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MEMORANDUM

July 16, 2012

TO: Tribal Health Clients

FROM: Hobbs, Straus, Dean & Walker LLP

Re: *House Votes to Repeal ACA; White House/HHS Monthly Tribal Leaders ACA Update Call*

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1. *House Votes to Repeal ACA*

The House of Representatives voted on July 11 to approve HR 6079, the "Repeal of Obamacare Act," introduced just two days before on July 9, 2012. The bill's language includes lengthy findings on certain impacts of the Affordable Care Act (ACA), but the critical language is as follows: "Effective as of the enactment of Public Law 111-148 [the ACA], such Act … is repealed, and the provisions of law amended or repealed by such Act … are restored or revived as if such Act had not been enacted." HR 6079 would only preserve sections 3403 and 10320 of the ACA, which relate to the Independent Medicare Advisory Board created by the ACA. The bill's language does not preserve the permanent reauthorization and amendments to the Indian Health Care Improvement Act that was included in the ACA. The bill would also repeal health care-related provisions of the Health Care and Education Reconciliation Act of 2010.

HR 6079 passed by a vote of 244 to 185, largely along party lines. Regardless of the House vote, HR 6079 is unlikely to be taken up by the Senate, though we understand that Senate Republicans are looking for a vehicle to attach an ACA repeal vote. The President has also stated that he would veto the bill even if it were passed by both chambers.

2. *White House/HHS Monthly Tribal Leaders ACA Update Call*

On July 10, 2012, the White House held its monthly Tribal outreach call on the Affordable Care Act (ACA) in conjunction with the Office of Personnel Management (OPM) and the U.S. Department of Health and Human Services (HHS). Charles Galbraith, of the White House Office of Intergovernmental Affairs, opened the call with an announcement of last month's Supreme Court decision largely upholding the ACA as constitutional. The ACA includes a permanent reauthorization of the Indian Health Care Improvement Act (IHCIA).

Referencing HR 6079, the House bill to repeal the ACA discussed above, Mr. Galbraith said that the Court has "issued a clear and final ruling" and that the last thing Congress should do now is "re-fight old political battles" in order to repeal the vital protections embodied in the law. When asked about the likelihood that Congress would pass a repeal, Mr. Galbraith responded that while he could not speculate on what Congress might do, the President has stated that he would veto a bill repealing the ACA.

Myra Alvarez, the Director of Public Health in the White House Office of Health Reform, said the ACA is designed to improve the health care system through a focus on four key areas: (1) protecting against the worst insurance company abuses; (2) spending health care dollars more wisely; (3) strengthening the Medicare program; and (4) providing better access to care. She reviewed several announcements made in the last month regarding implementation of the general provisions of the ACA, but did not address how that implementation would affect Tribes or provide any update on implementation of the Indian-specific provisions of the ACA.

First, she reported on the implementation of the "80/20 rule" in the ACA, which went into effect this year and requires that health insurance companies spend at least 80% of the premiums they charge to consumers on medical care and quality (as opposed to administrative, marketing, or other costs). Second, she announced that the Surgeon General last month released the National Prevention Council Action Plan, outlining coordinated federal government actions intended to shift the focus of the health care system from sickness and disease to prevention and wellness. Seventeen government departments, including the Bureau of Indian Affairs, participate in the National Prevention Council and will take actions pursuant to the Plan. Third, she announced that as of the beginning of July, 89 new Accountable Care Organizations (ACOs) will be serving 1.2 million Medicaid beneficiaries in 40 states and Washington, D.C. ACOs are voluntary associations of health care providers meant to improve coordination and quality of patient care while also achieving cost savings. The announcement is posted at: http://www.hhs.gov/news/press/2012pres/07/20120709a.html. She also made a number of other announcements regarding ACA implementation that are not specific to Tribes.

Dr. Yvette Roubideaux, Director for the Indian Health Service (IHS), announced that on July 3, 2012 IHS released a Dear Tribal Leader letter initiating consultation on the health care facilities construction process. She said that the IHCIA reauthorization made changes to the process by authorizing a new Facilities Appropriation Advisory Board (FAAB) to review and revise the Health Care Facilities Construction Priority System. In the July 3 letter, the IHS seeks nominations to the FAAB as well as other input from tribes. Nominations are requested by **July 31, 2012**, and other comments should be submitted by **August 31, 2012** either by email (to consultation@ihs.gov) or by postal mail to the IHS Director. The letter and its enclosure are attached. Dr. Roubideaux said the IHS will also be posting a draft confer policy for Urban Indian Organizations, which is authorized by the IHCIA, in the near future. She reminded participants that the National Indian Health Outreach and Education initiative is available to help tribes with

education and outreach in Indian communities (more information is available at http://tribalhealthcare.org) and that the next tribal consultation summit is planned for August 7-8 in Denver, Colorado.

Rachel Aksman of OPM announced that the Federal Employee Health Benefits (FEHB) program for Tribes is now fully implemented. The FEHB program allows tribes to purchase for their employees the same health insurance that the federal government offers to its employees. Currently, Ms. Aksman said about 30 tribes are participating in the program, providing coverage to around 3,000 enrollees. Tribes may contact OPM, tribalprograms@opm.gov, at any time to participate in the program. OPM is planning its next training session for July 26 in Dillingham, Alaska.

For further information on the topics discussed in this memorandum, please contact Elliott Milhollin at (202) 822-8282 or emilhollin@hobbsstraus.com or Geoff Strommer at (503) 242-1754 or gstrommer@hobbsstraus.com.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Indian Health Service
Rockville MD 20852

JUL 3 2012

Dear Tribal Leader:

As part of the Affordable Care Act, the Indian Health Care Improvement Act (IHCIA) was permanently reauthorized and contains new provisions on health care facility construction priorities, methodology, innovation, and demonstrations. I am writing to request your input on **how to improve the Indian Health Service (IHS) health care facilities construction process**.

Since I have been the IHS Director, the topic of health care facilities construction and the associated staffing and operational needs is mentioned very frequently in my meetings with Tribes. As you may know, the IHS has a priority list for health care facilities construction that has been in place for many years. The ongoing challenge related to this list is that the amount of annual funding for construction, staffing, and operations of new health care facilities is greater than available resources in the IHS budget. In recent years (excluding the Recovery Act), appropriated health care facility construction funding has been between $29 million and $85 million each year.

The IHCIA's Subtitle C, "Health Facilities," authorizes a new Facilities Appropriation Advisory Board (FAAB) to review and revise the IHS Health Care Facilities Construction Priority System and to be "comprised of 12 members representing Indian tribes and 2 members representing the Service, established at the discretion of the Director."

The IHCIA Health Care Facility provisions provide new authorities that:

- Expand the types of health care facilities that must be assessed and prioritized in a report to Congress; in addition to inpatient and outpatient facilities, the IHS must report the priority need for "specialized health care facilities (such as for long-term care and alcohol and drug abuse treatment), wellness centers, and staff quarters."
- Ensure projects on the current priority list will not be affected by any changes in the Priority System.
- Require a report by March 23, 2011 that ranked facility need. A Report to Congress on Estimated Need for Tribal and IHS Health Facilities was submitted on time and described the current priority list and Tribal consultation needed on the new IHCIA authorities.
- Require IHS to establish, by regulation, standards for the planning, design, construction, and operation of health care or sanitation facilities serving Indians.
- Include the authority for other agencies to contribute to the IHS and for IHS to accept contributions for facility planning, design, construction and maintenance. These funds may be placed into Public Law 93-638 accounts and contracts.
- Direct the IHS to establish a demonstration program for modular component construction. IHS requested and received $1 million in the FY 2012 budget to conduct a feasibility study on this provision.

- Authorize a demonstration program "for consortia of two or more service units to access funding to purchase a mobile health station to provide specialty health care services such as dentistry, mammography and dialysis."
- Authorize Indian Tribes to set rental rates and collect rents at federally-owned quarters operated under the ISDEAA.
- Reauthorize the demonstration to test or use alternative means of delivering health care through health facilities to Indians. This authorization includes specific direction to develop new health programs offering care outside of regular clinic operational hours and/or in alternative settings, and to use alternate or innovative methods of delivering health care services to Indians.

I am requesting your input and recommendations on how the IHS should move forward with health care facilities construction in light of the new health facilities construction language in the IHCIA. I have listed some questions for your consideration below and have also enclosed a summary of IHS health care facility construction programs for your reference.

1. IHS plans to proceed with establishing the **FAAB** as authorized by Section 141 of the IHCIA. The IHCIA establishes it as advisory to the IHS Director. Do you have any recommendations on the structure, focus, or composition of the Board? Please also submit nominations for members to your IHS Area Director by July 31, 2012.

2. How should the IHS proceed with establishing the **Facilities Needs Assessment Workgroup** as authorized by Section 141 of the IHCIA? Should this be a separate group from #1?

3. How should the IHS improve our overall **health care facilities planning and construction process** and the way we do business related to health care facility construction?

4. How could the IHS improve our approach to health care facilities construction within the **Budget Formulation process**?

5. Do you have suggestions for **innovative strategies** for health care facilities construction?

6. How could the IHS improve the overall process for determining **staffing and operational costs** related to specific types of health care facilities?

7. Do you have suggestions about how the IHS could change and improve our **small ambulatory program**?

8. Do you have suggestions about how the IHS could change and improve our **joint venture construction program**?

Please submit your health care facilities construction recommendations in writing to me by August 31, 2012, at either of the following addresses:

By e-mail at consultation@ihs.gov; or by postal mail at:

Yvette Roubideaux, M.D., M.P.H.
Director, Indian Health Service
801 Thompson Avenue, Suite 440
Rockville, MD 20852

Thank you for your input on this very important program.

Sincerely,

/Yvette Roubideaux/

Yvette Roubideaux, M.D., M.P.H.
Director

Enclosure
IHS Health Care Facilities Construction Programs (Summary Description)

IHS Health Care Facilities Construction Program

The Indian Health Service (IHS) Health Care Facilities Construction (HCFC) Program is authorized to construct health care facilities and staff quarters, renovate/construct Youth Regional Treatment Centers for substance abuse, Joint Venture Construction Projects, provide construction funding for Tribal small ambulatory care facilities projects, replace/provide new dental units, and to assist non-IHS funded renovation projects.

Pursuant to the Indian Health Care Improvement Act (IHCIA), Public Law (P.L.) 94-437, the need for construction to provide health care facilities, including specialized facilities, and staff quarters is assessed through application of comprehensive priority system methodologies. The proposals are then evaluated objectively and ranked according to need.

The current IHS Health Care Facility Construction Priority List was last updated in 1991 and, according to the IHCIA, must be completed before new facilities are added. To determine the locations where new and replacement facilities are most critically needed, the IHS uses a comprehensive priority system, including methodologies for health care facilities and staff quarters construction. Projects for other authorized programs are identified in separate processes.

The Health Care Facilities Construction Priority System (HFCPS) is a three-phase process that establishes one national list for funding:

- Phase I: IHS Headquarters solicits proposals from the IHS Areas for urgently needed new or replacement health care facilities and essential staff quarters projects. Area Offices submit proposals and IHS uses the data (which has not yet been validated) in these proposals to apply a formulaic analysis to obtain a short list of proposals for more systematic review.

- Phase II: Area Offices review and update data for proposals identified in Phase I. These data are validated and then reviewed based on formulaic analysis of Facility Deficiency and Isolation criteria:
    - Facility Deficiency is determined using both the difference between the required space and the existing space (absolute need) and the ratio of the existing space/required space (relative need). Since the required space is determined by population and the workload to serve that population, the existing HFCPS is driven strongly by population. Existing space is the space available to support the provision of health care services. This space is adjusted for its condition and age.
    - Isolation is determined using the distance to alternative sources of care.

- Phase III: The HFCPS does not limit the number of projects to be evaluated for prioritization in Phase III. Proposals showing greatest need are evaluated in a detailed planning process that involves development and approval of a Program Justification Document (PJD). Formal justification documents are prepared for those scoring highest. Once justified and approved, projects are placed on the appropriate construction priority list and proposed for funding. The HFCPS establishes one national list that prioritizes funding needs for the top 10 inpatient and the top 10 outpatient facilities. Appropriations

for health care facility construction are allocated only to facilities on the national priority list.

Joint Venture Construction Program

Section 818 of the IHCIA, P.L. 94-437, authorizes the IHS to establish joint venture projects under which Tribes or Tribal organizations would acquire, construct, or renovate a health care facility and lease it to the IHS, at no cost, for a period of 20 years. Participants in this competitive program are selected from among eligible applicants who agree to provide an appropriate facility to IHS. The facility may be an inpatient or outpatient facility. The Tribe must use Tribal, private or other available (non-IHS) funds to design and construct the facility. In return the IHS will submit requests to Congress for funding for the staff, operations, and maintenance of the facility per the Joint Venture Agreement.

Proposals considered under this program are evaluated against the following criteria:

- The need for space at the location is verifiable when evaluated by using the criteria in the IHS planning methodologies;
- The Tribe is able to fund and manage the proposed project using its own (non-IHS) funds;
- The project is consistent with the IHS Health Systems Planning program; and
- The project is consistent with the IHS Area Health Facilities Master Plan.

Additional consideration is given to Tribes that elect to fully fund the equipment for the facility.

Small Ambulatory Program

Section 306 of the IHCIA, P.L. 94-437, authorizes the IHS to award grants to Tribes and/or Tribal organizations for construction, expansion, or modernization of ambulatory health care facilities located apart from a hospital. Where non-Indians will be served in a facility, the funds awarded under this authority may be used only to support construction proportionate to services provided to eligible American Indian and Alaska Native (AI/AN) people. The last year that IHS received appropriations to fund the Small Ambulatory Program was in 2006.

Participants in this program are selected competititively from eligible applicants who meet the following criteria:

- Only federally recognized Tribes that operate non-IHS outpatient facilities under P.L. 93-638 contracts are eligible to apply for this program.
- Facilities for which construction is funded under Section 301 or Section 307 of P.L. 94-437 are not eligible for this type of grant.
- Priority will be given to Tribes that can demonstrate a need for increased ambulatory health care services and insufficient capacity to deliver such services.
- The completed facility will be available to eligible Indians without regard to ability to pay or source of payment.

- The applicant can demonstrate the ability to financially support services at the completed facility.
- The completed facility will:
    - Have sufficent capacity to provide the required services.
    - Serve at least 500 eligible AI/AN people annually.
    - Provide care for a service area with a population of at least 2,000 eligible persons.