	Phoenix, AZ
October 5-8	NIEA National Convention	Reno, NV
October 9-14	73rd Annual NCAI Convention & Marketplace	Phoenix, AZ
October 25-26	DOI SGAC Quarterly Meeting	Embassy Suites-DC Convention Center
October 26-27	IHS TSGAC Quarterly Meeting	
November 7-9	TBIC	Washington, DC
November 14-17	RES	Santa Fe, NM

2017 Self-Governance Meetings

January 24-25	IHS TSGAC Quarterly Meeting	Embassy Suites – DC Convention Center Charlotte, NC
January 25-26	DOI SGAC Quarterly Meeting	
March 28-29	IHS TSGAC Quarterly Meeting	Embassy Suites – DC Convention Center Charlotte, NC
March 29-30	DOI SGAC Quarterly Meeting	
April 23-27	Annual Tribal Self-Governance Consultation Conference	Spokane, WA
July 18-19	IHS TSGAC Quarterly Meeting	Embassy Suites – DC Convention Center Charlotte, NC
July 19-20	DOI SGAC Quarterly Meeting	
October 24-25	IHS TSGAC Quarterly Meeting	Embassy Suites – DC Convention Center Charlotte, NC
October 25-26	DOI SGAC Quarterly Meeting	

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MEMBERSHIP LIST

(May 16, 2016)

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	**Benito M. Sandoval, Governor** Pueblo of Taos	**Primary**	PO Box 1846 Taos, NM 87571 P: 575-758-9593 ~ F: 575-758-4604
	Raymond Loretto, DVM, Governor 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	**Greg Matson, Vice Chairman** Oneida Tribe of Wisconsin	**Primary**	PO Box 365 Oneida, WI 54155 P: (920) 869-4403 Email: gmatson@oneidanation.org
	Jessica Burger, Tribal Councilor, 9-County Representative Little River Band of Ottawa Indians	Alternate	2608 Government Center Drive Manistee, MI 49660 P: (231) 398-6867 Email: jlburger@lrboi-nsn.gov
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
	Robert Smith, Chairman Pala Band of Mission Indians	Alternate	35961 Pala-Temecula Rd. Pala, CA 92059 P: 760-891-3519 ~ F: 760-891-3584 Email: rsmith@palatribe.com
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

TSGAC & Technical Work Group Membership List
May 16, 2016

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	**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
	VACANT	Alternate	
Oklahoma	**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	**Lindsey Manning, Chairman** Shoshone-Paiute Tribes of the Duck Valley Indian Reservation	**Primary**	PO BOX 219 Owyhee, Nevada 89832 P: 208-759-3100 ~ F: 208-759-3102 Email: manning.lindseyw@shopai.org
	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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P.O. Box 1734, McAlester, OK 74501
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TSGAC TECHNICAL WORKGROUP

AREA	MEMBER (name/title/organization)	STATUS	CONTACT INFORMATION
Alaska	Dave Mather, Ph.D Mather & Associates	Tech Rep	1569 Northfield Rd Fairbanks, AK 99709 P: 907-455-6942 ~ F: 907-455-7391 Email: mather.david@gmail.com
	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	Tech Rep	P.O. Box 1846 Taos, N.M. 87571 Office: 575.758.8626 ext. 115 Fax: 575.758.8831 Mobile: 575.741.0208 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
Billings	Ed Parisian Chippewa Cree Tribe	Tech Rep	PO Box 544 Box Elder, MT 59521 Email: eparisian@rbclinic.org
D.C. (National)	C. Juliet Pittman SENSE Incorporated	Tech Rep	Upshaw Place 1130 -20th Street, NW; Suite 220 Washington, DC 20036 P: 202-628-1151 ~ F: 202-638-4502 Email: pitt@senseinc.com
	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
Nashville	Dee Sabattus United South and Eastern Tribes	Tech Rep	711 Stewarts Pike Ferry, Suite 100 Nashville, TN 37214 Email: dsabattus@usetinc.org
	Hillary Andrews United South and Eastern Tribes	Tech Rep	400 North Capitol Street, NW Suite 585 Washington, DC 20001 Email: HAndrews@USETINC.ORG
Navajo	Carolyn Drouin Navajo Nation Washington Office		750 First Street NE, Suite 1010 Washington, D.C. 20002 P: 202.682.7390 ~ F: 202.682.7391

			E-mail: cdrouin@nnwo.org
Oklahoma	Rhonda Farrimond Choctaw Nation	Tech Rep	PO Box 1210 Durant, OK 74702 P: 580-924-8280 ~ F: 580-920-3138 Email: rfarrimond@choctawnation.com
	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 kasie.nichols@potawatomi.org
Portland	Jennifer McLaughlin Jamestown S'Klallam Tribe	Tech Rep	1033 Old Blyn Highway Sequim, WA 98382 P: (360) 681-4612 ~ F: (360) 681-4648 Email: jmclaughlin@jamestowntribe.org
	Eugena R Hobucket Quinault Indian Nation	Tech Rep	PO BOX 189 Taholah WA 98587 P: (360) 276-8211 ~ F: (360) 276-8201 Email: ehobucket@quinault.org

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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	Evangelyn Dotomain (POC) Director, Office of Tribal Programs	Area Rep	141 Ambassador Drive Anchorage, AK 99508-5928 P: 907-729-3677 ~F: 907-729-3678 Evangelyn.Dotomain@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 (Acting) IHS Agency Lead Negotiator (Alaska)	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

TSGAC Mailing Address:
c/o Self-Governance Communication and Education
P.O. Box 1734, McAlester, OK 74501
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Technical Workgroup
Assignment Matrix
Updated: June 11, 2016

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

	Assignment	Person(s) Responsible	Date Task Originated	Status
1.	All correspondence with Secretary: discuss impact, relationships, and teamwork (refer to TSGAC summary 7/30/14). If the TSGAC specifically desires a response from the Sec'y, the letter should state so.	All	July 31, 2014	INFORMATIONAL ONLY. Consider when drafting correspondence to HHS Secretary.
2.	Continue to gather data from all Areas about impact of CR/shutdown. Specific programmatic impact, such as layoffs, closed programs, PRC, bad patient outcomes, etc. Reach out to the Health Directors in each Area.	Terra Branson	July 31, 2014	Ongoing – SGCE requested additional data and stories at the Strategy Session hosted recently
3.	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.] Update: TSGAC Meeting March 2016, approved implementation of the recommendations dealing with IHS developing and posting standard information for PSFA descriptions, residuals, formulas, tables, etc	Ben Smith OTSG Mickey Peercy Rhonda Farrimond Melanie Fourkiller Cyndi Ferguson Terra Branson SGCE	March 2016	TWG met on 6/8/16, recommendations are included in the meeting packet.
4.	Appropriations "Think Tank" -- Develop ideas/options for potential solutions to CRs (alternatives to Advanced Appropriations, such as an entire year CR with a "true up", etc)	Carolyn Crowder Brandon Biddle Caitrin Shuy Liz Malerba Lloyd Miller	July 31, 2014	Refer to Budget Formulation workgroup.

5.	Develop metrics to evaluate effectiveness of MLR after implementation.	Mickey Peercy (PRC Workgroup) Doneg McDonough	April 13, 2015	
6.	Develop a concept paper to suggest new ways to measure need that include pieces beyond LNF.	Doneg McDonough Laura Bird Rhonda Butcher	October 7, 2015	
7.	Develop comments on the proposed CSC Policy	Lloyd Miller Geoff Strommer Melanie Fourkiller Rhonda Butcher	March, 2016	Template Completed. TSGAC comments will be submitted 6/9/16
8.	Letter requesting Tribal consultation on Proposed Rule for Protection of Human Subjects in Research.	Jennifer McLaughlin	March, 2016	Completed.
9.	Letter to Steve Petzinger, OMB Examiner for IHS, EOP • Thanks for attending the TSGAC meeting • Restating issue of parity with other Federal health programs • Exemption from sequestration • Advanced approps • Mandatory CSC • Use Medical Inflation rate for CSC	Sense, Inc	March 2016	Completed.
10.	Letter to CMS regarding having IHS/Tribes at the table when developing quality metrics for MACRA and MIPS – addressed to HHS Secretary with copies to IHS Deputy Mary Smith and CMS Administrator Andrew Slavitt	Devin Delrow	March 2016	Completed.
11.	Letter to IHS Principal Deputy requesting the CHEF rule be withdrawn for a Tribal Consultation process to occur.	Melissa Gower	March 2016	Completed
12.	Joint letter to VA Secretary and HHS Secretary requesting them to pursue VA reimbursement of eligible PRC services	Melanie Fourkiller	March 2016	Completed
13.	Letter to VA -- Tribal Service officers needed in VA and requesting copy of care coordination agreements (NIHB is working on this)	Devin Delrow	March 2016	
14.	Develop proposals/recommendations for Facilities to IHS, such as: • Loan authority • Loan guarantees • POR/PJD process • Leveraging other appropriations (USDA/HUD/BIA/etc) • Prioritization and moving facilities ahead in a timely manner	Melanie Fourkiller Melissa Gower	March 2016	Completed.
15.	Letter to IHS on payor of last resort guidance – request Tribal Consultation prior to issuing anything.	Unassigned	March 2016	CMS TTAG ACA Policy Subcommittee will follow

				up on the scenarios from IHS/CMS. Hold until ACA Policy Subcommittee gets copies of scenarios
16.	Meeting for TSGAC Chair(s) with Mary Wakefield to discuss how to better access (currently appropriated) funding for Indian health	SGCE	March 2016	
17.	MLR final rule – develop comments from TSGAC.	Unassigned	March 2016	Completed.
18.	Letter to request Treasury to conduct Tribal Consultation prior to making any determination on the Cadillac Tax (applicability to Tribal governments)	Laura Bird	March 2016	
19.	Set up call with Technical representatives of Treasury and TSGAC on Employer Mandate	Devin Delrow	March 2016	Completed.
20.	Letter to request a meeting with Treasury for the TSGAC Co-Chairs on Employer Mandate next steps	Terra Branson	March 2016	Treasury is still considering options. Employer reporting deadline has been extended.

Summary of IHS Tribal Self-Governance Advisory Committee (TSGAC) Correspondence
Year: 2016

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
1.	**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.	
2.	**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	
3.	**6/9/16**	IHS Principal Deputy Director via consultation@ihs.gov	Proposed IHS Contract Support Costs Policy	TSGAC Formal Comments	
4.	**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	
5.	**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.	
6.	**5/10/16**	IHS Principal Deputy Director	Catastrophic Health Emergency Fund Proposed Rule (RIN 0905-AC97)	TSGAC formal comments on proposed rule	
7.	**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	
8.	**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	
9.	**5/5/16**	CMS	CMS-10458, "Consumer Research Supporting Outreach for Health Insurance Marketplace	TSGAC Formal Comments	
10.	**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	
11.	**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.	

12.	**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.
13.	**4/18/16**	Mary Smith, IHS Principal Deputy Director	Recommendations for Health Care Facilities	TSGAC Recommendations	
14.	**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.	
15.	**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	
16.	**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)	
17.	**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	

18.	**2/19/16**	Centers for Medicare & Medicaid Services	Comments on CMS-9936-N; Waivers for State Innovation	TSGAC Formal Comments	
19.	**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.**
20.	**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	
21.	**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.
22.	**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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c/o Self-Governance Communication and Education
P.O. Box 1734, McAlester, Oklahoma 74501
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WORKGROUP REPORTING FORM

NAME OF WORKGROUP *(please check which Committee this report will be for)*

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

DATE OF MEETINGS	TTAG: June 8, 2016; July 11, 2016 MMPC: April 6, 2016; May 4, 2016; June 13-14, 2016 (Retreat)	**LOCATION OF MEETINGS**	All meetings were via conference call except for the MMPC Retreat which was in Nashville, TN.
COMMITTEE CHAIRMAN	W. Ron Allen		
COMMITTEE RECORDER	Laura Bird		

ATTENDANCE *(please list all present during the meeting)*

W. Ron Allen, Melanie Fourkiller	Doneg McDonough, and Laura Bird, Technical Advisors		

AGENDA ITEM	SUMMARY/HIGHLIGHTS *(Committee action should be noted in this section)*
Expanding 100% FMAP	On February 26, 2016, CMS issued a letter to states and Tribes providing guidance to update its policy regarding the circumstances in which 100% FMAP would be available for services furnished to Medicaid-eligible AI/AN through facilities operated by IHS or Tribes. A copy of the letter can be found at: https://www.medicaid.gov/federal-policy-guidance/download. CMS held an All Tribes Call on March 8, 2016. CMS adopted Tribal recommendations to: (1) broaden application of 100% FMAP to additional services; and, (2) ensure there is a meaningful connection to Tribal health programs in order for a State to secure 100% FMAP. CMS is preparing sub-regulatory guidance on implementation of 100% FMAP. TSGAC addressed this issue in its ACA Current Topics Webinar held on June 9, 2016. Tribes are encouraged to work with State governments to implement the new 100% FMAP authorities in ways that facilitate greater access to health services for AI/ANs and strengthen the Tribal health system. Tribal reps are sharing information with each other on (1) approaches taken to implement the new policy and (2) opportunities to expand the breadth of services provided by Tribes and IHS, which the state would be reimbursed under the 100% FMAP policy.
Issues related to Limited Cost Sharing Variation (L-CSV) Plans for AI/AN through the Marketplace	TSGAC and TTAG have pursued several issues to ensure Tribal members receive the comprehensive Indian-specific cost-sharing protections established under the ACA, such as: (1) Eligibility: CMS/CCIIO concurred with Tribal position that L-CSV plans are available to all AI/ANs meeting the definition of Indian, regardless of income. CMS/CCIIO has revised CMS/CCIIO documents to correctly describe L-CSV; and (2) CCIIO reviewed their guidance issued on this topic. CCIIO concluded their review and indicated they will not change the guidance issued. CCIIO will assist THOs and individual AI/ANs if they have problems with the proper application of the cost-sharing protections by health plans. Technical advisors are reviewing the CCIIO-provided data to monitor enrollment in various types of cost-sharing protections.

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Summary of Benefits and Coverage (SBC)	The TTAG requested that (1) QHP issuers provide an SBC for each Indian-specific zero and limited cost-sharing variation (Z-CSV; L-CSV) and (2) CCIIO prepare a sample Z-CSV SBC and L-CSV SBC and share these with QHPs in order for QHPs to accurately describe the cost-sharing protections. On December 2, 2015, there was a meeting with CCIIO Director Kevin Counihan on the need for an SBC template On March 16, 2016, CCIIO provided to TTAG for review draft SBC templates for the Z-CSV and L-CSV. On March 18, 2016, TTAG/TSGAC provided edits on the draft SBCs. It is anticipated that CCIIO will incorporate Tribal recommendations and provide sample SBCs to QHPs shortly. TSGAC reviewedthis issue in its Current Topics webinar on June 8, 2016. In response to TSGAC/TTAG inquiries, CCIIO set a target date of June 8, 2016 for release of "sample templates" for the two Indian-specific cost-sharing protections. The date passed without release of the documents, but CCIIO indicated the documents are in final stages of review before releasing.
Exemption to Tribal Employer insurance mandate	The Employer Mandate under the ACA requires all employers with 50 or more full time equivalent employees to offer health insurance or pay a fixed per FT employee amount to the federal government. TSGAC has been engaging the Treasury Department (through Dr. Elaine Buckberg and now Thomas West) on modifying regulations to limit the impact on Tribes. The TSGAC recommendations are contained in two letters to Treasury (from Oct 2015) requesting (1) extension of transition relief for 1 – 2 years and (2) targeted permanent relief for employers that would eliminate "shared responsibility payments" on Tribal member employees and enable Tribal member employees with an offer of coverage from a Tribal employer to have the ability to secure coverage through a Marketplace and be eligible for premium tax credits and Indian-specific cost-sharing protections. Tribal request is pending with Treasury/Administration. Mr. West attended the TSGAC March 2016 quarterly meeting with Kathryn Johnson, Attorney Advisor, Office of Benefits Counsel at Treasury. TSGAC restated its prior request for administrative relief and also requested that Treasury continue to work with a small Tribal workgroup on an administrative relief solution. The workgroup met with Mr. Robert Neis, Benefits Tax Counsel at Treasury, Ms. Johnson, and other Treasury officials on May 9, 2016, where the proposed relief was discussed. The Treasury also held a Tribal consultation on the Employer Shared Responsibility Mandate on May 13, 2016. Subsequent letters from TSGAC have re-confirmed the TSGAC recommendations on potential partial administrative fixes to the application of the employer mandate to Tribes. TSGAC is working to schedule a follow-up meeting with Treasury to hear and discuss any responses from Treasury to the TSGAC recommendations. The meeting is targeted for late July/early August 2016. Concurrent to the request for administrative relief, NIHB, NCAI and TSGAC, has been working with Congress on a legislative fix.
Tribal Exemption to Excise Tax (Cadillac Tax) provision in ACA	A provision in ACA would create a tax on insurance issuers that would likely be passed along to employers if the cost of health insurance exceeds a fixed amount. Depending on how the cost of insurance is calculated this could be costly for Tribes. NIHB, TSGAC and other organizations/Tribes submitted comments asserting that the Cadillac Tax (Section 4980I) does not apply to Tribes and that implementing regulations should expressly exclude Tribal government plans. If Treasury disagrees with the Tribes' position, then Tribal consultation was requested prior to the issuance of proposed regulations. At the March 2016 quarterly meeting, TSGAC reiterated its position on the Cadillac Tax and its request for Tribal consultation if Treasury takes an opposing position to the Tribes' interpretation of 4980I. The Cadillac Tax was scheduled to go into effect in 2018 but has been delayed until 2020.

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Managed Care Regulations	The Managed Care regulations are being revised by Medicaid for the first time since 2003. The Notice of Proposed Rule Making (NPRM) was released on May 26, 2015 and comments were submitted July 27, 2015. The regulations were submitted to OMB In December 2015. CMS published the final rule on April 25, 2016. The final rule incorporates the Indian managed care protections in section 5006 of the American Recovery and Reinvestment Act (ARRA). CMS is currently working on an informational bulletin to highlight the Indian provisions in the regulations with an Indian addendum for managed care. CMS, through the Tribal Affairs Group, is working to prepare a set of "STCs" (Standard Terms and Conditions) that could be incorporated into each state waiver request, thereby maintaining and confirming the Indian-specific benefits and protections under Medicaid.
CMS Tribal Consultation Policy	The revised CMS Tribal Consultation Policy was circulated by CMS in November, 2015 and approved by the TTAG. The Treasury Department issued its final Tribal Consultation policy on September 23rd. At the MMPC retreat, the #1 priority is implementation of the CMS Tribal Consultation Policy, i.e. CMS should provide a regularly report (as directed by the Consultation Policy) to Tribes on its performance in implementing the Tribal Consultation Policy. NIHB agreed to host a Tribal-only call to discuss further prior to the upcoming July 27, 2016 TTAG meeting.
Payer of Last Resort	On the January call, Nancy Dieter, Technical Director for Coordination of Benefits and Third Party Liability presented to the TTAG on a payer of last resort issue. Some Tribes and Tribal third party administrators, as employers, have been refusing to pay claims if a person is a Medicaid beneficiary. IHS and CMS are planning on issuing joint policy guidelines that Tribal employer coverage is the primary payer (and Medicaid the payer of last resort). TTAG raised concerns about the policy and requested further discussion prior to the issuance of further guidance by CMS. The joint policy guidelines are still outstanding.
AI/AN Enrollment in Medicaid, CHIP and Marketplace plans	On the June 8, 2016 TTAG call, Michael Cohen from CCIIO presented Marketplace enrollment data on AI/ANs for 2015 and 2016 (through May 23, 2016). The TTAG Data Subcommittee had repeatedly made requests for this data in order to understand level of AI/AN enrollment and to secure data on which cost-sharing variations AI/ANs are enrolling as to whether AI/ANs are being properly enrolled in limited cost sharing plans. As of May 2016, 26,222 AI/ANs meeting the definition of Indian under the ACA had made a plan selection through a federally-facilitated Marketplace (36 of 50 states). This compares to 22,227 plan selections as of December 31, 2015. (Because of the different reporting dates, the numbers are not directly comparable.) TSGAC recently coordinated the submission of a letter by TTAG asking for enrollment data for the State-Based Marketplaces.
CCIIO Tribal Workgroup	The meetings with CCIIO Director Kevin Counihan have become less frequent, but the CCIIO staff (Lisa Wilson, Lina Rashid) have increased their participation in the regularly scheduled TTAG ACA Policy Subcommittee monthly calls. One current focus of the calls is receiving regular reports on AI/AN enrollment in Marketplace coverage and, possibly, access to original Marketplace enrollment data sets.

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I/T/U Participation in QHP provider networks	The CMS 2015 letter to issuers requires all QHPs in the FFM to make a good faith effort to offer contracts with the contents of the Indian Addendum to all I/T/Us. CMS has reported that all QHPs have provided contracts with the Indian Addendum to all I/T/Us. In response to concerns from THOs that the QHP issuers were not fully complying with these requirements, TSGAC prepared a report on this issue. The report determined compliance was not uniform, and many QHPs had zero I/T/Us in their plan networks. TSGAC/TTAG recommended: 1) the requirements on QHP be put into regulations; and, 2) the requirements under the FFM be extended to state-operated Marketplaces. CCIIO is using the report to engage specific QHP issuers on compliance issues. In April of 2016, TSGAC prepared a memorandum on the HHS ECP Lists for Coverage Years (CYs) 2016, 2017, and 2018. The memorandum provides Tribes with a summary of findings from a review of the IHCPs that appear on HHS ECP for CYs 2016, 2017, and 2018 and includes a spreadsheet comparing the year-to-year listings of IHCPs on the HHS ECP List. It also identifies steps IHCPs might need to take to remain on the HHS ECP List for CY 2018. TSGAC is reminding Indian Health Care Providers to add / update their entries on the HHS ECP List. **August 22, 2016 is the deadline to add facilities to the HHS ECP List for the 2018 coverage year.** CCIIO prepared a one page "Tip Sheet" with instructions for adding and updating entries on the HHS ECP List. TTAG provided comments to CCIIO on the draft document.
Definition of Indian in Exchanges	TTAG, NCAI, NIHB, and TSGAC leadership and technical advisors are continuing to look for a vehicle for a legislative fix for the definition of Indian in ACA. The President's Budget for FY 2017 included a request for a consistent definition of "Indian" to ensure all AI/AN eligible for IHS services will be treated equally with respect to the Act's coverage provisions, including access to zero and limited cost sharing plans and special enrollment period.
Payment for Services provided by Tribes	Previous analyses have shown that cost sharing reductions were not being applied properly for AI/ANs who have insurance through the FFM and receive services at a Tribal facility or at non-ICHPs (payment to Tribal facilities reduced by standard patient cost-sharing amounts.) Release of Summary of Benefits and Coverage (SBC) documents for Z-CSV and L-CSV expected to increase the understanding of health plans, providers and enrollees on proper application of Indian-specific cost-sharing protections. (See item above.) TTAG and TSGAC technical advisors continue to monitor plan compliance and bring issues to CCIIO as needed.
Medicare Provider-based rules	CMS has held Tribal Consultation on grandfathering the use of the Encounter Rate for Medicare for hospital-based provider services. Recent interpretation that hospitals and clinics are required to have same operating Board is a threat to Tribal sovereignty and the self-determination/self-governance process. CMS has agreed to meet with each Tribal facility impacted by the transition rule to see if any negative impact can be minimized.
Medicare Payment Reforms	Value based purchasing and other payment reforms may reduce Medicare payments for IHS and Tribal hospitals that do not score high enough on quality measures. MMPC has formed a workgroup to consider these issues. The workgroup reviewed CMS's Request for Information on the Certification Frequency and Requirements for the Reporting of Quality Measures Under CMS Programs and the proposed rule on Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (CMS–5517–P). TTAG has expressed concerns about the requirements and has made requests for Tribal consultation.

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Medicaid Estate Recovery	While this applies primarily to people over 55 who may not otherwise qualify for long term care or community-based services, fear of estate recovery deters others from enrolling in Medicaid. STAC has requested the HHS Secretary to use her authority to waive estate recovery for AI/AN. CMS is working with the TTAG Outreach and Education (O&E) Subcommittee to develop consumer education materials on Medicaid estate recovery.
Catastrophic Health Emergency Fund (CHEF)	IHS's NPRM on the Catastrophic Health Emergency Fund (CHEF) was published on January 26, 2016. Comments were due on March 11, 2016 but have been extended to May 10, 2016. Of concern is that the rule interprets "alternate resource" and payer of last resort to the detriment of Tribes by making Tribes and Tribal self-insured health plans primary to federal health programs. IHS did not seek Tribal consultation prior to issuing the NPRM. TSGAC submitted comments on the NPRM and requested Tribal consultation. On June 1, 2016, Mary Smith, Principal Deputy Director at IHS, issued a DTTL stating that IHS would seek Tribal consultation before moving forward on the rule. Two telephonic consultation sessions will be scheduled; and two in-person consultations will be held, one at NIHB's Annual Consumer Conference (September 19-22, 2016 in Scottsdale, AZ) and the other at NCAI's Annual Convention (October 9-14, 2016 in Phoenix, AZ). TSGAC addressed this issue in its Current Topics webinar on 6/9/16.
Medicare Like-Rates To Physicians and Other Non-Hospital Providers	IHS implemented a final rule on March 21, 2016 with a comment period that gives the I/T/U programs the ability to cap payment rates at a "Medicare-like rate" to physician and other non-hospital providers and suppliers who provide services through the PRC program. TSGAC, and other Tribes and organizations, submitted comments on the final rule. TSGAC's major concerns were that the definitions section does not make an adequate distinction between a "referral for services" and an "authorization for payment" by the IHS; and that the applicability provision establishes an overly complicated procedure for Tribes to "opt in" to the requirements. IHS has stated a willingness to review this issue with Tribes to determine the most appropriate actions to clarify the definitions. TSGAC addressed this issue in its ACA Current Topics webinar held on June 9, 2016.
National IHS Community Health Aide Program (CHAP)	On June 1, 2016, Mary Smith, Principal Deputy Director at IHS, issued a policy statement that IHS is "exploring necessary steps to create a national CHAP, including creation of a national certification board. Comments are due on July 29, 2016. The MMPC discussed this policy at the MMPC Retreat. TSGAC will submit comments on the policy statement.

RECOMMENDED TSGAC ACTIONS

1. Legislative advocacy:
   a. Make the definition of Indian in ACA the same as in Medicaid.
   b. Statutory requirement for Medicare-like rates for ambulatory services provided through CHS/PRC.
   c. Exempt Tribes from the employer mandate under ACA, and reaffirm that Tribes are exempt from "Cadillac Tax."
   d. Eliminate or modify the ACA's employer requirements on Tribes.
2. Advocate with HHS Secretary to:
   a. Use authority for an administrative fix for definition of Indian in ACA.
   b. Use existing authority to waive Medicaid estate recovery for AI/AN.
3. Advocate with the Treasury Department the implementation of targeted partial administrative fixes to the application of the ACA's employer mandate on Tribes.
4. Continue to monitor developments in the implementation of ACA, participate in Tribal Consultations and policy subcommittees, and make formal comments. Current focus is:
   a. Proper assignment of people to limited cost sharing plans and proper application of cost sharing reductions in payment of invoices for services provided by I/T/U.
   b. Data for better monitoring of enrollment.
   c. Network adequacy and assuring the IHCPs receive contracts with the Indian Addendum.
5. Advocate for implementation of the CMS AI/AN Strategic Plan, 2015-2018, as revised Feb 20, 2014.

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INDIAN HEALTH SERVICE TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE
AND TECHNICAL WORKGROUP QUARTERLY MEETING
Wednesday, March 30, 2016 (1:00 pm to 5:00 pm)
Thursday, March 31, 2016 (8:30 am to 4:30 pm)

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

MEETING SUMMARY

Wednesday, March 30, 2016 (1:00 pm to 5:00 pm)
Meeting of IHS Tribal Self-Governance Advisory Committee (TSGAC) and Technical Workgroup with Principal Deputy Director Mary Smith

Tribal Caucus

- TSGAC hosted a Tribal caucus from 1:00 PM to 2:00 PM.

Welcome

Chief Malerba provided a brief welcome and introduction of Dr. Mary Wakefield.

Dr. Mary Wakefield, Acting Deputy Secretary, Department of Health and Human Services

- Expressed thanks for TSGAC's willingness to partner and work together.
- Strong Federal-Tribal relationships have been critical to the success of the Tribal Self-Governance Program.
- Self-Governance Leadership continues to be engaged with HHS and are represented on the Department of Health and Human Services (HHS) Secretary's Tribal Advisory Committee (STAC). In fact, all five of the at-large representatives are Self-Governance Tribal Leaders.
- Ms. Smith and Dr. Wakefield have been in regular communication regarding progress on the Contract Support Costs (CSC) Policy.
- HHS hopes that the IHS developed template will assist in consistent negotiations with Tribes.

Tribal Response:

- The issues the Indian Health Service (IHS) is currently working on are issues that Tribes have been working on for several years.
- Something in the IHS has fallen down and it is up to this Administration to make the corrections necessary to resolve previous issues.
- There is a frustration with IHS management of civil servants suit and management of health care quality in the Great Plains.
- The Federal side has been depleted of historical knowledge and drive to negotiate Title V contracts. The IHS is chronically dysfunctional and will take nearly a decade to resolve issues that are desperate today. If these issues occurred at a Tribal facility, Tribal employees would have been absolved of their duties.

HHS Response:

- We find the situation as unacceptable as you do.
- Resources that are allocated should be well spent.

- We are not consistently meeting quality care across direct service facilities.
- As stated earlier, the reason Mary Smith and Dr. Wakefield are in regular communication are to change the tide of services provided to Tribes in the Great Plains.
- We welcome your continued feedback and support as IHS makes these changes.

Tribal Response:

- Billings recently conducted a search for an Area Director, however it was clear that IHS skewed the panel to select one person.
- The Tribes requested a list of individuals who applied, but IHS refused to provide the additional applicants.
- Third party collection for Medicare and Medicaid
    - The coding system has become incredibly burdensome and is affecting the delivery of care from providers.

HHS/IHS Response:

- CMS should make sure that billing tools and technical assistance are available to Tribes.

Tribal Discussion:

- Chief Malerba request to have a side meeting with Dr. Wakefield to discuss a few more issues in detail.
- The HHS grant funding (557 grants) is not the best way to strengthen the Federal-Tribal relationship. Discussion regarding how Tribes access HHS funding is necessary.
- Tribes are still waiting for Suicide Prevention funding to come through the IHS to support Tribal efforts to combat suicide.

HHS/IHS Response:

- Models from other communities are available to replicate best practices.
- Suicide is of great importance to this administration and funding was requested in FY16 and FY17.

Invocation

Tyson Johnston, Vice President, Quinault Indian Nation provided the opening invocation.

Roll Call

Alaska:	Jaylene Peterson-Nren, Executive Director, Kenatize Indian Tribe
Albuquerque:	Benito Sandoval, Governor, Taos Pueblo
	Daniel Lucero, Secretary, Tao Pueblo
Billings:	Ken St. Marks, Chairman, Chippewa Cree Tribe
California:	Maybelline Peterson, Self-Governance Office, Hoopa Valley Tribe
Nashville:	Marilyn “Lynn” Malerba, Chief, Mohegan Tribe
	Tobias Vanderhoop, Chairman, Wampanoag Tribe of Gay Head (Aquinnah)
	Stephanie White, Treasurer, Wampanoag Tribe of Gay Head (Aquinnah)
Navajo:	Jonathon Nez, Vice President, Navajo Nation
Oklahoma 1:	Mickey Peercy, Executive Director of Self-Governance, Choctaw Nation
Phoenix:	Lindsay Manning, Chairman, Shoshone-Paiute Tribes of the Duck Valley Indian Reservation
Portland:	Tyson Johnston, Vice President, Quinault Indian Nation

Introduction of all participants and invited guests

TSGAC Opening Remarks

Mary Smith, Principal Deputy Director, Indian Health Service

- 60% of the IHS budget goes out to Tribes operating contracts or compacts.
- She is trying to create a culture of leadership and mission-driven work.
- She recognized the long-term struggle to move things along, however she hopes that Tribes will continue to work with IHS to improve delivery of care.
- Termination has occurred at the Winnebago Hospital, but been delayed at Rosebud Sioux Hospital.
    - The issues did not happen overnight, but the solutions have been short term.
    - We must make improvements in a sustainable way to prevent these issues from happening again.
    - IHS wants to be transparent throughout the process.
- IHS is going to the Great Plains next week to begin address the systemic issues and consult with Tribes to identify solutions.
    - Hiring in rural areas is similar for all rural employers. What are best practices that can be replicated by IHS.
    - Alternate service delivery models.
    - Telemedicine is an opportunity.
    - Dorothy Dupree is the new Deputy Director of Quality a new office to help improve quality of care within the IHS.
- A new CSC policy will be released for sixty-day comment period.
- Behavioral Health funding and pilots
    - $48 million for behavioral health, including $15 million for GEN-I to train behavioral health providers for young people.
    - $4 million for zero suicide pilot programs, $2 million to address gap in services after Regional Youth Treatment Centers.
    - $25 million mandatory funding, including $15 million for behavioral health crises and $10 million for scholarship and loan repayment programs.
- Improve service and management
    - Recently received an approval to increase pay for emergency room doctors.
    - Personal goal is to leave IHS better than when she arrived.

Tribal Response

- Request to follow up on the Billings Area Director question.

IHS Response

- The last panel was not acceptable to the Tribes and there was a request to add more health care experience.
- The notice is public again or should be available again soon.
- Area Director positions have been publicized in Phoenix, Albuquerque, and Navajo this week.

Tribal Discussion

- The USAJobs system often kicks out qualified individuals because of technical writing issues with resumes. Perhaps IHS should review applications by hand instead of relying on the system to choose a panel.
- Navajo Nation has been working closely with Mr. McSwain to advocate for a few initiatives, including the Gold King Mine Spill.
- This is a political year and there is great importance to get a budget for Fiscal Year for 2017. We need to partner and make sure that we have a plan to implement quality care with a stagnant IHS budget.

TSGAC Committee Business

- Approval of Meeting Summary (October 2015)
  - Approved without objections.
- National Institutes of Health Tribal Advisory Committee Self-Governance Representative
  - We need an alternate.
  - Vice President Johnston expressed interest in becoming an alternate.
- Planning for 2016 Annual Consultation Conference "Celebrating Success, Shaping the Future" (April 24-28, 2016 in Orlando, Florida)
  - Update from the Self-Governance Communication and Education (SGCE) Office
  - Registration is projected to be around 800
  - Room block is closed; alternate hotels are available. Please visit the website.
  - Please take a look at the Moderator and Recorder documents being passed around and fill in the blanks where you can assist.

Office of Tribal Self-Governance Update

P. Benjamin Smith, Director, Office of Tribal Self-Governance, IHS

- 352 Tribes are participating in Self-Governance
- There are two IHS Areas where Self-Governance is finally being considered.
  - Ask that Tribes contribute support to both Tribes and IHS officials participating in negotiations in these areas.
- IHS was in Phoenix during the last week providing ISDEAA Training (the last training of this kind took place in 2006)
- IHS is working to train themselves regarding Self-Governance and assumptions
  - Additionally, Tribes should consider also training new staff on the Tribal side regarding Self-Governance transitions and assumptions.
- Yukon Kuskokwim Health Corporation signed their Joint Venture Project earlier this week.
- Extended gratitude to SGCE and ACA teams who lend assistance to Tribes and IHS employees to learn more about Self-Governance, ACA, and CSC.
- OTSG recently participated in a Self-Governance training in the Great Plains Area.
- Self-Governance Planning and Negotiation Cooperative Agreements are now available for Tribes to apply.
- Self-Governance negotiations continue to be a topic of great importance within IHS. They are looking for ideas from TSGAC.

Tribal Response

- Tribes need to be aware if we are negotiating with the Agency Lead Negotiator (ALN) or the Office of General Counsel (OGC).
- Tribes should be able to go back to negotiating with ALN and an arbitrator if necessary.

Information Technology Update

LCDR, Andrea Scott, Deputy Director and Deputy Director ICO, Office of Information Technology

- ICD-10 and Meaningful Use
  - Resource Patient Management System and ICD-10 are tied
  - Finalized and released 92 patches for RPMS to meet Meaningful Use (MU)
  - 100% deployment of MU Stage 2 and ICD-10 after October 2015
  - Patches will be released on a quarterly basis rather than the informal releases as in the past for easier use by IHS, Tribal, and Urban facilities.
  - New Measures available
    - 27 quality measures
    - 15 provider measures

        - 12 hospital measures
    - Meaningful Use Stage 3
        - Requested a hardship exemption, because of onboarding IHS systems. New deadline is July 1, 2016.

Randall Hughes, Tribal Liaison, Office of Information Technology, IHS

- Service Catalogue
    - Replaces 2002 packages
    - Cover every single service provided by IHS Headquarters
    - Present Business catalogue side to the Information Service Advisory Committee (ISAC) and TSGAC before final approval this year.
    - Please feel free to reach out to OIT for discussion
- Will there be a price listing on the Catalogue?
    - Response:
        - OIT will be working with OTSG to standardize prices.
        - It will not be a fee-for-service type of catalogue because of the Tribal-sized adjustment formula.
        - ISAC and TSGAC will have to weigh in on the pricing of the catalogue
- Are we close to catching IHS up with the industry?
    - Response:
        - They are working to protect facilities and it does seem to be working properly.
- Is OIT working to make sure that Tribes can upload data into the National Data System electronically?
    - Response:
        - The catalogue does include some of these services, however there are challenges to incorporate each, individual states' requirements.
- We need to be able to capture those who we are serving and those who we are not?
    - Response:
        - We do capture tribal affiliations; which off-the-shelf systems do not offer this detail.
- We understand you are beta-testing the personal electronic health record?
    - Response:
        - OIT is trying to be response to tribal requests to PEHR.

Patient Protection and Affordable Care Act Implementation Update

Cyndi Ferguson, Self-Governance Specialist/Policy Analyst, SENSE Incorporated

- ACA Workgroup
    - Continuing webinar trainings every other month. These are archived on the www.tribalselfgov.org.
    - There is a face-to-face training in Alaska and Bemidji next month.
    - Other opportunities will be available during the Annual Meeting.
    - Policy briefs are available for Self-Governance Tribes through the broadcast and website.
    - Technical assistance is still available to Tribes regarding Tribal Sponsorship.

Laura Bird, TSGAC ACA Consultant

- Compliance Dates for Employer Reporting
    - Deadlines are arriving employer reporting is May 31st and June 30th.
    - Self-Insured Tribes must also report.
    - There is information about how to comply the requirements on the website.
- 100% FMAP for Services "Received Through" an IHS/Tribal Facility
    - Tribes should be working closely with states to implement the 100% FMAP regulation.

Budget Update

Elizabeth Fowler, Deputy Director for Management Operations, IHS

- Planning for FY 2018 Budget Formulation
  - The Tribes have met and developed their national priorities for the FY18 formulation. The recommendation is roughly 30% higher than the FY17 Budget request.
  - Recommendations were submitted to the HHS Annual Budget Formulation Tribal Consultation.
  - We expect the development will be very different because of the election.
  - HHS is waiting to receive instruction from the Administration
  - Evaluation of the FY18 Formulation
    - Looking at the end of June in Denver for the evaluation meeting
- President's Budget Request for FY 2017
  - 377 million increase over FY16 enacted levels
  - $6 billion total for IHS
  - "Purchased/Referred Care (PRC) Rate: 'Medicare-like Rate' (MLR) Payment for Non-ITU Physician and Other Health Care Professional Services Associated with Either Outpatient or Inpatient Care Provided at Non-ITU Facilities"
    - Final rule was recently published.
    - Why was the final rule published with a comment period?
      - Because IHS was not able to share the final rule prior to publication, so IHS wanted to ensure that Tribes could submit comments after the final rule.
    - Ensures that when referrals are made outside the IHS system are similar to the MLR rate to save PRC money.
    - The rule requires Tribes to opt-in to the rule, to allow for maximum flexibility for Tribes to negotiate other rates.
    - High rates may be negotiated in certain circumstances.
- FY 2016 Omnibus Appropriations - Funding Plan
  - All funds have now been apportioned, however it did take much longer this year because of changes to the CSC accounts.
    - Changes were a result of appropriations language to protect IHS services.
    - CSC lines are indefinite discretionary funds. IHS must fully obligate the needs by the end of the year in order to ensure that CSC is fully paid.
    - IHS will work hard this summer to determine what the full amount of need is.
    - This may mean that IHS will require great coordination with Tribes to make sure that funds are available to pay CSC in full.

Melanie Fourkiller, Policy Analyst, Choctaw Nation and TSGAC Tribal Co-Chair

- Long term care, Diabetes prevention, mental health professionals, chronic provider shortage, behavioral health have been a top unfunded priorities for Tribes. This year Tribes were very intentional about presenting the need for additional funding.

Recess until March 31, 2016

Thursday, March 31, 2016 (8:30 am – 4:30 pm)

Meeting of IHS Tribal Self-Governance Advisory Committee (TSGAC) and Technical Workgroup with IHS Principal Deputy Director Mary Smith

Welcome and Introductions (Take Break as Needed)

Mary Smith, Principal Deputy Director, IHS
Chief Marilynn (Lynn) Malerba, Mohegan Tribe of Indians of Connecticut and Chairwoman, IHS TSGAC
Tribal Chairman/CEO W. Ron Allen, Jamestown S'Klallam Tribe, and Co-Chair IHS TSGAC

- Introduction of Steve Petzinger from OMB who provided a brief update on the 2016 budget and the decision process of OMB. Mr. Petzinger expressed his willingness to be available to answer questions and discuss priorities for future budgeting process.

Office of Management and Budget (OMB) Introductions and Overview of Self-Governance Priorities for Remainder of Obama Administration

Steve Petzinger, OMB Program Examiner for IHS, Executive Office of the President

Tribal Discussion:

- What are the things that are being looked for with regards to lessening the impacts on budget?
    - Response:
        - Justifications are necessary for approval of needs. Best to submit trends or data from previous years.
- Does anyone in OMB know the impact that the budget cuts have had on Indian Country? Request that OMB examiner spend real time in Indian Country.
    - Response:
        - There was a recent visit to Indian Country recently and will be back soon to discuss budgets and priorities at the local level.

Contract Support Cost Workgroup Update and Discussion

Chief Marilynn (Lynn) Malerba, Mohegan Tribe of Indians of Connecticut
Mickey Peercy and Melanie Fourkiller, IHS Contract Support Costs Workgroup Members

- Close to having final draft which should be released on April 8th, time has been spent on Federal and Tribal side to complete the policy.
- Several letters have been drafted on incurred cost and duplication. Tribal representatives anticipate these items being heavily discussed during consultations. There are some very complex issues which have resulted in a detailed which should lead to less misunderstandings.
- Improvements have been listed in new policy which will include practices in policy and new options for new circumstances, for example, renegotiation of Direct CSC, can add new programs to CSC.
- Incurred cost needed to be a different reconciliation process for SG Tribes, now no undue burden for Tribes to negotiate.
- Indirect Cost will not be left open for years. Tribes can choose to close and reconcile rate or wait for rate to come through and be paid for rate for current year.
- The policy does not concede either the Tribal or Federal position on duplication and there is still no agreement on the issue. During implementation is where issues will arise. Process was not consistent across areas, with new policy process will now be standardized and will use the same calculation tool across the board. Will have consultation at SGCE Annual Conference in April for briefing and discussion.
- Following sixty-day comment period, workgroup will reconvene to discuss any edits and comments that have arose targeted time to meet and discuss comments will be the first week of July.

Roselyn Tso, IHS CSC Team Lead

- In final stages to release the draft policy on April 8th.
- IHS included a citation in the policy to make use of the medical inflation rate and at what point it will be applied.
- Changes were made to be able to reconcile incurred costs within 90 days after contract term based on what information will be used to close out. A grace period between 2013-2014 has been built into the policy.
- 80/20 Tribal shares already included have now included a 97.3% at service level for consistency.
- On quarterly basis working on changes at service level, including consistently asking staff for updated data for better allocation.
- Areas that change calculation, rate changes, past exclusions, additional funding must work with Tribes prior to changes.
- Templates that IHS have created to be used to add consistency to calculations.

Implementation of the Indian Health Care Improvement Act: Behavioral Health

Benjamin Whittemore, Native American Issues Coordinator in the Office of Legal and Victim Programs, Executive Office of the United States Attorneys (EOUSA), U.S. Department of Justice

- Mr. Whittemore introduced himself and explained the USA Office in Coordination of Behavioral Health resources and programs
- Need for services of victims of crime, the continued services after crime is limited however there is a need to improve the availability of resources.
- Outreach and regional meetings would be helpful. The US Attorney is tasked with holding regional meetings that are not occurring on a regular basis to the best of our knowledge. However, these meetings may not meet the standard of what a formal consultation should be.

Tribal discussion:

- Behavioral health funding is far from adequate
- Domestic violence and sexual assault rates are overwhelming in Indian Country.
- Juvenile justice system is inadequate and has been neglected with regards to education and reform.
- How does cross agency participation how does DOJ work with HHS/IHS, need to breakdown walls for these agencies to work together?

Mr. Whittemore:

- There is a lot of silo-ing not only Federally but Tribally creating a duplication of efforts in this very important area, making success in this are all the more difficult.

Tribal Discussion:

- Need the funding to build infrastructures to make things work.
- Notifications needed to identify when Tribal youth have been placed in the juvenile justice system

Mr. Whittemore:

- DOJ is working with IHS and SAMHSA to eliminate the silo-ing effect.

Veteran's Affairs Update

Stephanie Birdwell, Director, VA Office of Tribal Government Relations
Gina Capra, Director, VHA Office of Rural Health
Kristin Cunningham, Director, Business Policy, VHA Chief Business Office

- VHA continues to make changes to improve the community care program.
- Over the past 6-8 months they have worked to consolidate standards to provide the highest level of care for veterans.
- Held consultation to get feedback from veterans about the needs of the communities which have been utilized to develop a new plan of care for veterans.
- The plan includes short and long term improvements that provide a more comprehensive and streamlined plan of service and billing.
- In the short term the Choice program will be implemented to define how providers are paid and how veterans are served.
- The VHA has also implemented a call center for veterans' concerns.
- Providers are now eligible for payment without immediate medical records.
- Changes to criteria for those who can be eligible for the choice program have also been implemented.
- There is a draft performance work statement for how VA will purchase care in the future to address the long term issue of providing care to veterans.

Tribal Discussion:

- With regards to increasing access to care, include reimbursement for referred care to Tribes, is VA ready to provide and amendment?

Birdwell:

- This is being addressed in the long term within the work statement and the outsourcing of care.

ACA Employer Mandate Exemption and Cadillac Tax Discussion

Chairman W. Ron Allen, Jamestown S'Klallam Tribe
Chief Marilynn (Lynn) Malerba, Mohegan Tribe of Indians of Connecticut and Chairwoman, IHS TSGAC
Thomas C. West, Jr., Tax Legislative Counsel, Office of Economic Policy, Department of Treasury
Kathryn Johnson, Attorney Advisor, Office of the Benefits Tax Counsel, Department of Treasury

- Treasury is working to address concerns of the requirements for Tribal entities with regards to Tribal member employees
- Treasury has concluded at present time that they are not able to provide a permanent exemption for Tribal employers from the employer shared responsibility provision.
- Deadline requirements have been extended the payments for employees is not required when forms are submitted.

Tribal Discussion

- May be cheaper for Tribes to get penalties than purchase insurance.
- What are next steps with continuing dialogue and will there be an opportunity for Tribal Leader involvement?

Ms. Johnson:

- Substantively we are prepared for turnover and are continuing to analyze correspondence.

Tribal Discussion

- TSGAC requests a meeting with Chief Malerba, Chairman Allen, and Treasury.

Cadillac Tax:

- This issue has now moved to 2020, Treasury provided two notices that to which TSGAC has responded.
- Coverage should not be subject to tax by Tribal entities, cannot respond to issue at this time because it is under discussion, no time frame for when guidance will come out.

Tribal Discussion

- If coverage is required by Tribes, TSGAC requests Tribal consultation beforehand.

OTSG Policy Program Information Review Workgroup

Cyndi Ferguson, Self-Governance Specialist/ Policy Analyst, SENSE Incorporated

- The workgroup hosted a meeting in December to review years of documents and develop a series of recommendations for TSGAC to consider.

Melanie Fourkiller, Policy Analyst, Choctaw Nation and TSGAC Tribal Co-Chair

- There were some questions from the workgroup for TSGAC to consider:
    - Role of OTSG in budget process: Should OTSG assume full responsibility for payments?
    - Role of OTSG in negotiation process: Is the current role sufficient or should the role be increased?
    - ALNs: Should the ALN Position be a formalized position and with that who will they report to and what are the job requirements?
    - Develop Committee Charter: Does TSGAC want to include a reference to TSGAC within the IHS manual?
    - Other recommendations:
        - IHS to share negotiations documents and update every year online. Recommend a direct request from TSGAC to IHS to release to release the documents.
        - Update IHS functions and authorities to reflect changes in law.

Tribal Discussion

- TSGAC agreed the negotiations documents should be requested and a letter sent to Principal Deputy Director Smith to request such documents.
- They committee recommended the workgroup prepare a short list of recommendations that can be acted on in the short term and those that require additional research before action can be taken by leadership.

TSGAC Working Lunch and Joint Discussion between TSGAC and IHS Principal Deputy Director

- Medicare-Like Rate Final Rule
    - Opt in rule, not applicable if not chosen.

- Inclusion of Purchased and Referred Care in the VA-IHS National MOU
    - IHS Would like to create a National MOU, Dr. Wakefield and Karen Diver are both very supportive of system and would like to make an effort into making this change.

- Update regarding Payment of Settlements to Civil Service Employees
    - Entirety of funds have been paid to Union, still gathering information and no payments have been made to individuals as of yet.

- Aligning Quality Data Requirements for Medicare, Medicaid and GPRA
    - Have efforts underway to address this, Dorothy Dupree is establishing a quality department including data analytics.

  - TSGAC requests Tribal consultation on front end on the development for better alignment on front end rather than in the after effects, need help to get IHS together with Center for Medicare and Medicaid Service (CMS) to discuss common measures.
  - Recommendation to draft comment addressed by committee. TTAG did send letter to CMS requesting consultation and was highly disappointed on the process. TTAG received a response that comment period had closed, sent follow up letter to Andy Slavit and stated issues along with the original letter.
  - TTAG and TSGAC will follow up with subsequent letter and cc the IHS Principal Deputy Director.

- Catastrophic Health Emergency Fund Rule
  - The final comment period is now May 10th and major concern is that there was no consultation. Formal request will be sent for Tribal consultation.
  - Payer of Last Resort: requesting specific consultation before this proposal comes out.

- IHS has resurrected line item for repair and replacement of quarters the request for $12 million.
  - Look into working with other groups ie.. HUD and USDA
  - Set up a list of recommendations to submit to IHS

TSGAC Technical Workgroup Meeting

Adjourn TSGAC Meeting

Tribal Self-Governance Advisory Committee

Tribal Self-Governance Program Review Workgroup

MEETING SUMMARY
June 8, 2016
8:00 am – 12:00 pm

The TSGAC Tribal Self-Governance Program Review Workgroup meet on Wednesday, June 8, 2016 in Ferndale, WA. The purpose of the Workgroup is to review policy letters, memos, and recommendations regarding the Indian Health Service (IHS) Tribal Self-Governance Program and provide recommendations back to IHS and TSGAC leadership regarding recommended improvements and actions.

Present at the Meeting:

- Melanie Fourkiller, Policy Analyst, Choctaw Nation and TSGAC Co-Chair
- Terra Branson, Director, Self-Governance Communication and Education
- Jennifer Cooper, Deputy Director, Office of Tribal Self-Governance, Indian Health Service (IHS)
- Tammy Clay, Policy Analyst, Office of Tribal Self-Governance, IHS

TSGAC Direction to Workgroup:

- What can be achieved in the short term?
- What issues need additional information and/or research?

Recommendations from the December 2015 Workgroup Meeting

- Reorganize IHS Office of Tribal Self-Governance to include budgeting authority.
- Formalize the role, responsibility and expectation for Agency Lead Negotiators (ALNs).
- Include Office of Environmental Health and Engineering funding in the recurring budget.
- Develop and codify definitions that are used, but not specified in regulation or statute.
- Formalize TSGAC as an IHS Advisory Committee.

TSGAC Request to Share Information Publicly

- Draft letter requesting that IHS share and post related documents regularly and publicly to the greatest extent possible.
    - Headquarters Tables 1-3 should be routinely provided in a timely and efficient manner.
    - Annually update information regarding Headquarters and Area residuals and PSFAs manuals.
    - Headquarters PSFA Manual and Area PSFA Manual should be available publicly.
    - Make the Joint Allocation Methodologies document public.
    - Determination of Tribal Share Distribution Formula.
    - Request IHS Areas without a PSFA Manual to develop and publish manuals online.
    - Include this question on the FAQ list: What is the process for Tribes to question or appeal the formulas and process for determining Tribal Shares and Residual?

Recommendations for Short Term Action

- *Formalize the role, responsibility and expectation for ALNs.* After lengthy discussion, the Workgroup recommends a two pronged approach.

Short Term Action:

- Request the letter IHS uses to designate IHS employees as ALNs. This letter should include clear expectations and responsibilities for the employee.
- After receipt of the ALN designation letter, TSGAC should provide suggested edits and additions to IHS. If accepted, IHS should then update each ALNs designation letter.
- Host national negotiation training to improve Tribally-driven negotiations and better clarify Self-Governance Tribe's expectations.

Long Term Action:

- TSGAC should make recommendation to the Principal Deputy Director regarding formalizing the ALN role. However, those recommendations should be specific. The recommendations should include eligibility criteria for applicants, organizational reporting structure, and expectations and responsibilities for ALNs.
- Issues the Workgroup discussed related to this recommendation:
    1. Reporting Structure
    2. Physical location of ALNs
- PHYSICAL LOCATION OF ALNs: One of many advantages to keeping ALNs in the Area Office is access to Tribes and knowledge of Area Office practices and funding. TSGAC should consider making recommendations about where ALNs should conduct their business.
- Eligibility criteria, job expectations and responsibilities were not discussed in detail.
- REPORTING STRUCTURES: The Workgroup discusses several options for reporting structure. The following are those discussed included advantages and disadvantages:

  <u>Option A: ALNs report to the IHS Deputy Director</u> [The current IHS Organizational Chart is included for your review].

ADVANTAGES	DISADVANTAGES
• The Deputy Director currently has no direct reports, allowing increased time to manage the initial transition and continued oversight. • The Deputy Director, similar to the ALN, is often designated to represent the agency in place of the Director. • The Deputy Director, would be able to elevate negotiation issues to the highest level of the agency quickly. • Establishing this reporting structure sets a precedent to maintain negotiations at the highest level of the agency's leadership.	• The Deputy Director does not directly oversee or coordinate with the OTSG. This maintains a degree of distance between the ALNs and OTSG.

  <u>Option B: ALNs report to the Deputy Director Intergovernmental Affairs.</u>

ADVANTAGES	DISADVANTAGES
• The Deputy Director of Intergovernmental Affairs also oversees the OTSG, which may allow for greater partnership and communication between OTSG and ALNs. • This reporting structure keeps ALNs close to the IHS Director.	• This is not a permanent position within IHS, meaning it could change or dissolve in the future.

Option C: ALNs report to the OTSG Director.

ADVANTAGES	DISADVANTAGES
• OTSG often assists in facilitation of negotiation. • There would be cohesion between program, policy, and financial analysts and the ALNs. • A single report structure would help Tribes when issues do arise that need to be addressed by the IHS Director.	• OTSG is often a mediator between Tribes and the ALN, this reporting structure may create an awkward work environment if the Director of OTSGC is the ALN's direct supervisor when there is disagreement. • OTSG does not directly report to the IHS Director, distancing the IHS Director designation.

- *Formalize TSGAC as an IHS Advisory Committee.* A draft charter is available for review and includes the statutory citation for TSGAC. The charter should be reviewed and finalized for inclusion in the IHS Manual.

Recommendations for Additional Research and Action

- Reorganize IHS Office of Tribal Self-Governance to include budgeting authority (i.e., to execute the payment process).
    - TSGAC needs additional information from IHS and OTSG regarding the current SG payment process to better assess the advantages and disadvantages of this recommendation.
- Include Office of Environmental Health and Engineering funding in the recurring budget.
    - The Workgroup will develop questions to be included in an invitation to a future TSGAC agenda.
- Develop and codify definitions that are used, but not specified in regulation or statute.
    - Recommended definitions must be developed and vetted with TSGAC for consideration after the Administration changes.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE

Approved: /Mary Smith/
Mary Smith

Date: June 15, 2016

PRINCIPAL DEPUTY DIRECTOR
Mary Smith

DEPUTY DIRECTOR
Christopher Mandregan
(Acting)

DEPUTY DIRECTOR FOR MANAGEMENT OPERATIONS
Elizabeth Fowler

CHIEF MEDICAL OFFICER
Sarah Linde
(Acting)

DEPUTY DIRECTOR FOR QUALITY HEALTH CARE
Vacant

DEPUTY DIRECTOR FOR INTER-GOVERNMENTAL AFFAIRS
Sandra Pattea

DEPUTY DIRECTOR FOR FIELD OPERATIONS
Richie Grinnell

CHIEF OF STAFF
Hilary Frierson Keeley
(Acting)

(Positions are listed in order of succession to the IHS Principal Deputy Director)

(GA)

OFFICE OF TRIBAL SELF-GOVERNANCE
DIRECTOR
Benjamin Smith
(GAA)

OFFICE OF DIRECT SERVICE AND CONTRACTING TRIBES
DIRECTOR
Chris Buchanan
(GAB)

OFFICE OF URBAN INDIAN HEALTH PROGRAMS
DIRECTOR
Sherriann Moore
(Acting)
(GAC)

OFFICE OF CLINICAL AND PREVENTIVE SERVICES
DIRECTOR
Alec Thundercloud
(GAF)

OFFICE OF INFORMATION TECHNOLOGY
DIRECTOR
Mark Rives
(GAG)

OFFICE OF PUBLIC HEALTH SUPPORT
DIRECTOR
Francis Frazier
(Acting)
(GAH)

OFFICE OF RESOURCE ACCESS AND PARTNERSHIPS
DIRECTOR
Terri Schmidt
(Acting)
(GAJ)

OFFICE OF FINANCE AND ACCOUNTING
DIRECTOR
Ann Church
(Acting)
(GAK)

OFFICE OF MANAGEMENT SERVICES
DIRECTOR
Robert McSwain
(GAL)

OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING
DIRECTOR
Gary Hartz
(GAM)

OFFICE OF HUMAN RESOURCES
DIRECTOR
Lisa Gyorda
(Acting)
(GAN)

ALASKA AREA OFFICE
DIRECTOR
Kenneth Glifort
(Acting)
(GFB)

ALBUQUERQUE AREA OFFICE
DIRECTOR
Leonard Thomas
(Acting)
(GFC)

BEMIDJI AREA OFFICE
DIRECTOR
Keith Longie
(GFE)

BILLINGS AREA OFFICE
DIRECTOR
Dorothy Dupree
(GFF)

CALIFORNIA AREA OFFICE
DIRECTOR
Beverly Miller
(GFG)

GREAT PLAINS AREA OFFICE
DIRECTOR
Chris Buchanan
(Acting)
(GFA)

NASHVILLE AREA OFFICE
DIRECTOR
Martha Ketcher
(GFH)

NAVAJO AREA OFFICE
DIRECTOR
Douglas Peter
(Acting)
(GFJ)

OKLAHOMA CITY AREA OFFICE
DIRECTOR
Kevin Meeks
(GFK)

PHOENIX AREA OFFICE
DIRECTOR
Ty Reidhead
(Acting)
(GFL)

PORTLAND AREA OFFICE
DIRECTOR
Dean Seyler
(GFM)

TUCSON AREA OFFICE
DIRECTOR
Dixie Gaikowski
(GFN)

NOTE: THE STANDARD ADMINISTRATIVE CODE IS LOCATED IN THE LOWER LEFT HAND CORNER OF EACH BOX.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

JUN 15 2016

Dear Tribal Leader:

I am writing to provide an update on the Indian Health Service's (IHS) strategy to improve quality health care delivery for American Indians and Alaska Natives. Our top priority at the IHS is making sure that American Indian and Alaska Native families have access to quality health care. We are not accepting business as usual here at IHS. We are hard at work to make sustainable improvements.

This year, we laid out an aggressive strategy to improve the quality of care in the Great Plains Area and across the country. It is a strategy that consists of five major areas. First, we are taking a close look to assess the quality of care and to work quickly to make any needed improvements. Second, we are transforming the way these hospitals deliver care. Third, we are strengthening our Area management. Fourth, we are bringing experts in health care quality to support these direct service facilities. Fifth, and most importantly, we are doing this work hand-in-hand with the Tribes and local organizations that are valuable sources of expertise and partnership.

Point 1: Assessing Care

We want to lift up the facilities across Indian Country that deliver high quality care, and we want to work closely with those that need improvement. We are taking a very close look at the quality of care delivered through direct service hospitals at IHS facilities across the Great Plains Area as well as throughout Indian Country. For the past 10 years, health care systems have been embracing a new focus on quality improvement, and it is that orientation that we are working to bring into sharper focus within IHS. For example, IHS is beginning a system-wide mock survey initiative at all 27 of its hospitals to assess compliance with the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation and readiness for re-accreditation. These mock surveys are being conducted by survey teams from outside each respective Area to reduce potential bias. And this information will be shared widely – summaries of the information collected from the surveys will be shared with Tribal leadership.

Point 2: Improving How We Deliver Services

The IHS continues to face significant workforce challenges with a chronic shortage of quality health care providers. While we have taken immediate steps to address some local shortages and are in the process of adding more, such as telemedicine, these longstanding challenges require building up and expanding the training and deployment pipelines and full use of innovative approaches to delivering care. In the near-term, with Secretary Burwell, Acting Deputy Secretary Wakefield, and the U.S. Surgeon General's support, over two dozen Commissioned Corps clinicians have been deployed for temporary placements into the Great Plains Area hospitals with CMS findings. In addition, the National Institutes of Health has been helping IHS deploy strategies it has used to recruit nurses into its clinical program. IHS is also revising position descriptions and deploying more comprehensive recruitment plans around key positions, in an effort to recruit a greater number of qualified candidates. IHS is also deploying pay

increases for high-demand physicians and has established relocation pay for GS-12 and lower clinical positions and lower grades.

However, even with these and a number of other strategies that have been deployed during the past two months or that are in development right now, there is still much more work that needs to be done to attract and retain an adequate health care workforce.

In that regard, I will soon be announcing a Tribal consultation on workforce issues.

Point 3: Strengthening Management
We want every hospital to be a top quality facility on its own. But we are also taking a broad view by bringing top quality management to the Great Plains Area and our other Areas. We have implemented a stronger search committee process for recruiting highly qualified managers and executives. IHS is also more widely advertising vacancies through federal, state, and non-profit partners. Additionally, we have expanded Tribal participation in filling vacant Area Director positions and members of a Tribe from each area will, for the first time, play a role at the outset of the hiring process.

Point 4: Bringing Health Care Quality Expertise to IHS
One of the best ways that we can improve the quality of care at IHS facilities is by helping these facilities share and benefit from innovative ideas and evidence-based tools that work. For example, we recently launched a Hospital Engagement Network (HEN 2.0) that can reach across all 27 hospitals operated by IHS. Through this network, these hospitals can share strategies on how to reduce avoidable readmissions and hospital-acquired conditions. Working together, they can learn more, and improve faster. We are also bringing in quality experts from different parts of HHS to consult with IHS hospitals. These experts will help make sure that our improvements are real and measurable.

Point 5: Engaging Local Resources
Our government-to-government relationship with Tribes is the foundation of our work at IHS. That is why we are always working to strengthen and renew our partnerships with Tribes. Some of the most helpful expertise and the most effective leadership is right in the Tribal communities we work with every day. We are committed to strengthening these relationships, and also engaging further with partners from the local community – like local and regional health care systems, local colleges and universities, and the leadership of direct service hospitals. We are all stronger when we work together.

The IHS is committed to working together to bring about needed changes and improvements. I will provide regular updates on the progress we make in implementing these strategies.

Sincerely,

/Mary Smith/

Mary Smith
Principal Deputy Director

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: INDIAN HEALTH SERVICE: ACTIONS NEEDED TO IMPROVE OVERSIGHT OF PATIENT WAIT TIMES (GAO-16-333)

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report.

GAO Recommendation

To help ensure that timely primary care is available and accessible to American Indians/Alaska Natives (AI/AN) people, the Secretary of HHS should direct the Director of the Indian Health Service (IHS) to take the following two actions:

1. Develop and communicate specific agency-wide standards for patient wait times in its federally operated facilities. As part of its process, IHS should review its experience with the timelines goals it set as part of its Improving Patient Care program.

2. Monitor patient wait times in its federally operated facilities and ensure corrective actions are taken when standards are not met.

HHS Response

HHS concurs with the need to improve patient wait times at IHS federally operated facilities to ensure timely primary care is available and accessible to AI/AN. The IHS mission is to "raise the physical, mental, social, and spiritual health of AI/AN to the highest level." HHS is committed to improving patient care in accordance with the Agency mission. HHS appreciates the GAO's recommendations and agrees that setting quality standards and monitoring against those standards is a key strategy for improving patient care.

IHS is actively implementing a plan to establish an Office of Quality Management in IHS Headquarters. The goal of this office will be to provide for national policy and oversight of critical quality improvement strategies and ensure their success and accountability. Consistent with that goal, the Office of Quality Management will implement a data analytics function, which will increase overall capacity for centralized monitoring, training and technical assistance coordination and improve tracking and monitoring of metrics, including quality metrics, deficiencies and corrective action plans to ensure critical program standards are consistently met and sustained. As part of this data analytics function, IHS is committed to considering how setting specific agency-wide standards for patient wait times in federally operated facilities could be incorporated into the data analytics plan that it is currently being developed. While establishing and monitoring metrics is important, achieving improvement in access to timely primary care requires IHS to continue to work to address a number of complex underlying challenges that are at the root of the issue of patient wait times, including staffing shortages and other areas of focus for quality improvement. IHS will enhance short-term and long-term efforts in medical provider recruitment and retention and make additional quality improvements that will address patient wait times.

In 2016, IHS is cascading annual Senior Executive Service performance standards that specifically address improving access to patient care by establishing accountability for all senior managers to "implement at least two activities to improve wait times and access to quality health care for patients that are based on enhanced implementation of current quality initiatives or new quality initiatives and that have measurable goals, measures and outcomes", and requiring improvements to be documented at Headquarters, Area Office and facility levels.

Sources Sought Notice:
IHS Hospital Management Teams

INTRODUCTION

This is an unrestricted Sources Sought notice being issued on an open market basis. This is NOT a solicitation for proposals, proposal abstracts, or quotations. The purpose of this notice is to obtain information regarding: (1) the availability and capability of qualified sources; (2) whether they are other than small businesses; HUBZone small businesses; service-disabled, veteran-owned small businesses; 8(a) small businesses; veteran-owned small businesses; woman-owned small businesses; or small disadvantaged businesses; and (3) their size classification relative to the North American Industry Classification System (NAICS) code for the proposed acquisition. Your responses to the information requested will assist the Government in determining the appropriate acquisition method.

CONTEXT OF TRIBAL/INDIAN HEALTH CARE

The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally-recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. The IHS is the principal federal health care provider and health advocate for Indian people, and its goal is to raise their health status to the highest possible level. The IHS provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives who belong to 567 federally recognized tribes in 35 states.

An awareness of the legal basis for the federal obligation to provide health care to American Indians and Alaska Natives is important when designing health care programs. American Indians and Alaska Natives, as citizens of the United States, are eligible to participate in all public, private, and state health programs available to the general population. In addition, they also have treaty rights to federal health care services though the Department of Health and Human Services. The federal trust responsibility to uphold the treaty responsibility for health care to Indians is accomplished by consulting with Indian Tribes and then actively advocating for policy, legislative, and budgetary planning for Indian health care.the IHS is committed to regular and meaningful consultation and collaboration with tribal governments. Consultation is considered an essential element for a sound and productive relationship with tribes. Tribal leaders and representatives have come to play an important role in setting health priorities at the national and regional levels.

BACKGROUND OF REQUIREMENT

Systems Improvement Agreements between the Centers for Medicare & Medicaid Services (CMS) of the United States Department of Health and Human Services, and the Indian Health Service of the United States Department of Health and Human Services (IHS) regarding the Rosebud and Pine Ridge Public Health Service Indian Hospitals were signed on April 30, 2016 for a one-year period through May 17, 2017. The SIAs are being implemented to further the objectives of Titles XVIII and XIX of the Social Security Act, to facilitate the delivery of quality health care services to the community served by the Hospitals, and to promote consistent compliance by the Hospitals with all of the applicable Medicare Conditions of Participation (CoPs) and the requirements of the Emergency Medical Treatment and Labor Act ("EMTALA").

One of the key requirements of the SIAs is for IHS to identify two management teams: a Phase I and a Phase II IHS Hospital Management Team. The Phase I Team is comprised of IHS staff from outside the Great Plains Area (GPA), and consists of a Chief Executive Officer, Chief Operations Officer, Chief Nursing Officer, Chief Medical Officer and Director of Quality and Performance Improvement (QAPI). The Phase 1 Team will provide immediate onsite management, leadership and support for the two hospitals in South Dakota, and will remain available for support of the successor Hospital managers after their immediate onsite phase as needed for a duration of time to be determined by IHS.

The Phase 1 Team will gradually transition management responsibilities to the successor, Phase II Hospital Management Team, which is the subject of this Sources Sought Notice.

IHS is also considering expanding this contract option to a national in scope contract, to be available for any federally operated hospital on a short term basis as it may be needed for similar purposes.

IHS is seeking recommendations from potential sources as to which options or combinations of options below may be viewed by the potential source as most efficient or preferred.

RESPONSE INFORMATION

IHS is considering four **separate options** for the Phase II Management Team. We are seeking responses from potential sources to **any one, two, three or all four**, of the options below.

Option 1 – Contracted C-Suite

IHS will engage the services of an experienced and qualified hospital management firm to manage the hospital full-time on-site for at least the duration of the SIA, through May 17, 2017, to include a Chief Executive Officer, Chief Operations Officer, Chief Nursing Officer, Chief Medical Officer and Director of Quality and Performance Improvement (QAPI). The Hospital Management Firm will provide a team to manage the Hospital while working with the individuals, if any, who will serve as the permanent Hospital managers to build the structures, processes and

skills the permanent Hospital management team will need to achieve successful outcomes both clinically and operationally; provide support and coaching to address identified learning needs; and make interim, ongoing and final recommendations to support effective succession planning and successful transition to sustained and sustainable successful administration of the hospital.

Option 2 – Coaches to a federal C-Suite

IHS will engage the services of an experienced and qualified hospital management firm to provide a team of Coaches/Consultants to work full-time on-site with each of these managers, consisting of a Chief Executive Officer Coach/Consultant, Chief Operations Officer Coach/Consultant, Chief Nursing Officer Coach/Consultant, Chief Medical Officer Coach/Consultant and Director of Quality and Performance Improvement (QAPI) Coach/Consultant. The permanent leadership staff will work closely with the Hospital Coaches/Consultants to build the structures, processes and skills the permanent Hospital management team will need to achieve successful outcomes both clinically and operationally; provide support and coaching to address identified learning needs; and make interim, ongoing and final recommendations to support effective succession planning and successful transition to sustained and sustainable successful administration of the hospital.

Option 3 – Contracted C-Suite except for CEO - reporting to federal CEO

IHS will engage the services of an experienced and qualified hospital management firm to work under the executive direction of a permanent, federal Chief Executive Officer to manage the hospital full-time on-site for at least the duration of the SIA, through May 17, 2017, to include a Chief Operations Officer, Chief Nursing Officer, Chief Medical Officer and Director of Quality and Performance Improvement (QAPI). The Hospital Management Firm will provide a team to manage the Hospital while working with the individuals, if any, who will serve as the permanent Hospital managers to build the structures, processes and skills the permanent Hospital management team will need to achieve successful outcomes both clinically and operationally; provide support and coaching to address identified learning needs; and make interim, ongoing and final recommendations to support effective succession planning and successful transition to sustained and sustainable successful administration of the hospital.

Option 4 – Fully Contracted Hospital Management Firm

IHS will engage the services of an experienced and qualified hospital management firm. The Hospital Management Firm will provide a fully staffed, comprehensive team to temporarily manage the Hospital while working with the individuals, if any, who will serve as the permanent Hospital managers to build the structures, processes and skills that the permanent Hospital management team will need to achieve successful outcomes both clinically and operationally; provide support and coaching to address identified learning needs; and make interim, ongoing and final recommendations to support effective succession planning and successful transition to sustained and sustainable successful administration of the hospital.

Applicable to all options

At a minimum, the Hospital Management Firm Team members must include individuals with demonstrated expertise and experience in hospital management, leadership, governance and organizational effectiveness; evaluation, design and implementation of clinical and non-clinical hospital protocols and practices meeting evidence-based standards of practice for hospital services; and quality improvement and patient safety, with particular expertise in organizational development as it relates to safety climate and culture; application of high reliability and human factors engineering principles; and successful implementation of patient safety modalities involving team training/crew resource management and engagement of front-line staff and hospital leadership.

INSTRUCTIONS TO INDUSTRY

Questions: The Government will entertain questions regarding this Market Research; all questions should be submitted to the point of contact listed below no later than **12:00pm EST on June 13, 2016.** All questions shall be submitted to Michael Fischer at Michael.Fischer@ihs.gov

Interested small business firms are highly encouraged to respond to this notice. However, firms should understand that generic capability statements are not sufficient for effective evaluation of their capacity and capability to perform the work required. Responses must directly demonstrate the company's capability, experience, and ability to marshal resources to effectively and efficiently perform the objectives described above.

The written response to this notice should consist of the following items:

a. Company Name.
b. Company DUNS number.
c. Company point of contact, mailing address, telephone and fax numbers, and website address
d. Name, telephone number, and e-mail address of a company point of contact who has the authority and knowledge to clarify responses with government representatives
e. Date submitted.
f. Applicable company GSA Schedule number or other available procurement vehicle.
g. Do you have a Government approved accounting system? If so, please identify the agency that approved the system.
h. Type of Company (i.e., small business, 8(a), woman owned, veteran owned, etc.) as validated via the System for Award Management. All respondents must register on the SAM located at http://www.sam.gov

Disclaimer and Important Notes. This notice does not obligate the Government to award a contract. Any information provided by industry to the Government as a result of this sources sought synopsis is strictly voluntary. Responses will not be returned. No entitlements to payment of direct or indirect costs or charges to the Government will arise as a result of contractor submission of responses, or the Government's use of such information or otherwise pay for the information provided in response. The Government reserves the right to use information provided by respondents for any purpose deemed necessary and legally appropriate. Any organization responding to this notice should ensure that its response is complete and sufficiently detailed to allow the Government to determine the organization's qualifications to perform the work. Respondents are advised that the Government is under no obligation to acknowledge receipt of the information received or provide feedback to respondents with respect to any information submitted. After a review of the responses received, a pre-solicitation synopsis and solicitation may be published on a government GPE. However, responses to this notice will not be considered adequate responses to a solicitation.

Confidentiality. No proprietary, classified, confidential, or sensitive information should be included in your response. The Government reserves the right to use any non-proprietary technical information in any resultant solicitation(s).

Responses must be submitted directly via email to:

Michael Fischer at Michael.Fischer@ihs.gov no later **than 5:00pm EST on July 7, 2016**

Capability statements will not be returned and will not be accepted after the due date. The maximum number of pages for this submission is five (5) pages.

THE NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP'S RECOMMENDATIONS ON THE INDIAN HEALTH SERVICE FISCAL YEAR 2018 BUDGET

"Federal Indian Trust Responsibility: The Quest for Equitable and Quality Indian Healthcare"

Tribal Leaders on the national Tribal Budget Formulation Workgroup (TBFWG), representing all twelve Indian Health Service (IHS) Areas, met on February 11-12, 2016, to develop the national Indian Health Service budget recommendations for the FY 2018 budget year. The budget priorities are highlighted below:

- Fully fund IHS at $30.8 billion phased in over 12 years
- Increase the President's FY 2017 Budget Request for the IHS by a minimum of 37**% (~$7.1 billion)** in FY 2018:
  - +$169.1 million for full funding of current services
  - +$171.9 million for binding fiscal obligations*
  - +$1.6 billion for program expansion increases
- Provide dedicated funding to begin implementing the following provisions of the Indian Healthcare Improvement Act (IHCIA)
  - Section 205: Funding for Long-term Care Services ($37 million)
  - Section 704: Comprehensive Behavioral Health Prevention and Treatment Program ($20 million)
  - Section 204: Diabetes Prevention, Treatment, and Control ($20 million)
  - Section 123: Health Professional Chronic Shortage Demonstration Project ($15 million)
  - Section 705: Mental Health Technician Program ($5 million)
- Advocate that Tribes and Tribal programs be permanently exempt from sequestration
- Support Advance Appropriations for the Indian Health Service

**includes placeholder estimates for Contract Support Costs (CSC) and staffing for new facilities and new Tribes*

The federal Indian trust responsibility for health is a sacred promise that our ancestors made with the United States long ago. In exchange for land and peace, American Indians and Alaska Natives (AI/ANs) were promised access to benefits, including healthcare. However, the federal government has failed to fully live up to its side of this promise by chronically underfunding the Indian Health Service (IHS) far below the level of need. For example, in 2015, IHS spending per user was only $3,136, but the national average spending per user was $8,517. This lack of funding means that our people continue to live sicker and die younger than other Americans. While the average life expectancy is 4.2 years less for AI/ANs than it was for other Americans, in Montana it was actually 20 years less. Meaning, we are losing a whole generation of people due to inadequate healthcare resources.

During the last several years, bipartisan collaboration between Congress and the Administration has resulted in strong increases in the IHS budget, with an overall increase of 54% since FY 2008. However, much of these increases have gone to support increases due to population growth, inflation, and the rightful funding of Contract Support Costs (CSC). We must do more to ensure that healthcare services are actually increasing.

FY 2018 represents an opportunity for a new Administration to continue this trend in increased Indian health funding by sending a bold budget for Indian health to Congress. The TBFWG requests a minimum 37% increase for the IHS in FY 2018 so that our people can start to realize actual health gains and begin moving toward a health system that is more in line with the healthcare other Americans access. While this will not fully satisfy the health needs of

AI/ANs, it would be a strong start toward the quest for more equitable and quality healthcare for all of Indian Country.

During this Administration, Tribes have also strengthened relationships with federal officials who have prioritized meaningful Tribal consultation, input and priorities over the last several years. We are grateful for the strides we have made on collaboration and coordination of health services and hope to continue this in the future. This new partnership respects federally recognized Tribes as sovereign nations, and has resulted in meaningful consultations that work to find culturally-viable solutions to address unacceptable health and other disparities which still persist within Indian Country.

$30.8 BILLION

TOTAL TRIBAL NEEDS BUDGET

$30.8 billion request for services & facilities**:**

- **$16.82 billion** for Medical Services
- **$1.72 billion** for Dental and Vision Services
- **$386 billion** for Community and Public Health Services
- **$8.77 billion** for facility upgrades and upfront costs (non-recurring investments)

The costs are calculated using comparisons with other federal benchmarks such as federal employee vision and dental coverage and current IHS spending ratios. Population data is estimated based on expanded user populations for IHS eligible AI/ANs. One time facility upgrades included in this calculation would not be required year after year. After the initial investment recurring infrastructure costs are built into annual per capita cost factors, which is typically between 6 to 8 percent of the average US health care spending for capitalized costs associated with space. This model establishes the parameters needed to obtain rough parity with the population at large.

However, we still have a lot of work to do. Recent findings by the Centers for Medicare and Medicaid Services (CMS) have exposed instances where care at several IHS-operated hospitals was substandard and resulted in dangerous patient environments, and even deaths. Additional funding must go toward the reform of the IHS. Tribes must no longer live with healthcare options that put their people in danger. America is too great a nation to stand by while our people live with these realities. IHS must make a commitment to change the culture at these affected facilities and ensure that it does not happen to any others. As one Tribal leader recently stated at a Senate hearing: *"[IHS] is all we have to count on. We don't go there because they have superior health care. We go there because it is our treaty right. And we go there because many of us lack the resources to go elsewhere. We're literally at the mercy of IHS."*

Tribes have also set forth priorities this year to ensure funding for the provisions of the IHCIA. This historic law has opened up many new opportunities for the Indian health system, but not all provisions have been equally implemented - representing yet another broken promise to Indian Country. With the passage of the Patient Protection and Affordable Care Act (ACA), the American health care delivery system has been revolutionized while the Indian healthcare system still waits for the full implementation of the IHCIA. For example, mainstream American healthcare increased its focus on prevention as a priority and coordinated mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs and is now a standard of practice. Replicating these same improvements for Tribes in the IHCIA was a critical aspect of the reauthorization effort. Tribes fought for over a decade to renew IHCIA and it is critical for Congress and the Administration to ensure that the full intentions of the law are realized.

In summary, the TBFWG calls on the next Administration to continue the positive steps made to advance Indian health over the last several years. This means, proposing a budget for IHS that is bold, effective, and contains important policy reforms to ensure that AI/ANs experience the highest standard of care possible. To start, funding IHS at a total of $7.1 billion in FY 2018 will serve as a message to Indian Country that the gains we have made are real, and that we are truly seeking a more equitable and quality-driven Indian health system.

37% INCREASE FOR IHS
OVER FY 2017 PRESIDENT'S BUDGET
FY2018 SUMMARY OF NATIONAL TRIBAL BUDGET RECOMMENDATIONS

FY 2018 National Tribal Recommendation	
Planning Base - FY 2017 President's Budget	**$5,185,015,000**
Current Services & Binding Agreements	**$340,987,000**
Current Services	**$169,074,000**
Federal Pay Costs	7,964,000
Tribal Pay Costs	11,946,000
Inflation (non-medical)	10,385,000
Inflation (medical)	70,068,000
Population Growth	68,711,000
Binding Agreements	**$171,913,000**
New Staffing for New & Replacement Facilities	62,500,000
Contract Support Costs - Need	26,080,000
Health Care Facilities Construction (Planned)	83,333,000
Program Expansion Increases - Services	**$1,397,995,686**
Hospitals & Health Clinics	422,536,330
Dental Services	80,433,813
Mental Health	186,849,208
Alcohol and Substance Abuse	155,882,258
Purchased / Referred Care (*formerly CHS*)	422,454,388
Public Health Nursing	14,295,199
Health Education	9,019,524
Community Health Representatives	26,948,771
Alaska Immunization	7,373
Urban Indian Health	46,630,329
Indian Health Professions	22,320,781
Tribal Management Grants	23,964
Direct Operations	2,847,980
Self-Governance	5,294,109
Contract Support Costs - New & Expanded	**$2,451,659**
Program Expansion Increases - Facilities	**$172,772,564**
Maintenance & Improvement	43,750,655
Sanitation Facilities Construction	51,726,449
Health Care Facilities Construction-Other Authorities	49,302,308
Facilities & Environmental Health Support	19,292,528
Equipment	8,700,624
GRAND TOTAL	***$7,096,770,250***
$ Change over Planning Base	$1,911,755,250
% Change over Planning Base	36.9%

FY 2018 AI/AN Needs Based Funding
Aggregate Cost Estimate

GROSS COST ESTIMATES

Source of Funding is not estimated

Need Based on FY 2015 Existing Users at I/T Sites	Need based on FY 2015 Expanded for Eligible AIAN at I/T/U Sites*
1,594,229	2,710,893

SERVICES	*$ Per Capita*	*Billions*	*Billions*
Medical Services	$6,069	**$9.68**	**$16.45**
Medical services and supplies provided by health care professionals; Surgical and anesthesia services provided by health care professionals; Services provided by a hospital or other facility, and ambulance services; Emergency services/accidents; Mental health and substance abuse benefits; Prescription drug benefits.	Based on 2008 FDI benchmark ($4,100) inflated to 2013 @4% per year	$ Per Capita * Users	$ Per Capita* Eligible AIAN
Dental & Vision Services	$635	**$1.01**	**$1.72**
Dental and Vision services and supplies as covered in the Federal Employees Dental and Vision Insurance Program	2008 BC/BS PPO Vision ($87) and Dental benchmarks ($342) inflated to 2012 @4% per year		
Community & Public Health	$1,424	**$2.27**	**$3.86**
Public health nursing, community health representatives, environmental health services, sanitation facilities, and supplemental services such as exercise hearing, infant car seats, and traditional healing.	19% of *IHS $* is spent on Public Health. Applying this ratio, $1,316 per capita = (.19/.81*$5611).		
Total Annualized Services	$8,128	**$12.96**	**$22.03**

FACILITIES	*$ Per Capita*	*Billions*	*Billions*
Facility Upgrades Upfront Costs		**$6.51**	**$8.77**
Annualized for 30 year useful Life		**$0.38**	**$0.51**

IHS assessed facilities condition (old, outdated, inadequate) and has estimated a one-time cost of $6.5b to upgrade and modernize. A 30 year useful life assumption is used to estimate the annualized cost (assuming 4% interest) of the upgrades.

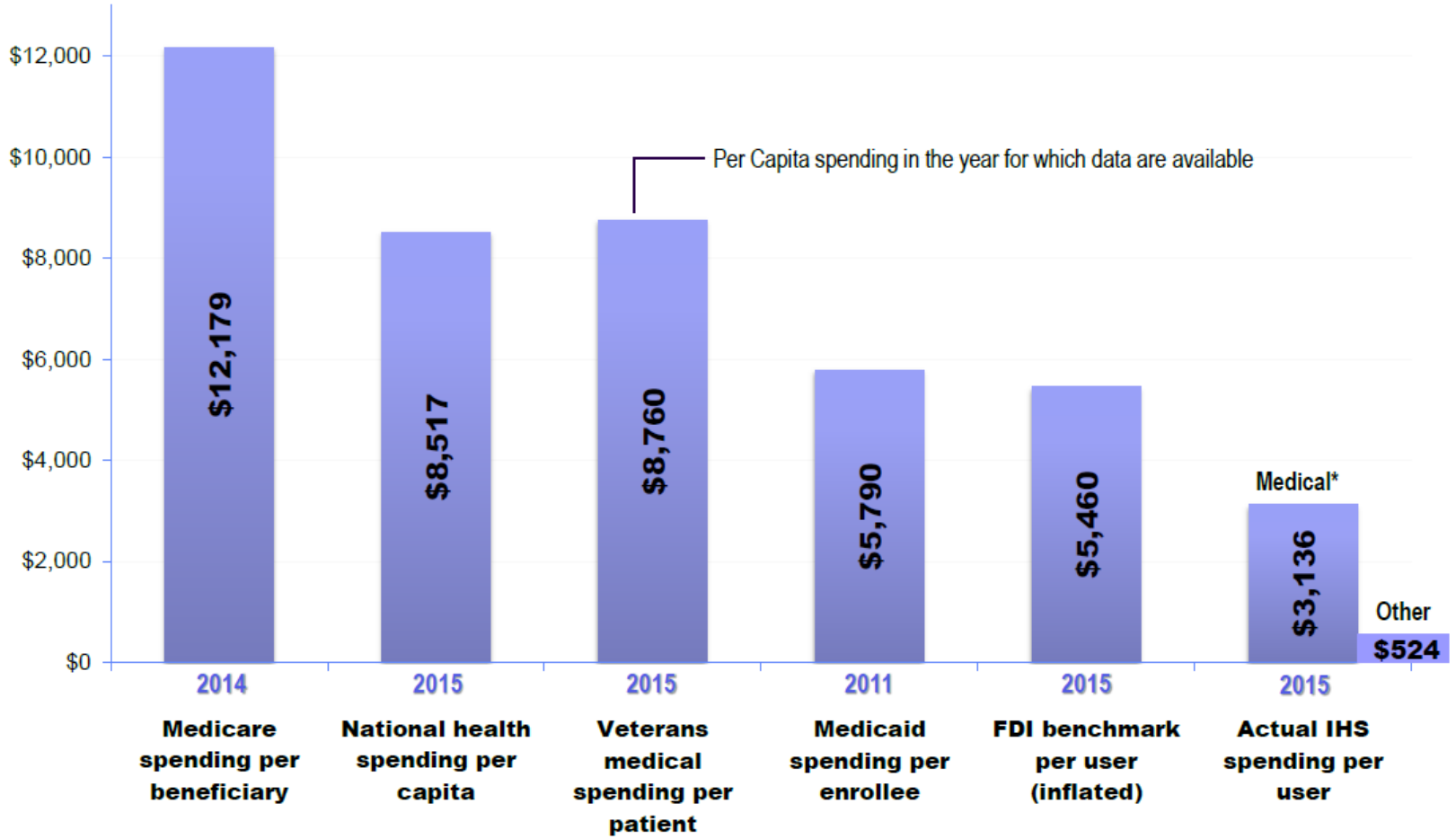
TOTAL

Total Annualized Services + One-time Upfront Facilities Upgrades	**$19.47**	**$30.80**

Gross costs for mainstream health care to AIAN and facilities upgrades are based on typical cost factors. The actual costs that would be experienced among I/T/U sites would vary. Gross costs are estimated expenses without specifying sources of payment. Under current law, a portion of gross costs would be paid by Medicare, Medicaid, and private insurance depending on the number of AIAN eligible—which varies place-to-place and time-to-time. The extent that gross costs would be offset is not precisely known. For certain planning assumptions, IHS assumes a crude 25% nation-wide.

*Crudely—AIANs residing in service areas, including urban areas, discounted for AIAN already partially served by I/T sites.

2015 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita



*See page 2 notes on reverse for sources. *Payments by other sources for medical services provided to AIANs outside IHS is unknown.*

12/29/2015

In fiscal year 2015, Veterans Integrated Service Networks reported **415 unique events and focused efforts** across the country, impacting an estimated total of **34,000 American Indian and Alaska Native Veterans.**

VA-IHS MOU Work Groups

There are seven combined work groups that help implement the VA-IHS MOU's goals. The seven groups are:

- Care Coordination
- Health Information Technology
- New Technologies
- Payment and Reimbursement
- Sharing Care Process, Programs, and Services
- Cultural Competency and Awareness
- Training and Recruitment

Joint VA-IHS Listening Session

On September 24, 2015, VA and IHS held a joint listening session focused on American Indian and Alaska Native access to care during the National Indian Health Board Annual Consumer Conference in Washington, DC. VA executives from the Office of Rural Health, the Office of Intergovernmental Affairs, OTGR, the Veterans Health Administration Chief Business Office, and representatives from the IHS Chief Medical Officer's office received direct feedback from tribal members about issues pertaining to VA benefits and access to health care.

VA-IHS MOU Outreach and Awareness

VA makes an ongoing effort to ensure that tribal communities know about the VA-IHS MOU and the programs and opportunities available under it. In April 2015, leaders from the Veterans Health Administration Chief Business Office, Office of Rural Health, OTGR, IHS, and the National Indian Health Board met to strategize about outreach to tribal communities about the VA-IHS MOU.

During that meeting, the leadership group agreed that VA will send a Dear Tribal Leader letter each year to all Federally recognized tribes to share information and

Mr. Philip Coon, WWII Veteran and Bataan Death March Survivor, at the 13th Annual Oklahoma City VA Health Care System Native American Veterans Honor Dance

opportunities about the VA-IHS MOU. This letter will also help VA to meet the requirement in Section 102(a) of the Veterans Choice Act to conduct outreach to medical facilities operated by tribes to promote the VA-IHS reimbursement program.

VA provides tremendous resources to ensure that all American Indian Veterans at our clinics gain awareness of the numerous benefits available to them aside from health care. VA routinely sends individuals and teams who help identify Veterans who, for one reason or another, never had an opportunity to learn about the benefits available to them. Then, Veterans receive assistance in completing the necessary paperwork, and many determine they are eligible for numerous benefits that enhance their lives in many ways.

– ***Charles Magruder, M.D., M.P.H., Chief Medical Officer, California Area Indian Health Service***

IHS and Tribal Health Program Reimbursement Agreements

The VA-IHS MOU discusses the development of payment and reimbursement policies and mechanisms. Reimbursement agreements enable VA to reimburse IHS and tribally operated health programs for direct care services provided to eligible American Indian and Alaska Native Veterans.

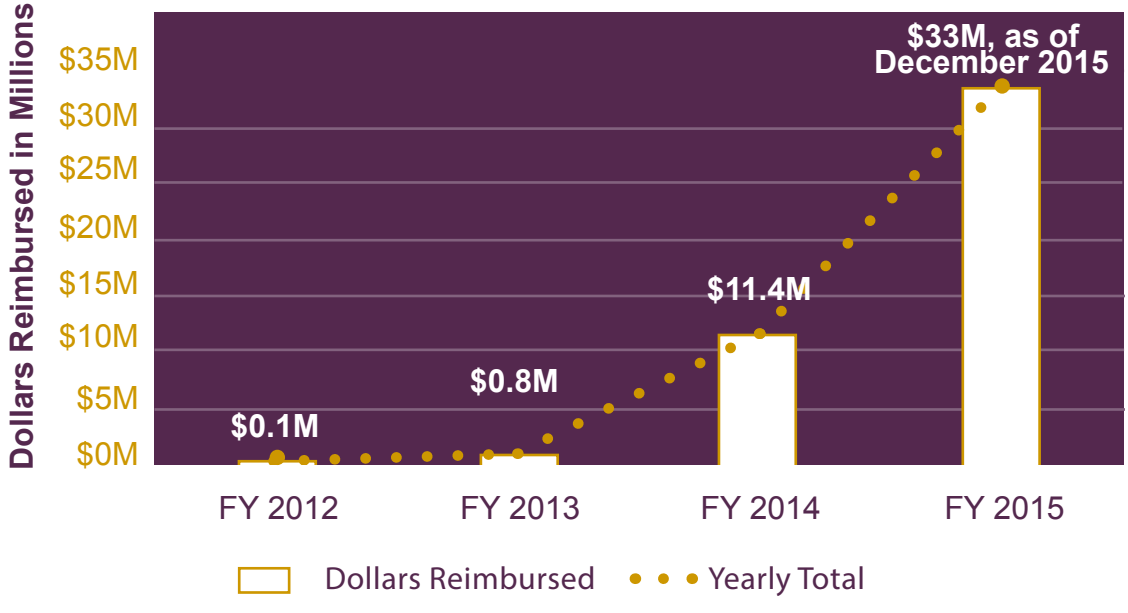
A reimbursement agreement was signed between VHA and IHS in 2012, and this agreement allows VA to reimburse for direct care services provided to eligible American Indian and Alaska Native Veterans at all IHS sites across the country. Implementation plans were developed between local VHA and IHS sites.

Tribal health programs enter into local reimbursement agreements with nearby VA medical centers. As of 2015, there are a total of 89 signed local reimbursement agreements with tribal health programs. More are in process.

Reimbursement Agreement – Accomplishments	Total
Local reimbursement agreements with tribal health programs	**89**
IHS implementation plans in effect	**83**
IHS sites covered	**108**

Reimbursements through the reimbursement agreements have grown steadily since they first began to be implemented in 2012. The graph below includes reimbursements under the IHS and tribal health program reimbursement agreements.

VA Reimbursements to IHS and Tribal Health Programs



Drummers at the Annual Native American Veterans Honor Dance at Oklahoma City VA Health Care System

Outreach and Technical Assistance for Reimbursement Agreements

To promote reimbursement agreements and support IHS implementation plans, OTGR and Veterans Health Administration staff conducts site visits, calls, and other outreach activities on an ongoing basis. For example, OTGR representatives facilitate national technical assistance calls to answer questions and provide support to IHS sites that are working with implementation plans.

The Veterans Health Administration Chief Business Office offers orientations to tribal health programs interested in establishing local reimbursement agreements, and other technical assistance resources are offered online.

Other Health Initiatives

Beyond VA-IHS MOU activities, VA is involved in ongoing efforts to address challenges to health care access for American Indian and Alaska Native Veterans.

Office of Rural Health Investments in Health Access

In fiscal year 2015, the Office of Rural Health invested $3.9 million in 13 initiatives focused on American Indian and Alaska Native Veterans, addressing topics such as mental health, home-based primary care, primary care, telehealth, and eligibility and benefits services. The initiatives reached 5,961 Veterans. Of those reached, 43 percent were American Indian and Alaska Native Veterans.

Native Domain

Many Native Veterans live in rural areas and face special challenges to accessing health care. The Office of Rural Health provides the Native Domain online resource to share information, research, and toolkits focused on the American Indian and Alaska Native population. These resources are available on the Native Domain website at **ruralhealth.va.gov/native**.

In 2015, the Veterans Rural Health Resource Center in Salt Lake City, UT, which manages the Native Domain, conducted research, consultation, and demonstration projects on:

- Expanding telemental health services for rural American Indian and Alaska Native Veterans
- Providing online resources for Veterans Health Administration personnel to learn more about serving rural American Indian and Alaska Native Veterans
- Collaborating with tribal colleges and universities to improve health access for American Indian and Alaska Native Veterans in rural areas

Finding Care with VA

Jack Flowers, an Army Veteran and member of the Citizen Potawatomi Nation, was "ecstatic about VA's care" for Hepatitis C after a VA staff member helped connect him with treatment in 2015. Mr. Flowers believes he contracted Hepatitis C from immunizations he received during his service as a Vietnam-era Veteran. He is now viral free after receiving a new treatment.

Veterans are twice as likely as the general public to contract this disease. Jack urges other Veterans who have Hepatitis C to entrust their care to VA and to ask about newer treatment options.

Cultural Competency in Delivering Health Care

All of VA's programs strive to engage with Indian Country effectively, respectfully, and with cultural sensitivity. Below are some of the cultural competency activities and trainings conducted in 2015.

Office of Diversity and Inclusion

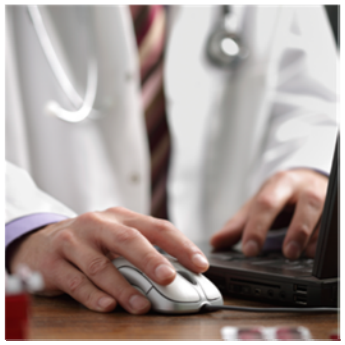
The Office of Diversity and Inclusion held cultural competency trainings in areas of the country for VA staff who are likely to work with American Indian and Alaska Native Veterans. Training locations and American Indian and Alaska Native populations addressed included:

- Fort Harrison, MT – Blackfeet Nation
- Sheridan, WY – Crow Nation
- Fort Meade and Hot Springs, SD – Oglala Sioux Tribe
- Salt Lake City, UT – Shoshone-Bannock and Ute Indian Tribes
- Fargo, ND – Chippewa Tribes
- Reno, NV – Paiute and Western Shoshone Tribes
- Omaha and Lincoln, NE – Santee Sioux Nation and Omaha Tribe
- Sioux Falls, SD – Oglala Sioux Tribe

At each location, hundreds of VA service providers received training.







Transforming VA Community Care – How Will We Get There?

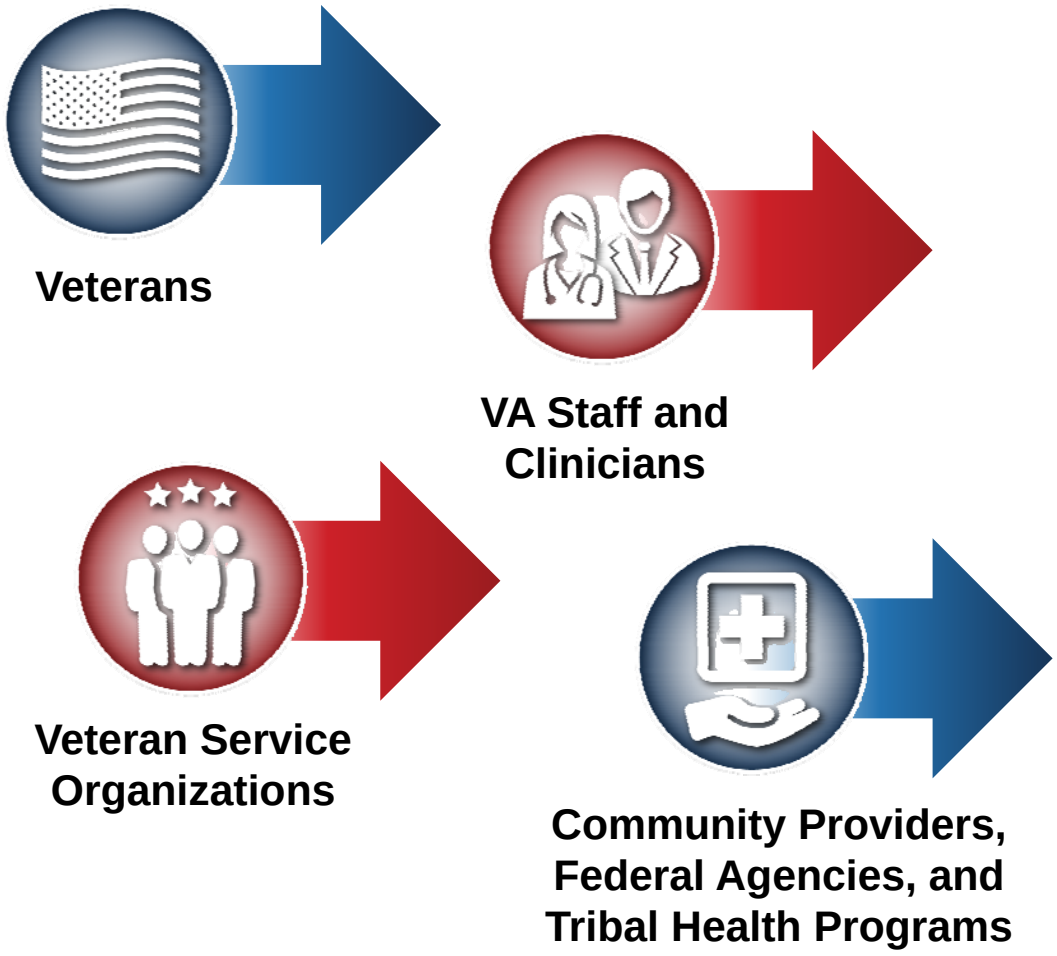
Current Community Care Programs Are Confusing

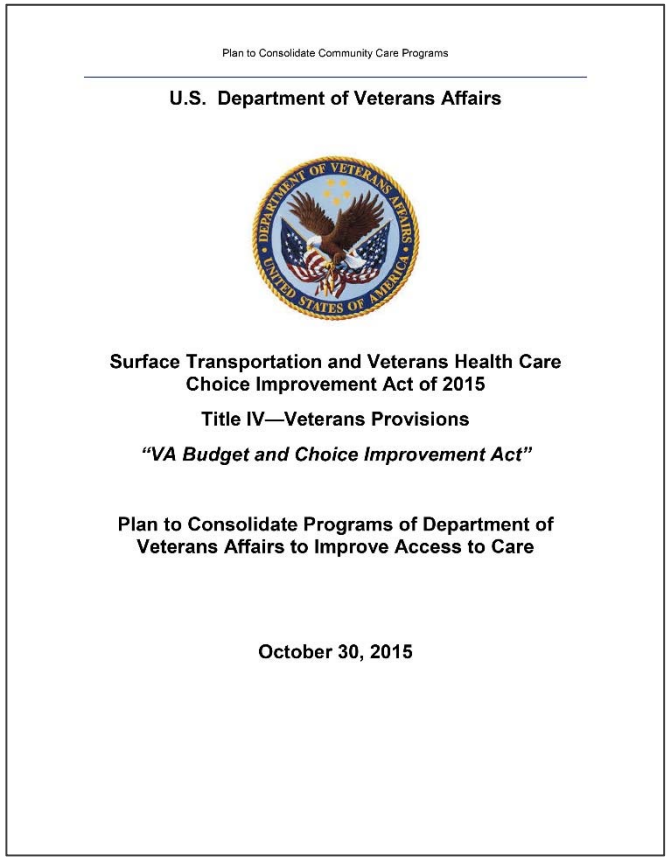
Community Care today is complicated and consists of multiple programs that cause confusion for Veterans, community providers, and VA staff.

To address this issue, VA proposed a plan to Congress. This plan addresses immediate improvements to community care while driving towards the future.

Gathered Feedback from Key Stakeholders

We made sure to incorporate feedback from key stakeholders representing diverse groups and backgrounds to create the plan.





Plan to Consolidate Community Care Programs

U.S. Department of Veterans Affairs

Surface Transportation and Veterans Health Care Choice Improvement Act of 2015

Title IV—Veterans Provisions

"VA Budget and Choice Improvement Act"

Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care

October 30, 2015

[VA Community Care Plan]

Tribal Consultation

Tribes from around the country were given the opportunity to provide feedback about VHA's effort to improve continuity of care and health care access through the development of a non-VA care core provider network utilizing agreements with high quality partners who also share the privilege of serving Veterans.

Feedback received from tribes:

Strong support for the inclusion of IHS and THP as key partners in VA's community network.

Maintain and strengthen the current agreements between VA, IHS, and THPs.

Interest from IHS and THPs in potentially serving non-Native Veterans.

Rapid Changes to the Veterans Choice Program

2013

September 2013
- PC3 was established as the regional contracting vehicle to partner with community providers
- VA awarded the PC3 contract to TriWest and Health Net

2014

April 2014
- Completed PC3 rollout

August 2014
- Congress enacted the "Veterans Access, Choice and Accountability Act of 2014" (PL 113-146)
- VA established the VCP expanding access to community care in response to excessive wait times and delays

November 2014
- Rulemaking to implement PL 113-146
- Modified PC3 contracts to support the VCP

November 2014- January 30, 2015
- Contractors mailed out approximately 8.6 million Choice Cards to Veterans

2015

April 2015
- Changed eligibility requirement to 40 mile driving distance from geodesic

May 2015
- Congress enacted the "Construction Authorization and Choice Improvement Act of 2015" (PL 114-19)

June 2015
- Implemented three provisions related to unusual and excessive burden

July 2015
- Implemented Choice First 1B
- Congress enacted the "Veterans Health Care Choice Improvement Act of 2015" (PL 114-41)

October 2015
- Removed the Choice enrollment date
- Submit report to Congress October 30

November 2015
- Contractors began to make outbound calls to Veterans
- Dr. Yehia appointed ADUSH Community Care

December 2015
- Rulemaking to implement PL 114-19 & PL 114-41
- Implemented final provision related to unusual and excessive burden
- Conducted Network PWS Industry Day

2016

January 2016
- Changed episode of care from 60 days to 1 year

February 2016
- Released Draft Network PWS
- Provider expansion to begin phased implementation of provider types to mental health and treatment facilities
- Authorization return codes standardized

March 2016
- Removed requirement for medical records for provider payment
- Clarified type of medical information to be returned
- IT Industry Day

April 2016
- Draft Network RFP Released
- Follow up Network Industry Day for Community Care Network

May 2016
- Completed national deployment of Choice provider agreements
- IT Industry Day

July 2016
- Expand Choice Program to include current ARCH participants
- Implemented Scheduling changes in Alaska

VA's Plan Includes Short- and Long-Term Improvements

VA is taking immediate steps to improve stakeholders' experiences while also planning and implementing long-term improvements for the new community care program.

Our Goal for VA Community Care

Deliver a program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA Staff

How Will We Get There?
Short-Term Steps

Short-Term Accomplishments

Implemented a joint VA / Contractor Rapid Response Team to address payment issues

Implemented adverse credit support for Veterans

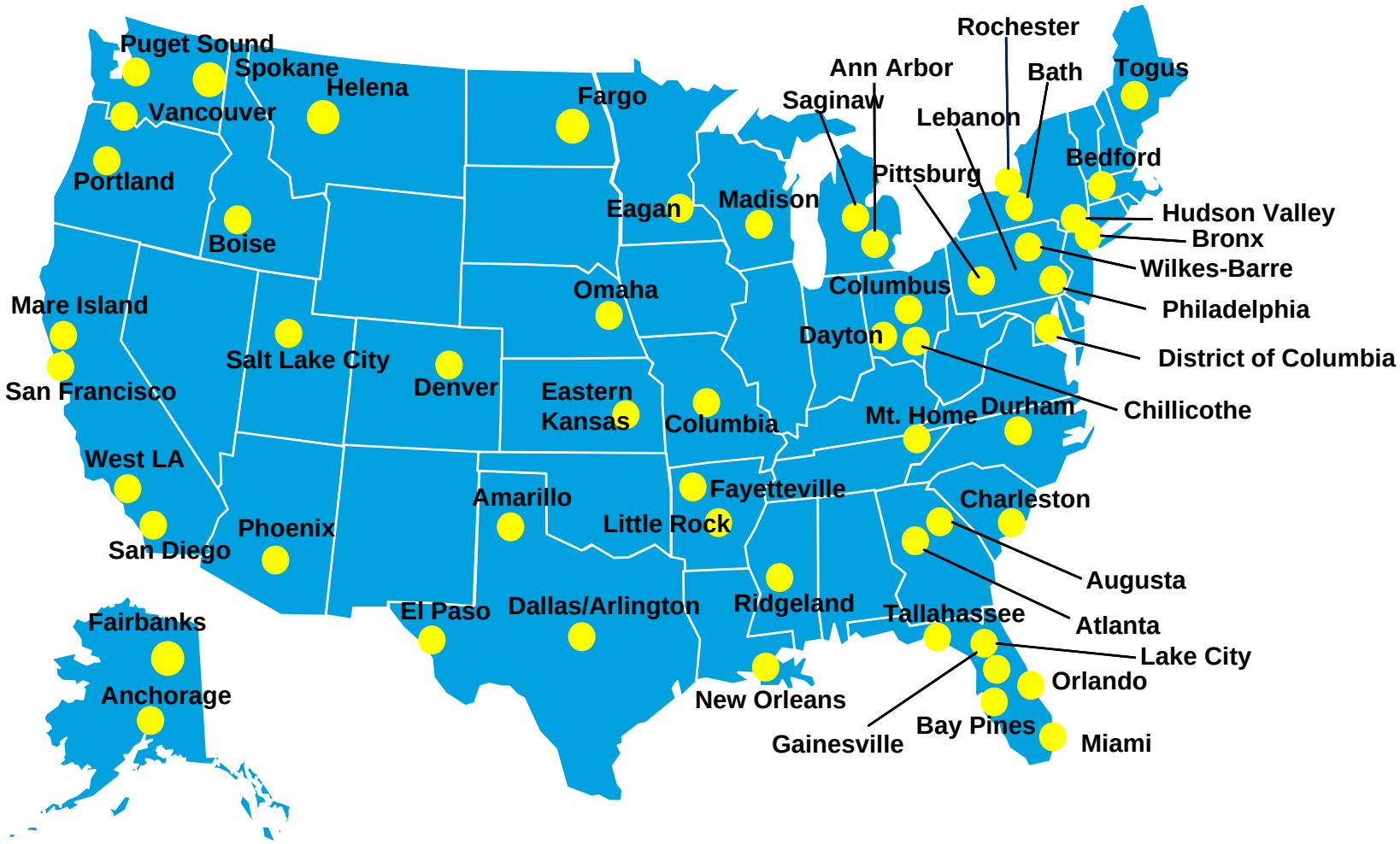
Improved timely payments by separating medical record submission from provider payments

Implemented revised eligibility criteria for 40 miles, enrollment date, and excessive burden

Embedded contractor staff with VA staff in 14 locations to ensure a more seamless transition for Veterans into community care

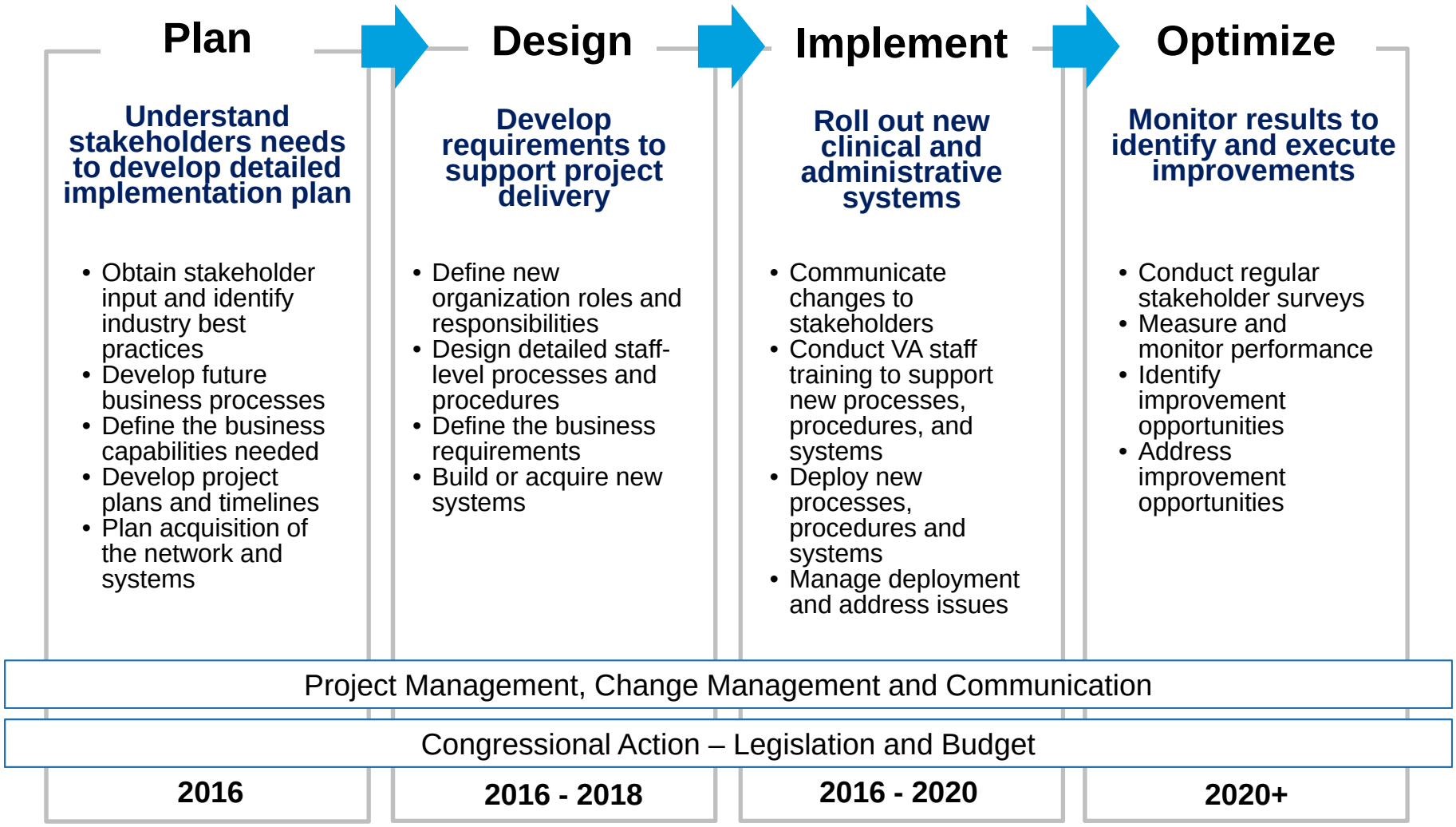
Conducted Field Site Research

Our teams have conducted interviews, site visits, and data gathering exercises with VISN and VA medical center staff across the country to inform the future state design.



How Will We Get There?
Long-Term Steps

Approach to Improving the Community Care Experience



Five Key Components Trace the Veteran Community Care Journey

Provide easy to understand eligibility information to Veterans, community providers, and VA staff

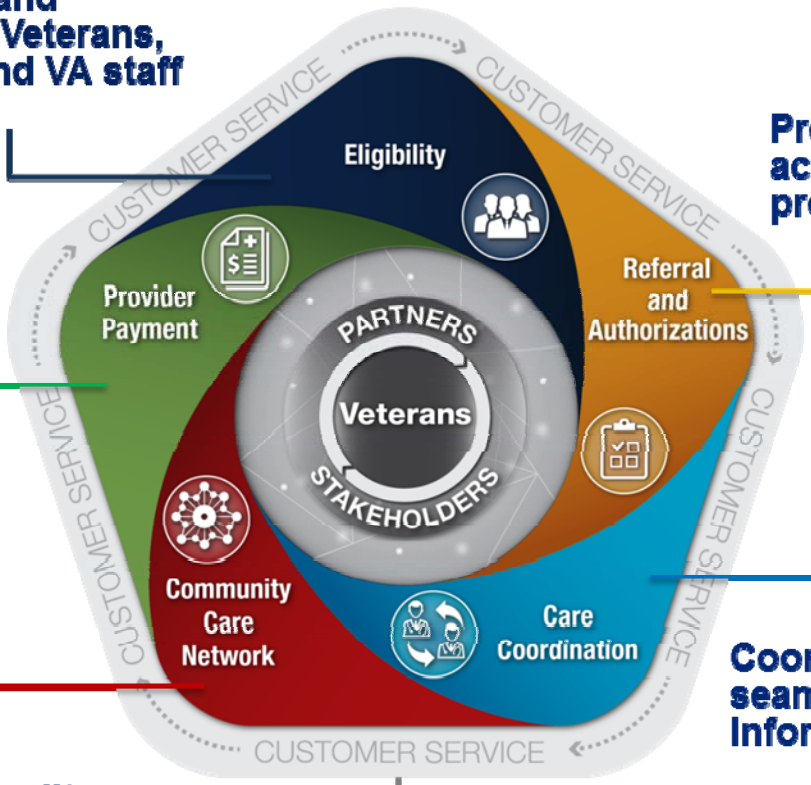
Provide Veterans timely access to a community provider of their choice

Support accurate and timely payment of community providers

Coordinate care through seamless health information exchange

Implement a network that provides access to high-quality care inside and outside VA

Provide quick resolution of questions and issues for Veterans, community providers, and VA staff



Congressional Action – Supporting Legislation

VA cannot move to the future state without Congressional action. Our proposals are less complex, allow for flexibility, and reflect industry standards.

Action	Supporting Legislation Needed	Benefit
Simplify the Program	• Improving Veterans Access to Community Care by Establishing the New VCP • Improving Veterans Experience by Consolidating Existing Programs • Improving VA's Partnerships with Community Providers to Increase Access to Care (Provider Agreements)	Enables VA to provide simplified and consistent access to community care.
Improve Emergency Care	• Improving Veterans Access to Emergency Treatment and Urgent Care	Provides clarity to Veterans when they need Emergent or Urgent care.
Ensure Accurate Provider Payment	• Formalizing VA's Prompt Payment Standard to Promote Timely Payments to Providers • Aligning with Best Practices on Collection of Health Insurance Information • Increasing Accuracy of Funding by Recording Community Care Obligations at Payment	Allows VA to pay community providers in a consistent and timely manner.
Flexibility in Community Care Funding	• Improving Access to Community Care through Choice Fund Flexibility • Increasing Access and Transparency by Requesting Budget Authority for a Community Care Account • Streamlining Community Care Funding	Supports transparency and visibility of VA's Community Care funding.
Improve Care Coordination	• Improving Care Coordination for Veterans through Exchange of Certain Medical Records	Improves care coordination for Veterans.

Action for Immediate Veterans Choice Program Improvements

Current Challenges	Solution	Outcome
Contracts create unnecessary administrative burdens for community providers.	**Provider Agreements**	Larger provider network would increase access to care.
Inconsistency of VA as primary or secondary payer creates confusion.	**Primary Payer**	More timely and consistent provider payments.
Obligate funding at the time of authorization leads to inaccurate accounting.	**Obligation of Funding**	Improved accounting of community care funds.
Unnecessary funding constraints.	**Funding Flexibility**	More transparency into VA's community care funding.

Continuing our Partnership with Tribal Health Programs

The Value of Continued Partnership

VA believes there is significant value in partnering with THPs to improve Veterans experience and increase access to care.

Unique Value of THPs:

- Provides eligible AI/AN Veterans with access to care closer to their homes
- Promotes cultural competence and quality health care
- Focuses on increasing care coordination, collaboration, and resource-sharing for eligible AI/AN Veterans
- Increases capacity at certain VA Medical Centers

THPs are Working with Choice Partners

Currently, THPs are beginning to the join the Choice provider network. VA is working to further increase access to by suggesting that all THPs join the Choice network.

To improve access, VA is working with Choice Contractors to add additional facilities and providers to the network

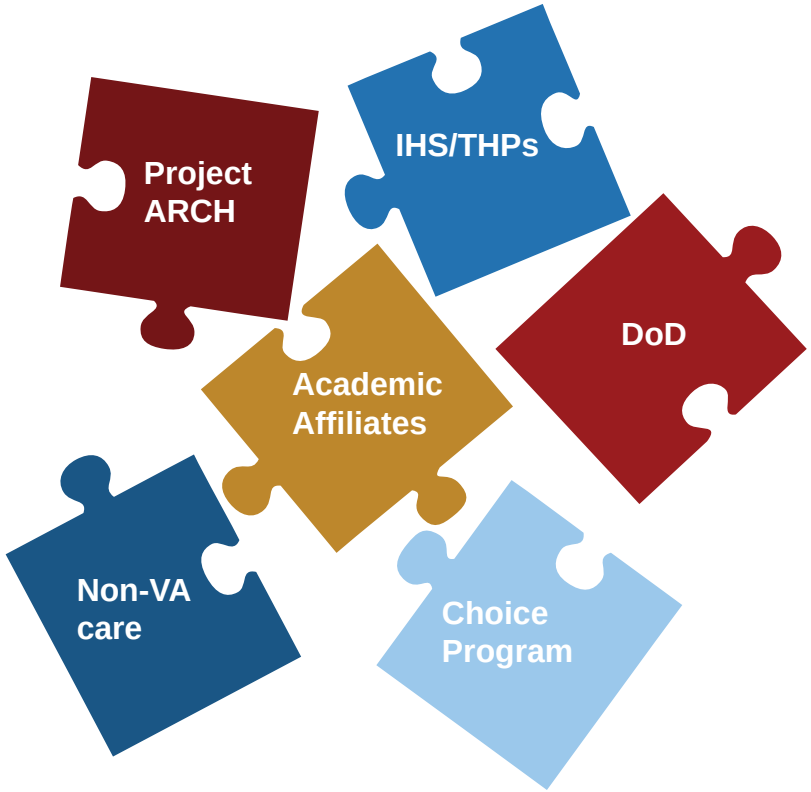
TriWest:
- 7 Facilities Contracted
- 33 relationships with providers

Health Net:
- 4 relationships with providers

Current Locations

- St. Regis Mohawk Health Services
- Lac Vieux Desert Health Clinic and Pharmacy (Lac Vieux Desert (LVD) Band of Lake Superior Chippewa Indians)
- Stockbridge-Munsee Health and Wellness Center (Stockbridge Munsee)
- Tuba City Regional Health Corporation (Navajo Nation)
- Winslow Indian Health Care Center (WIHCC)
- Black Hawk Health Center (Sac and Fox Nation)
- Choctaw Nation Health Care Center (Choctaw Nation)
- Muscogee (Creek) Nation Health System (Muscogee (Creek) Nation of Oklahoma)
- Southern Ute Indian Tribe Health Center
- Utah Navajo Health System, Inc.
- Alaska Native Tribal Med Ctr
- Aleutian Pribilof Islands Association
- Bristol Bay Area Health Corporation
- Cow Creek Health and Wellness Center (Cow Creek Band of Umpqua Tribe of Indians)
- Eastern Aleutian Tribes, Inc.
- Ilanka Community Health Center (Native Village of Eyak)
- Ketchikan Indian Community Tribal Health
- Lake Roosevelt Community Health Centers (Colville)
- Maniilaq Association
- Ninilchik Community Clinic
- Nooksack Indian Tribe
- Norton Sound Health Corporation
- Seldovia Village Tribe
- Sophie Trettevick Indian Health Center (Makah Tribe)
- Southcentral Foundation
- Southeast Alaska Regional Health Consortium
- Yakutat Tlingit Tribe
- Yukon-Kuskokwim Health Corporation
- Central Valley Indian Health, Inc.
- Consolidated Tribal Health Project
- Greenville Rancheria Tribal Health Program
- Karuk Tribal Health and Human Service Program
- Pit River Health Service
- United Indian Health Services, Inc./PHV-MED
- Yerington Paiute Tribal Health Clinic
- Riverside-San Bernardino County Indian Health, Inc.
- Santa Ynez Tribal Health Clinic
- Toiyabe Indian Health Clinic

VA Need THPs Support to Improve Veterans Experience



VA COMMUNITY CARE

VA and THPs Partnership

VA needs THPs help to strengthen our partnership while reducing Veterans confusion:

- What is the Role of VA and THPs Existing Agreements?
- How Can We Evolve Our Agreements to support the future state?

Closing Remarks

Questions?

Thank you for your time and support.

Memorandum

Date: July 11, 2016 (Revised)

To: Chief Lynn Malerba
Chairman Ron Allen
TSGAC Committee Members

From: Doneg McDonough, TSGAC Technical Advisor

Subject: Options for Advancing Legislation to Exempt Tribes from Affordable Care Act's (ACA) Employer Mandate

This memorandum is for the purpose of providing background information on the issue of Congressional actions on legislation to exempt Tribal employers from the ACA's employer mandate, as well as to offer options for continuing to advance the legislation through Congress.

Current Status

The Tribal Employment and Jobs Protection Act (H.R. 3080) was introduced by Representative Kristi Noem (R-SD), a member of the House Ways and Means Committee. The legislation provides a complete exemption for Tribes and Tribally-owned entities from the ACA's employer mandate, including the requirement to offer coverage to full-time employees and to submit related reports.

On June 15, 2016, on a 20 – 13 party-line vote, the bill was passed out of the House Ways and Means Committee.[1] The bill was scored as having a $119 million ten-year cost to the federal budget. Six other health insurance / ACA-related bills were marked-up and passed—several with bi-partisan support—by the Ways and Means Committee the same day.[2] Funding offsets were not provided for any of the seven bills that were passed out of the Ways and Means Committee. At least two of the bills approved by the Ways and Means Committee on a bi-partisan basis were passed by the full House of Representatives and sent to the Senate. No further action has been taken on H.R. 3080.[3]

Three concerns were raised by Democrats in the Ways and Means Committee consideration of H.R. 3080. First, the legislation would "creat[e] loopholes for employers to avoid offering insurance and could entice some businesses to partner with tribes for that purpose." Second, concerns were

[1] *See* http://waysandmeans.house.gov/ways-means-advances-7-bills-improve-access-health-care-provide-targeted-relief-obamacare/ for the Ways and Means Committee description of actions taken.

[2] One of the other measures (**HR 5452**) would allow patients receiving services through the federal Indian Health Service to access health savings accounts.

[3] The Ways and Means Committee report on H.R. 3080 can be found at: https://www.congress.gov/114/crpt/hrpt656/CRPT-114hrpt656.pdf

stated that "non-Native American employees who work at tribal-owned companies could be left out of coverage." The Joint Tax Committee estimates that approximately 5,600 employees would lose employer coverage, of which approximately 2,000 would become uninsured. Finally, the costs of this legislation (and the other bills passed) were not offset with savings identified elsewhere.

A companion bill (S. 1771) by Senator Steve Daines (R-MT) has been introduced in the Senate and referred to the Senate Finance Committee. There are four Republican co-sponsors (Thune - SD; Crapo - ID; Rounds – SD; McCain – AZ; Risch – ID); Senators Thune and Crapo are members of the Senate Finance Committee. No action has been taken on the bill by the Senate Finance Committee.

Next Steps / Potential Strategy

Staff and technical advisors to NIHB, NCAI, TSGAC, USET and other Tribes and Tribal organizations are working to (1) secure support for H.R. 3080 / S. 1771 and (2) gather more information from Congressional offices and committees on prospects for this legislation.

The following are potential options for moving the legislation through Congress:

HOUSE OF REPRESENTATIVES: NIHB staff spoke with Representative Noem's office, and NIHB staff were told that H.R. 3080 is expected to go to the House floor for a vote before the end of the current Congressional session. As of today, H.R. 3080 has not been placed on the House floor schedule for the week of July 11 – 15 for a vote of the full House of Representatives. (The House is scheduled to be on recess from July 16th through September 6th.)

It is uncertain whether the full House will vote on H.R. 3080 prior to the end of the year. Because legislation impacting revenues (revenue bills) are to originate in the House, it is important that the House take action as soon as possible. NIHB is coordinating outreach to Tribes, requesting that Tribes contact Members of Congress to request their support.

Discussions with Ways and Means Committee staff and other House offices (such as Democratic opponents) might provide additional information on prospects in the House. If support from Democrats would increase the likelihood of the legislation being brought to the House floor for a vote, modifications to the legislation might be considered to achieve the support of Democrats.

SENATE: To date, the Senate Finance Committee has not held hearings or taken other action on the companion bill (S. 1771).

Potential options for advancing the legislation through the Senate are:

- Option 1: Lobby Senate Finance Committee members to move H.R. 3080 / S. 1771 in the same form as passed by the House Ways and Means Committee.
- Option 2: Make modifications to the legislation (in the form of an amendment during Senate Finance Committee consideration or by introducing a new bill) to secure broader support of Senate Republicans, Senate Democrats, and the Obama Administration.

- Engage Democratic Ranking Member Ron Wyden's staff to determine level of support for current version of legislation. If opposed, determine if Senator might be supportive of a modified version.
- Engage Finance Committee Chairman Orrin Hatch's staff to determine willingness to move the legislation in its current form and/or in a modified form.
- Engage Obama Administration over H.R. 3080 and potential amendments to it; seek endorsement of Obama Administration.
- **If modifications would increase support for the legislation and likelihood of passage, consider modifying the legislation to narrow the exemption for Tribes (which is currently a wholesale exemption from the employer requirements) to an exemption for Tribes and Tribally-owned entities from paying "assessable payments" <u>for Tribal member employees</u> (including other Indian Health Service beneficiaries.)** This narrower exemption would mirror the approach recommended by TSGAC to the Treasury Department as an administrative remedy.
    - If the legislation is modified, an additional change might be to adopt a second TSGAC recommendation to the Treasury Department to permit Tribal members and their families to access premium tax credits through the Marketplace even if they have an offer of coverage from a Tribal employer.
- Confer with Representative Noem on modifications, if any, to H.R. 3080.
- Engage House Democrats (particularly Representatives Levin, McDermott, and Becerra) to secure support for (the narrowed version of) H.R. 3080.

Attachments:

- Attachment A: Members of the Committees of Jurisdiction
- Attachment B: CQ Article on Ways and Means Committee Action on H.R. 3080 and Other Measures
- Attachment C: Memorandum from NIHB on Advancing H.R. 3080, July 7, 2016

Attachment A: Members of Committees of Jurisdiction

Attachment A1: Members of Senate Finance Committee

- **Orrin Hatch**, Utah, ***Chairman***
- Chuck Grassley, Iowa
- **Mike Crapo, Idaho**
- Pat Roberts, Kansas
- Mike Enzi, Wyoming
- John Cornyn, Texas
- **John Thune, South Dakota**
- Richard Burr, North Carolina
- Johnny Isakson, Georgia
- Rob Portman, Ohio
- Pat Toomey, Pennsylvania
- Dan Coats, Indiana
- Dean Heller, Nevada
- Tim Scott, South Carolina

- Ron Wyden, Oregon, ***Ranking Member***
- Chuck Schumer, New York
- Debbie Stabenow, Michigan
- Maria Cantwell, Washington
- Bill Nelson, Florida
- Bob Menendez, New Jersey
- Tom Carper, Delaware
- Ben Cardin, Maryland
- Sherrod Brown, Ohio
- Michael Bennet, Colorado
- Bob Casey, Pennsylvania
- Mark Warner, Virginia

Members shown in bold/red are Senate co-sponsors

Attachment A2: Members of the House Ways and Means Committee

- **Kevin Brady, Texas's 8th, *Chairman***
- Sam Johnson, Texas's 3rd
- Devin Nunes, California's 22nd
- Pat Tiberi, Ohio's 12th
- Dave Reichert, Washington's 8th
- Charles Boustany, Louisiana's 3rd
- Peter Roskam, Illinois's 6th
- Tom Price, Georgia's 6th
- Vern Buchanan, Florida's 16th
- Adrian Smith, Nebraska's 3rd
- Robert Dold, Illinois's 10th[7]
- Lynn Jenkins, Kansas's 2nd
- Erik Paulsen, Minnesota's 3rd
- Kenny Marchant, Texas's 24th
- Diane Black, Tennessee's 6th
- Tom Reed, New York's 23rd
- Todd Young, Indiana's 9th
- Mike Kelly, Pennsylvania's 3rd
- Jim Renacci, Ohio's 16th
- Pat Meehan, Pennsylvania's 7th
- Kristi Noem, South Dakota's at-large
- George Holding, North Carolina's 13th
- Jason T. Smith, Missouri's 8th
- Tom Rice, South Carolina's 7th

- **Sander M. Levin, Michigan's 9th, *Ranking Member***
- Charles B. Rangel, New York's 13th
- Jim McDermott, Washington's 7th
- John Lewis, Georgia's 5th
- Richard Neal, Massachusetts's 1st
- Xavier Becerra, California's 34th

- Lloyd Doggett, Texas's 35th
- Mike Thompson, California's 5th
- John B. Larson, Connecticut's 1st
- Earl Blumenauer, Oregon's 3rd
- Ron Kind, Wisconsin's 3rd
- Bill Pascrell, New Jersey's 9th
- Joseph Crowley, New York's 14th
- Danny K. Davis, Illinois's 7th
- Linda Sánchez, California's 38th

Attachment B: CQ Article on Ways and Means Committee Action on H.R. 3080 and Other Bills

CQ NEWS
June 15, 2016; Updated 7:53 p.m.

Republicans Look to Adjust Obamacare, Expand Health Accounts

By Erin Mershon, CQ Roll Call

The House Ways and Means Committee approved a series of bills Wednesday that would revise the 2010 health care overhaul, earning the ire of Democrats who blasted the majority for failing to pay for the changes.

The eight bills, which included measures to expand health savings accounts and update the foster care system, could be up for floor consideration as soon as next week, said Chairman **Kevin Brady**, R-Texas, after the hearing.

Two of the eight bills under consideration would exempt different groups from the insurance mandates in the health law (**PL 111-148**, **PL 111-152**). A third would repeal part of the law dealing with tax deductions for high medical expenses, and a fourth would revoke a regulation discouraging small businesses from providing certain health reimbursement arrangements.

Many House Republicans have publicly rejected past attempts to change the law in favor of scrapping it. A task force organized by Speaker **Paul D. Ryan**, R-Wis., is set next week to unveil another repeal plan.

However, Ways and Means consideration of the measures comes on the heels of an Energy and Commerce hearing Friday on several other bills that would also offer relatively modest changes to the law.

The new efforts to adjust the law would build on a number of smaller revisions that Congress has in recent years quietly cleared.

"These bills are another demonstration of our commitment to identifying and advancing member-driven solutions that provide Americans more access, better choices and greater flexibility in health care," Brady said.

Democrats, however, were quick to blast some of the proposals as partisan attempts to undermine the law. They praised one bill (**HR 5447**) for making it easier for small businesses to help employees purchase insurance on the health law's individual exchanges, but said the rest would leave consumers with fewer choices for health coverage and care.

"Other bills coming up today seem designed to shift people from affordable, comprehensive coverage to savings accounts and high-deductible health plans," ranking member **Sander M. Levin**, D-Mich., said. “This is more of the same for the Republican Party — tax breaks for the wealthy, while critical priorities for working-class Americans remain unaddressed."

Fight Over Funding

The most heated debate centered on a package (**HR 5445**) from Rep. **Erik Paulsen**, R-Minn., that would expand contribution limits for health savings accounts and offer other tweaks to the program. Republicans called it a package of commonsense solutions to help individuals and families pay for health care. It passed on a party-line vote, 23-15.

Democrats blasted Republicans for offering no offsets for a package that would cost $20.5 billion over a decade. Many called it a "tax break for the wealthy." Several dinged Republicans for not paying for the package while refusing to pass funds to address the Zika virus, the Flint water crisis or changes to the foster care program that were considered early in the markup. The president requested about a tenth as much money to address Zika, as Rep. **Xavier Becerra**, D-Calif., noted.

"This may be good public policy, but it's terrible fiscal policy," **Mike Thompson**, D-Calif., said.

"Once again, there you march to help families who are better off and not pay one dime for it," Levin said.

Brady pushed back.

"So in the last five minutes, we've learned Republicans are for people acquiring Zika and Ebola. We are for two-year-olds not being adopted, dirty water in Flint, and supporting the middle class against generally all mankind. Did we leave out puppies and Santa Claus?" he asked.

Democrats voiced concerns over offsets for several other bills that they otherwise might have supported, as some indicated during the markup. They blasted a bill (**HR 3590**) from Rep. **Martha McSally**, R-Ariz., that would lower the threshold for determining tax deductions for medical expenses and would cost $32.7 billion over 10 years. The provision was originally in the 2010 law as an offset. Its repeal is supported by the seniors' advocacy group AARP.

The bill passed 24-11.

Rep. **John B. Larson**, D-Conn., supported the McSally bill with "big reservations," saying it should have had a hearing and been fully offset. Rep. **Bill Pascrell Jr.**, D-N.J., also broke party lines to support it.

"Wouldn't it be refreshing for a change if we worked together on this? I can't believe that if we had a hearing and went through this testimony . . . that these [issues] couldn't be worked out," Larson said.

Most Democrats also criticized the $119 million, 10-year price tag of another bill (**HR 3080**) from Rep. **Kristi Noem**, R-S.D., which would exempt tribal-owned businesses from being required to offer coverage under the health care law.

Becerra said the bill would be “creating loopholes” for employers to avoid offering insurance and could entice some businesses to partner with tribes for that purpose. He also said non-Native American employees who work at tribal-owned companies could be left out of coverage. The measure passed 20-13, on party lines.

Another exemption from the law's mandates was less controversial. A bill (**HR 210**) by **Mark Meadows**, R-N.C., which would exempt full-time students working for universities from the university's employer mandate, passed by voice vote.

Its price tag was only about $3 million over a decade. Democrats said they didn't understand the bill's impact and asked for further time to consider it.

Brady took issue with Democrats' criticisms over funding, reminding them that when the 2010 health law was marked up as a bill years ago in the Ways and Means Committee the measure did not yet include offsets.

"We're heard this over and over and over about repealing Obamacare: 'Let's fix it.' But every commonsense bill we've brought up is voted down," Brady said.

Other Bills Approved by Voice Votes

The partisan fireworks were preceded, however, by bipartisan approval of measures to make it easier for small businesses to use so-called health reimbursement arrangements, to let veterans and tribal members take out HSAs, and to change the foster care system.

All four measures passed by voice vote.

Those bills included a package (**HR 5447**) from Reps. **Charles Boustany Jr.**, R-La., and Thompson that would roll back a rule, implemented as part of the 2010 health law, that fines small business that offer their employees HRAs. Both parties agreed the measure, which has substantial support among employers, would improve the 2010 law. Sen. **Charles E. Grassley**, R-Iowa, sponsored similar Senate legislation.

The panel also easily approved a measure (**HR 5456**) by Rep. **Vern Buchanan**, R-Fla., that would give states more flexibility to put foster care funding toward preventive services aimed at keep children out of the foster care system. Its forthcoming Senate companion will be sponsored by Finance Chairman **Orrin G. Hatch**, R-Utah, and ranking member **Ron Wyden**, D-Ore., according to a committee press release.

Another bill (**HR 5452**), as amended, would allow patients receiving services through the federal Indian Health Service to access health savings accounts. Rep. **Earl Blumenauer**, D-Ore., said the bill is “a minimum” that lawmakers could do for Native Americans and Alaska Natives considering how difficult it is for them to receive care through the Indian Health Service, saying IHS is "chronically underfunded."

Legislation by Rep. **Chris Stewart**, R-Utah, allowing veterans to access the accounts (**HR 5458**) earned similar praise before the panel approved it by voice vote.

Attachment C: Memorandum from NIHB on Advancing H.R. 3080, dated July 7, 2016

National Indian Health Board

MEMORANDUM

To: Tribal Partners

From: National Indian Health Board

Date: July 7, 2016

Subject: Advancing the Tribal Employment and Jobs Protection Act (H.R. 3080/S.1771)

This memorandum is for the purpose of providing background information on the proposed legislation to exempt Tribal employers from the Patient Protection and Affordable Care Act (ACA) Employer Shared Responsibility Rule, as well as to outline the strategy and next steps to advance the legislation.

ISSUE: The ACA created the Employer Shared Responsibility Rule, otherwise known as the Employer Mandate, which states that all employers must offer health insurance to their employees or pay a penalty. Tribal governments and Tribal owned enterprises are currently counted as large employers for application of this rule. However, American Indians and Alaska Natives (AI/AN) are exempt from the Individual Mandate to purchase health insurance through the ACA. This is in recognition of the fact that AI/ANs should not be forced to purchase health insurance, since healthcare is obligated by the federal government's trust responsibility and is primarily delivered through the Indian Health Service (IHS). Requiring Tribal employers to provide the largely American Indian and Alaska Native populations they employ with such coverage anyway, and penalizing them if they do not, functionally invalidates the AI/AN exemption from the individual mandate by shifting the penalty from individuals to Tribal governments.

Representative Kristi Noem (R-SD) introduced the "Tribal Employment and Jobs Protection Act" (H.R. 3080) on July 15, 2015 that would exempt Tribal governments and Tribal owned enterprises from the Employer Mandate. There are 27 co-sponsors to the bill (25 R, 2 D).

Senator Steve Daines (R-MT) introduced the Senate version (S. 1771) also in July 2015 and the bill has five Republican co-sponsors. S. 1771 was referred to the Senate Finance Committee.

CURRENT STATUS: On June 15, 2016, on a party-line vote, H.R. 3080 was passed out of the House Ways and Means Committee. The bill was scored at $119 million over the next decade. Six other health insurance /ACA-related bills were marked-up and passed—several with bipartisan support—by the Ways and Means Committee the same day. Funding offsets were not provided for any of the seven bills that were passed out of the Ways and Means Committee. Four of the bi-partisan bills were scheduled for House floor votes on Tuesday, June 21, 2016. No floor vote has been scheduled for H.R. 3080.

No action has been taken on the bill by the Senate Finance Committee on S. 1771.

STRATEGY:

Step 1: Assess why H.R. 3080 did advance to the House floor with the other bills that reported out of Ways and Means last week.

- **Action Taken:** NIHB talked with Kristi Noem's office on Wednesday 6/22 and determined the H.R. 3080 bill did not move to the floor because of the nature of the bill that addresses updates to the tax code. They expect it to move to the floor before the end of this session.

Step 2: Gather qualitative and quantitative information from Tribes on the impact of the Employer Mandate, and the June 30 reporting deadline.

- **Action Taken**: NIHB gathered information from Tribes in Montana on 6/14. Questions include:
  - How many people does the Tribe employ?
  - Of those employees, how many are Native/non-Native?
  - Does the Tribe currently offer employees health insurance?
  - Does the Tribe offer employees health insurance because of the Employer Mandate? (If so, how much extra is it costing the Tribe to offer this insurance per year/If not, how much will it cost them in tax penalties?)
  - Will they continue to offer health insurance if Tribes become exempt from the mandate?
  - Did the Tribe meet the June 30 reporting deadline?

- **Follow-Up Needed**: Further outreach is needed to gather information from Tribes in the states and districts of Democrat Members on the Ways and Means Committee, Senate Finance Committee leadership, and South Dakota Tribes. NIHB has been calling Tribes in Oregon, Washington, Utah, South Dakota, California, Wisconsin and Michigan. A more detailed report will be available soon.

Step 3: Meet with Steve Daines' Office to determine if there is bi-partisan support for S. 1771 and what their sense is of needing bi-partisan support or possible changes in the language to get it moving.

- **Follow-Up Needed:** NIHB to set up meeting with Daines' Office for the week of 7/4 or 7/11.

Step 4: Contact Senate Finance Committee staff and determine how likely S. 1771 is to move in the Senate.

- **Follow-Up Needed:** NIHB and partners to set up meetings with Finance staff to assess likeliness of this moving and what language changes, if any, might be necessary to make it possible.

Step 5: Meet with Ways and Means Democrats and Senate Finance Committee leadership to educate them on findings from outreach to Tribes and how devastating the tax penalties will be for Tribes.

House	Senate
Blumenauer (D-OR)	Hatch (R-UT)
Kind (D-WI)	Wyden (D-OR)
Davis (D-IL)	Stabenow (D-MI)
Levin (D-MI)	Thune (R-SD)
Thompson (D-CA)	
Becerra (D-CA)	

Other Actions:

- The U.S. Chamber of Commerce Native American Enterprise Initiative sent a letter to the House Ways and Means Committee in support of H.R. 3080: https://www.uschamber.com/sites/default/files/documents/files/160511_hr3080_tribalemploymentandjobsprotectionact_noem.pdf

- The National Indian Gaming Association has sent multiple alerts out to members to do outreach to their own Senators and Representatives in support of this legislation. NIGA now has the list of states to target and will be reaching out to members in those specific states to encourage letters and phone calls of support.

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

Need for Action to Maintain Status on the HHS ECP List[1]

July 12, 2016

Two documents are attached pertaining to the federal Department of Health and Human Services Essential Community Provider Lists (HHS ECP Lists).

- New (*draft*) HHS ECP List Tip Sheet issued by the Center for Consumer Information and Insurance Oversight (CCIIO). This document outlines the steps to enter and update entries on the HHS ECP List. (The document is currently in draft form, and the document might be further revised.)

- TSGAC memo on the HHS ECP List, dated April 2, 2016, explaining the function / importance of the HHS ECP List. This document includes an attached spreadsheet comparing the year-to-year listings of Indian Health Care Providers (IHCPs) on the HHS ECP List. This memorandum identifies steps IHCPs take to be on the HHS ECP List for CY 2018.

Two actions are needed to be taken by Indian Health Care Providers:

- **IHCPs have until August 22, 2016 to add their facilities to the HHS ECP List for the 2018 plan year.** For the 2016 (current) and 2017 plan years, IHCPs will need to contact health plans directly to request a contract with the health plan.

- **All THOs already on the HHS ECP List should review their entries and update information as might be necessary.** For instance, email contact information should be updated, if needed, to ensure that the health plans are able to contact the IHCP.

[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.

ESSENTIAL COMMUNITY PROVIDER PETITION
TIP SHEET FOR INDIAN HEALTH CARE PROVIDERS (DRAFT VERSION)

Four Quick Steps for Inclusion on the Essential Community Provider List[1]

STEP 1: Determine if your Indian health care facility ***wants*** to be included on the HHS Essential Community Provider (ECP) List. Inclusion on the HHS ECP list means that:

- You want insurance companies operating on the Federally-facilitated Marketplace (FFM) to offer you a contract in good faith to participate in their provider network as an "in-network" provider.~~, meaning that your facility is capable of submitting claims to health insurance companies~~.
- You are not required to provide health care to non-Indians at your facility if you accept a contract with an FFM issuer.
- You can change your mind and remove your facility from the ECP list if you wish to discontinue your provider participation on the Marketplace at a later time.

STEP 2: Determine if your provider facility ***qualifies*** for inclusion on the HHS ECP list. An Indian health care provider qualifies to be included on the ECP list if your provider facility:

- Accepts patients regardless of coverage source (i.e., Medicare, Medicaid, CHIP, private health insurance, etc.);
- Is capable of submitting claims to health insurance companies;
- Employ at least one practitioner holding one of the following licenses: MD, DO, PA, NP, DMD, or DDS;
- Submits an Essential Community Provider petition for inclusion on our HHS ECP List.

STEP 3: Complete the online Essential Community Provider petition, which can be found at the following link: https://data.healthcare.gov/cciio/ecp_petition. Detailed instructions are available within the "i" icon that appears next to each question within the petition. FAQs are available within the "Need Help" button at the bottom of the ECP petition by clicking on the hyperlinked word "here" in the pop-up window.

- Find your ECP list row number by clicking on the button labeled "*Check to see if your are on the list*" (this button appears beside question #6 within the online petition).
- If your facility currently appears on the ECP list, you will want to update your information each year to remain on the ECP list and to ensure that there are no missing required data fields. This ensures we are providing insurance companies with your most current contact information so they can offer you a provider contract.
- If your facilty does *not* currently appear on the ECP list, complete the online petition for consideration.
- **The deadline for submitting the ECP petition for plan year 2018 is August 22, 2016.**
- You will need the following information to complete the ECP petition: your facility's National Provider Identifier, facility type, facility address and contact information, the number of full-time-equivalent (FTE) practitioners at your facility (MDs, DOs, PAs, NPs for medical providers or DMDs, DDSs for dental providers). You do *not* need to distinguish among the practitioner types in the FTE practitioner counts.

STEP 4: Contact us with any questions or if you need help completing the ECP petition. Email us at **EssentialCommunityProviders@cms.hhs.gov**.

[1] In accordance with section 1311(c)(1)(C) of the Affordable Care Act (ACA), Qualified Health Plans (QHPs), including Stand-alone Dental Plan (SADP) issuers, are required to include within their network essential community providers (ECPs), where available, that serve predominantly low-income, medically-underserved individuals. To satisfy this ECP requirement, QHP and SADP issuers must submit an ECP template as part of their QHP application, in which they must list the ECPs with whom they have contracted to provide health care services to low-income, medically underserved individuals in their service areas. HHS has compiled a list of available ECPs and updates this ECP list annually to assist issuers with identifying providers that qualify for inclusion in an issuer's plan network toward satisfaction of the ECP standard under 45 CFR 156.235.

Health Care Reform in Indian Country
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Review of HHS ECP Lists for Coverage Years 2016, 2017, and 2018[1]

April 2, 2016

This brief seeks to provide Tribes with a summary of findings from a review, conducted by the Tribal Self-Governance Advisory Committee (TSGAC) to the Indian Health Service (IHS), of Indian health care providers (IHCPs) that appear on the federal Department of Health and Human Services Essential Community Provider Lists (HHS ECP Lists) for coverage years (CYs) 2016, 2017, and 2018. In addition, this brief includes an attached spreadsheet comparing the year-to-year listings of IHCPs on the HHS ECP List. This memorandum identifies steps IHCPs might need to take to remain on the HHS ECP List for CY 2018.

Methodology

TSGAC assessed whether IHCPs were listed on one or more of the HHS ECP Lists for 2016, 2017, and 2018. And TSGAC calculated the total number of entries on the various HHS ECP Lists for a given year against the totals listed for other years, in addition to calculating these numbers as percentages of each other.

To conduct this review for CYs 2016 and 2017, TSGAC compiled a list of IHCPs by examining the list of health care facilities provided on the IHS Web site, as well as the IHCPs appearing on the CY 2016 and CY 2017 HHS ECP Lists, and determined whether the IHCPs appear on one or both of the HHS ECP lists for 2016 and 2017.

To determine whether an IHCP is "on the HHS ECP List for 2018," an assessment was made as to whether, for those entries on the HHS ECP List for 2017, all data fields were populated. (CCIIO has established a requirement—applicable to the HHS ECP List for 2018—that all data fields in an entry be populated. So, although an entry can be incomplete and remain on the 2016 and 2017 HHS ECP Lists, for a facility to be on the HHS ECP List for 2018, the facility must provide all the requested data.) Because a number of new data fields were added to the HHS ECP List for 2017 and subsequent years, an IHCP could populate the newly-added data fields by submitting a new entry or updating an existing entry on the HHS ECP List for 2017. For TSGAC assessment purposes, if an entry on the HHS ECP List for 2017 had one new data field in particular populated (the field for the national provider identifier (NPI)), the entry was considered "updated" or complete and assumed to be included on the HHS ECP List for 2018.

Major Provisions of Final Rule

A total of 677 IHCP entries are on the HHS ECP List for 2016. A total of 791 IHCP entries are on the HHS ECP List for 2017, an increase of 114 or 17%.

A total of 426 IHCP entries are included on the HHS ECP List for 2018. This compares with a total of 791 IHCP entries on the HHS ECP List for 2017, a 46% reduction in entries from 2017 to 2018.

- With regard to entries on the HHS ECP List for 2018 *that are in Federally-facilitated Marketplace (FFM) states*,[2] there are 345 entries (a 43% reduction from 2017).

[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] In FFM states, qualified health plan (QHP) issuers are required to make good faith contract offers to all available IHCPs.

- For non-FFM states, there are 81 entries (a 57% reduction from 2017).

The inclusion of an IHCP on the HHS ECP List is important, as it serves as the way to maintain the right of an IHCP (in an FFM state) that is located in a QHP's service area to receive a contract offer from the QHP. In non-FFM states, this requirement for QHPs to offer contracts to IHCPs currently does not apply, but Tribal representatives have requested that CCIIO extend the requirement to QHPs operating in non-FFM states as well. And, in fact, for CY 2017 CCIIO has extended the mandatory contract offer requirement from FFM states to QHP issuers operating in State-based Marketplace Federal Platform (SBM-FP) states.[3]

Analysis

The number of IHCP entries on the HHS ECP List increased from 2016 to 2017.

- This might be the result of HHS clarifying that, for the HHS ECP List for 2017, an organization's providers located at the same street site should be included under a single entry. Rather than having the effect of reducing the number of entries on the HHS ECP List for 2017, IHCPs might have updated their facility entries from 2016 by submitting a new entry, rather than modifying their existing entries that are/were on the HHS ECP List for 2016. (In addition to the new entries, the "old" entries would be carried over to the HHS ECP List for 2017.)

Comparison of Total Number of Indian Health Care Provider Entries on HHS ECP List, by Coverage Year

	CY 2016	CY 2017	CY 2018	CY 2018 vs CY 2017
On list:	677	791	426	54%
No longer on list:			365	46%

The number of IHCP entries on the HHS ECP List for 2018 is estimated to be significantly lower than the number of IHCP entries on the HHS ECP List for 2017.

The drop in the number of IHCP entries estimated to be on the CY 2018 HHS ECP List in comparison with the number that are on the CY 2017 HHS ECP List might have resulted from:

1. The entries on the HHS ECP List for 2017 include those carried forward from the 2016 HHS ECP List, as well as any new entries submitted by January 15, 2016.

2. The consolidation of shared location entries under a single IHCP entry (as CCIIO requested the listing of providers at a single location be included under one entry) would have reduced the total number of entries for 2018, after the non-updated entries were dropped for 2018.

3. Some of the entries on the CY 2017 HHS ECP List were tribal health organizations which do not provide direct medical care; these entries will correctly not be carried forward to the CY 2018 list.

4. The entries on the HHS ECP List for 2018 (as determined by the TSGAC analysis) are only those entries that were updated or newly submitted between December 8, 2015, and January 15, 2016;

[3] As of January 2016, the SBM-FPs subject to the new requirements beginning in 2017 are NV, HI, NM, and OR. SBM-FPs are Marketplaces operated by states that use the FFM (healthcare.gov) technology platform.

the entries determined to be "on the HHS ECP List for 2018" are only those entries with the new NPI data field populated.

5. The limited time frame (December 8, 2015, to January 15, 2016) for updating and adding entries for the CY 2018 HHS ECP List, in particular being over a holiday period, might have restricted the number of IHCPs that were able to update their entries.

6. The potential difficulty of IHCPs navigating the "petition" process on the CMS Web site during the 5-week period that was allowed for updating and adding entries on the CY 2018 HHS ECP List might have reduced the number of IHCPs that successfully updated their entries.

7. Some IHCPs might have been unaware of the need to update existing entries on the HHS ECP List in order to remain on the CY 2018 HHS ECP List.

8. A number of IHCPs located in non-FFM states might have concluded that it is not useful to remain on the HHS ECP List (as Marketplace rules in non-FFM states generally do not require QHPs issuers to make good faith contract offers to all available ICHPs on the HHS ECP List.)

Next Steps—Action Needed by Tribes

1. As indicated in the attached document from CCIIO, the petition process remains open to add an IHCP to the HHS ECP List for 2018. The document reads:

   "For providers who remain on the 2017 HHS ECP list with missing data (such as a missing NPI or FTE practitioner count), these providers represent those who have not yet submitted an ECP petition to correct and update their provider data. Although the provider submission window for corrections and updates to be reflected on the final ECP list for the benefit year 2017 closed on January 15, 2016, the ECP petition process remains open throughout the year for providers to correct and update their data for future plan year ECP list releases." (Emphasis added.)

   The HHS ECP List petition can be accessed at https://data.healthcare.gov/cciio/ecp_petition.

2. Although the "petition" process is not generally available to add new entries to the HHS ECP List for 2017, IHCPs are able to engage QHP issuers directly to secure an in-network provider contract. The QHP issuer would then "write-in" the IHCP as one of the facilities, enabling the QHP issuer to meet Marketplace-imposed provider network requirements, as long as the IHCP submits a petition to CCIIO through the process identified above by no later than August 22, 2016.

3. IHCPs should update their entries on the HHS ECP List on an ongoing basis. For example, it is important to maintain the contact information in an IHCP entry on the HHS ECP List in order for QHP issuers to contact an IHCP and provide network contract offers. To update an entry on the HHS ECP List, use the Web link identified above and described in the attached CCIIO document.

Attachment:

- CCIIO, "Description and Purpose of Non-Exhaustive HHS List of Essential Community Providers"
- TSGAC, "Matrix of CMS Policies on Select Health Insurance Marketplace Issues, 2017 – 2018"
- TSGAC, "Table of TSGAC Analysis of IHCPs in HHS ECP Lists – 2016-2018"

Description and Purpose of Non-Exhaustive HHS List of Essential Community Providers

DESCRIPTION OF THE NON-EXHAUSTIVE HHS LIST OF ECPs:

For the 2017 benefit year, the Centers for Medicare & Medicaid Services (CMS) is releasing an updated list of Essential Community Providers (ECPs) to assist issuers with identifying providers that qualify for inclusion in an issuer's plan network toward satisfaction of the ECP standard under 45 CFR 156.235 for the 2017 benefit year. Under that regulation, ECPs are defined as providers who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service (PHS) Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act (SSA).

This HHS ECP list contains the following essential community providers:

- Federally Qualified Health Centers (FQHCs) and FQHC look-alikes
- Ryan White HIV/AIDS Program providers
- Health centers providing dental services
- Hospitals: Critical Access Hospitals, Rural Referral Centers, Disproportionate Share (DSH) and DSH-eligible Hospitals, Children's Hospitals, Sole Community Hospitals, Free-standing Cancer Centers.
- STD Clinics, TB Clinics, Hemophilia Treatment Centers, and Black Lung Clinics
- Rural Health Clinics
- Family planning providers receiving grants under Title X of the PHS Act and not-for-profit or governmental family planning service sites that do not receive Federal funding under Title X of the PHS Act or other 340B-qualifying funding
- Indian Health Care Providers: Tribal Health Programs operated under P.L. 93-638, Tribal Organization and Urban Indian Organization providers, and Indian Health Service Facilities

Providers included on the HHS final ECP list for the benefit year 2017 were included in one of the verified datasets from our Federal partners [i.e., the Health Resources and Services Administration (HRSA), the Indian Health Service (IHS), and the Office of the Assistant Secretary for Health/Office of Population Affairs (OASH/OPA)] as reflected on the Draft 2017 ECP List, or were among the providers who submitted an ECP petition by January 15, 2016 to be added to the ECP list for the benefit year 2017 and were approved by CMS through the ECP petition review process.

This HHS list of ECPs is not exhaustive and does not include every provider that participates or is eligible to participate in the 340B drug program, every provider that is described under section 1927(c)(c)(1)(D)(i)(IV) of the SSA, or every provider that might otherwise qualify under the regulatory standard under 45 CFR 156.235. While CMS is providing this updated list for the 2017 benefit year, Qualified Health Plan (QHP) issuers may continue to write-in providers in their QHP application for consideration that meet the regulatory standard but do not appear in the HHS list of ECPs, as long as the issuer arranges that the written-in provider has submitted an ECP petition to CMS by no later than August 22, 2016. The ECP petition is available at https://data.healthcare.gov/cciio/ecp_petition. HHS is collecting provider data directly from providers through the ECP petition and will not accept petitions from third-party entities on behalf of the provider. Third-party entities include issuers, advocacy groups, State departments of health, State-based provider associations, and providers other than the provider that is the subject of the petition. However, if one of the above entities own or is the authorized legal representative of an ECP, it may submit a petition on behalf of the provider. For example, a local health department that operates its own family planning clinics may appropriately petition for those clinics.

PURPOSE OF HHS LIST OF ECPs:
CMS will use this non-exhaustive HHS list of ECPs, together with any CMS-approved ECPs that a respective issuer may write-in on their QHP application, as the basis for determining the number of available ECPs in the QHP's service area. In other words, the denominator of the percentage of available ECPs included in the issuer's provider network(s) includes ECPs in the QHP's service area that are listed in the HHS list of ECPs, as well as eligible ECPs that a respective issuer lists as ECP write-ins based on ECP write-in criteria provided in the forthcoming 2017 Letter to Issuers.[1] All providers included in a QHP issuer's application that meet the Federal regulatory standard will count toward the numerator of the ECP evaluation percentage. Additionally, issuers may use the contacts on the list to aid in provider network development.

IMPROVEMENTS TO HHS LIST OF ECPs:
CMS has made significant improvements to the accuracy of the provider data on the HHS List of ECPs for benefit year 2017. In addition to coordinating closely with HRSA, IHS, and OASH/OPA to obtain updated provider data from their provider datasets, CMS launched the ECP petition initiative in early December 2015 to solicit qualified providers to correct and update their provider data on the ECP list. CMS also solicited qualified providers to petition to be added to the ECP list to ensure a more accurate reflection of the available ECPs in a given service area.

In response to public comments received on the Draft Payment Notice and Letter to Issuers in the Federally-facilitated Marketplaces, we also made some formatting changes to the ECP list for benefit year 2017 to accommodate additional provider data, such as the National Provider Identifier (NPI), the number of full-time equivalent (FTE) practitioners available at each facility, additional ECP category indicators, and points of contacts and phone numbers for each ECP type listed in the ECP list. For providers who remain on the 2017 HHS ECP list with missing data (such as a missing NPI or FTE practitioner count), these providers represent those who have not yet submitted an ECP petition to correct and update their provider data. Although the provider submission window for corrections and updates to be reflected on the final ECP list for the benefit year 2017 closed on January 15, 2016, the ECP petition process remains open throughout the year for providers to correct and update their data for future plan year ECP list releases.

CMS intends to make no additional changes to the ECP list for the 2017 benefit year. We will endeavor to continue improving the accuracy of the provider data for future years. These efforts will include outreach to ECPs themselves, as well as reviewing the provider data with our Federal partners. We recommend that individual ECPs submit an ECP petition to ensure that they remain on the ECP list for future years and regularly review their provider data on the HHS ECP list to ensure that their information is up to date. We ask that issuers, trade associations, and other third parties refer concerns about individual listings to the respective providers themselves.

[1] The Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces is available at: http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html.

CMS Policies on Select Health Insurance Marketplace Issues, 2014-2017

Except where noted, QHP issuer requirements apply to Federally-Facilitated Marketplaces (FFMs), including the newly created State-Based Marketplaces on the Federal Platform (SBM-FPs),[1] but not State-Based Marketplaces (SBMs)

Issue	2014	2015	2016	2017 (and/or 2018, where indicated)
Essential community providers (ECPs)				
Contract offers to Indian health care providers (IHCPs)	QHP issuers must make contract offers to all available ICHPs to meet the ECP standard. If not meeting this standard, a QHP issuer must provide an explanation of the reasons why and the corrective actions (to be) taken. CMS may verify the offering of contracts after certification.	QHP issuers must make <u>good faith</u> contract offers to all available ICHPs to meet the ECP standard. <u>When required to submit a narrative justification because did not meet the 30% ECP contracting requirement, must attest to making good faith contract offers to all available IHCPs</u>. <u>In application, issuer to</u>	QHP issuers must make good faith contract offers to all available ICHPs to meet the ECP standard. When required to submit a narrative justification because did not meet the 30% ECP contracting requirement, <u>do not have to attest to making good faith contract offers to all available IHCPs</u>. <u>CMS will expect issuers</u>	Same as 2016.

[1] This Marketplace model, newly established in the HHS Notice of Benefit and Payment Parameters for 2017, will enable SBMs to execute certain processes using the federal eligibility enrollment infrastructure (namely HealthCare.gov). SBM-FPs and HHS will have to enter into a federal platform agreement that will define a set of mutual obligations, including the set of federal services upon which the SBM-FP agrees to rely. Under this model, certain requirements previously only applicable to QHPs offered on FFMs will apply to QHPs offered on SBM-FPs, such as the requirement for QHP issuers to offer contracts to all IHCPs. SBM-FPs must agree to enforce certain QHP and QHP issuer requirements no less strict than those HHS applies to QHPs and QHP issuers in FFMs, as follows:

- 45 CFR 156.122(d)(2): the standards for QHPs to make available published up-to-date, accurate, and complete formulary drug lists on its website in a format and at times determined by HHS;
- 45 CFR 156.230: network adequacy standards;
- 45 CFR 156.235: ECP standards;
- 45 CFR 156.298: meaningful difference standards;
- 45 CFR 156.330: issuer change of ownership standards;
- 45 CFR 156.340(a)(4): issuer compliance and compliance of delegated and downstream entity standards; and
- 45 CFR 156.1010: casework standards.

		list the contract offers that it has extended to all available Indian health providers.	to be able to provide verification of such offers if CMS requests to verify compliance with the policy.	
Good faith contract offers to ECPs	Not addressed.	QHP issuers must offer contract terms that a "willing, similarly-situated, non-ECP provider would accept or has accepted."	Same as 2015.	QHP issuers must "offer contract terms comparable to terms that it offers to a similarly-situated non-ECP provider."[2]
Inclusion of Model QHP Addendum (Addendum) in contracts offered to IHCPs	QHP issuer contract offers to IHCPs must use the Addendum to meet the ECP standard (CMS also notes that use of the Addendum is voluntary).	QHP issuers are to offer contracts "using the recommended model QHP Addendum for Indian health providers developed by CMS". "CMS is continuing to recommend the use of the Model QHP Addendum (Addendum) as described in the 2014 Letter to Issuers". (CMS also notes that use of the Addendum is expected)	QHP issuer contract offers to IHCPs must "applying" the special terms and conditions necessitated by federal law and regulations as referenced in the Model QHP Addendum.	Same as previous year.
Inclusion of ECPs on HHS ECP List	HHS compiled a "non-exhaustive list of available ECPs" (HHS ECP List), based on data it and other federal agencies maintained, and allowed QHP issuers to	Same as previous year.	Same as previous year.	To remain on the HHS ECP List, IHCPs and other ECPs must submit a revised entry to provide missing required data (IHCPs and other ECPs

[2] For Stand Alone Dental Plans (SADPs), the CCIIO Issuer Letter uses the same terminology for what is a "good faith offer" as used in the 2015 and 2016 Issuer Letters, namely "QHP issuers must offer contract terms that a willing, similarly-situated, non-ECP provider would accept or has accepted."

	include qualified providers not on the list when calculating whether they met the ECP standard.			seeking placement on the list for the first time also must submit the petition).[3] QHP issuers will no longer be permitted to "write-in" providers not on HHS ECP List in order to satisfy requirement.[4]
Hardship exemption (from shared responsibility payment): eligibility determination and claiming exemption	Tribal members and IHS-eligible individuals can apply for an exemption through the Marketplace. In addition to Tribal members who can establish eligibility for an exemption through the federal tax-filing process, IHS eligible persons are provided that option as well (applicable for 2014 and subsequent years). Persons in either category each claim exemption through tax-filing process.	Same as previous year.	Same as previous year.	The Marketplace would no longer make eligibility determinations for exemptions based on tribal membership or IHS eligibility. (New) eligibility determinations made only through tax-filing process. AI/ANs who already have received an exemption certificate number (ECN) from the Marketplace could continue to use their ECN on their federal income tax return to claim this exemption until such time that they no longer qualify for the exemption.

[3] This requirement will apply in 2018; CCIIO relaxed this requirement for 2017. The 2017 HHS ECP List includes available ECPs based on data maintained by CMS and other federal agencies, as well as provider data that CMS received directly from providers through the ECP petition process for the 2017 plan year. Although the provider submission window for corrections and updates for the 2017 HHS ECP List closed on January 15, 2016, the ECP petition process remains open throughout the year for providers to correct and update their data for future plan year lists.

[4] As a transition to this new policy, CMS will allow issuers to count their qualified ECP write-ins toward satisfaction of the 30 percent ECP standard for plan year 2017 as long as the issuer arranges that the written-in provider has submitted an ECP petition to CMS by no later than August 22, 2016.

Network adequacy				
Inclusion of certain percentage of available ECPs[5]	QHP issuers must contract with at least 20% of available ECPs in the service area of their plan(s).	QHP issuers must contract with at least 30% of available ECPs in the service area of their plan(s).	Same as previous year.	Same as previous year.
Inclusion of at least one ECP from each category in each county	QHP issuers must offer contracts in good faith to at least one ECP in each ECP category in each county in the service area of their plan(s), where available.	Same as previous year.	Same as previous year.	Same as previous year.
Provider directory information on ICHPs	QHP provider directories should include information about whether the provider is an IHCP.	QHP provider directories should include information about whether the provider is an IHCP, and directory information for IHCPs should describe the population they serve, as some IHCPs might limit services to AI/ANs.	Not discussed.	Same as previous year (i.e., not discussed).
Summary of Benefits and Coverage (SBC)*	QHP issuers must prepare an SBC for their plans.	QHP issuers must prepare an SBC for their plans but do not have to prepare an SBC for each plan variation, such as the zero cost-sharing variation and the limited cost-sharing variation.	QHP issuers must prepare an SBC for their plans and must prepare an SBC for each plan variation, such as the zero cost-sharing variation and the limited cost-sharing variation.	Same as previous year.
Tribal sponsorship of premiums (third-party payment of premiums and	In **§ 156.1250,** CMS "requires issuers of QHPs… to accept premium and	Same as previous year (in regulations and not Issuer Letter).	Added reference to regulations (45 CFR § 156.1250) in Issuer	Same as previous year. In addition, Tribes (and

[5] Also, see discussion under "Inclusion of ECPs on HHS ECP List" under "ECPs" above.

cost-sharing)	cost-sharing payments made on behalf of enrollees by… Indian tribes, tribal organizations, and urban Indian organizations. (In regulations, not Issuer Letter. In Issuer Letter, CMS noted that it assessed its various systems to determine how FFMs could establish a process to facilitate sponsorship and concluded FFMs do not have the ability to establish such a process. CMS encourages T/TO/Us to work with SBMs and QHPs to facilitate aggregate premium payments.		Letter.	other entities) that engage in sponsorship would have to notify HHS, indicating their intent to sponsor individuals and the number of individuals they intend to sponsor.

Sources: CCIIO Letter to Issuers in the Federally Facilitated Marketplaces, 2014-2017; HHS Notice of Benefit and Payment Parameters, 2014-2017; Summary of Benefits and Coverage and Uniform Glossary; Essential Community Provider Petition for the 2017 Benefit Year

*Applies to both FFMs and SBMs, as well as outside the Marketplace.

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf
https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf
https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf
https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf

THO Name*	IHS Service Area**	State ¥,˜	Entry on HHS ECP List for 2016	Entry on ECP List for 2017	Entry Updated on HHS ECP List for 2018***
Adak Medical Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
Akhiok Village Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
Alaska Native Medical Center	Alaska	AK	**Yes**	**Yes**	**Yes**
Alaska Native Medical Center - Fast Track	Alaska	AK	**No**	**Yes**	**No**
Alaska Native Tribal Health Consortium	Alaska	AK	**Yes**	**Yes**	**No**
Alatna Health Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Aleutian Pribilof Islands Association/St. George Traditional Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
Allakaket Health Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
Altona Brown Health Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Ambler Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Anchorage Native Primary Care Center Behavioral Health Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
Anesia Kudrin Memorial Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
Anna Hoblet Memorial Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Anna Livingston Memorial Clinic	Alaska	AK	**No**	**Yes**	**Yes**
APIAI	Alaska	AK	**Yes**	**Yes**	**No**
APIAI	Alaska	AK	**Yes**	**Yes**	**Yes**
APIAI Atka Village Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
APIAI Nikolski Village Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
APIAI Oonalaska Wellness Center	Alaska	AK	**Yes**	**Yes**	**Yes**
Arctic Slope Native Association/Samuel Simmonds Memorial Hospital	Alaska	AK	**Yes**	**Yes**	**No**
Arctic Village Health Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
BBAHC Aleknagik North Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
BBAHC Aleknagik South Side Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
BBAHC Chignik Bay Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
BBAHC Chignik Lake Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
BBAHC Clarks Point Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
BBAHC Egegik Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
BBAHC Ekwok Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
BBAHC Goodnews Bay Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
BBAHC Igiugig Health Clinic	Alaska	AK	**Yes**	**No**	**No**
BBAHC Iliamna Clinic	Alaska	AK	**Yes**	**No**	**No**
BBAHC Ivanoff Bay Clinic	Alaska	AK	**Yes**	**No**	**No**
BBAHC King Salmon Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
BBAHC Kokhanok Clinic	Alaska	AK	**Yes**	**No**	**No**
BBAHC Koliganek Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
BBAHC Levelock Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
BBAHC Lewis Point Fish Camp	Alaska	AK	**Yes**	**No**	**No**
BBAHC Manokotak Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
BBAHC Naknek Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
BBAHC New Stuyahok Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
BBAHC Newhalen Clinic	Alaska	AK	**Yes**	**No**	**No**
BBAHC Nondalton Clinic	Alaska	AK	**Yes**	**No**	**No**
BBAHC Pedro Bay Clinic	Alaska	AK	**Yes**	**No**	**No**
BBAHC Perryville Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
BBAHC Pilot Point Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
BBAHC Port Heiden Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
BBAHC Portage Creek Clinic	Alaska	AK	**Yes**	**No**	**No**
BBAHC South Naknek Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
BBAHC Togiak Clinic	Alaska	AK	**Yes**	**No**	**No**
BBAHC Togiak Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
BBAHC Twin Hills Clinic	Alaska	AK	**Yes**	**No**	**No**
BBAHC Twin Hills Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
Beaver Village Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
Behavioral Health Fireweed	Alaska	AK	**Yes**	**Yes**	**Yes**
Bessie Kaningok Health Clinic	Alaska	AK	**No**	**Yes**	**No**
Birch Creek Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
Bo Zt Ow Zho Eagle Health Clinic	Alaska	AK	**No**	**Yes**	**Yes**
CATG Yukon Flats Health Center	Alaska	AK	**Yes**	**Yes**	**Yes**
C'eyiits' Hwnax Life House Community Health Center	Alaska	AK	**No**	**Yes**	**Yes**
Chalkyitsik Village Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Chickaloon Native Village	Alaska	AK	**Yes**	**No**	**No**
Chief Andrew Issac Health Center	Alaska	AK	**Yes**	**Yes**	**Yes**

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Chignik Lagoon Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
Chitina Traditional Indian Village Council/Tribal & Community Health Center	Alaska	AK	**Yes**	**Yes**	**No**
Chugachmiut Anesia Anahonak Moonin Clinic (Port Graham)	Alaska	AK	**Yes**	**Yes**	**Yes**
Chugachmiut Chenega Bay Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
Chugachmiut Nanwalek Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
Chugachmiut North Star Health Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
Chugachmiut Tatitlek Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
Circle Village Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Cook Inlet Tribal Council	Alaska	AK	**Yes**	**Yes**	**No**
Copper River Native Association	Alaska	AK	**Yes**	**Yes**	**Yes**
CRNA Gulkana Clinic	Alaska	AK	**Yes**	**Yes**	**No**
CRNA Gulkana Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Dena A Coy Residential	Alaska	AK	**Yes**	**Yes**	**Yes**
Dena'ina Health Center (Kenai)	Alaska	AK	**Yes**	**Yes**	**Yes**
Dene Care	Alaska	AK	**Yes**	**Yes**	**No**
Dot Lake Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Edgar Nollner Health Center	Alaska	AK	**No**	**Yes**	**Yes**
Eklutna Native Village	Alaska	AK	**Yes**	**Yes**	**No**
Evansville Village Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Evelyn Alexander "To Draak" Health Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Fairbanks Native Association Graf Rheeneerhaanjii	Alaska	AK	**Yes**	**Yes**	**No**
Fairbanks Native Association Ralph Perdue Center	Alaska	AK	**Yes**	**Yes**	**No**
Fairbanks Native Association Women & Children's Center for Inner	Alaska	AK	**Yes**	**Yes**	**No**
Frank Tobuk Sr. Health Center	Alaska	AK	**No**	**Yes**	**Yes**
Igiugig Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Ilanka Community Health Center	Alaska	AK	**Yes**	**Yes**	**Yes**
Indian Creek Health Center	Alaska	AK	**No**	**Yes**	**Yes**
Kaltag Health Clinic	Alaska	AK	**No**	**Yes**	**Yes**
KANA (Alutiiq Enwia Clinic-Kodiak)	Alaska	AK	**Yes**	**Yes**	**Yes**
KANA (Mill Bay Health Clinic)	Alaska	AK	**No**	**Yes**	**Yes**
Kanakanak Hospital	Alaska	AK	**Yes**	**Yes**	**Yes**
Karluk Health Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Katherine Miksruaq Olanna Memorial Health Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Kathleen L. Kobuk Memorial Clinic (St. Michael)	Alaska	AK	**Yes**	**No**	**No**
Kenaitze Indian Tribe	Alaska	AK	**Yes**	**Yes**	**Yes**
Ketchikan Indian Community	Alaska	AK	**Yes**	**Yes**	**Yes**
King Cove Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Kivalina Village Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Knik Tribe	Alaska	AK	**Yes**	**Yes**	**No**
Kokhanok Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Kootenai Tribal Health Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Koyuk Clinic	Alaska	AK	**No**	**Yes**	**No**
Koyukuk Health Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Larsen Bay Health Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Little Diomede Clinic	Alaska	AK	**No**	**Yes**	**No**
Maniilaq Association	Alaska	AK	**Yes**	**Yes**	**Yes**
Maniilaq Association Esther Barger Memorial Health Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Maniilaq Association Kiana Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Maniilaq Association Kobuk Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Maniilaq Association Pt. Hope Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Maniilaq Association Selawik Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Maniilaq Association Utuqqanaat Inaat	Alaska	AK	**Yes**	**Yes**	**No**
Maniilaq Health Center (Kotzebue)	Alaska	AK	**Yes**	**Yes**	**No**
Maniilaq Health Center Pharmacy (Kotzebue)	Alaska	AK	**Yes**	**Yes**	**No**
Maniilaq Recovery Center	Alaska	AK	**Yes**	**Yes**	**No**
Manley Hot Springs Health Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Marilyn E. Koyukuk Evans Health Center	Alaska	AK	**No**	**Yes**	**Yes**
Mary C. Demientieff Health Clinic (Nenana)	Alaska	AK	**No**	**Yes**	**Yes**
McGrath Sub-Regional Health Center	Alaska	AK	**Yes**	**Yes**	**Yes**
Meltakatla Indian Community (Annette Island Service Unit)	N/A	AK	**Yes**	**Yes**	**No**

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Metlakatla Indian Community (Metlakatla Children's Intervention Project)	N/A	AK	**Yes**	**Yes**	**No**
Mt. Edgecumbe Hospital (Sitka) - SEARHC	Alaska	AK	**Yes**	**Yes**	**Yes**
Mt. Sanford Tribal Consortium	Alaska	AK	**Yes**	**Yes**	**No**
Myra Roberts Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
Nakenu Family Center Behavioral Health Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Natchirsvik Health Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Native Village of Eyak	Alaska	AK	**Yes**	**Yes**	**No**
Nelson Lagoon Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
Newhalen Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Nikolai Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Nilavena Subregional Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
Ninilchik Traditional Council	Alaska	AK	**Yes**	**Yes**	**Yes**
Nondalton Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Northway Health Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Norton Sound Health Corporation	Alaska	AK	**Yes**	**No**	**No**
Norton Sound Regional Hospital	Alaska	AK	**Yes**	**Yes**	**No**
NSHC Unalakleet Subregional Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Nulato Health Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Old Harbor Health Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Ouzinkie Health Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Pauline Aliitchaq Barr Health Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Platinum Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
Port Lions Health Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Quyana Club House	Alaska	AK	**Yes**	**Yes**	**Yes**
Rampart Health Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Rose Ambrose Health Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Saint Paul Health Center Behavioral Health	Alaska	AK	**No**	**Yes**	**Yes**
Sally Harvey Memorial Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Sand Point Health Center	Alaska	AK	**No**	**Yes**	**Yes**
Savoonga Clinic	Alaska	AK	**Yes**	**Yes**	**No**
SCF Cleveland Home	Alaska	AK	**Yes**	**Yes**	**No**
SCF Diabetes Wellness Gathering Program	Alaska	AK	**Yes**	**Yes**	**No**
SCF Head Start Chugach	Alaska	AK	**Yes**	**Yes**	**No**
SCF Head Start Northway Mall	Alaska	AK	**No**	**Yes**	**No**
SCF Medical Center	Alaska	AK	**Yes**	**Yes**	**No**
SCF The Pathway Home Cottonwood	Alaska	AK	**Yes**	**Yes**	**No**
SCF The Pathway Home Rendezvous	Alaska	AK	**Yes**	**Yes**	**No**
SEARHC Alicia Roberts Medical Center	Alaska	AK	**Yes**	**Yes**	**Yes**
SEARHC Alma Cook Health Center	Alaska	AK	**No**	**Yes**	**Yes**
SEARHC Angoon Health Center	Alaska	AK	**Yes**	**No**	**No**
SEARHC Ethal Lund Medical Center	Alaska	AK	**No**	**Yes**	**Yes**
SEARHC Hoonah Health Center	Alaska	AK	**Yes**	**Yes**	**Yes**
SEARHC Hydaburg Health Center	Alaska	AK	**Yes**	**No**	**No**
SEARHC Jessie Norma Jim Health Center	Alaska	AK	**No**	**Yes**	**Yes**
SEARHC Juneau Pharmacy	Alaska	AK	**Yes**	**No**	**No**
SEARHC Kake Health Center	Alaska	AK	**Yes**	**Yes**	**Yes**
SEARHC Kasaan Health Center	Alaska	AK	**Yes**	**Yes**	**Yes**
SEARHC Klukwan Health Center	Alaska	AK	**Yes**	**Yes**	**Yes**
SEARHC Montana Creek Residential Facility	Alaska	AK	**Yes**	**No**	**No**
SEARHC Pelican Health Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
SEARHC Petersburg Clinic	Alaska	AK	**Yes**	**No**	**No**
SEARHC Tenakee Springs	Alaska	AK	**Yes**	**No**	**No**
SEARHC Thorne Bay Health Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
SEARHC Yakutat Community Health Center	Alaska	AK	**Yes**	**No**	**No**
Seldovia Village Tribe/SVT Health & Wellness	Alaska	AK	**Yes**	**Yes**	**Yes**
Shungnak Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Southeast Alaska Regional Health Consortium/Haines Health Center	Alaska	AK	**Yes**	**Yes**	**Yes**
St Paul Health Center	Alaska	AK	**Yes**	**Yes**	**Yes**
St. George Village Clinic	Alaska	AK	**Yes**	**Yes**	**Yes**
St. Michael Clinic	Alaska	AK	**No**	**Yes**	**No**
Stevens Village Health Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Tanacross Health Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Tanana Native Council (Title I Contract w/IHS)	N/A	AK	**Yes**	**Yes**	**No**

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TCC Edgar Nollner Health Center	Alaska	AK	**Yes**	**No**	**No**
Teller Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Tetlin Health Clinic	Alaska	AK	**No**	**Yes**	**Yes**
The Pathway Home	Alaska	AK	**Yes**	**Yes**	**Yes**
Tigautchiaq Amainiq Health Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Toby Anungazuk Sr. Memorial Health Clinic	Alaska	AK	**Yes**	**Yes**	**No**
Tyonek, Native Village of	N/A	AK	**Yes**	**Yes**	**No**
Ukpeagvik Inupiat Corporation	Alaska	AK	**Yes**	**Yes**	**No**
Upper Tanana Health Center	Alaska	AK	**No**	**Yes**	**Yes**
Valdez Native Tribe ('638 Tribal Org.)	Alaska	AK	**Yes**	**Yes**	**No**
Valley Native Primary Care Center	Alaska	AK	**Yes**	**Yes**	**Yes**
Whittier Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yakutat Tlingit Tribe	N/A	AK	**Yes**	**Yes**	**Yes**
YKHC Yukon Kuskokwim Elder's Home	Alaska	AK	**Yes**	**No**	**No**
Yukon Kuskokwim Delta Regional Hospital	Alaska	AK	**No**	**Yes**	**Yes**
Yukon Kuskokwim Health Corporation	Alaska	AK	**Yes**	**No**	**No**
Yukon Kuskokwim Health Corporation	Alaska	AK	**Yes**	**No**	**No**
Yukon Kuskokwim Health Corporation	Alaska	AK	**Yes**	**No**	**No**
Yukon Kuskokwim Health Corporation	Alaska	AK	**Yes**	**No**	**No**
Yukon Kuskokwim Health Corporation	Alaska	AK	**Yes**	**No**	**No**
Yukon Kuskokwim Health Corporation	Alaska	AK	**Yes**	**No**	**No**
Yukon Kuskokwim Health Corporation Clinic Dispensed Pharmacy	Alaska	AK	**Yes**	**No**	**No**
Yukon-Kuskokwim Health Corporation Akiachak Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Akiak Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Alakanuk Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Anvik Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Atmautluak Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Behavioral Health	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Chefornak Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Chevak Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Chuathbaluk Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Crooked Creek Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Eek Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Grayling Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Holy Cross Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Kasigluk Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Kipnuk Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Kongiganak Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Kotlik Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Kwethluk Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Kwigillingok Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Lime Villiage Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Lower Kalskag Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Marshal Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Mccann Treatment Center	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Mekoryuk Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Mountain Village Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Napakiak Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Napaskiak Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Newtok Clinic	Alaska	AK	**No**	**Yes**	**Yes**

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Yukon-Kuskokwim Health Corporation Nightmute Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Nunam Iqua Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Nunapitchuk Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Oscarville Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Pilot Station Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Pitka's Point Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Quinhagak Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Russian Mission Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Scammon Bay Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Shageluk Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Sleetmute Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Stony River Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Tuluksak Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Tuntutuliak Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Tununak Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Upper Kalskag Clinic	Alaska	AK	**No**	**Yes**	**Yes**
Yukon-Kuskokwim Health Corporation Womens Care And Support Center	Alaska	AK	**No**	**Yes**	**Yes**
Buford L. Rolin Health Clinic	Nashville	AL	**No**	**Yes**	**Yes**
Poarch Creek Health Center	Nashville	AL	**Yes**	**Yes**	**No**
Ak-Chin Indian Community/Ak-Chin Health Station	Phoenix	AZ	**Yes**	**Yes**	**No**
Behavioral Health Services/Salt River Pima-Maricopa Indian Community	N/A	AZ	**No**	**Yes**	**Yes**
Cameron Dental	Navajo	AZ	**No**	**Yes**	**Yes**
Chinle Comprehensive Health Care Facility	Navajo	AZ	**Yes**	**Yes**	**Yes**
Cibecue Health Center	N/A	AZ	**Yes**	**Yes**	**Yes**
Clarence Wesley/Bylas Health Center	Phoenix	AZ	**Yes**	**Yes**	**Yes**
Cocopah Alcohol Center	Phoenix	AZ	**Yes**	**Yes**	**No**
Colorado River Indian Tribes Department of Health and Human Services	Phoenix	AZ	**Yes**	**Yes**	**No**
Colorado River Service Unit - Parker Hospital/Peach Springs Health Center/Supai Clinic/Chemehuevi Clinic/Moapa Clinic	Phoenix	AZ	**Yes**	**Yes**	**Yes**
Dennehotso Health Clinic (Kayenta Service Unit)	Navajo	AZ	**No**	**Yes**	**No**
Desert Visions Youth Wellness Center	N/A	AZ	**Yes**	**Yes**	**Yes**
Dilkon Health Center	N/A	AZ	**Yes**	**Yes**	**No**
Dinnebito Health Station	N/A	AZ	**Yes**	**Yes**	**No**
Fort Defiance Indian Hospital	Navajo	AZ	**Yes**	**Yes**	**No**
Fort McDowell Yavapai Nation	Phoenix	AZ	**Yes**	**Yes**	**No**
Fort Mojave Indian Health Center	N/A	AZ	**Yes**	**Yes**	**No**
Fort Yuma Clinic	Phoenix	AZ	**Yes**	**Yes**	**No**
Four Corners Regional Health Center	Navajo	AZ	**Yes**	**Yes**	**Yes**
Gila River Health Care Corporation	Phoenix	AZ	**Yes**	**No**	**No**
Gila River Indian Community	Phoenix	AZ	**Yes**	**Yes**	**No**
Greasewood Clinic	N/A	AZ	**Yes**	**Yes**	**No**
Havasupai Tribe	Phoenix	AZ	**Yes**	**No**	**No**
Hopi Health Care Center	Phoenix	AZ	**Yes**	**Yes**	**Yes**
Hualapai Tribe, Health Education & Wellness Department	Phoenix	AZ	**Yes**	**Yes**	**No**
Hu-Hu-Kam Memorial Hospital (Sacaton)	Phoenix	AZ	**Yes**	**Yes**	**No**
Inscription House Health Center	Navajo	AZ	**Yes**	**Yes**	**Yes**
Inscription House Health Center (Kayenta Service Unit)	Navajo	AZ	**Yes**	**Yes**	**No**
Inter-Tribal Council of Arizona	Phoenix	AZ	**Yes**	**Yes**	**No**

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Kaibab Band of Paiute Indians	Phoenix	AZ	**Yes**	**Yes**	**No**
Kayenta Health Center	Navajo	AZ	**Yes**	**Yes**	**Yes**
LeChee Health Facility	Navajo	AZ	**No**	**Yes**	**Yes**
Leupp Health Center	N/A	AZ	**Yes**	**Yes**	**No**
Nahata Dziil Health Center	N/A	AZ	**Yes**	**Yes**	**No**
Native American Cardiology Program	N/A	AZ	**Yes**	**Yes**	**Yes**
Native American Community Health Center, Inc. (Phoenix, AZ)	N/A	AZ	**Yes**	**Yes**	**No**
Native Americans for Community Action (Flagstaff, AZ)/NACA Family Health Center	N/A	AZ	**Yes**	**Yes**	**Yes**
Native Health Central	N/A	AZ	**No**	**Yes**	**Yes**
Navajo Nation	Navajo	AZ	**Yes**	**Yes**	**No**
NHW Community Health Center	N/A	AZ	**No**	**Yes**	**Yes**
Pascua Yaqui Tribe/Health Center	Tuscon	AZ	**Yes**	**Yes**	**Yes**
Peach Springs Health Center (included in Colorado River Service Unit)	N/A	AZ	**Yes**	**Yes**	**Yes**
Phoenix Indian Medical Center	Phoenix	AZ	**Yes**	**Yes**	**Yes**
Pinon Health Center	Navajo	AZ	**Yes**	**Yes**	**Yes**
Sacred Peaks Health Center	N/A	AZ	**Yes**	**Yes**	**Yes**
Sage Memorial Hospital	N/A	AZ	**Yes**	**Yes**	**No**
Salt River Health Center	N/A	AZ	**Yes**	**Yes**	**Yes**
Salt River Tribal Health Center (includes Alcohol Program)	N/A	AZ	**Yes**	**Yes**	**Yes**
San Carlos Apache Health Care Corporation	Phoenix	AZ	**Yes**	**Yes**	**Yes**
San Carlos Apache Wellness Center	Phoenix	AZ	**Yes**	**Yes**	**Yes**
San Juan Southern Paiute Tribe	N/A	AZ	**Yes**	**Yes**	**No**
San Simon Health Center	Tuscon	AZ	**Yes**	**Yes**	**Yes**
San Xavier Health Center	Tuscon	AZ	**Yes**	**Yes**	**Yes**
Santa Rosa Health Center	Tuscon	AZ	**Yes**	**Yes**	**Yes**
Sells Hospital	Tuscon	AZ	**Yes**	**Yes**	**Yes**
Supai Health Clinic	Phoenix	AZ	**No**	**Yes**	**Yes**
Tohono O'odham Nation/Alcohol Program San Lucy/High School Health center	Tuscon	AZ	**Yes**	**Yes**	**No**
Tonto Apache Tribal Alcohol Center	Phoenix	AZ	**Yes**	**Yes**	**No**
Tsaile Health Center	Navajo	AZ	**Yes**	**Yes**	**Yes**
Tuba City Regional Health Care Corporation	Navajo	AZ	**Yes**	**Yes**	**Yes**
Tucson Indian Center (Tucson, AZ)	N/A	AZ	**Yes**	**Yes**	**No**
Wassaja Memorial Health Center	Phoenix	AZ	**No**	**Yes**	**Yes**
White Mountain Apache Behavioral Health Services (Guidance Center)	Phoenix	AZ	**Yes**	**Yes**	**No**
Whiteriver Indian Hospital	Phoenix	AZ	**Yes**	**Yes**	**Yes**
Winslow Indian Health Care Center	Navajo	AZ	**Yes**	**No**	**No**
Yavapai Apache Health Station and Alcohol Center	Phoenix	AZ	**Yes**	**Yes**	**No**
Yavapai Prescott Alcohol Center	Phoenix	AZ	**Yes**	**Yes**	**No**
Agua Caliente Band of Cahuilla - Riverside San-Bernardino County Indian Health, Inc.	California	CA	**Yes**	**Yes**	**No**
American Indian Health & Services Corporation (Santa Barbara)	California	CA	**Yes**	**Yes**	**Yes**
Anza Indian Health - Outreach Office	California	CA	**Yes**	**Yes**	**Yes**
Bakersfield American Indian Health Project	California	CA	**Yes**	**Yes**	**No**
Barstow Indian Health	California	CA	**Yes**	**Yes**	**No**
Cabazon Band of Mission Indians (Indio)	California	CA	**Yes**	**Yes**	**No**
Central Valley Indian Health, Inc. (Clovis)	California	CA	**Yes**	**Yes**	**Yes**
Central Valley Indian Health, Prather Clinic	California	CA	**Yes**	**Yes**	**Yes**
Chapa-De Indian Health Program, Inc. (Auburn)	California	CA	**Yes**	**Yes**	**No**
Coleville Clinic	California	CA	**No**	**Yes**	**Yes**
Colusa Indian Health Community Council/Clinic	California	CA	**Yes**	**Yes**	**No**
Consolidated Tribal Health Project, Inc. (Redwood Valley)	California	CA	**Yes**	**Yes**	**Yes**
Feather River Tribal Health (Oroville)	California	CA	**Yes**	**Yes**	**Yes**
Feather River Tribal Health (Yuba City)	California	CA	**No**	**Yes**	**Yes**
Fort Mojave Indian Tribe	California	CA	**Yes**	**Yes**	**No**
Fort Yuma Health Center	California	CA	**No**	**Yes**	**Yes**
Fresno American Indian Health Project	California	CA	**Yes**	**Yes**	**Yes**

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Friendship House Association of American Indians (San Francisco)	California	CA	**Yes**	**Yes**	**No**
Grass Valley Clinic	California	CA	**Yes**	**Yes**	**No**
Greenville Rancheria Tribal Health Program	California	CA	**Yes**	**Yes**	**No**
Indian Health Center of Santa Clara Valley (San Jose)	California	CA	**Yes**	**Yes**	**No**
Indian Health Council, Inc. (Valley Center)	California	CA	**Yes**	**Yes**	**No**
Jackson Rancheria Health Center - M.A.C.T. Health Board, Inc.	California	CA	**Yes**	**Yes**	**Yes**
Karuk Tribal Health Clinic - Yreka	California	CA	**Yes**	**Yes**	**No**
Karuk Tribe - Orleans Clinic	California	CA	**Yes**	**Yes**	**No**
Karuk Tribe (Happy Camp)/Karuk Community Health Clinic	California	CA	**Yes**	**Yes**	**No**
K'ima:w Medical Center (Hoopa)	California	CA	**Yes**	**Yes**	**No**
La Posta Outreach Substance Abuse Center	California	CA	**Yes**	**Yes**	**No**
Lake County Tribal Health Clinic - Middletown Clinic	California	CA	**No**	**Yes**	**No**
Lake County Tribal Health Clinic - Pediatrics & Obstetrics	California	CA	**No**	**Yes**	**No**
Lake County Tribal Health Clinic - South Shore Clinic	California	CA	**No**	**Yes**	**No**
Lake County Tribal Health Consortium, Inc.	California	CA	**Yes**	**Yes**	**Yes**
Lone Pine Indian Health Clinic	California	CA	**Yes**	**Yes**	**No**
Manchester-Point Arena Clinic	California	CA	**Yes**	**Yes**	**No**
Mariposa Indian Health Center - M.A.C.T. Health Board, Inc.	California	CA	**Yes**	**Yes**	**Yes**
Mathiesen Memorial Health Clinic (Jamestown)	California	CA	**Yes**	**Yes**	**No**
Morongo Indian Health Clinic	California	CA	**Yes**	**Yes**	**Yes**
Native American Health Center, Inc. (Oakland)	California	CA	**Yes**	**Yes**	**Yes**
Native American Health Center, Inc. (San Francisco, CA)	California	CA	**Yes**	**Yes**	**No**
Native Directions, Inc. (Manteca)	California	CA	**Yes**	**Yes**	**No**
North Fork Indian & Community Health Center	California	CA	**Yes**	**Yes**	**Yes**
Northern Valley Indian Health - Chico	California	CA	**Yes**	**Yes**	**No**
Northern Valley Indian Health - Children's Center	California	CA	**Yes**	**Yes**	**No**
Northern Valley Indian Health - Willows Clinic	California	CA	**Yes**	**Yes**	**No**
Northern Valley Indian Health - Woodland Clinic	California	CA	**Yes**	**Yes**	**No**
Pechanga Indian Health Center	California	CA	**Yes**	**Yes**	**Yes**
Pit River Health Service, Inc. (Burney Clinic)	California	CA	**Yes**	**Yes**	**Yes**
Pit River Health Service, Inc. (XL Clinic)	California	CA	**Yes**	**Yes**	**Yes**
Potawot Health Village (UIHS)	California	CA	**Yes**	**Yes**	**Yes**
Quartz Valley Program (Fort Jones)/Anav Tribal Health Clinic	California	CA	**Yes**	**Yes**	**No**
Red Bluff Clinic	California	CA	**Yes**	**Yes**	**No**
Red Bluff Dental Clinic	California	CA	**Yes**	**Yes**	**No**
Redding Rancheria Indian Health Clinic	California	CA	**Yes**	**Yes**	**No**
Rolling Hills Clinic (Corning)	California	CA	**Yes**	**Yes**	**No**
Rolling Hills Clinic (Red Bluff)	California	CA	**Yes**	**Yes**	**No**
Round Valley Indian Health Center, Inc. (Covelo)	California	CA	**Yes**	**Yes**	**No**
Sacramento Native American Health Center, Inc	California	CA	**Yes**	**Yes**	**Yes**
San Andreas Community Clinic - M.A.C.T. Health Board, Inc.	California	CA	**Yes**	**Yes**	**Yes**
San Diego American Indian Health Center	California	CA	**Yes**	**Yes**	**Yes**
San Manual Health Clinic	California	CA	**Yes**	**Yes**	**Yes**
Santa Ynez Tribal Health Program	California	CA	**Yes**	**No**	**No**
Santa Ysabel Community Health Center	California	CA	**Yes**	**Yes**	**No**
Sherman Indian School Clinic	California	CA	**No**	**Yes**	**Yes**
Shingle Springs Tribal Health Program	California	CA	**Yes**	**Yes**	**No**
Soboba Health Clinic	California	CA	**Yes**	**Yes**	**No**
Sonoma County Indian Health (Santa Rosa)	California	CA	**Yes**	**Yes**	**Yes**
Sonora Indian Health Center - M.A.C.T. Health Board, Inc.	California	CA	**Yes**	**Yes**	**Yes**
Southern Indian Health Council - Campo Clinic	California	CA	**Yes**	**Yes**	**Yes**
Southern Indian Health Council, Inc. (Alpine)	California	CA	**Yes**	**Yes**	**Yes**
Strong Family Health Center (Alturas)	California	CA	**Yes**	**Yes**	**No**
Susanville Indian Rancheria/Lassen Indian Health Center	California	CA	**Yes**	**Yes**	**No**

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Sycuan Band of Mission Indians (El Cajon)/Sycuan Medica Dental Center	California	CA	**Yes**	**Yes**	**Yes**
Table Mountain Medical (Friant)/Table Mountain Rancheria Medical Center	California	CA	**Yes**	**Yes**	**No**
Tachi Medical Center	California	CA	**Yes**	**Yes**	**Yes**
Toiyabe Indian Health Project, Inc. (Bishop)	California	CA	**Yes**	**Yes**	**No**
Torres-Martinez Health Clinic	California	CA	**Yes**	**Yes**	**Yes**
Tule River Alcohol Program (Porterville)	California	CA	**No**	**No**	**No**
Tule River Indian Health Center, Inc. (Porterville)	California	CA	**Yes**	**Yes**	**Yes**
Tuolumne Me-Wuk Health and Wellness Center (Sonora)	California	CA	**Yes**	**Yes**	**Yes**
Tuolumne Me-Wuk Indian Health Center (Tuolumne)	California	CA	**Yes**	**Yes**	**Yes**
UIHS - Crescent City Medical Center	California	CA	**Yes**	**Yes**	**Yes**
UIHS - Fortuna Health Center	California	CA	**Yes**	**Yes**	**Yes**
UIHS - Howonquet Health Center	California	CA	**Yes**	**Yes**	**Yes**
UIHS - Klamath Health Center	California	CA	**Yes**	**Yes**	**Yes**
UIHS - Weitchpec Health Center	California	CA	**Yes**	**Yes**	**Yes**
United American Indian Involvement, Inc. (Los Angeles)	California	CA	**Yes**	**Yes**	**No**
Warner Mountain Indian Health Program (Ft. Bidwell)	California	CA	**Yes**	**Yes**	**No**
Yuba City Indian Health Station	California	CA	**Yes**	**Yes**	**No**
Denver Indian Health and Family Services (Denver, CO)	N/A	CO	**Yes**	**Yes**	**Yes**
Southern Ute Indian Tribe/Southern Ute (Ignacio) Health Center/White Mesa Health Station	N/A	CO	**Yes**	**Yes**	**No**
Ute Mountain Ute Health Center	Albuquerque	CO	**Yes**	**Yes**	**No**
Mashantucket Pequot Health Center	Nashville	CT	**Yes**	**Yes**	**Yes**
Mohegan Tribe of Indians of Connecticut	Nashville	CT	**Yes**	**Yes**	**No**
Big Cypress Health Center	N/A	FL	**Yes**	**Yes**	**No**
Brighton Health Center	N/A	FL	**Yes**	**Yes**	**No**
Hollywood Health Center	N/A	FL	**Yes**	**Yes**	**No**
Immokalee Health Center	N/A	FL	**Yes**	**Yes**	**No**
Miccosukee Health Center	Nashville	FL	**Yes**	**Yes**	**No**
Seminole Tribe of Florida	Nashville	FL	**Yes**	**No**	**No**
Access to Health Care Services for American Indians Living in Hawaii Ke Ola Mamo	California	HI	**No**	**No**	**No**
Papa Ola Lokahi	N/A	HI	**Yes**	**Yes**	**No**
Meskwaki Tribal Health Center (Sac and Fox)	Great Plains	IA	**Yes**	**Yes**	**Yes**
Benewah Medical Center	N/A	ID	**Yes**	**Yes**	**Yes**
Coeur D'Alene Tribal Wellness Center	Portland	ID	**Yes**	**Yes**	**No**
Fort Hall Service Unit/Nto-Tsoo Gah-Nee Indian Health Center	Portland	ID	**Yes**	**No**	**No**
Kootenai Tribal Health Clinic	Portland	ID	**Yes**	**Yes**	**Yes**
Nez Perce Tribe	Portland	ID	**Yes**	**No**	**No**
Ni-Mii-Puu Health Center-Kamiah	N/A	ID	**Yes**	**Yes**	**No**
Ni-Mii-Puu Tribal Health Center	N/A	ID	**Yes**	**Yes**	**Yes**
Pocatello Tribal Office	N/A	ID	**Yes**	**Yes**	**No**
Shoshone-Bannock Tribal Health	Portland	ID	**Yes**	**Yes**	**No**
American Indian Health Service (Chicago)	Bemidji	IL	**Yes**	**Yes**	**Yes**
Haskell Indian Health Center	Oklahoma City	KS˜	**Yes**	**Yes**	**Yes**
Hunter Health Clinic	Oklahoma City	KS˜	**Yes**	**No**	**No**
Iowa Tribe	N/A	KS˜	**Yes**	**No**	**No**
Kickapoo Nation Health Center	Oklahoma City	KS˜	**Yes**	**Yes**	**No**
Prairie Band Potawatomi Tribe	Oklahoma City	KS˜	**Yes**	**Yes**	**No**
White Cloud Indian Health Station	Oklahoma City	KS˜	**Yes**	**Yes**	**Yes**
Lon Lafferty, MD	N/A	KY	**Yes**	**Yes**	**No**
London Women's Care, PLLC	N/A	KY	**Yes**	**Yes**	**No**
Chitimacha Health Center	N/A	LA	**Yes**	**Yes**	**Yes**
Coushatta Health Station	Nashville	LA	**Yes**	**Yes**	**No**
Jena Band of Choctaw Indians	Nashville	LA	**Yes**	**Yes**	**No**
Tunica-Biloxi Tribe of Louisiana	Nashville	LA	**Yes**	**Yes**	**No**
Mashpee Wampanoag Health Service Unit	Nashville	MA	**Yes**	**Yes**	**Yes**
Native American Lifelines Foundation, Inc. of Boston	Nashville	MA	**Yes**	**Yes**	**No**
Wampanoag Health Center	Nashville	MA	**Yes**	**Yes**	**No**
Native American Lifelines Foundation, Inc. of Baltimore	Nashville	MD	**No**	**No**	**No**

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Houlton Band of Maliseet Indians	Nashville	ME˜	**No**	**Yes**	**Yes**
Houlton Health Center	Nashville	ME˜	**Yes**	**Yes**	**No**
Micmac Service Unit/Presque Isle Health Center	Nashville	ME˜	**Yes**	**Yes**	**Yes**
Passamaquoddy Tribe Indian Township	Nashville	ME˜	**Yes**	**Yes**	**No**
Passamaquoddy Tribe Pleasant Point	Nashville	ME˜	**Yes**	**No**	**No**
Penobscot Health Center	Nashville	ME˜	**Yes**	**Yes**	**No**
Penobscot Nation Health Department	Nashville	ME˜	**No**	**Yes**	**Yes**
American Indian Health & Family Services of Southeast Michigan (Detroit Urban)	Bemidji	MI	**Yes**	**Yes**	**Yes**
Bay Mills Ellen Marshall Memorial Health Center	Bemidji	MI	**Yes**	**Yes**	**Yes**
Hannahville Health Center	Bemidji	MI	**Yes**	**Yes**	**Yes**
Keweenaw Bay Indian Community Health Center	Bemidji	MI	**Yes**	**Yes**	**Yes**
Lac Vieux Desert Band of Lake Superior Chippewa Indians, Michigan	Bemidji	MI	**Yes**	**Yes**	**No**
Little River Band of Ottawa Indians, Michigan	Bemidji	MI	**Yes**	**Yes**	**No**
Little Traverse Bay Band of Odawa Indians, Michigan	Bemidji	MI	**Yes**	**Yes**	**No**
Manistique Tribal Health Center	Bemidji	MI	**No**	**Yes**	**Yes**
Match-e-be-nash-she-wish Band of Pottawatomi Indians of Michigan	Bemidji	MI	**Yes**	**Yes**	**No**
Munising Tribal Health Center	Bemidji	MI	**No**	**Yes**	**Yes**
Nottawaseppi Huron Band of Potawatomi, Michigan	Bemidji	MI	**Yes**	**Yes**	**No**
Pokagon Band of Potawatomi Health Center	Bemidji	MI	**Yes**	**Yes**	**No**
Pokagon Health Services	Bemidji	MI	**No**	**Yes**	**Yes**
Saginaw Chippewa Indian of Michigan	Bemidji	MI	**Yes**	**Yes**	**No**
Sault Tribal Health Center	Bemidji	MI	**Yes**	**Yes**	**Yes**
St. Ignace Tribal Health Center	Bemidji	MI	**No**	**Yes**	**Yes**
Bois Forte Band (Nett Lake Health Center)	Bemidji	MN	**Yes**	**Yes**	**No**
Cass Lake Hospital	Bemidji	MN	**Yes**	**Yes**	**Yes**
Fond du Lac Band	Bemidji	MN	**Yes**	**Yes**	**Yes**
Grand Portage Band	Bemidji	MN	**Yes**	**Yes**	**No**
Leech Lake Band	Bemidji	MN	**Yes**	**Yes**	**No**
Lower Sioux Indian Community in the State of Minnesota	Bemidji	MN	**Yes**	**Yes**	**No**
Mille Lacs Band	Bemidji	MN	**Yes**	**Yes**	**Yes**
Minneapolis Indian Health Board, Inc. (Minneapolis Urban)	Bemidji	MN	**Yes**	**Yes**	**Yes**
Prairie Island Indian Community Family Health Clinic	Bemidji	MN	**Yes**	**Yes**	**No**
Red Lake Band of Chippewa Indians, Minnesota	Bemidji	MN	**Yes**	**Yes**	**No**
Red Lake Hospital	Bemidji	MN	**Yes**	**Yes**	**Yes**
Shakopee Mdewakanton Sioux Community of Minnesota	Bemidji	MN	**Yes**	**Yes**	**No**
Upper Sioux Community, Minnesota	Bemidji	MN	**Yes**	**Yes**	**No**
White Earth Band	Bemidji	MN	**Yes**	**Yes**	**Yes**
White Earth Health Center	Bemidji	MN	**Yes**	**Yes**	**Yes**
Bogue Chitto Community Satellite Clinic	Nashville	MS	**No**	**Yes**	**Yes**
Choctaw Hospital (Philadelphia)	Nashville	MS	**Yes**	**Yes**	**Yes**
Conehatta Community Satellite Clinic	Nashville	MS	**No**	**Yes**	**Yes**
Mantachie Rural Health Dental Clinic	Nashville	MS	**No**	**Yes**	**Yes**
Mississippi Band of Choctaw Indians	Nashville	MS	**Yes**	**No**	**No**
Red Water Community Satellite Clinic	Nashville	MS	**No**	**Yes**	**Yes**
Arlee Health Station	N/A	MT˜	**Yes**	**Yes**	**Yes**
Blackfeet Community Hospital (Browning Indian Hospital)	Billings	MT˜	**Yes**	**Yes**	**Yes**
Blackfeet Tribal Health	Billings	MT˜	**No**	**Yes**	**Yes**
Chief Sits In the Middle Nursing Home	N/A	MT˜	**No**	**Yes**	**No**
Chippewa-Cree Tribe - (Rocky Boy's)	Billings	MT˜	**Yes**	**Yes**	**Yes**
Contract Health Representatives	N/A	MT˜	**No**	**Yes**	**No**
Crow Tribe of Montana (Crow Agency Indian Hospital)	Billings	MT˜	**Yes**	**Yes**	**Yes**
Crystal Creek Lodge	N/A	MT˜	**Yes**	**Yes**	**Yes**
Elmo Health Station	Billings	MT˜	**No**	**Yes**	**Yes**
Emergency Medical Services	N/A	MT˜	**No**	**Yes**	**No**
Family Violence Resource Center	N/A	MT˜	**No**	**Yes**	**No**
Flathead Tribal (St. Ignatius) Health Center	Billings	MT˜	**Yes**	**Yes**	**Yes**
Fort Belknap Indian Community (Harlem Indian Hospital)	Billings	MT˜	**Yes**	**Yes**	**Yes**

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Fort Belknap Treatment Center (CDC)	Billings	MT˜	**No**	**Yes**	**No**
Fort Peck Tribal Health Department	Billings	MT˜	**No**	**Yes**	**Yes**
Fort Peck Tribal Health Program (Verne E. Gibbs Health Center(Poplar))	Billings	MT˜	**Yes**	**Yes**	**Yes**
Ft. Belknap Tribal Health Program	Billings	MT˜	**No**	**Yes**	**No**
Hayes Health Center	N/A	MT˜	**Yes**	**Yes**	**No**
Hays (Eagle Child) Health Station	Billings	MT˜	**Yes**	**No**	**No**
Heart Butte Health Station	Billings	MT˜	**Yes**	**Yes**	**No**
Helena Indian Alliance	N/A	MT˜	**Yes**	**Yes**	**Yes**
Hot Springs	N/A	MT˜	**No**	**Yes**	**No**
Indian Family Health Clinic (Great Falls, MT)	N/A	MT˜	**Yes**	**Yes**	**Yes**
Indian Health Board of Billings (Billings, MT)	N/A	MT˜	**Yes**	**Yes**	**No**
Lame Deer Health Center (Northern Cheyenne Tribe)	Billings	MT˜	**Yes**	**Yes**	**Yes**
Lodge Grass Health Center	Billings	MT˜	**Yes**	**Yes**	**Yes**
Mental Health - HPDP	Billings	MT˜	**No**	**Yes**	**Yes**
Missoula Indian Center	N/A	MT˜	**Yes**	**Yes**	**No**
NC Tribal Board of Health Ambulance	Billings	MT˜	**No**	**Yes**	**No**
NC Tribal Board of Health Behavioral Health	Billings	MT˜	**No**	**Yes**	**No**
NC Tribal Board of Health PHN	Billings	MT˜	**No**	**Yes**	**No**
NC Tribal Board of Health Wellness	Billings	MT˜	**No**	**Yes**	**No**
North American Indian Alliance (Butte, MT)	N/A	MT˜	**Yes**	**Yes**	**No**
Northern Cheyenne Recovery Program	Billings	MT˜	**Yes**	**Yes**	**No**
Polson Health Center	Billings	MT˜	**No**	**Yes**	**Yes**
Pryor Health Center/Health Station	Billings	MT˜	**Yes**	**Yes**	**Yes**
Ronan Health Station	Billings	MT˜	**No**	**Yes**	**Yes**
Spotted Bull Treatment Center	Billings	MT˜	**No**	**Yes**	**No**
Tribal Health Diabetes	N/A	MT˜	**No**	**Yes**	**No**
White Sky Hope Center - Rocky Boy	Billings	MT˜	**Yes**	**Yes**	**Yes**
Wolf Point (Chief Redstone) Indian Health Center	Billings	MT˜	**Yes**	**Yes**	**Yes**
Cherokee Hospital	Nashville	NC	**No**	**Yes**	**No**
Cherokee Indian Hospital	Nashville	NC	**Yes**	**Yes**	**Yes**
Eastern Band of Cherokee	N/A	NC	**Yes**	**Yes**	**No**
Unity Healing Center/Regional Youth Treatment Center	Nashville	NC	**Yes**	**Yes**	**No**
Elbowoods Memorial Health Center	N/A	ND	**Yes**	**Yes**	**Yes**
Fort Berthhold Service Unit (Minni-Tohe) Health Center	N/A	ND	**Yes**	**Yes**	**No**
Fort Totten Service Unit/Spirit Lake Health Center	Great Plains	ND	**Yes**	**Yes**	**No**
Fort Yates Hospital (Standing Rock Service Unit)	Great Plains	ND	**Yes**	**Yes**	**No**
Quentin N. Burdick Hospital/Belcourt Indian Hospital	Great Plains	ND	**Yes**	**Yes**	**Yes**
TAT Kidney Dialysis Unit	N/A	ND	**Yes**	**Yes**	**No**
Trenton Service Unit	Great Plains	ND	**Yes**	**Yes**	**No**
Turtle Mountain Band of Chippewa Indians	Great Plains	ND	**Yes**	**Yes**	**No**
Carl T. Curtis Health Center	N/A	NE˜	**Yes**	**Yes**	**Yes**
Four Hills of Life Wellness Center	N/A	NE˜	**Yes**	**Yes**	**No**
Fred LeRoy Health & Wellness Center	N/A	NE˜	**Yes**	**Yes**	**Yes**
Macy Alcohol Counseling Center	N/A	NE˜	**Yes**	**Yes**	**No**
Nebraska Urban Indian Health Coalition, Inc. (Omaha, NE)	N/A	NE˜	**Yes**	**Yes**	**No**
Omaha Service Unit	Great Plains	NE˜	**No**	**No**	**No**
Ponca Hills Health & Wellness	Great Plains	NE˜	**No**	**Yes**	**Yes**
Santee Health Center	Great Plains	NE˜	**Yes**	**Yes**	**No**
Winnebago Hospital	Great Plains	NE˜	**Yes**	**Yes**	**Yes**
Winnebago Tribe of Nebraska Health	Great Plains	NE˜	**No**	**Yes**	**Yes**
Acoma-Canoncito-Laguna Hospital	Albuquerque	NM	**Yes**	**Yes**	**Yes**
Alamo Navajo Health Center	N/A	NM	**Yes**	**Yes**	**No**
Albuquerque Indian Dental Clinic	Albuquerque	NM	**Yes**	**Yes**	**No**
Albuquerque Indian Hospital	Albuquerque	NM	**Yes**	**Yes**	**No**
Canocito Health Center (To'hajiilee)	N/A	NM	**Yes**	**Yes**	**No**
Cochiti Health Center	N/A	NM	**Yes**	**Yes**	**No**
Crownpoint Health Care Facility	Navajo	NM	**Yes**	**Yes**	**Yes**
Dzilth-Na-O-Dith-Hle Health Center	Navajo	NM	**Yes**	**Yes**	**Yes**
First Nations Community Healthsource (Albuquerque, NM)	N/A	NM	**Yes**	**Yes**	**Yes**

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Five Sandoval Behavioral Health	N/A	NM	**Yes**	**Yes**	**No**
Gallup Indian Medical Center	Navajo	NM	**Yes**	**Yes**	**Yes**
Isleta Health Center	N/A	NM	**Yes**	**Yes**	**No**
Jemez Health Center	N/A	NM	**Yes**	**Yes**	**No**
Jicarilla/Dulce Health Center	Albuquerque	NM	**Yes**	**Yes**	**No**
Kewa Pueblo Health Center (Santo Domingo)	N/A	NM	**Yes**	**Yes**	**Yes**
Laguna Dental Clinic	N/A	NM	**Yes**	**Yes**	**No**
Mescalero Hospital/Service Unit	Albuquerque	NM	**Yes**	**Yes**	**Yes**
New Sunrise Regional Treatment Center	Albuquerque	NM	**Yes**	**Yes**	**No**
Pine Hill Health Center	N/A	NM	**Yes**	**Yes**	**Yes**
Pueblo of Jemez	N/A	NM	**Yes**	**Yes**	**No**
Pueblo Pintado Health Center	N/A	NM	**Yes**	**Yes**	**Yes**
San Felipe Health Center	N/A	NM	**Yes**	**Yes**	**No**
Sandia Health Center	N/A	NM	**Yes**	**Yes**	**No**
Sanostee Health Station	Navajo	NM	**No**	**Yes**	**Yes**
Santa Ana Health Center	Albuquerque	NM	**Yes**	**Yes**	**No**
Santa Clara Health Center	N/A	NM	**Yes**	**Yes**	**No**
Santa Fe Indian Hospital	Albuquerque	NM	**Yes**	**Yes**	**No**
Shiprock-Northern Navajo Medical Center	Navajo	NM	**Yes**	**Yes**	**Yes**
Taos-Picuris Health Center	Albuquerque	NM	**Yes**	**Yes**	**Yes**
Thoreau Health Station	N/A	NM	**Yes**	**Yes**	**Yes**
Toadlena Health Station	Navajo	NM	**No**	**Yes**	**Yes**
Tohatchi Health Care Center	Navajo	NM	**Yes**	**Yes**	**Yes**
Zia Health Clinic	Albuquerque	NM	**Yes**	**Yes**	**No**
Zuni Comprehensive Health Center	Albuquerque	NM	**Yes**	**Yes**	**Yes**
Battle Mountain Health Station	Phoenix	NV	**Yes**	**Yes**	**No**
Duck Valley Shoshone-Paiute Tribes	N/A	NV	**Yes**	**Yes**	**No**
Duckwater Shoshone Tribe	Phoenix	NV	**Yes**	**Yes**	**No**
Elko Service Unit/Southern Bands Health Center	Phoenix	NV	**Yes**	**Yes**	**Yes**
Ely Shoshone Tribe/Ely Shoshone Tribal Clinic/Health Station/Ely Shoshone Alcohol Center	Phoenix	NV	**Yes**	**Yes**	**No**
Fallon Paiute-Shoshone Health Center	N/A	NV	**Yes**	**Yes**	**Yes**
Fort McDermitt Health Station	Phoenix	NV	**Yes**	**Yes**	**Yes**
Inter-Tribal Council of Nevada	Phoenix	NV	**Yes**	**Yes**	**No**
Irene Benn Medical Center (Moapa Clinic)	N/A	NV	**Yes**	**Yes**	**Yes**
Las Vegas Paiute Health Station	Phoenix	NV	**Yes**	**Yes**	**No**
Lovelock Paiute Tribe	Phoenix	NV	**Yes**	**Yes**	**No**
Moapa Band of Paiute Indians	Phoenix	NV	**Yes**	**Yes**	**No**
Nevada Skies Youth Wellness Center	N/A	NV	**Yes**	**Yes**	**Yes**
Nevada Urban Indians, Inc (Reno, NV)	N/A	NV	**Yes**	**Yes**	**No**
Owyhee Community Health Center	Phoenix	NV	**Yes**	**Yes**	**Yes**
Pyramid Lake Tribal Health Center	Phoenix	NV	**Yes**	**Yes**	**No**
Reno Sparks Shoshone Paiute Health Center	Phoenix	NV	**Yes**	**Yes**	**Yes**
Schurz Service Unit	Phoenix	NV	**Yes**	**No**	**No**
Summit Lake Paiute Tribe	Phoenix	NV	**Yes**	**Yes**	**No**
Te-Moak Tribe - Elko Colony	Phoenix	NV	**Yes**	**Yes**	**No**
Te-Moak Tribe - South Fork	Phoenix	NV	**Yes**	**Yes**	**No**
Te-Moak Tribe - Wells Colony	Phoenix	NV	**Yes**	**Yes**	**No**
Te-Moak Tribe of Western Shoshone	Phoenix	NV	**Yes**	**Yes**	**No**
Walker River Tribe/Tribal Health Center Alcohol Center	Phoenix	NV	**Yes**	**Yes**	**No**
Washoe Tribe Health Center	Phoenix	NV	**Yes**	**Yes**	**Yes**
Winnemucca Indian Colony	Phoenix	NV	**Yes**	**Yes**	**No**
Yerington Tribal Health Center	Phoenix	NV	**Yes**	**Yes**	**No**
Yomba Shoshone Tribe (Yomba Res.)	Phoenix	NV	**Yes**	**Yes**	**No**
American Indian Community House	Nashville	NY	**Yes**	**Yes**	**No**
Cattaraugus I.R. Health Center	N/A	NY	**Yes**	**Yes**	**Yes**
Cayuga Nation	Nashville	NY	**Yes**	**Yes**	**No**
Lockport Service Unit	Nashville	NY	**Yes**	**Yes**	**Yes**
Manilus Service Unit	N/A	NY	**Yes**	**Yes**	**No**
Oneida Indian Nation Health Services	Nashville	NY	**Yes**	**Yes**	**No**
Onondaga Nation	N/A	NY	**Yes**	**Yes**	**No**
Seneca Nation (Lionel R. John Health Center)	Nashville	NY	**Yes**	**Yes**	**Yes**
Shinnecock Indian Nation	N/A	NY	**Yes**	**Yes**	**Yes**
St. Regis Mohawk Health Center	Nashville	NY	**Yes**	**Yes**	**Yes**

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Tonawanda Seneca Nation	Nashville	NY	**Yes**	**Yes**	**No**
Tuscarora Nation	N/A	NY	**Yes**	**Yes**	**No**
River East Community Health Center	N/A	OH	**No**	**Yes**	**Yes**
Absentee Shawnee Tribal Clinic	Oklahoma City	OK	**Yes**	**Yes**	**No**
Absentee Shawnee Tribe	Oklahoma City	OK	**Yes**	**Yes**	**No**
Alabama-Quassarte Tribal Town	N/A	OK	**Yes**	**Yes**	**No**
Anadarko Indian Health Center	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Apache Tribe	N/A	OK	**Yes**	**Yes**	**No**
Ardmore Health Center	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Bartlesville Health Clinic	Oklahoma City	OK	**Yes**	**Yes**	**No**
Bearskin Health Center	Oklahoma City	OK	**Yes**	**Yes**	**No**
Black Hawk Health Center	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Caddo Tribe	N/A	OK	**Yes**	**Yes**	**No**
Carnegie Indian Health Center	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Cherokee Nation A-MO Health Center (Salina Community Clinic)	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Cherokee Nation Ga Du Gi Clinic	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Cherokee Nation W.W. Hastings Hospital	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Cherokee-Program All-Inclusive Care for Elderly	Oklahoma City	OK	**Yes**	**Yes**	**No**
Chickasaw Nation - Purcell Indian Health Clinic	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Chickasaw Nation Medical Center (Carl Albert Indian Hospital)	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Choctaw Nation	Oklahoma City	OK	**Yes**	**No**	**No**
Choctaw Nation Health Clinic and Hospital Talihina	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Choctaw Nation Health Clinic Atoka	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Choctaw Nation Health Clinic Broken Bow	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Choctaw Nation Health Clinic Durant	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Choctaw Nation Health Clinic Hugo	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Choctaw Nation Health Clinic Idabel	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Choctaw Nation Health Clinic McAlester	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Choctaw Nation Health Clinic Poteau	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Choctaw Nation Health Clinic Stigler	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Citizen Potawatomi Nation	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Citizen Potawatomi Nation West Clinic	Oklahoma City	OK	**No**	**Yes**	**Yes**
Claremore Indian Hospital	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Clinton Indian Health Center	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Comanche Tribe	N/A	OK	**Yes**	**Yes**	**No**
Cooweescoowee Health Center	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Creek Nation - Koweta Clinic	Oklahoma City	OK	**Yes**	**Yes**	**No**
Delaware Nation	N/A	OK	**Yes**	**Yes**	**No**
Eastern Shawnee Tribe - Northeastern Tribal Health System	Oklahoma City	OK	**Yes**	**Yes**	**No**
El Reno Indian Health Center	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Eufaula (Creek Nation of Oklahoma) Health Center	Oklahoma City	OK	**Yes**	**Yes**	**No**
Fort Sill Apache Tribe	N/A	OK	**Yes**	**Yes**	**No**
Indian Health Care Resource Center	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Iowa Tribe of Oklahoma	Oklahoma City	OK	**Yes**	**Yes**	**No**
Kanza Health Center	Oklahoma City	OK	**Yes**	**Yes**	**No**
Kaw Nation	Oklahoma City	OK	**Yes**	**Yes**	**No**
Kickapoo (Shawnee Service Unit) Ambulatory Health Center (McLoud)	Oklahoma City	OK	**Yes**	**Yes**	**No**
Kickapoo Tribe of Oklahoma	Oklahoma City	OK	**Yes**	**Yes**	**No**
Kiowa Indian Tribe	N/A	OK	**Yes**	**Yes**	**No**
Lawton Indian Hospital	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Little Axe Health Center	Oklahoma City	OK	**Yes**	**Yes**	**No**
MCN Medical Center	Oklahoma City	OK	**Yes**	**Yes**	**No**
MCN Physical Rehab Center	Oklahoma City	OK	**Yes**	**Yes**	**No**
Modoc Tribe - Northeastern Tribal Health System	Oklahoma City	OK	**Yes**	**Yes**	**No**
Muscogee (Creek) Nation - Northeastern Tribal Health System	Oklahoma City	OK	**Yes**	**Yes**	**No**
National Supply Service Center (NSSC)	Oklahoma City	OK	**No**	**No**	**No**
Northeastern Tribal Health System/Health Center	Oklahoma City	OK	**Yes**	**Yes**	**No**
Okemah Health Center	Oklahoma City	OK	**Yes**	**Yes**	**No**
Oklahoma City Area Office Clinic	Oklahoma City	OK	**Yes**	**Yes**	**No**
Oklahoma City Indian Clinic	Oklahoma City	OK	**Yes**	**Yes**	**Yes**

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Okmulgee Health Center	Oklahoma City	OK	**Yes**	**Yes**	**No**
Osage Tribe/Wah Zha Zhi Health Center	N/A	OK	**Yes**	**Yes**	**Yes**
Otoe-Missouria Tribe	N/A	OK	**Yes**	**Yes**	**No**
Ottawa Tribe - Northeastern Tribal Health System	Oklahoma City	OK	**Yes**	**Yes**	**No**
Pawhuska Indian Health Center	Oklahoma City	OK	**Yes**	**No**	**No**
Pawnee Indian Health Center	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Pawnee Indian Tribe	Oklahoma City	OK	**Yes**	**Yes**	**No**
Peoria Tribe - Northeastern Tribal Health System	Oklahoma City	OK	**Yes**	**Yes**	**No**
Perkins Family Clinic - Iowa Tribe	Oklahoma City	OK	**Yes**	**Yes**	**No**
Ponca Tribe	Oklahoma City	OK	**Yes**	**Yes**	**No**
Quapaw Tribe Community Health Services - Northeastern Tribal Health System	Oklahoma City	OK	**Yes**	**Yes**	**No**
Redbird Smith Health Center	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Sac and Fox Nation Of Oklahoma	Oklahoma City	OK	**Yes**	**Yes**	**No**
Sam Hider Health Center	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Sapulpa Health Center	Oklahoma City	OK	**Yes**	**Yes**	**No**
Seminole Nation	N/A	OK	**Yes**	**Yes**	**No**
Thlopthlocco Tribal Town	N/A	OK	**Yes**	**Yes**	**No**
Three Rivers Health Center	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Tishomingo Health Center	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Tonkawa Tribe of Indians	N/A	OK	**Yes**	**Yes**	**No**
Vinita Health Center	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Watonga Indian Health Center	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Wetumka Health Center	Oklahoma City	OK	**Yes**	**Yes**	**No**
Wewoka Indian Health Center	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
White Eagle Health Center	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Wichita and Affiliated Tribes	N/A	OK	**Yes**	**Yes**	**No**
Will Rogers Health Center	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Wilma P. Mankiller Health Center	Oklahoma City	OK	**Yes**	**Yes**	**Yes**
Wyandotte Nation - Northeastern Tribal Health System	Oklahoma City	OK	**Yes**	**Yes**	**No**
Burns Paiute/Wadatika Indian Health Center	Portland	OR	**Yes**	**Yes**	**No**
Confed.Tribes-Coos, L. Umpqua, Siuslaw/Outreach Office Florence & Springfield/Tribal Health Clinic	Portland	OR	**Yes**	**No**	**No**
Confederated Tribes Grand Ronde Reservation/Grand Ronde Hlth.&Wellness Ctr.	Portland	OR	**Yes**	**Yes**	**No**
Confederated Tribes of Siletz Indians	N/A	OR	**Yes**	**Yes**	**No**
Confederated Tribes of Umatilla	Portland	OR	**Yes**	**Yes**	**No**
Coquille Indian Tribe	Portland	OR	**Yes**	**Yes**	**No**
Coquille Tribal Health Center	Portland	OR	**Yes**	**Yes**	**No**
Cow Creek Band of Umpqua Indians/Cow Creek Tribal Clinic	Portland	OR	**Yes**	**Yes**	**No**
Klamath Indian Tribe/Klamath Tribal Health Center	Portland	OR	**Yes**	**Yes**	**No**
NARA - Lifeworks Satellite Clinic	Portland	OR	**No**	**Yes**	**Yes**
NARA - Youth Treatment Program	Portland	OR	**Yes**	**Yes**	**No**
NARA Health Clinic	Portland	OR	**No**	**Yes**	**Yes**
NARA Residential Treatment Center	Portland	OR	**No**	**Yes**	**Yes**
NARA Totem Lodge Community Center	Portland	OR	**No**	**Yes**	**Yes**
NARA Wellness Center	Portland	OR	**No**	**Yes**	**Yes**
Siletz Community Health Clinic	N/A	OR	**Yes**	**Yes**	**No**
Warm Springs Service Unit/Confederated Tribes - Warm Springs Reservation	Portland	OR	**Yes**	**Yes**	**No**
Wemble Naalam Tal'aksni	N/A	OR	**Yes**	**Yes**	**No**
Western Oregon Service Unit/Chemawa Indian Health Center	Portland	OR	**Yes**	**Yes**	**No**
Yellowhawk Tribal Health Center	N/A	OR	**Yes**	**Yes**	**Yes**
Narragansett Indian Tribe	Nashville	RI	**Yes**	**Yes**	**No**
Catawba Health Center	Nashville	SC	**Yes**	**Yes**	**Yes**
Aberdeen Youth Regional Treatment Center	N/A	SD˜	**Yes**	**Yes**	**No**
Anpetu Luta Otipi Adolescent Treatment Facility	N/A	SD˜	**Yes**	**Yes**	**No**
Cheyenne River Sioux Tribe Field Health	Great Plains	SD˜	**No**	**Yes**	**Yes**
Eagle Butte Hospital	Great Plains	SD˜	**Yes**	**Yes**	**No**
Flandreau Santee Sioux Tribe/Tribal Health Center/Counseling Center	Great Plains	SD˜	**Yes**	**Yes**	**No**
Fort Thompson Ambulance Service	Great Plains	SD˜	**Yes**	**Yes**	**No**
Fort Thompson Health Center	Great Plains	SD˜	**Yes**	**Yes**	**No**

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Four Bands Health Center	N/A	SD˜	**Yes**	**Yes**	**No**
Great Plains Youth Regional Treatment Center	Great Plains	SD˜	**No**	**No**	**No**
Kyle Health Center	Great Plains	SD˜	**Yes**	**Yes**	**Yes**
Lower Brule Health Center	Great Plains	SD˜	**Yes**	**Yes**	**Yes**
Manderson Field Clinic	Great Plains	SD˜	**No**	**Yes**	**Yes**
McLaughlin Health Center	Great Plains	SD˜	**Yes**	**Yes**	**No**
Oglala Sioux Tribe	Great Plains	SD˜	**Yes**	**Yes**	**No**
Pierre Indian Learning Center	N/A	SD˜	**Yes**	**Yes**	**No**
Pine Ridge Hospital	Great Plains	SD˜	**Yes**	**Yes**	**Yes**
Rapid City Hospital	Great Plains	SD˜	**Yes**	**Yes**	**No**
Rosebud Ambulance Service	Great Plains	SD˜	**No**	**Yes**	**Yes**
Rosebud Hospital	Great Plains	SD˜	**Yes**	**Yes**	**Yes**
Sisseton Wahpeton Oyate/Dakota Pride Adult Inpatient Treatment Facility	N/A	SD˜	**Yes**	**Yes**	**Yes**
South Dakota Urban Indian Health, Inc. (Pierre, SD)	N/A	SD˜	**No**	**Yes**	**Yes**
South Dakota Urban Indian Health, Inc. (Sioux Falls, SD)	N/A	SD˜	**Yes**	**Yes**	**Yes**
Wagner Health Center	Great Plains	SD˜	**Yes**	**Yes**	**Yes**
Wanblee Health Center	Great Plains	SD˜	**Yes**	**Yes**	**Yes**
Woodrow Wilson Keeble Memorial Health Care Center (WWKMHCC)	Great Plains	SD˜	**Yes**	**Yes**	**Yes**
Yankton Sioux Substance Abuse	Great Plains	SD˜	**Yes**	**Yes**	**No**
Alabama-Coushatta Tribe of Texas/Chief Kina Health Clinic	Nashville	TX	**Yes**	**Yes**	**Yes**
Kickapoo Indian Outreach Clinic - Eagle Pass Health Center	Oklahoma City	TX	**Yes**	**Yes**	**No**
Kickapoo Traditional Tribe	Oklahoma City	TX	**Yes**	**Yes**	**No**
Urban Inter-Tribal Center of Texas	Oklahoma City	TX	**Yes**	**Yes**	**No**
Ysleta Del Sur	N/A	TX	**Yes**	**Yes**	**No**
(Uintah & Ouray Res.) Fort Duchesne Health Center	Phoenix	UT	**Yes**	**Yes**	**Yes**
Blue Mountain Hospital	N/A	UT	**No**	**Yes**	**No**
Brigham Tribal Office	N/A	UT	**Yes**	**No**	**No**
Cedar Community Health Center	Phoenix	UT	**Yes**	**Yes**	**Yes**
Confederated Tribes of Goshute Reservation	Phoenix	UT	**Yes**	**No**	**No**
Kanosh Community Health Center	Phoenix	UT	**No**	**Yes**	**Yes**
Koosharem Community Health Center	Phoenix	UT	**No**	**Yes**	**Yes**
Montezuma Creek Community Health Center	N/A	UT	**Yes**	**Yes**	**No**
Monument Valley Community Health Center	N/A	UT	**Yes**	**Yes**	**No**
Navajo Mt. Community Health Center	N/A	UT	**Yes**	**Yes**	**No**
Shivwits Community Health Center	Phoenix	UT	**Yes**	**Yes**	**Yes**
Skull Valley Band of Goshute Indians	Phoenix	UT	**Yes**	**No**	**No**
Urban Indian Center of Salt Lake	Phoenix	UT	**Yes**	**No**	**No**
Ute Indian Tribe (Uintah & Ouray Res.)	Phoenix	UT	**Yes**	**Yes**	**Yes**
Colville Indian Health Center	Portland	WA	**Yes**	**Yes**	**No**
Confed. Tribes & Bands-Yakama Reservation/Yakama Nation Comprehensive Alcoholism Program/Yakama Nation Behavioral Health/Apas Goudy Health Station	Portland	WA	**Yes**	**Yes**	**No**
Confederated Tribes of Chehalis Res./Tsapowum Chehalis Tribal Chemical Dependency Program/Tribal Wellness Center/Family Services	Portland	WA	**Yes**	**Yes**	**No**
Confederated Tribes of Colville Res./Colville Conf. Tribes Behavior Hlth, Prog.	Portland	WA	**Yes**	**No**	**No**
Cowlitz Indian Tribe/Cowlitz Behavioral Health/Cowlitz Tribal Treatment (Vancouver & Longview)/Cowlitz Tribal Health Clinic	Portland	WA	**Yes**	**Yes**	**No**
David C. Wynecoop Memorial Clinic/Wellpinit Service Unit	Portland	WA	**Yes**	**Yes**	**No**
Hoh Indian Tribe	Portland	WA	**Yes**	**Yes**	**No**
Inchelium Community Health Center	N/A	WA	**Yes**	**Yes**	**Yes**
Jamestown S'Kllallam Tribe/Jamestown Family Health Clinic/Dental Clinic/Chemical Dependency/Mental Health	Portland	WA	**Yes**	**Yes**	**No**
Kalispel Indian Community/Camas Center for Community Wellness/Behavioral Health	Portland	WA	**Yes**	**Yes**	**Yes**
Lower Elwha Klallam Medical Clinic/Counseling Services/Behavior health program/Dental Clinc	Portland	WA	**Yes**	**Yes**	**No**

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Lower Elwha Klallam Tribe/Lower Elwah Klallam Health Clinic	Portland	WA	**Yes**	**Yes**	**No**
Lummi Behavioral Health	Portland	WA	**Yes**	**Yes**	**Yes**
Lummi Counseling Services	Portland	WA	**Yes**	**Yes**	**Yes**
Lummi Tribal Health Center	Portland	WA	**Yes**	**Yes**	**Yes**
Makah Tribe/Makah Wellness Center/Mekah Chemical Dependency/Sophie Trellevick Indian Hlth. Ctr.	Portland	WA	**Yes**	**Yes**	**No**
Muckleshoot Indian Tribe/Muckleshoot Tribe Health & Wellness Center/Dental Clinic/Optometry/Behavioral Health	Portland	WA	**Yes**	**Yes**	**Yes**
N.A.T.I.V.E. Project/Native Health of Spokane	Portland	WA	**Yes**	**Yes**	**Yes**
Nisqually Indian Tribe/Nisqually Tribal Health Clinic	Portland	WA	**Yes**	**Yes**	**No**
Nooksack Indian Tribe/Nooksack Community Clinic/Dental/Behavioral Health	Portland	WA	**Yes**	**Yes**	**Yes**
Omak Health Center	Portland	WA	**Yes**	**No**	**No**
Omak Tribal Heal Center	Portland	WA	**Yes**	**Yes**	**No**
Port Gamble S'Klallam Tribe(PGST)/ PGST See-yeels-out Wellness Center/PGST mental health/PGST Recoverty Ctr./PGST Tribal Clinic	Portland	WA	**Yes**	**Yes**	**Yes**
Puyallup Tribe/Takopid Indian Health Center/Kwawachee Counseling Center	Portland	WA	**Yes**	**Yes**	**No**
Quileute Tribe	Portland	WA	**Yes**	**Yes**	**No**
Quinault Indian Nation/Chemical Dependency Progam/Roger Saux Health Center	Portland	WA	**Yes**	**Yes**	**Yes**
Samish Indian Tribe	Portland	WA	**Yes**	**Yes**	**No**
San Poil Valley Community Health	N/A	WA	**No**	**Yes**	**Yes**
Sauk-Suiattle Indian Tribe/Sauk Suiattle Tribal Community Clinic	Portland	WA	**Yes**	**Yes**	**No**
Seattle Indian Health Board	Portland	WA	**Yes**	**Yes**	**Yes**
Shoalwater Bay Indian Tribe/Shoalwater Bay Wellness Center	Portland	WA	**Yes**	**Yes**	**Yes**
Skokomish Tribe/Skokomish Health Center	Portland	WA	**Yes**	**Yes**	**Yes**
Snoqualmie Tribe/Snogualmie Tribe Behavioral Health Program/North Bend Family Clinic/Raging River Recovery Center/Tolt Community Clinic	Portland	WA	**Yes**	**Yes**	**No**
Spokane Tribe of the Spokane Res.	Portland	WA	**Yes**	**Yes**	**Yes**
Squaxin Island Tribe/Sally Selvidge Clinic Hlth. & Human Srvs. Dept,/NW Treatment Center (Shelton & Elma)	Portland	WA	**Yes**	**Yes**	**No**
Stillaguamish Tribe/Stillaguamish Tribal Health Clinic/Dental/Mental Health/Behavior health/	Portland	WA	**Yes**	**Yes**	**No**
Suquamish Tribe/Suquamish Tribe Wellness Program	Portland	WA	**Yes**	**Yes**	**Yes**
Swinomish Indian Health Clinic	Portland	WA	**No**	**Yes**	**Yes**
Swinomish Indian Tribal Community/Swinomish Health Center/Dental/Mental Health/Chemical Dependency Clinic	Portland	WA	**Yes**	**Yes**	**No**
Tulalip Health Clinic	Portland	WA	**Yes**	**Yes**	**No**
Tulalip Tribes/Tulalip Health Clinic/Dental Program/Family Services	Portland	WA	**Yes**	**Yes**	**No**
Upper Skagit Indian Tribe/Upper Skagit Tribal Clinic/Chemical Dependency program	Portland	WA	**Yes**	**Yes**	**No**
White Swan Health Clinic	N/A	WA	**Yes**	**Yes**	**No**
Yakama Indian Health Center	Portland	WA	**Yes**	**Yes**	**No**
Bad River Band/Bad River Health & Wellness Center/Bad River Chemical Dependency Outpatient	Bemidji	WI	**Yes**	**Yes**	**No**
Forest County Potawatomi(FCP)/FCP Health and Wellness Center/Chemical Dependency Outpatient Program	Bemidji	WI	**Yes**	**Yes**	**Yes**
Gerald L. Ignace Indian Health Center	Bemidji	WI	**Yes**	**Yes**	**Yes**
Ho-Chunk Nation of Wisconsin	Bemidji	WI	**Yes**	**Yes**	**Yes**
Lac Courte Oreilles Health Center	Bemidji	WI	**Yes**	**Yes**	**No**
Menominee Tribal Clinic	Bemidji	WI	**Yes**	**Yes**	**No**
Oneida Health Center	Bemidji	WI	**Yes**	**Yes**	**No**

THO Name*	IHS Service Area**	State ¥,˜	Entry on HHS ECP List for 2016	Entry on ECP List for 2017	Entry Updated on HHS ECP List for 2018***
Peter Christensen Health Center/Lac du Flambeau Band of Lake Superior Chippewa Indians of the Lac du Flambeau Reservation of Wisconsin	Bemidji	WI	**Yes**	**Yes**	**Yes**
Red Cliff Band/Red Cliff Community Health Center/Red Cliff Ambulance/Red Cliff Chemical Dependency Outpatient Program	Bemidji	WI	**Yes**	**Yes**	**No**
Sokaogon Chippewa Community, Wisconsin	Bemidji	WI	**Yes**	**Yes**	**No**
St. Croix Chippewa Indians/St. Croix Health Center/St. Croix Chemical Dependency Outpatient Program	Bemidji	WI	**Yes**	**Yes**	**No**
Stockbridge-Munsee Health Center	Bemidji	WI	**Yes**	**Yes**	**No**
Arapahoe Health Center	Billings	WY	**Yes**	**Yes**	**Yes**
Eastern Shoshone Recovery Center	Billings	WY	**Yes**	**Yes**	**Yes**
Eastern Shoshone Tribal Health	Billings	WY	**No**	**Yes**	**Yes**
Fort Washakie Health Center (Wind River Service Unit)	Billings	WY	**Yes**	**Yes**	**Yes**
Fort Washakie Tribal Health Program	Billings	WY	**No**	**Yes**	**No**
Morning Star Care Center	Billings	WY	**No**	**Yes**	**Yes**
Northern Arapaho Tribe (of the Wind River Reservation)/White Buffalo Treatment Center	Billings	WY	**Yes**	**Yes**	**No**
Northern Cheyenne Wellbriety Center	Billings	WY	**No**	**Yes**	**No**
Wind River Dialysis Center	Billings	WY	**No**	**Yes**	**Yes**
Wind River Family & Community Health Care	Billings	WY	**No**	**Yes**	**Yes**

* Sources: IHS Web site and CMS, FINAL Non-Exhaustive HHS List of ECPs PY 2016 (INDIAN) and PY 2017.

** N/A indicates entry was not found on IHS Web site but appeared on the HHS ECP List for 2016 and/or 2017.

*** Source: CMS, FINAL Non-Exhaustive HHS List of ECPs PY 2017.

¥ Entries shown with shading are in states with a State-based Marketplace (SBMs), and as such the qualified health plan (QHP) issuers in the state are not required (under federal regulations) to offer a contract to all Indian health care providers listed on the HHS ECP List in the QHP's service area. A group of SBMs -- State-based Marketplaces on the Federal Platform (SBM-FPs) -- are not included with the other SBMs as the SBM-FPs, starting in 2017, will be subject to the ECP provisions of the FFM. As such, in the SBM-FP states of NV, HI, NM, and OR, QHP issuers will be required, beginning in 2017, to offer contracts to all IHCPs in the QHP's service area.

˜ In addition to the SBM states shown with shading, the states of Kansas, Maine, Montana, Nebraska, Ohio, South Dakota, and Virginia are considered have received approval from HHS to conduct plan management activities to support certification of qualified health plans in the Federally-facilitated Marketplace. As such, these states might not require the offering of contracts by QHP issuers to all Indian health care providers in the QHP's service areas.

Health Care Reform in Indian Country

Self-Governance Communication & Education

Self-Governance Tribes Striving Towards Excellence in Health Care

Self-Governance Health Reform National Outreach and Education

Semi-Annual Report

April 2016

Introduction

The Jamestown S'Klallam Tribe (JST) and U.S. Department of Health and Human Services (HHS) amended their multi-year funding agreement in September 2015 to transfer $300,000 to JST for the performance period September 1, 2015 – September 30, 2016, for "Self-Governance National Indian Health Outreach and Education." This semi-annual report is a required deliverable and covers the six-month period from October 1, 2015, through March 31, 2016.

This Project requires the Tribe to manage and provide outreach, education, technical, research and analytical support nationally to Self-Governance Tribes on the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, collectively known as the Affordable Care Act (ACA), and the Indian Health Care Improvement Act (IHCIA), as amended. The overall objective of this Project is to improve Indian health care by conducting training and technical assistance across Self-Governance communities to ensure that the Indian health care system and all American Indians/Alaska Natives (AI/ANs) are prepared to take advantage of the health insurance coverage options that will improve the quality of and access to health care services, and increase resources for AI/AN health care. This work is a part of a national campaign, comprised of national Indian organizations, IHS, and Tribal partners (Partners) that work together to conduct ACA/IHCIA training and technical assistance throughout Indian Country.

TSGAC submitted a Work Plan for 2015-2016 to the IHS Office of Tribal Self-Governance (OTSG) in October 2015 outlining the proposed activities and process for meeting the identified deliverables. This 2015-2016 Work Plan builds on JST's successful program of training and technical assistance from the previous two Project periods (2013-2014) and (2014-2015), as documented in the final reports for those respective years.

Consistent with the deliverables identified, this Work Plan is organized into the following sections:

- Outreach and Education
- Policy Analysis
- Technical Assistance and Information Sharing
- Training/Webinars

Final Approval for the 2014-2015 Work Plan was received from OTSG in December 2015. This progress report is organized to correspond to the four sections listed above and to the identified deliverables in the scope of work under the JST Amendment.

Policy Analysis

Policy Papers and Comments on Proposed Regulations. The TSGAC and Technical advisors continue to work with national Indian organizations to analyze proposed regulations and other policy issues related to ACA/IHCIA implementation. Correspondence and specific issues that have been submitted by TSGAC during this period include:

- Excise Tax on Certain Employer-Sponsored Health Benefits (submitted to Treasury Department; 4/11/16)
- Oklahoma Section 1115 Waiver Amendment Request (Submitted to HHS Secretary and CMS Administration; 4/5/16)
- Comments on CMS–10519, Agency Information Collection Activities: (Submitted to OMB for Review; 2/29/16)
- Comments on CMS-9936-N - Waivers for State Innovation (Submitted to CMS 2/19/16)
- Comments on Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces (Submitted to CMS 1/15/16)
- Comments on CMS-9937-P, Notice of Benefit and Payment Parameters for 2017 (Submitted to CMS 12/21/15)
- Support for 100 Percent FMAP Proposal 11/3/15 - TSGAC letter submitted to HHS Secretary, RE: request to expedite final rule on Medicare Like Rates (Submitted to CMS 11/17/15)
- Comment on VA Choice Act (Submitted to VA on 10/17/15)
- Request for Permanent Administrative Relief from Employer Mandate (Submitted to Treasury 10/26/16)
- Request for Extension of the Transition Relief from the Employer Mandate (Submitted to Treasury 10/23/15)
- Excise Tax on Employer-Sponsored Health Benefits (Submitted to Treasury 10/21/15)
- Notice 2015-52 on Section 4980I — Excise Tax on High Cost Employer Sponsored Health Coverage (Submitted to Internal Revenue Service 10/14/15)

Measuring Enrollment through the Marketplaces. To further the ability to measure outcomes of TSGAC and other Tribal organization activities, technical advisors have been working with the leadership of the Tribal Technical Advisory Group (TTAG) to secure data and regular reports on Marketplace enrollment from the Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight (CMS/CCIIO). In addition, on March 22, 2016, TSGAC requested two data sets from IHS in order to conduct analyses for Tribes and to provide uniform reports on progress with Marketplace enrollment. This data will support analyses of progress, by Service Unit, with reducing number of uninsured Tribal members.

Technical Assistance

Tribal Sponsorship and Billing Opportunities:
The TSGAC has been providing technical assistance regarding sponsorship and billing opportunities to ensure economic viability of Tribal health programs. In addition to hosting Webinars (see below), Technical Advisors have been working with IHS to gather baseline data for analysis of Sponsorship and Employer Options. Information and analysis has been collected from Self-Governance, Contracting and Direct Service Tribes. Additionally, efforts are also underway to determine if there is an Urban program that has a sponsorship program in place.

To date, thirteen case studies have been prepared on Sponsorship and Employer Options involving eleven Tribes or regional Tribal health organizations. The case studies were generated from analyses that were conducted with and for individual Tribes on Sponsorship and Employer Options. The case studies have been used in training sessions conducted by TSGAC, either through Webinars or in-persons sessions. As a result of the Tribe-specific analysis, one Direct Service Tribe has submitted a proposal to the IHS to create and conduct a Sponsorship function. In addition, one Self-Governance Tribe has established a Sponsorship function with the aim of enrolling approximately 2,200 uninsured Tribal members. Other Tribes continue in the planning phase, with one Tribe considering implementing a broad Sponsorship program for the nearly 60% of Tribal members (7,700 individuals) who lack health insurance coverage.

SGCE Website (Health Care Reform) Updated: The Question and Answer section on the SGCE website is continually and regularly updated as new information becomes available. The site is organized to include the following areas:

A. Marketplace Enrollment
B. Premium Tax Credits and Cost-Sharing Reductions
C. Tax Penalty Exemptions
D. Employer-Sponsored Coverage
E. Veterans
F. Other

The website allows for users to submit questions at any time. The Question and Answer section is continually and regularly updated as needed based on input and requests that are submitted through the website as well as those questions raised during Webinars.

Technical Assistance Provided through SGCE Website. Tribes are continuing to use the SGCE website to pose questions regarding ACA. As of April 1, 2016, all questions submitted through the Website have received a response which has been posted so that all Tribes can have access to the information.

Communication around key moments or events through the grant period to increase education efforts. Broadcast notices and e-mails continue to be sent regularly to all Self-Governance Tribes as new information and updates become available. The following is a list of the broadcast dates and topics that have been shared:

3/18/16:
- IHS Reimbursement Rates (aka "OMB Rate)
- Applicable Percentages and Thresholds: Adjustments Related to Certain Affordable Care Act Provisions for 2015, 2016, and 2017
- Review of HHS ECP Lists for Coverage Years 2016, 2017, and 2018

2/16/16:
- Federal Poverty Levels for Medicaid, Marketplace, and Medicare Savings Program Enrollment in 2016 and 2017 (updated TSGAC briefing memo)

1/28/16:
- HHS Releases the Federal Poverty Level Guidelines for 2016 ("2016 FPL")

1/19/16:
- Reminder of ACA Webinar – Case Study #9 (DST/TSG Joint Initiative

1/ 4 & 1/8/16 & 1/14/16:
- Notices and updated TSGAC Brief on Steps to Update (or Add) Entry on the HHS Essential Community Provider List

1/8/16:
- Information and briefing regarding IRS Extension of Deadlines for Employer

12/14/15:
- Information Regarding Webinar on New Process to Retain Status on the HHS Essential Community Provided (ECP) list

11/23/15:
- Save the Dates – Upcoming Webinars scheduled for Dec. 10 and Dec. 16.

11/3/15:
- Affordable Care Act National Tribal Day of Action

10/8 & 10/15/15:
- Survey of SG Tribes on preferences for ACA/IHCIA trainings and topics.

10/29/15:
- Ask Treasury and the White House for Employer Mandate Relief. Template letter drafted for use by SG Tribes in submitting comments.
- **I**nstructions for Updating HHS ECP List for 2017 Coverage Year

Development of Tools and Resources. In preparation for training and broadcasts of information, a number of PowerPoint presentations and other products have been developed in meeting the Project deliverables, including:

- Impact of Employer Mandate on Federally-Recognized Tribes: Case Studies 1 and 2 (November 12, 2015)

- Indexing Adjustments Related to Certain ACA Provisions for 2015 and 2016 (November 30, 2015)
- Tribal Sponsorship under Affordable Care Act (ACA)-- Case Study #7 (Dec 10, 2015)
- How does the "HHS ECP List" fit with the QHP issuer contracting requirements? (Dec 16, 2015)
- Tribal Sponsorship under Affordable Care Act (ACA)-- Case Study #7 (January 20, 2016)
- Tribal Sponsorship under Affordable Care Act (ACA)-- Case Study #7 (CMS Presentation – Updated Feb 11, 2016)
- Marketplace Coverage of Dental Services (Webinar on March 24, 2016)
- Bringing Oral Health Care into the 21st Century (Webinar on March 24, 2016)
- Affordable Care Act *Implementation Issues;* Great Lakes IHS Area Training **(**April 20, 2016)
- Advancing Sovereignty- Tribal Sponsorship under Affordable Care Act (ACA)--DST-SGT Joint Initiative (April 21, 2016)
- Advancing Sovereignty: Tribal Sponsorship under Affordable Care Act (ACA) Presentation at TSGAC –ANHB ACA Self-Governance Training (April 6, 2016)
- Indian Health Service Reimbursement Rates (aka "OMB Rate") for 2016 (March 10, 2016)
- Applicable Percentages and Thresholds: Indexing Adjustments Related to Certain Affordable Care Act Provisions for 2015, 2016, and 2017 (March 18, 2016)
- Review of HHS ECP Lists for Coverage Years 2016, 2017, and 2018 (Updated April 2016)
- Federal Poverty Levels for Medicaid, Marketplace, and Medicare Savings Program Enrollment in 2016 and 2017 (updated TSGAC briefing memo dated February 12, 2016)
- TSGAC brief on Federal Poverty Levels for Medicaid and Marketplace Enrollment in 2016 and 2017 (January 26, 2016)
- Extension of Due Dates for Employer and Issuer 2015 Information Reporting Under Internal Revenue Code Sections 6055 and 60561 (March 31, 2016 (Revised))

Training

Identifying Training Needs of Self-Governance Tribes. Updated information was collected under a Survey Monkey that was shared: (1) with TSGAC/Technical Workgroup during the October 2015 meeting; and, (2) sent out on SG ACA listserv to stakeholders in October 2015. Survey results summarized and included in the 2015-2016 Work Plan submitted to OTSG in November 2015.

Webinars. The primary means of delivering training has been Webinars. Four Webinars were hosted and conducted by the TSGAC in this 6-month period and have been held from noon to 1:30 pm Eastern time. Additionally, TSGAC Technical Advisors participated in another Webinar hosted by CMCS Division of Tribal Affairs (item #4 below). Webinar dates and topics included the following:

1. December 10, 2015 – Analysis of Tribal sponsorship conducted for one mid-sized Tribe as part of the Joint Initiative of Direct Service and Self-Governance Tribes
2. December 16, 2015 - Process for Updating HHS ECP List for 2017 Coverage Year (Joint Presentation with CMS/TSGAC)

3. January 20, 2016 - Employer Options under the Affordable Care Act: Case Study #8
4. February 11, 2016 – Tribal Sponsorship (Joint presentation with CMCS Division of Tribal Affairs/TSGAC)
5. March 24, 2016 – Marketplace Coverage of Dental Services & Dental Health Aide Therapists (Joint presentation with the Northwest Portland Area Indian Health Board)

Participation in the Webinars has ranged from 60 to 122 people. The 1-1/2 hour Webinars were conducted live, recorded and later posted on the Self-Governance Communication and Education (SGCE) website along with the PowerPoint presentations and related resource materials to allow for wider accessibility and use by IHS, Tribal and Urban (I/T/Us) health care users and programs. Time was allocated throughout the Webinar(s) for participants to raise questions. All attendees received a personalized Certificate for their participation in the Webinar(s).

Following the Webinars, all participants were sent an on-line evaluation. The input received from these Webinars remain positive. (*A summary of the evaluations is provided as Appendix A below)*.

Face-to-Face Trainings & Self-Governance 2016 Annual Conference Workshops.

A face-to-face training was held on April 6th in Anchorage, AK regarding Tribal Sponsorship under Affordable Care Act. Materials and a PPT presentation were prepared by TSGAC in conjunction with the Alaska Native Health Board. Unfortunately, due to unforeseen circumstances, the TSGAC technical advisors were unable to attend and present the training in person.

Break-out sessions on topics related to ACA/IHCIA have also been planned for the 2016 Annual Tribal Self-Governance Consultation Conference to be held in Orlando, FL April 24-28, 2016, including:

- Maximizing Revenue Generation under the Affordable Care Act
- Affordable Care Act: Hot Topics and Future Implementation

Other Activities

In addition to the policy analysis, training and technical assistance activities enumerated in this final report, the TSGAC coordinated with the IHS, HHS, and other national NIHOE groups. Technical staff have participated in meetings and monthly teleconferences with other National Tribal organizations and partners, including National Congress of American Indians, National Indian Health Board and the National Council of Urban Indian Health to assist in coordinating efforts and reduce any duplication of AI/AI training materials.

Attachment: Appendix A: Evaluation of Self-Governance Health Reform Training and Technical Assistance Plan (2015-2016), April 2016.

For more information on this report, please contact Cyndi Ferguson at cyndif@senseinc.com

Attachment A
Summary from Webinar Evaluation Survey Reports

As part of the 2015-2016 Work Plan, four ACA Webinars have been conducted in the first six month period (October 2015-March 2016). The dates and topics of Webinars provided include:

1. December 10, 2015 – Analysis of Tribal sponsorship conducted for one mid-sized Tribe as part of the Joint Initiative of Direct Service and Self-Governance Tribes
2. December 16, 2015 - Process for Updating HHS ECP List for 2017 Coverage Year (Joint Presentation with CMS/TSGAC)
3. January 20, 2016 - Employer Options under the Affordable Care Act: Case Study #8
4. March 24, 2016 – Marketplace Coverage of Dental Services & Dental Health Aide Therapists (Joint presentation with the Northwest Portland Area Indian Health Board)

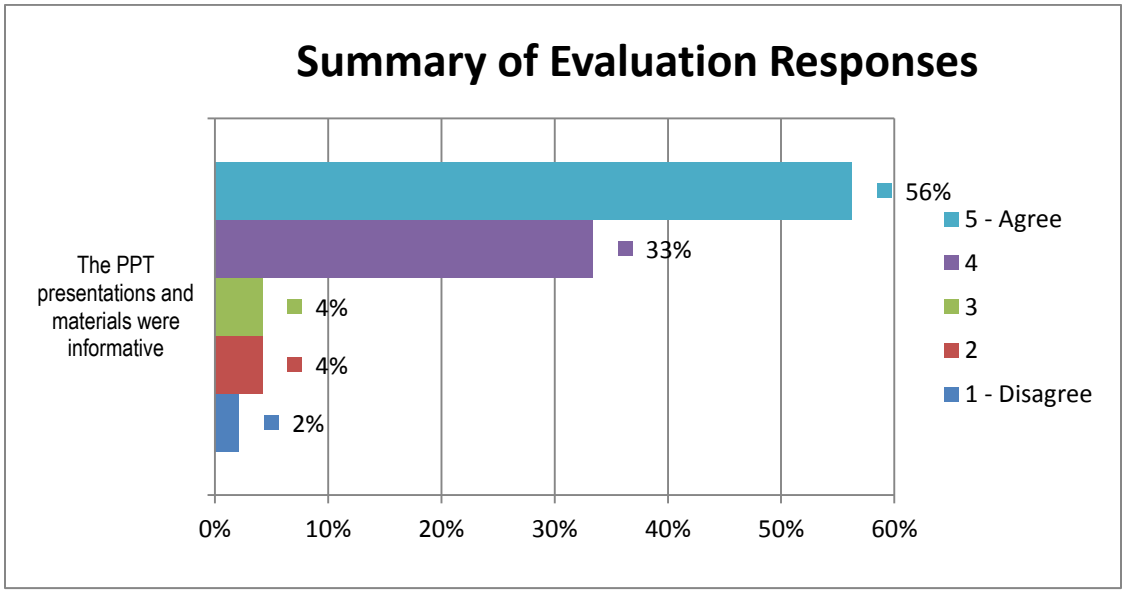
Approximately 84 registrants completed and participated in the 12/10/16 Webinar; 91 registrants in the 12/16/15 Webinar; 59 registrants in the 1/20/16 Webinar; and, 122 registrants in the 3/24/16 Webinar. Following completion of the Webinar(s), participants were asked to complete a brief evaluation survey.

Evaluation Categories

Participants were asked to rank the following items on a scale of 1 to 5; with 1 being the lowest (disagree) and 5 being the highest (agree):

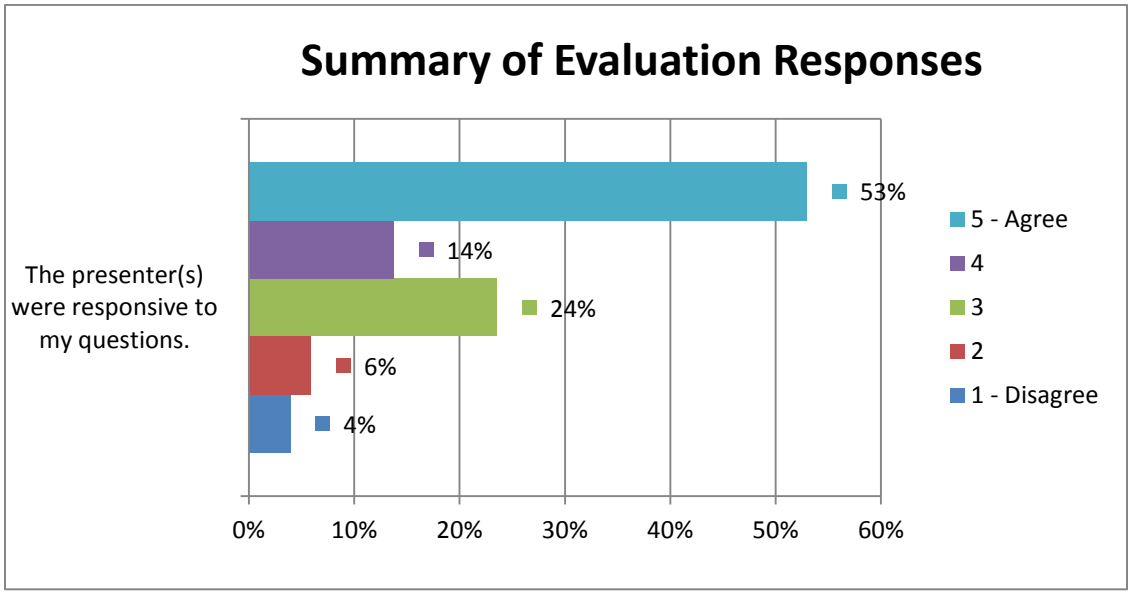
- Issues were relevant and presented in a user-friendly manner
- PowerPoint presentation and materials were informative and helpful
- Presenter(s) were responsive to questions
- Length of Webinar provided sufficient time to cover the issues

Chart 1 – Content Delivery (All Webinars Combined)



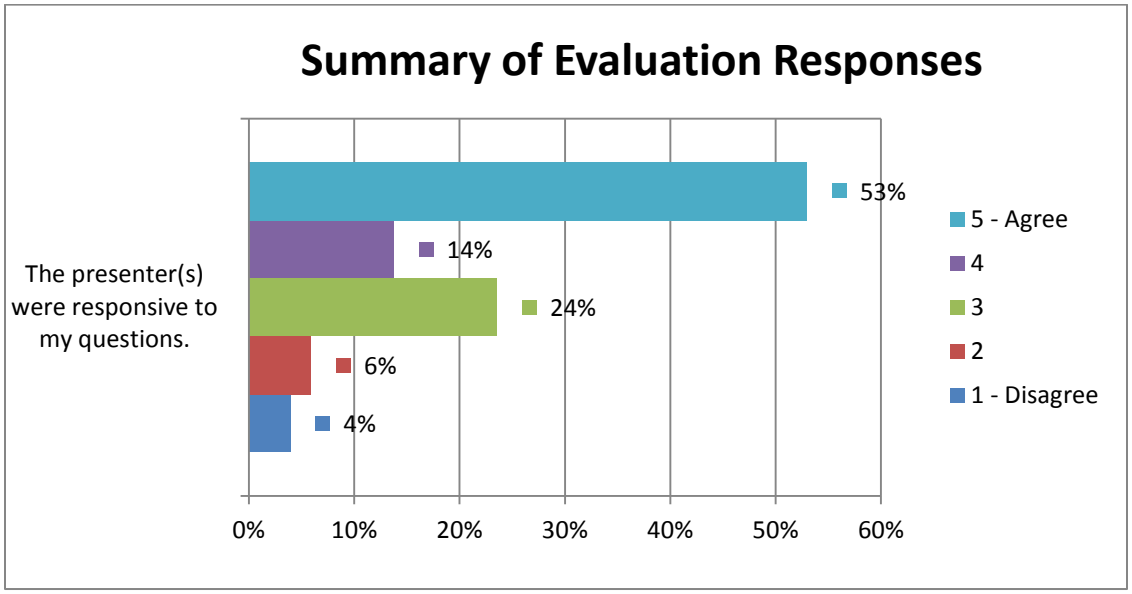
- Participants were complimentary of the information and issues presented.
- Overall, 90% of participants ranked this category as either 4 or 5.

Chart 2 – Resource Materials (All Webinars Combined)



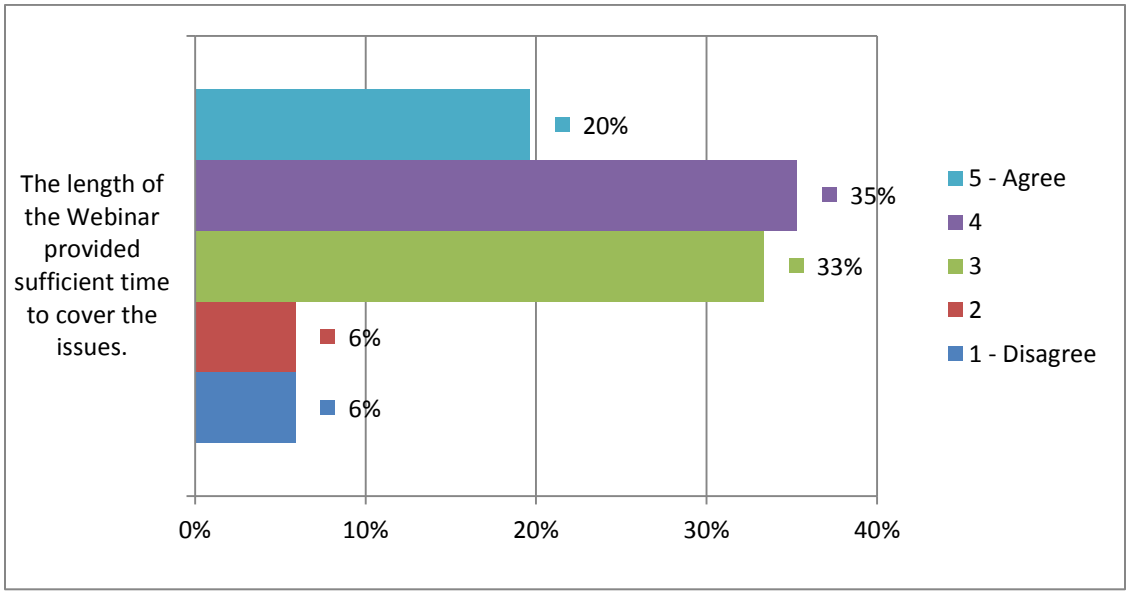
- Copies of the PPT presentations were shared 1 day in advance for all the Webinars.
- Overall, 81% of participants ranked this category as either 4 or 5.

Chart 3 – Responsive to Questions (All Webinars Combined)



- Opportunities were provided at various points throughout the Webinar(s) for participants to raise questions. However, time was not sufficient to answer all questions during the Webinar(s). Time was extended if needed to allow for ALL questions raised to be addressed during the Webinar.
- Overall, 67% of participants ranked this category as either 4 or 5. (*This is a drop of 10% from last year's Webinar analysis. May need to think of other ways to ensure that questions can be adequately addressed.)*

Chart 4 – Length of Webinar(s)-



- In a few cases, the length of the Webinar was extended by approximately 10-15 minutes to accommodate presentation of materials and to answer questions.
- Overall, 55% percent of participants ranked this category as either 4 or 5.

The following summarizes additional comments received for each respective Webinar:

12/10/15 Webinar - *"A Tribal Sponsorship Analysis"*

Please list other topics you would like to have covered in future trainings:

- Outreach & Education
- Contract Support Cost Claims

12/16/15 Webinar- *"Qualified Health Plans, Essential Community Providers and Indian Health Care Providers: How does the "HHS ECP List" fit with the QHP issuers contracting requirements?"*

Please list other topics you would like to have covered in future trainings:

- PQRS Quality initiatives for physicians... what this means, how it impacts and steps to incorporate for better reimbursement.

Please share any additional comments:

- Thanks so much. This session was highly informative for our Tribal Health organization. Looking forward to partaking in more of them.

1/20/16 Webinar - *"Employer Options under the Affordable Care Act: Case Study #8"*

- No additional comments received.

3/24/15 Webinar - *"Marketplace Coverage of Dental Services & Dental Health Aide Therapists"*

Please list other topics you would like to have covered in future trainings:

- Coverage requirements (new changes/rules) to expect for 2017.
- Anything to do with ACA
- Grant opportunities and writing

Please share any additional comments:

- The two-topic format worked.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service
Rockville, Maryland 20857

Refer to: ORAP

INDIAN HEALTH SERVICE CIRCULAR NO. 2016-08

PURCHASING HEALTH CARE COVERAGE

Sec.

1. PURPOSE. The purpose of this circular is to provide further detailed guidance into the current policy (Oct. 2013 Dear Tribal Leader Letter) if a Tribe, Tribal organization, or urban Indian organization wishes to purchase coverage for Indian Health Service (IHS) beneficiaries under 25 *United States Code* (U.S.C.) § 1642 with Indian Self-Determination and Education Assistance Act (ISDEAA) funding or other IHS appropriated funds.

2. CONTRACT/COMPACT LANGUAGE. The following language is recommended to be inserted into a new or an existing Tribal-IHS contract/compact or funding agreement to identify:

   A. The funding source, i.e., Purchased/Referred Care (PRC), Hospital & Clinic (H&C) funds, third-party revenues, or tribal supplements

   B. The specific amount of funding needed

   C. The type of coverage that will be provided

   D. Eligibility criteria

   E. Alternate resource rules, if applicable

Commented [RJC1]: "Recommended" and not required. This is an important distinction to make about this circular.

Formatted: Underline

Commented [RJC2]: Does this mean that IHS has taken a position that H&C can be used pursuant to section 402?

Commented [RJC3]: Some TSP may not know precisely how much they may need or allocate to a TSP. Some may use a case management approach to mitigate expending CHS resources above a certain price threshold. Cost avoidance models. Can be managed by stating up to a certain amount threshold.

Commented [RJC4]: This could be a problem. Recall the Yvette Roubideaux DTLL on section 402 that has never been withdrawn by IHS.

DRAFT
Distribution: IHS-wide
Date: XX/XX/2016

F. If third-party revenues collected by the Tribe are identified as part or all of the funding source, IHS recommends the following:

(1) The funds should have already been collected and not yet expended (i.e., not amounts owed or future projections for anticipated collections).

(2) In accordance with 25 U.S.C. § 1641, Medicare and Medicaid collections are intended to be used first to maintain or achieve compliance with the respective program.

(3) To the extent the third-party revenues are collected by IHS, the contract/compact should not promise or guarantee the award of third-party revenue, including revenue derived from sponsorship coverage. Such collections may only be transferred as authorized by law and shall be considered nonrecurring.

3. ELIGIBILITY CRITERIA. Tribes and Tribal Organizations may make eligibility determinations for IHS programs under 25 U.S.C. 450j-1, but must follow applicable eligibility rules and regulations. In addition, the purchase of health care coverage by an Indian tribe, tribal organization, or urban Indian organization may~~can~~ be based on the financial need of the beneficiary, if the Tribe/Tribal Organization or urban Indian organization wishes to limit the number of beneficiaries covered, pursuant to 25 U.S.C. §1642. The statute specifies that the financial need of the beneficiary is determined by the tribe(s) served, based upon a schedule of income levels developed by the tribe(s) served. The IHS makes the following recommendations with respect to eligibility:

A. Eligibility should follow the source of funding.

(1) If non-PRC funds are utilized, direct service eligibility rules should apply.

(2) If PRC funds are utilized, alone or in combination with non-H&C funds, including supplements from the tribe, PRC eligibility should apply.

(3) If both unrestricted H&C and PRC funds are utilized, the contract/compact should state whether direct service or PRC eligibility will be followed and the funds should be rebudgeted accordingly.

B. If any PRC funds are used and they are not rebudgeted as H&C funds according to the guidance above, PRC eligibility rules should be followed for the sponsorship and references to the following PRC eligibility rules **should be included in the contract or compact**:

(1) 42 Code of Federal Regulations (CFR) 136.23 – Persons to whom contract health services (now known as Purchased/Referred Care) will be provided.

Commented [RJC5]: Again, IHS "recommend the following." This is not a requirement for those Tribes conducting TSPs. This is important to note, since item(s) #1 and #2 could be a problem for some Tribes.

Commented [RJC6]: Some Tribes depending on their TSP eligibility criteria may not be able to forecast precisely this amount needed. Other Tribes may not have the necessary cash flow to make a TSP work without a business model that relies on 3rd party to subsidize the expense of paying premiums.

Commented [RJC7]: While this is accurate, it does not describe the full authority and should include the full requirement/authority of § 1641 Treatment of Payments under the SSA. This section also allows excess M&M third party collections after complying with M&M conditions and requirements to be used for reducing the health "resource deficiencies" described at § 1621(c) & § 1621(d) . The term "health status and resource deficiency" means the extent to which- (A) the health status objectives set forth in sections 3(1) and 3(2) [25 USCS § 1602(1) and (2)] are not being achieved..." § 1602 is the IHCIA Declaration of nation Indian health policy. This also broad flexibility besides just meeting M&M requirements and conditions.

Commented [RJC8]: This statement will be problematic for DST that operate CHS programs and have a TSP. Revenue generated through TSP could not be replenished to make the TSP sustainable over the long run.

Commented [RJC9]: § 1641 states consultation requirements with Tribes. If a Tribe requests that excess M&M third party resources replenish CHS resources use for a TSP, than IHS should be obligated to do so. This is a problem for DST.

Commented [RJC10]: (b) Financial need. The purchase of coverage under subsection (a) by an Indian tribe, tribal organization, or urban Indian organization may be based on the financial needs of such beneficiaries (as determined by the 1 or more Indian tribes being served based on a

Commented [RJC11]: Not required. IHS is only recommending.

Commented [RJC12]: If Tribe complements CHS funding with unrestricted Tribal general fund resources this provision should not apply. What if the TSP includes purchasing premiums for patients that have pierced their CHS eligibility, but continue to be direct care patients? Th

Commented [RJC13]: Tribes may not agree to melding of CHS and H&C funds and then use direct service eligibility to be followed. The opposite of the above issue.

Commented [RJC14]: See comment above. There may situations that Tribes use CHS funds and not want to follow CHS eligibility requirements in TSP.

Commented [RJC15]: "Should be". Again, IHS is providing flexibility and not making this a mandatory requirement. Most Tribes conducting TSP are likely not to be supportive of including this language in their AFA because of its limitations and impinges flexibility to manag

(2) The language of 42 CFR 136.22(a) – (PRC Service Delivery Area) - "In accordance with the congressional intention that funds appropriated for the general support of the health program of the IHS be used to provide health services for Indians who live on or near Indian reservations…"

C. Coverage can be provided to IHS beneficiaries who are also employees of tribal businesses, but eligibility should not be limited to tribal employees.

4. Purchased/Referred Care Residual Responsibility & Coordination of Benefits. IHS recommends the following:

A. When a Direct Service Tribe (DST) decides to take a portion of its PRC funds to purchase insurance for some or all of their tribal members, this leaves a residual of funds in the DST PRC program to provide care for those who are PRC eligible who do not have alternate resources. IHS makes the following recommendations with respect to PRC residual responsibility:

(1) IHS considers sponsorship through indemnity to be an alternate resource under the payer of last resort rule.

(2) In the case of sponsorship through a self-insurance plan, where the plan is self-funded in part or whole with ISDEAA funds and there is no reinsurance or indemnity, the self-funded plan will be considered a payer of last resort, but benefits will be coordinated between the PRC program and the self-funded plan as set forth in subsection 4.B., below.

(3) IHS does not consider an IHS beneficiary to be eligible for PRC to the extent that the sponsorship provides coverage.

B. Under the payer of last resort rule and a coordination of benefits process, the PRC program shall not pay primary to any third-party payers, including sponsorship in any form.

C. To the extent that a plan is indemnified or reinsured, it does not qualify as a self-insurance plan that is exempt from IHS' right of recovery under 25 U.S.C. § 1621e(f). IHS shall have the right to recover under 25 U.S.C. § 1621e(a) from any indemnity or reinsurance, whether or not it is purchased through 25 U.S.C. § 1642.

5. ELIGIBILITY FOR THE CATASTROPHIC HEALTH EMERGENCY FUND. In the case of sponsorship through a self-insurance plan, where the plan is entirely self-funded in part or whole with ISDEAA funds and there is no reinsurance or indemnity, and the plan is designed to follow PRC eligibility, the self-funded plan will be considered eligible

Commented [RJC16]: TSP individuals would no longer be eligible for CHS. But what is a TSP enrolls some into a catastrophic health plan and still requires CHS related services? What if service is outside of ESBs? What if service is required from non-network provider and there are cost sharing requirements that CHS might normally pay? Hence, the once size fits all language in this agreement impinges Tribal flexibility.

Commented [RJC17]: Note comment on item A(1). Same comment here.

Commented [RJC18]: Tribal self funded insurance implications. Continues to proffer the IHS position from the CHEF regulation.

Commented [RJC19]: Similar IHS position from the CHEF regulation.

Commented [RJC20]: Same CHEF regulation issue/IHS position.

for reimbursement from the Catastrophic Health Emergency Fund on the same basis and under the same terms that PRC programs are eligible for such reimbursement.

6. EFFECTIVE DATE. This circular becomes effective on date of signature.

Mary Smith
Principal Deputy Director
Indian Health Service

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Indian Health Service
Rockville MD 20852

JULY 18 2016

Dear Tribal Leader:

The Indian Health Service (IHS) is requesting your comments and recommendations on a draft Circular that the IHS has created to address the purchase of health care coverage, which is commonly referred to as Tribal Premium Sponsorship (Sponsorship). Sponsorship occurs when a Tribe pays health insurance premiums on behalf of IHS beneficiaries. As you know, when Tribal members enroll in coverage they are able to improve their access to care through increased options for health care. In turn, revenue collected by Tribal and IHS providers goes back into the facility to meet conditions of participation and provide additional funds to hire staff and purchase services and new equipment. In addition, with greater alternate resources, Purchased/Referred Care (PRC) funds go farther as more patients have coverage. The purpose of this draft Circular is to provide further detailed guidance to IHS Area Offices regarding the current IHS policy if a Tribe, Tribal organization, or Urban Indian organization wishes to purchase coverage for IHS beneficiaries with Indian Self-Determination and Education Assistance Act (ISDEAA) funding or other IHS-appropriated funds. Per Section 402 of the Indian Health Care Improvement Act (25 U.S.C. § 1642) Indian Tribes, Tribal organizations, and Urban Indian organizations may use federally appropriated funding, to the extent it is available under law, to purchase health insurance for IHS beneficiaries.

The draft Circular is needed as many Tribes across the country have created Sponsorship programs. Tribes have reported success stories as their members enroll in health benefits coverage and access care. Tribes have also reported increased revenues tied to these Sponsorships, which often result in additional revenue that lets them supplement operations, procure services and new equipment, and allows them to hire more providers. Tribes have also reported savings in PRC programs, which has led to PRC funds lasting longer and facilitated payment for lower priority services. The IHS is pleased to hear of this success and is committed to supporting and encouraging Tribes in their efforts to enhance access to care for their members, improve third party collections, and cost savings. Tribes have primarily used their own funds to pay premiums and some now seek to use appropriated funds.

The draft Circular provides guidance to IHS Area Offices regarding eligible beneficiaries and funding sources, along with recommended language to be included in new or existing contracts, compacts or funding agreements between Tribes, Tribal organizations, and the IHS. The draft Circular also addresses PRC Residual Responsibility and Coordination of Benefits when a Direct Service Tribe (DST) decides to take a portion of their PRC funds to purchase insurance for some or all of their Tribal members, and leaves a residual of funds in the DST PRC program to provide care for PRC-eligible patients who do not have alternate resources, and when a premium sponsorship program is self-funded in part or whole with ISDEAA funds. Finally, the draft Circular provides guidance on when a plan self-funded in part or whole with ISDEAA funds will be considered eligible for reimbursement from the Catastrophic Health Emergency Fund.

I hope that you will find the draft Circular to be useful in understanding IHS's views on the purchase of health care coverage and that it will be helpful in any planning and implementation efforts to provide health benefits coverage to IHS beneficiaries. The IHS is committed to working with all Tribes to improve access to care for American Indians and Alaska Natives.

The IHS will consult with Tribal Leaders from July 18 through August 17. Written comments by Tribal Leaders or Tribal organizations can be e-mailed to consultation@ihs.gov by COB August 17.

Please participate on a telephone Tribal Consultation and Urban Confer Call that will provide an overview and discussion of the draft Circular.

Telephone Tribal Consultation and Urban Confer Call:

Call date:	July 25, 2016 (Monday)
Call time:	3:00 p.m. – 4:00 p.m. (Eastern Time)
Call In Number:	(888) 323-5260
Passcode:	5432202

Thank you for your support and partnership. I look forward to hearing your input on this purchase of health care coverage draft Circular.

If you have any questions about this draft Circular, please contact Ms. Terri Schmidt, Acting Director, Office of Resource Access and Partnerships at (301) 443-4973 or by e-mail at terri.schmidt@ihs.gov.

Sincerely,

/Mary Smith/

Mary Smith
Principal Deputy Director

Enclosure

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

Submitted via: consultation@ihs.gov

June 9, 2016

Mary Smith, Principal Deputy Director
Indian Health Service
5600 Fishers Lane
Mail Stop: 08E86
Rockville, MD 20857

RE: TSGAC Comments on IHS Contract Support Costs Policy

Dear Principal Director Smith:

On behalf of the Tribal Self-Governance Advisory Committee (TSGAC), we submit the following comments on the agency's proposed revisions to Chapter 6-3 of the Indian Health Service (IHS) Manual addressing contract support cost (CSC) issues.

Introductory remarks.

At the outset, the TSGAC would like to note that Congress has declined to delegate any authority to the agency to write regulations on contract support cost issues. 25 U.S.C. § 450k(a)(1); *Ramah Navajo School Bd. v. Babbitt*, 87 F.3d 1338, 1349 (D.C. Cir. 1996) (interpreting § 450k(a)(1)). While the agency is free to amend its own Manual, the Indian Self-Determination and Education Assistance Act (ISDEAA) also makes it clear that agency manuals and guidelines are not binding on the Tribes. 25 U.S.C. § 450l(c), sec. 1(b)(11); § 458aaa-16(e). Nonetheless, we see substantial value in the agency setting forth in its Manual how it plans to deal with CSC issues. For that reason, we are pleased to see IHS moving forward to reform its internal CSC procedures in light of recent litigation requiring full payment of CSC (Salazar v Ramah, 132 S. Ct. 2181 (2012), the agency's own commitment to that goal, and the recent congressional decision to appropriate such sums as may be necessary each year to pay contract support costs in full. Having a policy in place—even with the shortcomings noted below—would mark an improvement over the recent state of affairs, in which IHS makes unilateral implementation decisions without notice that then may be implemented differently throughout the IHS Areas.

Before commenting on specific provisions, we also want to offer praise to IHS for pursuing an inclusive and collaborative consultation process over the past six months for developing the proposed new CSC Chapter. For years following the Ramah decision, IHS leadership refused to engage meaningfully and openly with Tribal leadership. But under your leadership and that of former Principal Deputy Robert McSwain, that approach changed and, consistent with the President's and the Department's consultation policies, IHS finally engaged in genuine government-to-government dialogue over the CSC Chapter. In this respect, IHS set an excellent example of the way in which the Federal-Tribal relationship should work in the context of developing Federal guidelines, manuals and regulations impacting Tribal governments.

Overview.

On the whole, the proposed new CSC chapter is helpful in laying out in considerable detail how IHS intends to negotiate, determine, and pay CSC. However, the Chapter is overly complex, and it imposes unnecessary accounting restrictions and requirements on the computation and reconciliation of CSC amounts. It appears to us that IHS's litigation experience over the past three years in the CSC claims arena has led IHS to adopt an increasingly narrow interpretation of the ISDEAA. This has occurred despite the Act's direction to IHS to interpret the Act's provisions "liberally" in favor of the Tribes. 25 U.S.C. § 450l(c), sec. 1(a)(2); § 458aaa-11(f). The Bureau of Indian Affairs (BIA) approach, on both scores, is both simpler and more in line with past BIA and IHS practice. That said, we appreciate that the approach laid out in the proposed CSC Chapter is a compromise between the Tribes' views of what the law commands and the agency's competing current views.

Because of the CSC Chapter's resulting complexity, the Chapter largely misses the goals laid out on pages 3-4 that the Chapter should "be simple and efficient," "align with the [BIA] CSC policy," "provid[e] needed certainty," and "minimize future litigation." However, we recommend that these provisions be retained in the hopes that upcoming and future revisions to the Chapter will hit closer to the mark. Moreover, we urge that these principles guide IHS's interpretation and implementation of the policy once finalized. The principles of simplicity, efficiency, transparency, consistency, and trust all should permeate IHS training on and implementation of the policy.

Duplication Issue.

Much of what is new in the proposed CSC Chapter concerns the so-called "duplication" issue—*i.e*., how to account for costs requested as CSC that may duplicate amounts already transferred by the Secretary. We recognize that the duplication issue has emerged in the last two years as a particularly contentious issue between IHS and Tribes; and that as a result the Chapter does not reflect a consensus on how the duplication issue should be addressed. To the contrary, footnote 1 on page 9 and footnote 10 on page 41 summarize the competing agency and Tribal views on this issue. Additional places where this issue arises are in several footnotes appearing on pages 60-65, concerning the negotiation of various types of direct CSC.

Without belaboring the issue, we agree with the Tribal position that nothing in the ISDEAA disqualifies any category of costs for consideration as CSC, so long as a given type of cost meets the definitional provisions set forth in 25 U.S.C. § 450j-1(a)(3), which is where the duplication provision appears. We therefore recommend that the final CSC Chapter either adopt the Tribal position or retain all these footnotes unchanged.

<u>Duplication in Recurring Service Unit Tribal Shares</u>. One area where the CSC Chapter specifically addresses the duplication issue in a practical compromise fashion concerns Recurring Service Unit Shares. The existing Manual provides an optional default rule that 20% of Area and Headquarters Tribal Shares are considered duplicative of CSC amounts otherwise due (page 19). The new draft Chapter provides a similar optional (and prospective) rule under which 3% of Recurring Service Unit Tribal Shares will be considered duplicative of CSC amounts otherwise due (page 18). As with the Area and Headquarters Shares offset, the new Chapter would provide Tribes with the alternative of engaging in a detailed analysis of the shares being contracted or compacted.

In principal, we support the proposed prospective 3% duplication provision as a reasonable and efficient optional approach to the duplication issue, provided (as the draft notes) that the provision

does not displace existing and longstanding agreements over contracted amounts (including existing agreements about duplicated amounts or the lack thereof). We support grandfathering in all existing agreements, so that the provision is only applied: (1) to new or expanded programs: (2) where new costs are placed into a Tribe's indirect cost pool, causing the pool to grow by more than 2% for that reason; or, (3) to past ongoing contracted operations where the Tribe chooses to negotiate a new amount with IHS.

We do suggest that the term "2% in the value of the IDC pool" at the top of page 18 be explained, since the provision may be read to mean a change in the pool leading to an increase in an indirect cost rate exceeding 2 percentage points (that is, from a 30% rate to a rate in excess of 32%). We believe what is intended is an increase in the size of the pool exceeding 2% of the value of the pool, such as from a $1,000,000 pool to a pool exceeding $1,020,000 where the $20,000 additional amount is attributable to placement of a new type of cost in the pool. Further, during the Tribal Consultation held at the Annual Tribal Self-Governance Consultation Conference in May, 2016, Tribes questioned the reasonableness of the 2% level as constituting a material change in the IDC pool. Typically, materiality for costs in an annual audit are closer to 10%, so we believe this threshold should be re-examined by the CSC Workgroup prior to finalizing the Policy.

Also, in deciding whether a cost is a "new type" so as to trigger a detailed duplication analysis (or the 3% offset), IHS should interpret this phrase liberally in favor of the awardee, in accordance with the letter and spirit of the ISDEAA. For example, if an awardee were to create a new compliance officer position, that would be a new cost but should not be deemed a new "type" of cost if it contributes to pre-existing administrative and management functions. Like all parts of the policy, the triggers to duplication analysis must also be subject to liberal interpretation in favor of Tribes.

Finally, we recommend this provision be modified to avoid a disproportionate impact on Tribes with low rates. Tribes with low indirect cost rates necessarily have few costs in their pools, and therefore less duplication. Yet, the draft policy makes no accommodation to such Tribes. In contrast, the Area shares 80-20 rule does seek an accommodation to Tribes with lower rates. Thus, while the 80-20 rule reflects a 25% rate, the manual accommodates Tribes with lower rates % by noting that any portion of the "20" amount over the Tribe's rate is not to be used as an offset and is instead available to provide additional direct services. To accomplish a similar goal in the context of service unit shares, we urge the agency to only apply the full 3% offset to Tribes whose rates are 25% or higher, and to proportionately reduce the offset for Tribes with lower rates. Thus (for instance), a Tribe with a 12.5% rate would only have offset one-half the amount that would be offset for a Tribe with a 25% rate.

Startup and Pre-award Costs (page 12).

We do not strongly oppose compromise provisions calling for a post year-end Tribal self-certification that startup costs have been spent on negotiated startup activities. (We agree with provisions addressing the negotiation of additional startup costs a Tribe incurs in excess of the negotiated amount.) We also do not strongly oppose the provisions stating that excess startup costs may either be repaid or applied to the subsequent year's CSC requirement—although this should be clarified to be a tribal option. In both instances, however, we would prefer to see any excess funds subjected to the Act's carryover provisions so that the funds would be applied to health care.

As with other aspects of the proposed new Manual chapter, we are concerned about the imposition of additional accounting burdens designed to force Tribes to return or credit funds, when the health

care system IHS supports is so deeply—even gravely—underfunded. Until IHS is fully funded, funds not needed for one purpose (such as CSC) should routinely be available to the Tribes for expenditure on other health care purposes.

Direct Contract Support Costs (DCSC) (pages 12-14; and pages 58 and 59).

Renegotiation of DCSC. We agree with provisions retaining DCSC costs as recurring costs, subject to an inflationary adjustment, and calling for renegotiation only in limited circumstances: (1) when a Tribe requests and concludes a renegotiation; (2) when a cost previously funded as DCSC is moved to an indirect cost pool; (3) when a Tribe withdraws from an inter-tribal consortium; or, (4) when a Tribe converts IPA or MOA personnel to direct hire (page 13).

Inflation adjustment. We strongly support switching the inflationary adjustment to a medical inflation rate (as discussed in footnote 2, page 13), and urge the agency to make this change in 2016. DCSC costs are part of the medical program being operated and there is accordingly no sound reason for not adjusting such costs by a medical inflation rate.

Identification of Additional Permissible DCSC Item: Examples of DCSC are described in the standards for the review and approval of CSC in Manual Exhibit 6-3-G. In addition, in the tables on pages 58 and 59,[1] items that are permissible for inclusion in the DCSC calculations as fringe benefits are shown. These include Federal Insurance Contributions Act (FICA) payments, Medicare taxes, and payments made for Life, Health, and Disability insurance, as well as payments to satisfy federal and / or state law requirements for workers' compensation insurance and unemployment insurance.

We recommend that payments made to satisfy federal Employer Shared Responsibility requirements under section 4980H of the Internal Revenue Code for applicable employees (added to the Code by the Affordable Care Act) also be identified in the page 58 and page 59 tables as examples of allowable fringe costs under DCSCs. Under the ACA, an employer has an option of either: (1) offering and paying at least a minimum amount of the cost of employee health insurance coverage; or, (2) making a per full-time employee payment to the federal government (*e.g.*, approximately $2,000 or $3,000 per applicable employee in 2015). The Option 1 expenditures for the purchase of health insurance coverage are already shown in these tables as permissible costs. Also identifying Option 2 Employer Shared Responsibility payment expenditures as permissible costs would provide an important clarification for Tribes and Tribal organizations.

In requesting that the Employer Shared Responsibility payments be included as an allowable DCSC, it is important to clarify that these payments are distinct from "penalties" that are not allowable as DCSCs. Although the Employer Shared Responsibility payments are sometimes referred to casually as "penalties", the Internal Revenue Service (IRS) refers to Shared Responsibility amounts as payments. For example, in one IRS explanatory document it states: "An applicable large employer (ALE) member may choose to either offer affordable minimum essential coverage that provides minimum value to its full-time employees (and their dependents) or potentially owe an employer shared responsibility payment to the IRS."[2] Another IRS Frequently Asked Questions document also indicates that employers have the option of offering coverage that meets certain requirements or not offer coverage and make Employer Shared Responsibility

[1] On page 59, the table at the top of the page contains examples of other fringe benefit items.

[2] *See* https://www.irs.gov/Affordable-Care-Act/Employers/Types-of-Employer-Payments-and-How-They-Are-Calculated, May 27, 2016.

payments in amounts determined by an established formula. In contrast, employers failing to satisfy the requirements under the Affordable Care Act, such as those pertaining to market reforms, are potentially subject to an excise tax penalty.[3]

A parallel example to the Employer Shared Responsibility payments is the requirement that employers pay the IRS matching amounts to an employee's Medicare and Social Security taxes. The payment of the Social Security and Medicare amounts are includable costs for DCSC purposes. In contrast, employers who do not comply with the employment tax laws may be subject to criminal and civil sanctions for failing to pay the Social Security and Medicare employment taxes.[4] Amounts paid pursuant to these sanctions would not be includable costs.

Indirect Costs (pages 14-17).

Negotiating the estimated indirect CSC requirement at the front end. Given the agency's insistence upon a so-called "incurred cost" approach to estimating and paying CSC requirements, we appreciate the agency's decision to assume that CSC is to be calculated on the entire contracted amount if at least that much in total Tribal health care funding (from whatever source) was spent in the preceding year. The agency states in footnote 3 (page 15) that a "substantial majority of awardees" show total health care expenditures exceeding the IHS contract amount, and its internal study showed that over 95% of Tribal contractors and compactors fall into this category. While it is unfortunate that the agency is moving away from simply calculating CSC on the current year's contracted amount—a practice the BIA will continue to follow under its proposed new Manual—the assumption that IHS dollars are spent first will limit the adverse impact of IHS's position for most Tribes. Of course, far preferable would be for IHS to return to past practice and not overly complicate the calculation and payment of CSC amounts by including provisions driven by circumstances facing only 5% of Tribal contractors.

Negotiating the final indirect CSC requirement after year-end. In the past, IHS has negotiated final year-end amounts based upon the best available data on hand within the 90-day period following the close of the contract year. We understand this is how the BIA will continue to operate. But because IHS has seized upon the "incurred cost" approach, IHS has in recent years discussed waiting as long as 5 years to reconcile final CSC requirements against not only full audits, but subsequent indirect cost rate carryover schedules issued two and even four years out. This delay is unnecessary. We encourage IHS to return to a policy of negotiating final amounts for each year within 90 days of the end of that contract year based on the best available data at that time. This leads to the next issue.

Aged IDC rates. We are pleased to see that IHS has developed a compromise approach that will permit close-out of the CSC negotiation process within a few months after the close of the contract year. But we are concerned that this approach is only possible for a Tribe that has a fixed indirect cost rate that is no more than one year old (for Tribes with a fixed-with-carry-forward rate), or a final rate that is no more than two years old (for Tribes with provisional-final rates). We are concerned that the switch from using up to three year old rates for this purpose, to using one or two year old rates, will adversely impact a significant number of Tribes, even if (as footnote 4 on page 16 indicates) there is a three-year transition period for this change to be implemented. Indeed, the

[3] … such an arrangement fails to satisfy the market reforms and may be subject to a $100/day excise tax per applicable employee (which is $36,500 per year, per employee) under section 4980D of the Internal Revenue Code." https://www.irs.gov/affordable-care-act/employer-health-care-arrangements, May 27, 2016.

[4] *See* https://www.irs.gov/uac/employer-and-employee-responsibilities-employment-tax-enforcement, May 27, 2016.

burden will fall on the Tribes that are least able to suffer the impact of the burden—those that for whatever reason do not have sufficiently current rates. The abstract quest for greater accuracy should not come at the cost of further burdening Tribes doing their best to carry out health care services for their tribal citizens.

We urge the agency to carefully monitor the impact of this change. Given the relative stability of rates over time, we question whether the change is worth the substantial additional time it will take before final CSC amounts can be negotiated. We also note that the ability to obtain current rates may be heavily impacted by outside factors, such as whether the cognizant rate agencies are short-staffed.

Bilateral amendments. We support the new practice of doing post-year bilateral amendments to reflect finally-negotiated CSC amounts (pages 16-17). However, this new practice will impose a substantial additional burden upon IHS, as well as Tribal, personnel.

Overpayments. When the parties agree that the awardee was overpaid, the policy provides that the awardee will either pay back IHS or IHS will apply the overpayment to the awardee's CSC need in the subsequent year. Section 6-3.2E.1.b.6. But the better practice would be to recognize the Tribe's right to apply the "overpayment" to direct services. As noted earlier, Tribes are hardly being "overpaid" in the health care arena; to the contrary, they are being severely underpaid. Measures that seek the repayment of certain sums paid initially as CSC only make a bad funding situation worse.

Even if this section remains as drafted, this section needs to make clear that it is the *awardee's* option whether to reimburse or take the offset in the following year. Therefore, if the overpayment provision is not removed altogether, then we suggest revising the last sentence of section 6-3.2E.1.b.6 (page 17) to read as follows (new language underlined; removed language in strikethrough): "If the awardee was overpaid, the awardee will have the option to either (a) ~~it will~~ reimburse IHS for the overpayment; or, (b) agree that IHS will apply the overpayment to the awardee's CSC need in the subsequent year."

Negotiating Indirect-like Costs (pages 17, 57).

We are pleased to see IHS retain language on page 17 and in Exhibit H (page 57 and footnote 14) recognizing the right of a Tribe to negotiate indirect-like costs even if the Tribe is also receiving indirect CSC amounts as a result of having an indirect cost rate. A Tribe often has a relatively low indirect cost rate because indirect-type functions that the agency should be funding are simply not included in the Tribe's IDC pool for reasons that have nothing to do with the IHS program. Since the ISDEAA does not condition payment of administrative CSC based upon a Tribe's cost allocation system between indirect costs and direct costs, direct costs that are administrative in nature should be payable under the Act regardless of how they are classified. Language on page 17 and page 57 of Exhibit H, together with footnote 14, assure such Tribes will enjoy this right going forward.

Annual Funding Report to Tribes (pages 23-24).

We are pleased to see IHS make clear that it will produce a funding report that is independent of any reports due to Congress, and that the funding report to Tribes will be provided annually to the Tribes regardless of any delays associated with issuance of any congressional report. The two reports are entirely separate, and the special clearance process for issuing reports to Congress

should not delay the release of financial expenditure data. Receiving such data on a timely basis is critical for Tribes to provide meaningful and timely input to IHS on contract support cost issues.

CSC on Federal Programs, Services, Functions or Activities Supported with Third- Party Revenues, and on MSPI/SASP, DVPI and CHEF funds.

We believe the agency is required by law to add CSC funding to support the delivery of Federal programs, services, functions, or activities that are paid for with third-party revenues (page 55, note 12), as well as on MSPI/SASP, DVPI, and CHEF funds. We appreciate that the agency disagrees with Tribes on this issue, and further appreciate that the proposed Chapter leaves this issue unresolved. In some instances, congressional clarification may be warranted; in others, only litigation may be able to resolve the issue. Correctly, the Manual remains neutral on these issues.

Impact on Ratemaking Process.

The IHS CSC policy affects not only awardees' relationships with IHS, but also with the cognizant agencies charged with negotiating indirect cost rates, which in turn affects awardees' relationships with every other federal agency with which they interact. This policy raises additional questions, such as how these agencies would deal with the CSC policy's treatment of overpayments during the year-end reconciliation process—requiring either repayment to IHS or application of the overpayment to the CSC need in the subsequent year—which will necessarily affect the cognizant agency's carryforward calculation or final rate determination.

Training.

The policy is so long, complex, and daunting that non-expert Tribal leaders and staff—not to mention IHS negotiators—can be expected to have difficulty understanding and applying it. A thorough and thoughtful training curriculum for both Tribal and IHS personnel should already be under development. One of the Guiding Principles is that the policy "will be supplemented with regular training for IHS and Tribal personnel to assure consistency in its application" (page 4). This needs to happen early and often. We recommend that IHS seek input from the Workgroup on the best ways to make the necessary training available to federal and Tribal staff.

We also strongly recommend that IHS negotiators for CSC have experience in finance and familiarity with Tribal cost allocation methods and operations. Agency Lead Negotiators for Self-Governance will require the requisite training and support to effectively negotiate CSC requirements.

Other Issues.

Calculation Template. We are pleased to see that the agency and Tribal representatives have reached agreement on a summary worksheet showing the basic math behind the CSC calculation process (Exhibit F, page 37). However, we are concerned that the various tabs which feed into that summary sheet (which is part of an excel workbook) have not been included because they have not yet been negotiated. We urge the agency to make the negotiation of those templates its very highest priority. We also emphasize that deployment and adoption of any "tabs" supporting CSC calculations as IHS policy by practice not be conducted without such tabs being recommended by the CSC Workgroup and subjected to Tribal Consultation. We call to the agency's attention our strong opposition to some of the assumptions and limiting principles reflected in those tabs.

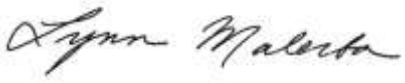
For instance, the tabs demand a federal duplication credit of 25.89% against Tribal fringe benefit requirements, even though the calculation of the federal credit is severely inflated by the treatment of substantial salary benefits such as housing and special pays as fringe amounts. It is deeply disturbing that at no time have IHS personnel disclosed to the CSC workgroup how the agency arrived at the 25.89% computation. We ask that the agency revisit this position in an open and collaborative manner so that agreement can be reached (and potential litigation avoided) on the appropriate federal fringe benefit offset calculation.

Another area of concern is the agency's unilateral cap on salaries as a proportion of programs, at 62%. Here, again, the agency has never shared with the CSC workgroup the data behind this limitation, nor explained why a national computation is appropriate as a flat rule for all contracting circumstances. Here, too, we ask that the agency revisit this position with Tribes in an open and collaborative manner.

There are a number of other tabs that have not been shared with the Workgroup in quite some time so it is impossible to discern if they reflect other areas of disagreement. Therefore, we suggest that any additional tabs be developed collaboratively by the Workgroup before being put into use by agency officials.

In closing, we thank you for the opportunity to submit comments on this proposed draft Chapter. TSGAC remains willing to assist IHS in any way possible. Should you have any questions or wish to discuss further, please do not hesitate to contact me at (860)862-6192; or via email: lmalerba@moheganmail.com.

Sincerely,



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

cc: P. Benjamin Smith, Director, Office of Tribal Self-Governance
TSGAC Members and Technical Workgroup

Contract Support Costs Update

TSGAC- Quarterly Meeting

July 21, 2016

IHS Business Principles & Goals

- Comply with requirement to pay full CSC need
- Improve communication
- Improve business practices
  - consistency and fairness for all Tribes
- Continued progress on CSC Contract Disputes Act claims
- Implement IHS CSC Policy

IHS CSC Policy – Tribal Consultation

- DTLL letter dated April 11; 60-day Tribal Consultation
- Self-Governance National meeting
- Region IX Meeting
- Region X Meeting
- 40 responses (email and letters)

Internal/External Training

- IHS All Federal Staff ISDEAA Meeting
  - February 2016 (Phoenix)
  - April 2016 (Orlando)
- Internal IHS monthly calls (ALN, CPLO, CO, FMO, EO)
- Great Plains – Tribal - July 2016

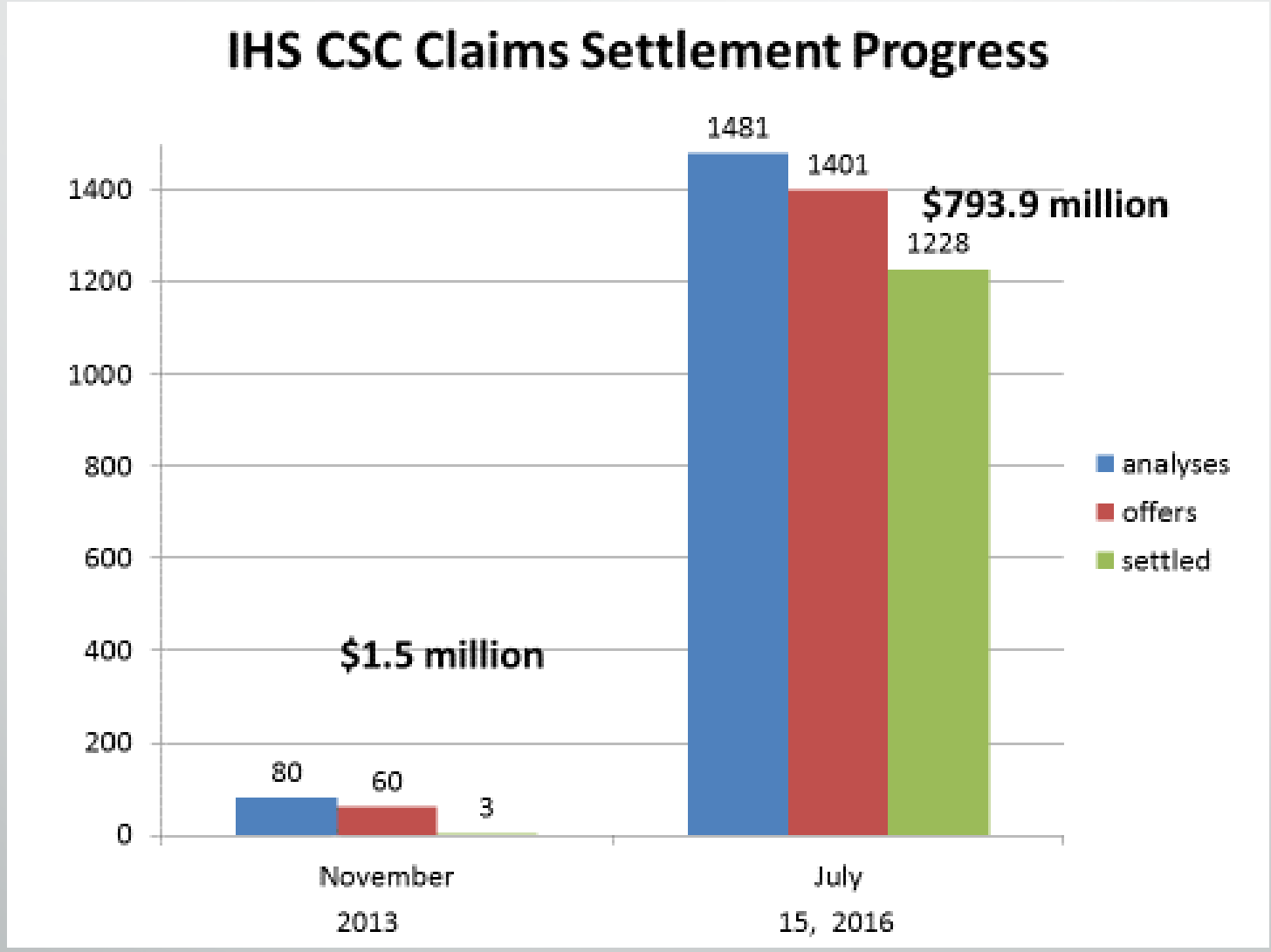
CSC Fund Balances

FY	Allowance	Disbursed	In process	Balance
2014	$612,483,901.00	$610,688,369.25	$ 935,181.73	$ 860,350.02
2015	$662,970,000.00	$622,322,218.17	$11,054,381.83	$29,593,400.00
2016	$717,970,000.00	$587,798,790.76	$54,484,207.24	$75,687,002.00

Next Funding Reconciliation – July 25

IHS Close Out Process

- Guidance on how to close out FY 2014 and FY 2015 CSC funding
- Steps:
  - Complete the ACC template with final information
    - Direct Cost Base – consistent with the IDC rate agreement
    - Tribe's IDC Rate
      - Provisional final – use most recent final rate, up to 3 years old
      - Fix with CR – use most recent rate, up to 3 years old
    - IDC already funded in the Secretarial Amount – 80/20 split or negotiated amount, pursuant to IHS CSC Policy
    - Use total health care costs to determine if tribe spent at least the amount funded by IHS.
      - If tribe spent at least the amount provided by IHS for the Secretarial amount plus direct CSC, work with tribe to negotiate and finalize amount
      - If the tribe did not spend at least the amount provided by IHS for the Secretarial amount plus direct CSC, work with tribe to review costs.
    - When IHS and tribe agree, execute bilateral agreement


IHS CSC Claims Settlement Progress
1481
1401
1228
$793.9 million
1400
1200
1000
800
600
400
200
0
$1.5 million
80
60
3
analyses
offers
settled
November
2013
July
15, 2016

Next Steps

- Next meeting date: September 15 & 16 proposed
- Topics:
  - Review Tribal Consultation comments
  - Review templates that support the ACC
  - Training for internal and external customers
- Implement IHS CSC Policy

Questions?

- Roselyn Tso, IHS CSC Lead
  - Roselyn.Tso@IHS.gov
  - 971-506-1928

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Indian Health Service
Rockville MD 20852

JUN 1 2016

Dear Tribal Leader:

I am writing to consult with Tribal Leaders on a draft policy statement that proposes an expansion in the use of community health aides at Indian Health Service (IHS) facilities across the country. Facilities operated by Tribes and the IHS could see expanded opportunities under the new draft policy for these aides, which could also include dental health aide therapists.

Partnership and collaboration are part of our ongoing work to deliver quality health care to patients. Increased access to care is a top priority, which is why the Agency is initiating Tribal Consultation on this important proposed change. Community health aides are proven partners, and utilizing them to the fullest extent permissible in hospitals and clinics operated by the IHS and Tribes will increase the availability of health workers in American Indian and Alaska Native communities.

The IHS is proposing to expand our existing community health aide program, including exploring administrative requirements for this expansion. This could include the creation of a national certification board for community health aides in the IHS system. The IHS already runs an evaluation system mandated by statute to monitor IHS community health aides to assure that quality health care is being provided to patients.

Community health aides include workers in health education, communicable disease control, maternal and child health, dental health, behavioral health, family planning, environmental health, and other areas. Examples of community health aides within the Indian health system and other Federal agencies include the following:

- The IHS Community Health Representative (CHR) program, which currently deploys more than 1,000 well-trained, medically guided health care workers who provide health education, case management, patient transport, patient advocacy, and other services in Tribal communities: http://www.ihs.gov/chr;

- The Dental Health Aide Therapist (DHAT) program, operated by the Alaska Native Tribal Health Consortium (ANTHC), is a community-driven program providing culturally appropriate dental education and routine dental services in 81 Alaska Native communities serving over 40,000 Alaska Native people since 2004: http://anthc.org/dental-health-aide/;

- The principal provider of health services at the village level in Alaska is the Community Health Aide (CHA). Overseen by the village council, CHAs are responsible for giving emergency first aid, providing patient examinations and follow-up in conjunction with a treating physician, carrying out treatment recommendations, patient- and family-focused education and instruction, and conducting preventive health programs. Community health aides store and dispense prescription drugs with physician instructions. https://www.ihs.gov/alaska/includes/themes/newihstheme/display_objects/documents/hf/area.pdf; and

- Behavioral Health Aides (BHAs) are counselors, health educators, and advocates. These practitioners help address individual and community-based behavioral health needs, including those related to alcohol, drug and tobacco abuse, as well as mental health problems, such as grief, depression, suicide, and related issues. Behavioral Health Aides seek to achieve balance in the community by integrating their sensitivity to cultural needs with specialized behavioral health training and approaches to treatment. http://anthc.org/behavioral-health-aide-program/.

Thank you for your support and partnership. I look forward to your input on the draft policy statement to expand the Community Health Aide program. Please provide your comments and recommendations by E-MAIL at consultation@ihs.gov or by POSTAL MAIL to the address indicated below. **The comment deadline is Friday, July 29, 2016.**

Sincerely,

/Mary Smith/
Mary Smith
Principal Deputy Director

Enclosure

E-MAIL your comments to:	consultation@ihs.gov **SUBJECT LINE**: IHS Expansion of Community Health Aide Program Draft Policy Statement Consultation
MAIL your comments to:	Alec Thundercloud, M.D. Director, Office of Clinical and Preventive Services Indian Health Service 5600 Fishers Lane Mail Stop: 08N34-A Rockville, MD 20857 **ATTN**: IHS Expansion of Community Health Aide Program Draft Policy Statement Consultation

INDIAN HEALTH SERVICE POLICY STATEMENT
On
CREATING A NATIONAL INDIAN HEALTH SERVICE COMMUNITY HEALTH AIDE PROGRAM

With rising demand for comprehensive, quality health care, communities are increasingly looking for innovative approaches to health service delivery. Recognizing the success of community health aides, Congress authorized the creation of a national federal Community Health Aide Program (CHAP).[1] *See* 25 U.S.C. § 1616*l*(d)(1).

The Indian Health Service (IHS) is currently exploring necessary steps to create a national CHAP,[2] including the creation of a national certification board. The IHS is supportive of and committed to the expansion of CHAPs throughout Indian Country. It is our goal to see community health aides[3] utilized to the fullest extent permissible in IHS and tribally run hospitals and clinics.

Access to care (particularly dental care) in remote areas among the population we serve is very low. The use of paraprofessional health care workers, like community health aides, is a proven strategy for increasing access to much-needed health services and improving the quality of those services in Indian Country, as well as other rural and frontier areas. The IHS has a long history of using community health aides, dating back to the 1960s. Bader, J. D., Lee, J. Y., Shugars, D. A., Burrus, B. B., & Wetterhall, S. (2011). Clinical technical performance of dental therapists in Alaska. *Journal of the American Dental Association, 142*(3), 322–326; *see also* "Evaluation of Dental Health Aide Therapist Workforce in Alaska," October 2010 study by RTI International of Research Triangle Park, North Carolina, available at *https://www.ihs.gov/doh/DHAT.pdf*.

The use of paraprofessional health care workers in public health programs has increased exponentially. Community health aides have been employed to perform a wide range of duties in health programs, such as health education, communicable disease control, maternal and child health, dental health, behavioral health, family planning, environmental health, and other areas. Because of this far-reaching need in so many areas of health care, CHAPs have included paraprofessionals such as nursing aides, behavioral health aides, community health workers, psychiatric aides, and others. In certain limited circumstances, CHAPs can also include the services of dental health aide therapists.

The IHS developed the community health aide concept in the 1960s in response to a number of health concerns in rural Alaska, including the tuberculosis epidemic, high infant mortality, and high rate of injuries. In 1968, the IHS initiated the CHAP in Alaska. Congress amended the Indian Health Care Improvement Act (IHCIA) to authorize the CHAP in 1992. *See* Public Law

[1] S. 1790, The Indian Health Care Improvement Reauthorization and Extension Act, as enacted and amended by P.L. 111-148, the Patient Protection and Affordable Care Act of 2010, which amended the IHCIA.
[2] Before any implementation, many issues would need to be reviewed and resolved, including any legislative changes or funding needed, and the development of an implementation plan.
[3] The term community health aide includes behavioral health aide, nursing aide, and dental health aide.

102-573. The IHCIA mandated IHS create a CHAP in Alaska to train persons to become community health aides, develop a curriculum for the training of community health aides, and create and maintain a Federal Community Health Aide Program Certification Board, by which individuals who complete the training curriculum are certified to provide services through the CHAP. 25 U.S.C. §§ 1616*l*(a), (b). Further, the IHS conducts a statutorily mandated system to evaluate community health aides to assure that quality health care, health promotion, and disease prevention services are being provided to the target population. 25 U.S.C. § 1616*l*(b)(6). By statute, the IHS through its Federal Community Health Aide Program Certification Board is responsible for these functions in the oversight and creation of the CHAP, including the Alaska Dental Health Aide Program, even though the daily operations of the program are carried out through Tribes and Tribal organizations.

Community health aides are currently utilized in a variety of health care and community settings in Alaska. While many provide medical and dental services in village clinics under the supervision of a remote licensed physician or dentist, some are employed by Tribal health organizations in regional clinics and hospitals under direct physician or dentist supervision. As a result of dental therapists in Alaska, an additional 40,000 Alaska Natives have direct access to care in their remote villages.[4]

The IHS and Tribal communities have found community health aides and other paraprofessional health care workers, like nursing, behavioral, and dental health aides, to be important and essential members of health care teams. Not only do CHAPs contribute to the overall health care team, but the additional advanced training they receive often leads to improved health and quality of life for the communities they serve.

CHAPs are proven partners in health, and the IHS is committed to seeing them expand outside of the State of Alaska.

June 1 2016
Date

/Mary Smith/
Mary Smith
Principal Deputy Director

[4] Alaska Tribal Health System, Oral Health, available at http://dhss.alaska.gov/ahcc/Documents/meetings/201303/AlaskaTribalHealth-OralHealth-Williard.pdf

National Indian Health Board

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

Creation of a National Indian Health Service Community Health Aide Program

IHS's Request for Comments: Due July 29th

On June 1, 2016, the Indian Health Service (IHS) released a Dear Tribal Leader Letter and a policy statement titled, "Creating a National Indian Health Service Community Health Aide Program." IHS is "exploring necessary steps to create a national Community Health Aide Program, including the creation of a national certification board." IHS's goal is to "see community health aides utilized to the fullest extent permissible in IHS and tribally run hospitals and clinics. "

Community health aide programs (CHAP) are not new to the Indian health system. Within the Indian health system, CHAP programs include the Alaska CHAP program and the IHS community health representative program (CHRP). CHAP services have proven to be a sustainable, effective, and culturally acceptable method for delivering health care. Poor recruitment and retention of providers at IHS facilities support national expansion of CHAP. Community health aides include workers in health education, communicable disease control, maternal and child health, dental health, behavioral health, family planning, environmental health, and other areas.

The purpose of this briefing paper is to provide Tribal leaders with background information on these programs, including the historical barriers to mid-level providers, for the comment making process. We strongly encourage Tribes and Tribal organizations to submit comments, as this is an excellent opportunity to work with the Indian Health Service to shape the proposed expansion in such a way that is truly beneficial to American Indians and Alaska Natives.

The National Indian Health Board and Northwest Portland Area Indian Health Board will work collaboratively to develop a template comment letter to assist Tribes in making their own comments. **Please join us on a Tribal Only Call on July 7, 2016 to discuss the proposed comments and to provide input on the CHAP program expansion.** Email Devin Delrow, National Indian Health Board, ddelrow@nihb.org to receive conference line information.

As Tribes and Tribal organizations work on developing their comments to this proposed expansion, it is important to consider how a national program would affect those programs already in effect in Alaska and Washington. Careful consideration must be given to what a national program would look like, what kind of oversight would such a program have over the different Areas? Would it be appropriate to have a national certification board or are Area specific certification boards more appropriate? In addition, what certification levels do we want for the CHA/Ps? Is there legislative language that we want to add or be changed to support the new program? Ideas around funding and implementation are extremely important to include in your comments.

Background

ALASKA COMMUNITY HEALTH AIDE PROGRAM

What is the Alaska Community Health Aide Program?

The Community Health Aide Program (CHAP) emerged from a 1960s program of the Indian Health Service (IHS) that successfully employed local, Alaska Native village workers to distribute medicines in response to a number of health concerns, including: the tuberculosis epidemic, high infant mortality and high rates of injury in rural Alaska. For the past 50 years, CHAP has proved an effective method for diminishing the health disparities of Alaska Natives by promoting access to health services for Alaska natives residing in rural and remote communities. These communities are generally too sparsely populated to sustain a physician, dentist or mid-level provider. CHAP trains local residents to provide basic health care, assuring that health services are available in the local community from culturally competent providers who speak the native language.

Formalized curriculum and training were developed in the 70s to assure Community Health Aides/Practitioners (CHA/Ps) could receive training with minimal time away from the communities and families. There is a CHAP Certification Board in Alaska that sets standards for all providers in the CHAP program and provides oversight of the program.

CHAP has evolved over time to accommodate advances in medicine and the health needs of the population, and doing so at a comparatively low cost. CHAP provides patient-centered primary care, as opposed to specialty care, and delivers more care in the community rather than in the acute care setting. CHAP now consists of a network of approximately 550 (CHA/Ps) in more than 170 rural Alaska villages. CHA/Ps work within the guidelines of the 2006 Alaska Community Health Aide/Practitioner Manual, which outlines assessment and treatment protocols. There is an established referral relationship which includes midlevel providers, physicians, regional hospitals and the Alaska Native Medical Center. In addition, providers such as public health nurses, physicians and dentists make visits to villages to see clients in collaboration with the CHA/Ps

Benefits of a CHAP program

The current healthcare delivery system is failing tribal communities in many ways. Not only is access often a challenge due to expense and location, but there is a significant lack of AI/AN providers. The Alaska CHAP program:

- Provides routine, preventative, and emergent care;
- Respects the knowledge and resources in the tribal community and grows providers from that source. Community Health Aids are selected by their communities to receive training;
- Trains AI/AN community members who speak the native languages and can provide culturally appropriate care;
- Breaks down barriers to care and barriers to training;
- Creates an accessible entry point for AI/AN people wishing to become health care providers;
- Utilizes a training program that emphasizes not just skill and proficiency but also ensure Aides could receive training with a minimal time away from communities and families.

- Brings care to communities;
- Fosters a team approach to delivering health care services.

Community Health Aide Program Certification Board

The Community Health Aide Program Certification Board sets standards for the Alaska CHAP and certifies individuals as community health aides and practitioners, dental health aides (including primary dental health aides, dental health aide hygienists, expanded function dental health aides, and dental health aide therapists), and behavioral health aides and practitioners. These individuals are subject to specific requirements and engage in specific scope of practices.

Providers in the Alaska CHAP program

The Alaska CHAP program includes Community Health Aides (CHA/Ps), Behavioral Health Aides (BHA/Ps) and Dental Health Aides (DHA/Ts). The CHAP program provides needed health, oral health, and behavioral health services while also emphasizing wellness and healthy choices.

There is an established referral relationship which includes midlevel providers, physicians, regional hospitals and the Alaska Native Medical Center. In addition, providers such as public health nurses, physicians and dentists make visits to villages to see clients in collaboration with the CHA/Ps, DHA/Ts, and BHA/Ps.

Community Health Aide

Alaska has 5 levels of Community Health Aides that build upon each other.

Community Health Aid level 1-4 (CHA I, CHA II, CHA III, CHA IV) and the top level, Community Health Practitioner (CHP). The scope of practice for each provider is different and encompasses all of the scope of practice for the levels below the highest level of training reached by the individual. Depending on their level of certification, CHAs can provide services such as:

- Emergency first aid
- Patient examinations
- Follow up (in collaboration with treating physician or mid-level provider)
- Carrying out treatment recommendations
- Patient and family focused education and instruction
- Preventive health programs
- Infection and disease control
- Immunizations
- Store and dispense prescription drugs (with physician instructions)

Dental Health Aide

Dental Health Aides are primary oral health care professionals. They provide basic clinical dental treatment and preventive services. They are multidisciplinary team members and advocate for the needs of patients.

There are 3 levels of Dental Health Aides that build upon each other.

Dental Health Aide level 1-2 (DHA I, DHA II) and the top level, Dental Health Aide Therapist (DHAT). The scope of practice for each provider is different and encompasses all of the scope of practice for the levels below the highest level of training reached by the provider. Depending on their level of certification, DHAs can provide services such as:

- Diagnosis and Treatment
- Planning, Prevention
- Basic Hygiene
- Radiographs
- Infection Control
- Restorative
- Pediatric
- Urgent Care
- Extractions
- Community Projects
- Clinic Management
- Equipment Repair and Maintenance

Behavioral Health Aide

The Alaska Behavioral Health Aide (BHA) Program is designed to promote behavioral health and wellness in Alaska Native individuals, families and communities through culturally relevant training and education for village-based counselors.

There are 4 levels of Behavioral Health Aides that build upon each other.

Behavioral Health Aide level 1-3 (BHA I, BHA II, BHA III) and the top level, Behavioral Health Practitioner (BHP).

Depending on their level of certification, a BHA:

- Is a counselor, health educator, and advocate.
- Helps address individual and community-based behavioral health needs, including:
    - those related to alcohol, drug and tobacco abuse
    - mental health problems
    - grief
    - depression
    - suicide
- BHAs seek to achieve balance in the community by integrating their sensitivity to cultural needs with specialized training in behavioral health concerns and approaches to treatment.

IHS COMMUNITY HEALTH REPRESENTATIVE PROGRAM

What is the IHS Community Health Representative Program?

The IHS Community Health Representative Program (CHRP) aims to create a workforce that improves health across the communities they serve. CHRP is a unique community-based outreach program, staffed by a cadre of well-trained, medically-guided, tribal and Native community people who provide a variety of health services within AI/AN communities.

Benefits of CHRP

CHRs are important because they are experts in the dialects and the unique cultural aspects of their patients' lives. CHRs are a role model for the communities they serve; they are the ones people can go to when they need guidance, an advocate their needs, and help. The daily roles of CHRs vary as do the clients they serve. The following are examples of typical duties a CHR might perform.

- Visiting clients at home and referring those in need of care to the proper facility.
- Explaining available health programs, the health policies and procedures that the community members must follow when seeking health care
- Organizing community health promotion and disease prevention events and facilitate learning.
- Offering transportation to health promotion facilities for those in need
- Entering diagnostic patient-specific data into official patient medical records through the use of the CHR component of the RPMS (Resource and Patient Management System)
- Arranging for police/ambulance transport during accidents or emergency situations

HISTORICAL BARRIERS TO COMMUNITY-BASED AND MID-LEVEL HEALTH CARE PROVIDERS

Transforming the health care system to meet the demand for safe, quality, and affordable care may require a fundamental rethinking of the roles of many health care professionals. A variety of historical, cultural, regulatory, and policy barriers often limit the ability of allied professionals to contribute to widespread and meaningful change. Organized medicine and dentistry have often challenged expanding the scope of practice for other allied and mid-level providers. Much of this work has invited genuine debate and has aided in the definition of strong practices for other health professions. As Nurse Practitioners, Nurses, Dental Therapists and Physicians Assistants have proven over the last 60 years, mid-level and allied health professionals can provide safe, affordable, high quality, patient-centered care.

There were early struggles to define the role of the Nurse Practitioner in medicine. Some physicians, especially those practicing in rural areas of the country, welcomed the Nurse Practitioner's help, while organized medicine guarded their profession's traditional roles. Legal challenges to the Nurse Practitioner's role followed, as they began to practice at the full extent of

their certification and licensure. In a 1980 landmark case, *Sermchief v. Gonzales* (1983), the Missouri medical board charged two women's healthcare Nurse Practitioners with practicing medicine without a license (Doyle & Meurer, 1983). The Missouri Supreme Court ruled that the scope of practice of advanced practice nurses (APNs) could evolve without statutory constraints (Wolff, 1984). Similar struggles are anticipated as the role of other health professionals is expanded and created.

The expansion of duties for Dental Health Aide Therapists has been as intensely fought as the expansion of Nurse Practitioners and Physicians Assistants. The American Dental Association and state dental associations have taken a strong position against dental therapy under the pretext of patient safety and quality. The ADA believes it is in the best interests of the public that only dentists diagnose dental disease and perform surgical and irreversible procedures. This position, however, is not evidence based, and has no peer reviewed literature to validate the position.

Similar to the legal challenges to the Nurse Practitioner's role, in 2006, the American Dental Association and Alaska Dental Society filed a suit against the Alaska Native Tribal Health Consortium (ANTHC), the State of Alaska, and eight Dental Health Aide Therapists (DHAT), claiming that DHATs were practicing dentistry without a license (*The Alaska Dental Society, et al v. SOA, et al*. (2006)). Ultimately, the ADA lost the court battle and were ordered to pay a settlement. DHATs, ANTHC, and the Corporations continued to grow the DHAT portion of the CHAP program. That has not stopped the ADA from continuing to oppose the DHAT program. The ADA lobbied successfully to include language in the Indian Health Care Improvement Act (IHCIA) that limits the ability of Tribes outside of Alaska to use DHAT services unless such services are authorized under state law.

IHS's request for comments on expansion of CHAP provides an opportunity for Tribes to express the need within their communities for every type of mid-level provider and propose how such providers could be incorporated into the Indian health system nationally.

For more information, please contact:

Devin Delrow, Director of Federal Relations, National Indian Health Board, 202-507-4072, ddelrow@nihb.org

Laura Bird, Policy Director, Northwest Portland Area Indian Health Board, 503-228-4185 ext. 276, lbird@npaihb.org

Online Resources:

Alaska CHAP Program: http://www.akchap.org/html/home-page.html

IHS Community Health Representative Program (CHRP): https://www.ihs.gov/chr/

IHS Dear Tribal Leader Letter on CHAP: http://www.npaihb.org/download/policy/fedpolicy/Dear-Tribal-Leader-Letter-CHAP-Expansion.pdf

IHS Policy Statement on the Expansion of CHAP: http://www.npaihb.org/download/policy/fedpolicy/IHS-Draft-Policy-Statement-on-the-Expansion-of-CHAP.pdf

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Indian Health Service
Rockville MD 20852

JUNE 1 2016

Dear Tribal Leader:

I am writing to provide an update on the Proposed Rule for the Catastrophic Health Emergency Fund (CHEF). The comment period for the Proposed Rule ended on May 11.

Several Tribes and Tribal Organizations expressed concern about provisions in the *Federal Register* Notice. In response to those concerns, the Indian Health Service (IHS) has made the determination that we will engage in additional Tribal consultation before moving forward. In addition to two telephonic consultation sessions to be scheduled during the summer and early fall, an in-person session is planned to be held during the National Congress of American Indians' Annual Convention, which is scheduled on October 9-14, in Phoenix, Arizona. The specific dates and times will be posted on the IHS Calendar of Events on our website when these details are available.

For additional information, please contact Ms. Terri Schmidt, Acting Director, Office of Resource Access and Partnerships. She can be reached by telephone at (301) 443-3216 or by e-mail at terri.schmidt@ihs.gov.

Sincerely,

/Mary Smith/

Mary Smith
Principal Deputy Director

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Indian Health Service
Rockville MD 20852

MAY 24 2016

Dear Tribal Leader:

I am writing to announce that on March 21, 2016, the Indian Health Service (IHS) published a final rule implementing the ability of health programs operated by the IHS, an Indian Tribe or Tribal Organization pursuant to a contract or compact with the IHS under the Indian Self-Determination and Education Assistance Act (ISDEAA), and Urban Indian organization pursuant through a contract or grant under Title V of the Indian Health Care Improvement Act (IHCIA) (collectively, I/T/U) to cap payment rates to physicians and other non-hospital providers and suppliers who provide services through the Purchased/Referred Care (PRC) program, formerly contract health services. These rates will be known as Purchased/Referred Care Rates. The effective date of the final rule is May 20, 2016. I have enclosed a copy of the Final Rule and a related press release for your review.

The final rule amends the regulations at Title 42, *Code of Federal Regulations* (CFR), Part 136, by adding Subpart I, which applies the Medicare payment methodologies to all physician and other health professional and non-hospital based services and supplies purchased by IHS or Tribal PRC programs, or Urban Indian organizations.

The PRC program funds primary and specialty health care services that are not available at IHS or Tribal health care facilities and are purchased from private health care providers and suppliers. This includes hospital and outpatient care, as well as physician, laboratory, dental, radiology, pharmacy, transportation services, and durable medical equipment.

The small market share of individual I/T/U health programs has made it difficult to negotiate discounted rates with private providers. Accordingly, these programs have had to pay full billed charges that substantially exceed the rates paid by the Medicare program, U.S. Department of Veterans Affairs, and Defense. The PRC Rates enable I/T/U health programs to pay rates that are consistent across Federal health care programs. The rule also aligns payment with inpatient services and enables I/T/U health programs to expand beneficiary access to medical care. To ensure I/T/U health programs receive information needed to implement this regulation, the IHS is providing outreach through a mass mailing to PRC administrators, as well as participating providers and suppliers. The PRC staff will receive training on the new rates through in-person training sessions, online modules, Webinars, and conference calls.

Tribes are offered the flexibility to opt-in to the regulation, if they choose, by contacting their contract proposal liaison officer or Area lead negotiator to modify or amend their

contract/compact with IHS. If a Tribe chooses not to opt-in, no action is necessary. If they choose to opt-in, the regulation offers Tribes the flexibility to negotiate reasonable prices that are higher than the payment caps set forth in this rule, as long as the award is in the best interest of the program, as determined by the Tribe.

The IHS defines the term "referral" in the regulation to clarify for beneficiaries and providers when the requirements for payment acceptance have been triggered. A PRC referral is an authorization for medical care by the appropriate ordering official in accordance with Title 42 CFR part 136 subpart C. Distinct from a medical referral, acceptance by a provider of a referral issued pursuant to subpart I means claims for authorized services should be processed in accordance with PRC rules, including alternate resource requirements. Pursuant to Federal law, patients may not be charged by the provider for authorized services.

If you have questions regarding this final rule, please contact Ms. Felicia Roach, Acting Director, Division of Contract Care. She can be reached by telephone at (301) 443-2694.

Sincerely,

/Mary Smith/
Mary Smith
Principal Deputy Director

Enclosures

U.S. Department of Health and Human Services

Indian Health Service

Part 3 - Professional Services
Chapter 32 - State Prescription Drug Monitoring Programs

3-32.1 INTRODUCTION

A. Purpose.

The purpose of this chapter is to establish and define participation of the Indian Health Service (IHS) with State Prescription Drug Monitoring Programs (PDMPs).

B. Background.

The PDMPs are considered to be a tool for prescribers and pharmacists to monitor and deter prescription medication misuse, abuse, addiction and diversion and ensure appropriate clinical care.

The PDMPs to date are State-based, electronic databases that collect data on controlled medications dispensed by registered pharmacies operating within the state. These programs have a variety of purposes and goals, including:

(1) Supporting medication safety and legitimate medical access to controlled substances.

(2) Determining individuals who may be misusing, abusing or diverting drugs and preventing inappropriate access to controlled substances.

(3) Helping identify individuals addicted to controlled prescription medications and intervening with treatment.

(4) Influencing public health legislative and financial agendas by presenting prescription medication use data.

(5) Educating the public about the purpose of PDMPs and the issues surrounding prescription drugs.

(6) While the goals of State PDMPs are similar, vast variations exist within State legislation, PDMP logistics, and program administration.

C. Definitions.

(1) Delegates. Those healthcare professionals who have been recognized by State legislation with authorization to receive PDMP access or request patient queries.

(2) Dispensers. The entities that must submit data to the PDMP for controlled drugs they have dispensed and administered. This includes pharmacies (both in and out of State), hospitals, and any prescriber-based dispensing.

(3) Illicit Drugs. Illicit drugs refer to marijuana, cocaine, inhalants, hallucinogens, heroin, or prescription-type drugs used non-medically.

(4) Prescribers. Those clinicians who have the authority to prescribe controlled substances under State law.

(5) Memorandum of Understanding (MOU). A formal agreement between the IHS Area and State PDMP that establishes the requirements for data disclosure to the State PDMP. Examples of PDMP MOUs may be obtained by contacting the IHS Principal Pharmacy Consultant.

(6) Solicited Reporting (Also known as Reactive Reporting). A request from the prescriber or delegate for patient profile information from the PDMP.

(7) Unsolicited Reporting (Also known as Proactive Reporting). A report generated and provided by the PDMP to the prescriber or dispenser of a particular patient that has exceeded dispensing thresholds established by the PDMP.

3-32.2 RESPONSIBILITIES

A. Area Director. Ensures the PDMP MOU is current, signed, and archived as required in the terms of the MOU and as allowable by State law.

B. Clinical Director. All PDMP reporting and prescriber utilization shall be a function of the medical staff under the direct oversight of the Clinical Director.

C. Pharmacy Director. All Federal IHS pharmacy sites with an approved MOU between the IHS Area and the State in which the facility is located shall ensure that Schedule CII-CV dispensing data is reported at the frequency required by the State in which the facility is located. Daily reporting is recommended to ensure a complete and accurate patient record.

D. Prescriber. The prescriber of a controlled substance prescription has the legal and ethical responsibility to ensure that all controlled substance prescriptions are issued in accordance with Federal law. Valid prescribing is for a legitimate medical purpose that includes patient assessment, a documented treatment plan, and appropriate monitoring. A PDMP query is one tool to assist practitioners with assessing patient prescription drug safe medication use, misuse, addiction, or diversion. Prescribers must:

(1) Register with State PDMP.

(2) Request a solicited PDMP report as a normal process of accepting a new patient. This information can assist the provider with determining any possible drug-drug interactions with any potential prescribed therapy or to identify recent doctor shopping behavior.

(3) Access PDMP patient data prior to patient appointment to facilitate meaningful interactions. Providers should review PDMP data when opioid prescriptions for acute pain exceed 7 days, when progressing from acute to chronic opioid pain therapy, and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months. Data can help prescribers to:

a. Check for drug interactions or other harm.

b. Check for addiction or undertreated pain.

c. Check for misuse or multiple prescribers.

d. Use reports to verify compliance with safe medication use/pain agreements.

(4) Evaluate and respond appropriately to unsolicited PDMP reports. Complete health chart review note regarding findings, prescriber assessment, and patient treatment plans.

(5) Use delegate accounts where authorized. Delegates can help prescribers reduce time conducting queries. Check with your state to see if delegates are allowed. It is recommend a maximum of two delegate accounts per prescriber, as the prescriber is ultimately responsible for reports requested by the delegates.

(6) Perform self-audits monthly with a copy of the report provided to the Clinical Director.

E. Pharmacist.

(1) The pharmacist shall access PDMP data during the following activities and discuss any potential abuse or diversion with prescribers:

a. Prior to processing an outside prescription for a controlled substance.

b. Every 3 months, prior to reissuing or refilling for a chronic controlled substance prescription for Schedules CII-CV medications.

(2) Pharmacists may:

a. Assist with conducting PDMP queries upon prescriber request.

b. Assist with provider education regarding report interpretation as appropriate.
