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MEMORANDUM

September 22, 2014

To: Tribal Health Clients

From: Hobbs, Straus, Dean & Walker, LLC

Re: *Report on Secretary's Tribal Advisory Committee (STAC) Meeting*

On September 17-18, 2014, the Secretary of Health and Human Services' ("HHS") Tribal Advisory Committee ("STAC") met in Washington D.C. at HHS headquarters. This was the first STAC meeting with the newly appointed Secretary of Health and Human Services, Sylvia Burwell. Following is a brief summary of the reports provided by Secretary Burwell and the heads of the HHS operating divisions.

Report from Secretary Sylvia Burwell

Secretary Burwell introduced herself to the STAC by noting that she has had experience working with Indian tribes in her prior work, and that one of her first visits to an operating division of HHS was to an IHS facility. She mentioned that she only has limited time to accomplish a number of goals, but that she was eager to build relationships in that time.

Chairman Cladoosby introduced the STAC, and discussed the critical importance of the government-to-government relationship between tribes and HHS. Chairman Allen provided the remarks of the STAC on the Affordable Care Act. He noted that the ACA presents numerous opportunities for tribes in the ACA, but that many American Indians and Alaska Natives have not been able to take advantage of those opportunities to date.

Chairman Allen encouraged Secretary Burwell to consider using uncompensated care and premium assistance waivers to ensure access to Medicaid for Indians in states that do not expand Medicaid. He asked HHS to administratively fix the definition of Indian, and to delegate authority to IRS to verify eligibility for the hardship exemption. He also asked for data metrics from HHS to measure AI/AN access to the ACA programs. Finally, he asked that the Qualified Health Plans be required to provide a summary of benefits for the limited and zero cost sharing plans made available to Indians. He urged the Secretary to continue to work with the TTAG on these issues.

Tucson Area representative Chester Antone expressed the hope that states embrace Medicaid expansion, and that HHS work with States to expand Medicaid. He mentioned how important the uncompensated care waiver is to Arizona, and urged

Secretary Burwell to approve the uncompensated care waiver extension which is pending at HHS.

Tribal representatives asked for the Secretary's assistance in implementing the Indian Child Welfare Act to protect native children from arbitrary child foster placements. They asked that HHS confirm that States are in fact consulting with tribes on these issues. Tribal representatives also asked Secretary Burwell for assistance in modernizing the RPMS system.

Tribal representatives also raised the issue of Contract Support Costs and the current shortfall. Tribal representatives noted that direct service tribes support full funding for contract support costs, but not at the cost of direct services.

Secretary Burwell responded by announcing that the IRS will be delegated authority to issue hardship exemptions, and that she is continuing to work with the States to encourage them to expand Medicaid. She also reported that the issues related to IT and funding issues are going to be difficult. She reported that she believes that they will have a budget for 2015, but 2016 will be very difficult. She stated that in tight funding times, investments in infrastructure like new IT systems for the IHS are the first to be cut.

IHS Report

Acting Director Yvette Roubideaux provided an overview of IHS issues for the STAC. She began by addressing a newly discovered shortfall in contract support cost funding. Dr. Roubideaux reported that Congress had removed the cap on contract support costs, and committed to fully funding contract support costs. Because contract support costs are in the services budget, if contract health service costs go up, then funds will have to come out of services. She reported that as of August 22, 2014, there is an estimated additional $48 million in contract support cost need. This discussion was superseded by a follow up call Acting Director Roubideaux had with tribes on Friday, September 19, in which she announced that IHS had revised the $48 million figure downward to $25.1 million. A copy of a report on that meeting is attached.

Dr. Roubideaux reported that IHS is going to have to take funding to pay shortfall from the rest of the budget. She said it would have been used for renovations, provider contracts, etc.

She remarked that she thought it was unproductive for people to say that IHS has not properly managed this issue, and that we should instead focus on solving the issue. She explained that IHS could not have estimated the amount of the CSC need, as new tribes come it and have a right to funding, and that is unpredictable. IHS reported that they will take the funding out of headquarters first, then the areas, and then the service

areas. She noted that if the appropriation continues in the same way each year, then this issue will recur every year. She said IHS has been consulting with Tribes on potential solutions, and considering those proposals. One proposed solution is to make contract support funding mandatory.

Dr. Roubideaux reported that IHS has brought forward the recommendations that a short term continuing resolution include $48 million to pay for CSC, but the Administration had not made a decision on that. She noted that there is still time to work on a budget for 2015 as well. She also reported that there will be a tribal budget summit on October 13-14, 2014 in Washington DC. She said items to be discussed include improving the way in which IHS defines its unmet needs, and to ask for full funding. IHS is now proposing its budget for 2016 to OMB.

Dr. Roubideaux also stated that IHS continues to work on Medicare-Like Rates, and increasing priorities of care provided through contract health services. Although she did not provide more detail on that subject, we understand that IHS is currently considering draft regulations that would expand Medicare-Like Rates to all providers and suppliers.

Chairman Ron Allen stated that mandatory CSC was not intended to affect direct service tribes, and that he does not believe that Congress intended that. He said IHS needs to revisit its policy with regard to determining the CSC need, and there needs to be a deadline earlier in the year, so that everyone will know what the CSC need is earlier in the year. Chairman Payment stated that the $48 million shortfall is the best argument for Advanced Appropriations and mandatory contract support costs. He also argued that the Administration should be prepared to make a full budget request to OMB.

Director Roubideaux stated that the $48 million shortfall was created by Congress when it removed the cap on CSC and committed to full funding of CSC. She stated it was not the IHS' fault, as IHS could not have known that tribes would want to renegotiate CSC in July and August of this year. However, she noted that IHS needs to work with tribes to solve this issue, and committed to doing so.

Representatives from the direct services tribes reported that it was unacceptable for this shortfall to affect direct service tribes. He stated they fully support the goals of self-governance tribes, but not at the expense of direct service tribes.

Tribal representatives also raised the issue of modernizing the RPMS system, which they said was antiquated, and provided difficulty for tribal facilities in talking to other hospitals. They argued that integrating these systems cost money that neither the IHS nor tribes had. Director Roubideaux noted that IHS is looking at whether they can replace or update the RPMS system. She noted that the VA, which uses a system with a

similar architecture as RPMS, was considering updating its system but abandoned those plans because it would have cost over $200 million. Dr. Roubideaux said that modernizing RPMS is a resource issue, and would require additional appropriations from Congress.

Tribal leaders recognized the cost of adopting a new system, but made the point that the RPMS system is so inefficient and ineffective that it costs tribes significant resources in FTEs and lost provider time each and every day.

OMB Report

Norris Cochrane, Deputy Assistant Secretary for Budget, reported that OMB is closing out 2014, and looking forward to 2015. He said there is no chance of a sequester for 2015, that Congress is expected to pass a continuing resolution and OMB does not anticipate any problems.

Julian Harris, Associate Director for Health Programs, Office of Management and Budget, Executive Office of the President OMB, is the head of OMB's health policy. His group is looking at how to strengthen the IHS budget. He also addressed contract support costs. He stated OMB is working with tribes and with Congress to achieve a balanced long term solution for contract support costs. He noted that IHS has had to redirect $48 million in 2014 to address contract support costs, but noted that there are sufficient funds in the 2015 budget to address contract support costs and also cover services. He recognized that sequestration had a disproportionate effect on Indian country, but noted that the Administration is continuing to seek higher spending caps for Indian programs.

Chairman Allen asked that OMB sit down with IHS and tribes to come up with solutions to the issues related to full funding of CSC. He suggested that tribes had suggested that an anomaly be added to the next CR to come up with the full funding amount for CSC. He also stated that tribes are pushing for mandatory funding for CSC.

Tribal representatives argued for mandatory CSC funding, and argued strenuously that third party revenues not be used as an offset against IHS funding.

CCIIO Report

Lisa Marie Wilson, Senior Advisor, CCIIO provided an overview of the new auto-reassignment rules, which will automatically re-enroll individuals in the federally-facilitated marketplace plans unless they ask not to be included. She also reported that CCIIO had sent out notices regarding income verification.

Chairman Allen requested that CCIIO clarify an issue that has been impacting

tribes. Section 1402(d) of the ACA provides that there is to be no cost-sharing for Indians below 300 percent of the Federal Poverty Level. However, CCIIO has interpreted the law to require individuals who qualify for that protection to also qualify for premium tax credits, which are not available to individuals below 100 percent of FPL. As a result, CCIIO is interpreting the law to make zero cost sharing plans unavailable to individuals below 100 percent FPL (although they could be eligible for limited cost sharing plans). Ms. Wilson stated CCIIO has been working on that issue internally.

Tribal representatives also asked about requiring Qualified Health Plans to describe the cost sharing reductions for AI/ANs in the explanation of benefits for the zero and limited cost sharing plans. They also requested that IRS be able to grant the hardship exemption, and use electronic sources of data to verify IHS eligibility. Ms. Wilson stated that CCIIO is working on all of those issues and shares the same priorities, but did not provide any concrete report on the status of those requests.

Tribal representatives also asked for increased funding for the TTAG and increased funding for outreach and education that is separate from Navigator and other sources of funding.

CMS Report

Eliot Fishman, Director, Children & Adults Health Programs Group, CMCS gave a report on CMS activities. The Children & Adults Health Programs Group is responsible for eligibility policy, waivers, CHIP and quality and outcomes measures. He was accompanied by Kitty Marx, Director, Tribal Affairs Group, CMS and Lane Terwilliger, Technical Director in the CMS Division of Waivers and State Demonstrations, CMS.

Mr. Fishman reported on the implementation of Medicaid Expansion and the Marketplaces. He stated that Marketplaces enrolled 8 million individuals over the course of open enrollment, and that Medicaid saw dramatic increases in enrollment as well. He noted, however, that AI/ANs did not fare as well. He said that of the 350,000 uninsured AI/ANs who fall within the Medicaid coverage option because they have incomes below 133% of federal poverty level, over half live in states that have not elected to expand Medicaid.

Tucson Area representative Chester Anton asked Mr. Fishman about the Uncompensated Care Waiver extension that was submitted to CMS for Arizona. Tribes in Arizona are asking that the tribal uncompensated care waiver be extended beyond 2014.

Mr. Fishman reported that in States like Alaska and Wyoming, tribes are trying to

cover Indians through uncompensated care waiver. The difficulty, he said, in those states is budget neutrality. In Arizona, it is much easier because there is no budget neutrality issue. However, that issue is currently in front of CMS right now.

Mr. Fishman also announced that CMS is seeking to revise its Tribal Consultation Policy, and seeking tribal input on how effective tribal consultation policy is. They are seeking comments by October 1, 2014. He said that CMS was very eager to get feedback from tribes on the policy.

In response to a question about access to dental providers, Mr. Fishman said that CMS recognizes that the lack of dentists is a significant public health crisis. He said that CMS is looking at the issue and working to develop solutions. He said they are very open to proposed solutions from Tribes.

With regard to Medicaid access in states that have not expanded Medicaid, Mr. Fishman noted that Medicaid expansion is accelerating, and a number of states are considering alternatives through the waiver process.

Chairman Ron Allen noted that tribal consultation is critical when CMS is considering new waiver proposals from States. He noted that many tribal citizens are falling through the cracks and are not being covered. He noted that the TTAG has made a number of recommendations and will continue to work with CMS to ensure these issues are addressed.

Tribal representatives raised the issue that States like Arizona and now Alaska are taking the position that youth who age out of tribal foster care are not eligible to enroll in Medicaid. CMS stated they would take the issue back and look into it.

SAMHSA Report

Pam Hyde, SAMHSA Administrator reported that Youth Residential Treatment Centers should be eligible for reimbursement for Medicaid. She noted that SAMHSA is continuing to try to clarify where tribes can use Medicaid dollars if included in a state plan. Tribal representatives asked SAMHSA to work with IHS and Medicaid to clarify how Medicaid dollars can be used for certain types on youth regional treatment centers.

CDC Report

The Center for Disease Control (CDC) announced it is trying to increase its direct funding of tribal facilities to address public health issues. The CDC also announced they will be trying to make general CDC programs more accessible to tribes. They reported that NIHB has been given a grant to create an accreditation program for tribal health

programs.

HRSA Report

Mary Wakefield, HRSA Administrator provided an overview of HRSA programs that could be used to benefit tribal health care facilities. Tribal representatives asked Administrator Wakefield about a proposed "mega-rule" HRSA is considering publishing that would redefine who a patient is for purposes of qualifying for the 340B discount drug program. They asked that HRSA consult with tribes before issuing a proposed rule.

Mary Wakefield confirmed that HRSA is considering a "mega rule," but that a recent court decision has caused them to reconsider the scope of the rule. HRSA is currently assessing whether that decision has any impact on the mega rule. Administrator Wakefield stated that when the rule is published, tribes will be able to comment on it.

We had follow up conversations with HRSA staff to discuss the need for tribal consultation on the mega rule under consideration prior to it being published as a proposed rule, as prior consultation is consistent with the HHS tribal consultation policy. HRSA staff committed to get back to us.

HRSA also reported that the administration has requested $1.5 billion in new funding for primary care providers, which would give them 15,000 new providers. These providers would be eligible to serve at IHS and tribal facilities.

Administration for Children and Families

The Administration for Children and Families announced they will be distributing $500 million for new Early Head Start-Child Care (EHS-CC) Partnerships. These new grants will allow new or existing Early Head Start programs to partner with local child care centers and family child care providers serving infants and toddlers from low-income families. There is currently a 2 percent tribal set aside for funding, but there is a bill pending in Congress that would make the 2 percent tribal set aside a floor, so that 2 percent would be a minimum, not a maximum.

Tribal representatives expressed support for a tribal set aside, but raised concerns about how tribes can qualify for the programs, citing conditions regarding size, etc. that were barriers to tribal participation.

ACF also reported on early childhood initiative programs that have provided small grants to tribes to increase collaboration. ACF now has a tribal early childhood research center to advise ACF on the types of research activities that could be used to assist native childhood research centers.

ACF also reported on the 102-477 program, and stated that earlier this year they provided forms for comment by tribes. Apparently, the Department of Interior has responded to those comments and the proposed rule is going to OMB for review. ACF stated that they have consolidated the reporting requirements for the program.

ACF is in the process of collecting information from States and tribes on ICWA compliance and will be compiling that information and provide it to tribes. Tribal representatives raised the issue of lack of tribal consultation with the States as they prepare their 5 year plans.

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