[[Insert Letterheads from various Tribes and Tribal Organizations]]

[[Insert date]]

[[White House
Insert address]]

Re: Request for Tribal Relief from the Affordable Care Act Employer Mandate.

On behalf of the National Congress of American Indians, the National Indian Health Board, the Tribal Self-Governance Advisory Committee, and the Direct Services Tribal Advisory Committee, we write to request a meeting with you to discuss the need for relief for Tribes from the Affordable Care Act's employer shared responsibility rule (the "employer mandate").

The Internal Revenue Service's (IRS) employer shared responsibility rule is inconsistent with the federal trust responsibility, denies many Tribal members the opportunity to take advantage of the benefits and protections designed for them in the Marketplace, and chills Marketplace enrollment for American Indians and Alaska Natives (AI/AN). It is cost-prohibitive for many Tribes and will result in a diminution of Tribal services for Indian people. If fully implemented in Indian Country, Tribes will be faced with having to choose between providing coverage, which will result in reducing governmental services and disqualifying their Tribal member employees from the benefits and protections for AI/AN in the marketplace, or using scarce federal resources to pay the IRS substantial penalties if they do not comply. Neither outcome represents good federal policy.

The employer shared responsibility rule is mandated by Section 4980H of the Tax Code, as added by Section 1513 of the Patient Protection and Affordable Care Act (ACA) (as amended).[1] Section 4980H of the Code does not specifically apply to Tribal governments, and Section 54.4980H-2(b)(4) of the employer shared responsibility regulations reserves application of special rules for government entities.

As discussed below, Tribal workforces include a significant number of Tribal member employees, who are otherwise exempt from the Individual Mandate. The ACA contains several provisions designed to encourage AI/AN enrollment in the ACA Marketplaces, including special cost-sharing exemptions for AI/ANs. The Center for Consumer Information and Insurance Oversight (CCIIO) has been actively encouraging Tribes to encourage their members take advantage of these provisions by enrolling in the Marketplaces, and Tribes have expended considerable resources to take CCIIO up on that challenge.

But the IRS's application of the employer mandate to Tribal governments works at cross purposes to encouraging Marketplace enrollment, as an offer of coverage to a Tribal member employee disqualifies that employee from the premium subsidies that are critical to facilitating Marketplace enrollment. With the employer mandate in place, Tribes are placed in the untenable position of either having to offer insurance at full price to their Tribal member employees, who will then be unable to take advantage of Marketplace premium subsidies even if they do not accept the employer-based coverage, or to forego offering coverage (or offer insufficient coverage) to their Tribal member employees and pay substantial penalties to the IRS.[2]

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[1] *See* 26 U.S.C. § 4980h; 26 C.F.R. § 54.4980H–1 - .4980H-5.

[2] We illustrate these various scenarios in the examples below.

These twin policies from IRS and CCIIO are inconsistent, and have combined to discourage AI/AN Marketplace participation and significantly increase costs to Tribal governments. Together, they create a federal policy that is both inconsistent with the right of AI/ANs to obtain trust-obligated health care without charge to the individual at I/T/U facilities and that forces many Tribal employers to purchase coverage for workforces largely comprised of Tribal members who are (1) exempt from the ACA's individual mandate to obtain coverage and (2) eligible to obtain health care through the I/T/U system. Finally, application of the employer mandate will be simply unaffordable to many Tribes and Tribal organizations and act as a barrier to the provision of critical governmental services.

With the employer mandate deadline set to take effect on January 1, 2015, we request consultation on the need for Tribal relief from the rule as soon as possible.

I. Background.

Congress has recognized that "[f]ederal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people."[3] The federal trust responsibility and laws enacted pursuant thereto provide ample authority for the federal agencies of the Executive Department to design, implement and tailor federal programs in a manner that recognizes and supports the unique government to government relationship between sovereign Tribal governments and the United States.[4]

Congress has also recognized that it is a "major national goal . . . to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States."[5] In recognition of this federal trust responsibility, AI/ANs are eligible to receive care through the Indian Health Service (IHS) system without charge to the individual patient.[6]

In light of the federal government's trust responsibility, many Tribal employers have not historically offered health coverage to their employees. Not only are the majority of many Tribal workforces eligible for IHS services, but the remote location of many I/T/U facilities creates additional difficulties in locating plans that treat Tribal facilities as in-network or otherwise preferred providers. This often leaves the I/T/U as the only viable health service option for the employee population, regardless of coverage status. In addition, insurance plans in these remote areas are frequently expensive, have high cost-sharing

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[3] 25 U.S.C. § 1601(1).

[4] Additional background on the authority of federal agencies to tailor their programs to meet the unique needs of federally-recognized tribes and American Indians and Alaska Natives is provided in Appendix B to the CMS TTAG Strategic Plan, "Appendix B: Legal Basis for Special CMS Provisions for American Indians and Alaska Natives." A copy of Appendix B is appended to this letter.

[5] 25 U.S.C. § 1601(2).

[6] 42 C.F.R. §§ 136.11 and 136.12.

amounts, or are less comprehensive than plans available in urban settings.[7] Federal responsibility for the provision of health services allows Tribal governments to expend scarce resources elsewhere rather than obtaining high cost, low quality employee insurance.[8]

II. Discussion.

With these unique circumstances in mind, the application of the employer mandate to Tribal employers presents three primary problems: (1) it undercuts multiple ACA provisions designed to encourage AI/AN enrollment in the Marketplaces; (2) it undercuts the federal government's trust responsibility by forcing AI/ANs to "pay" for health coverage (whether directly or by proxy through their Tribal employer); and (3) compliance with the mandate requires a significant diminution in Tribal governmental services. We discuss each issue in turn.

1. The Employer Mandate Undercuts the ACA's Indian-Specific Protections.

Applying the employer mandate to Tribal employers directly undercuts the ACA's Indian-specific protections in three ways. First, it punishes Tribes for assisting AI/AN enrollment in the Marketplaces, despite the multiple ACA provisions designed specifically to encourage such activities. Second, it can disqualify AI/ANs from eligibility for premium tax credits in Marketplace plans, thus leaving them unaffordable. Third, it ignores the fact that AI/ANs are exempt from the individual mandate and forces Tribal employers to pay for AI/AN insurance plans as a proxy for the individual. None of these outcomes benefit Tribal employers, individual AI/ANs, or the federal government.

The ACA contains several provisions designed to maximize AI/AN participation in Marketplace plans: for example, Indian-specific cost-sharing protections that help defray the cost of health coverage,[9] special AI/AN enrollment periods,[10] and the ability for Tribes to assist with Marketplace plan premium payments for Tribal members.[11] Many Tribes and Tribal organizations have aggressively sought to facilitate AI/AN enrollment in Marketplace plans in order to take advantage of these protections. However, the employer mandate actively discourages AI/AN Marketplace participation, in direct contradiction to the provisions described above.

First, Tribes may find it more affordable to offer Marketplace premium assistance to Tribal member employees than it is to pay for employee-sponsored coverage. However, it is our understanding that Tribal premium sponsorship for member employees does not satisfy the employer mandate. Tribes will therefore be forced to either continue offering premium assistance and pay the employer mandate penalty

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[7] *See, e.g.*, Letter from Monica J. Linden, Commissioner, Montana Department of Securities and Insurance, to Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services (Mar. 10, 2014) (recognizing practical difficulties for Tribal employers in finding and offering adequate coverage and seeking Tribal exemption from employer mandate).

[8] We note that the federal government's budgeting and expenditures do not come close to meeting the requirements of the trust responsibility: IHS is only funded at approximately 56% of need, and the most recent contract support cost shortfall was estimated at $90 million. NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP'S RECOMMENDATIONS ON THE INDIAN HEALTH SERVICE FISCAL YEAR 2015 BUDGET 3, 6 (2013).

[9] 42 U.S.C. § 18071(d).

[10] 42 U.S.C. § 18031(c)(6)(D).

[11] 25 U.S.C. §§ 1642, 1644.

(thus diminishing the funding available for premium assistance and AI/AN Marketplace enrollment) or else purchase employer coverage and discontinue premium assistance (which may not be financially viable and which forecloses Tribes from obtaining a benefit that Congress deliberately granted included in the ACA).

Second, even if a Tribe does offer employer coverage, AI/AN employees will almost certainly be personally responsible for paying premium costs and (depending on the type of plan and location of services) for deductibles, co-payments, and co-insurance. Recognizing that eligibility for IHS services acts as a natural disincentive for AI/AN enrollment in any insurance plan (employer-sponsored or otherwise) that requires such expenditures, Congress further incentivized AI/AN Marketplace participating through the availability of premium tax credits: various types of Indian-specific income is excluded when calculating AI/AN eligibility for the tax credits, thus leaving it comparatively easier for AI/ANs to qualify[12] and making many individual Marketplace plans significantly more affordable or comprehensive to AI/ANs than employer-sponsored coverage. However, employees are automatically disqualified from tax credit eligibility upon receiving a qualifying offer of coverage from their employer.[13] So, even if a Tribe provides employer-based insurance that is less affordable or comprehensive than a plan available through the individual Marketplace, the mere offer of coverage eliminates the ability of AI/ANs to obtain the tax credits that make the individual plan affordable in the first instance.

Finally, Congress exempted AI/ANs from the ACA's individual mandate out of recognition that AI/ANs are entitled to federal health care benefits and therefore should not be forced to pay for non-IHS coverage. Requiring Tribal employers to provide AI/ANs 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 the individual to the Tribe itself. This also leaves AI/AN employees with two choices: either accept the coverage and be personally responsible for any applicable employee share of premiums or cost-sharing (again invalidating the individual mandate) or else reject the coverage and lose eligibility for Marketplace tax credits. Under either scenario, the individual AI/AN is "paying" for health coverage.

The following examples illustrate the various ways in which the employer mandate uniquely disadvantages Tribal employers and AI/ANs:

1. **The Tribal employer complies with the employer mandate and offers minimum essential coverage to all employees.**
    a. Tribal employer offers minimum essential coverage to all of its employees, the majority of which are Tribal members.
    b. Due to extremely limited and zero sum nature of Tribal budgets, the Tribe is forced to diminish basic governmental services to make up for the cost of coverage.
    c. In partnership with CCIIO, the Tribe is actively encouraging Tribal members to enroll in the Marketplaces. Tribal members who are employees are disqualified from Marketplace tax credits due to the offer of coverage.

[12] *See* 26 U.S.C. § 36B(d) (tying tax credit eligibility to modified adjusted gross income); *see also* 43 U.S.C. § 1620; 25 U.S.C. § 1407; 25 U.S.C. § 171b(a) (exempting various AI/AN-specific income from modified adjusted gross income calculation).

[13] 26 U.S.C. § 36B(2)(B); 26 U.S.C. § 5000A(f)(1)(B), (f)(2).

d. By providing coverage to Tribal member employees, the Tribe is required by proxy to comply with the individual mandate "on behalf" of AI/AN employees, thus nullifying the AI/AN individual mandate exemption.

2. **The Tribal employer does not offer health insurance to any employees, and instead pays the "first" employer mandate penalty of $2,000 per employee per year.**[14]
   a. The Tribe does not offer coverage to its employees.
   b. The Tribe must pay $2,000 per employee per year in penalties to the IRS. The Tribe is forced to reduce government services in order to make up for the penalty costs.
   c. Tribal member employees do not have an offer of coverage and can take advantage of premium assistance and AI/AN cost-sharing exemption on the Marketplaces, but the Tribe must "pay" the IRS a penalty in order for those AI/AN employees to qualify for those statutory rights.
   d. Due to the zero sum funding of Tribal governments, the Tribe will be receiving federal funding to provide services to their members and then paying it back to the IRS in the form of an employer mandate penalty.

3. **The Tribal employer offers employees a "low end" plan (high deductible, few covered services, etc.) that satisfies the first employer mandate penalty but not the "second" employer mandate penalty.**[15]
   a. The Tribe purposefully designs its coverage options to result in significantly expensive plans for their employees. The Tribe is liable for payment of the "second" employer mandate penalty if employees go onto the Marketplace and obtain a premium tax credit or cost-sharing reduction.
   b. Tribal member employees are not likely to accept that coverage, as it results in high personal costs and they have a right to care through the IHS system.
   c. Tribal member employees are also not likely to obtain coverage through the Marketplaces, as they have a right to care through the IHS system, thus foregoing their statutory benefits under the ACA.
   d. In order to encourage members to take advantage of Marketplace premium assistance and AI/AN cost-sharing exemptions, the Tribe will have to pay the IRS a penalty of up to $3,000 per Tribal member employee that receives a tax credit or cost-sharing reduction in order to ensure that those members qualify for their statutory benefits.
   e. Due to the zero sum funding of Tribal governments, the Tribe will be receiving federal funding to provide services to their members and then paying it back to the IRS in the form of an employer mandate penalty.

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[14] This penalty applies when (1) an employer offers health coverage to less than 95% of its full-time employees and their dependents in a calendar month, and (2) at least one of the full-time employees then enrolls in a QHP through a Marketplace and receives an advance premium tax credit or cost sharing reduction. 26 U.S.C. § 4980H(a); 26 C.F.R. § 54.4980H–4(a). In such cases, the penalty amount for each applicable month is equal to the number of the employer's full-time employees for the month (subtracted by thirty), multiplied by 1/12 of $2,000. 26 U.S.C. § 4980H(c)(2)(D); 26 C.F.R. § 54.4980H–1(a)(41).

[15] This penalty applies when an employer does offer health coverage to at least 95% of its full-time employees and their dependents, but (1) at least one full-time employee receives a premium tax credit or cost sharing reduction to help pay for coverage in a Marketplace because the coverage was either unaffordable or failed to provide minimum essential coverage. 26 U.S.C. § 4980H(b)(1); 26 C.F.R. §§ 54.4980H–5(e)(1). In such cases, the penalty amount is calculated by taking the number of full-time employees who receive a premium tax credit in a given month and multiplying that amount by 1/12 of $3,000. 26 U.S.C. § 4980H(b)(1); 26 C.F.R. § 54.4980H–1(a)(41).

f. The Tribe is still responsible for paying for coverage for employees (AI/AN or otherwise) who do enroll in the employer-sponsored plan.

These scenarios underscore the employer mandate's inherent incompatibility with both the unique nature of the Tribal health system and the AI/AN-specific provisions of the ACA. Applying the mandate in any circumstances results in either a significant diminution in Tribal governmental services, a functional elimination of the AI/AN exemption from the individual mandate, or a disqualification of AI/ANs from their statutorily-established Marketplace benefits and protections. The end result is that the Tribe must either bear the burden of paying for expensive and/or low-quality coverage or else subject itself to significant employer mandate penalties, while the AI/AN employee must choose between accepting whatever coverage it is offered and losing tax credit eligibility, remaining uninsured, or having their Tribe "pay" the IRS so that they can qualify for the benefits and protections in the Marketplace to which they are legally entitled. This fundamentally undercuts congressional intent in crafting the ACA and requires a Tribal exemption from the mandate.

2. The Employer Mandate Runs Counter to the Federal Government's Trust Responsibility by Requiring Tribes to Either Pay the Federal Government Penalties or Subsidize Private Insurance Companies.

As noted above, the federal government owes a trust responsibility towards AI/ANs, through which they are eligible to receive health care through the IHS system without cost to the individual. However, IHS is chronically underfunded and AI/ANs continue to suffer the highest health disparities of any ethnic group in the United States and are disproportionately likely to be uninsured.[16] The employer mandate forces Tribes to divert funding necessary to sustain Tribal health programs, which by right should come from the federal government, and redirect it to the purchase of employee health insurance.

This contradicts the trust responsibility by resulting in a redundant payment cycle in which (1) Tribal employers use their own funding (most likely a combination of federal funding and outside revenue) to purchase employee insurance; (2) many employees visit the local IHS health program for services; and (3) the employee's insurer then reimburses IHS. In the alternative, the Tribal employer does not purchase insurance and instead simply pays penalties to the IRS, another federal agency.

In these circumstances, the employer mandate essentially results in Tribes funding the federal government: either they take their limited Tribal funding (some or all of which might be federal funding anyway) and pay it to the IRS in the form of a tax penalty, or they purchase insurance from private companies, which then pay IHS after keeping between 15-20% of the premium payments off the top.[17] Tribal subsidization of the United States does not respect either the trust responsibility or the government-to-government relationship between Tribes and the United States. It is also inefficient, as federal funds will be used to circuitously pay for the cost of insurance premiums or for tax penalties rather than directly funding health care through the IHS system. The trust responsibility neither envisions Tribes as

[16] *See generally* SAMANTHA ARTIGA ET AL., HENRY J. KAISER FAMILY FOUNDATION, HEALTH COVERAGE AND CARE FOR AMERICAN INDIANS AND ALASKA NATIVES (2013), *available at* http://kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-american-indians-and-alaska-natives/ (last visited July 18, 2014).

[17] *See* 45 C.F.R. § 158.210 (establishing acceptable insurance medical-loss ratios in the large group, and individual health markets).

middlemen for transactions between private insurers and IHS nor Tribal "funding" of federal agencies through the payment of penalties.

3. The Employer Mandate Will Be Unaffordable for Tribal Governments.

Compliance with the employer mandate forces Tribes to either absorb the cost of employee health insurance or else pay non-compliance penalties of up to $2,000 per year per full-time employee.[18] Not only is this potentially devastating for Tribes that are already faced with significant financial hardships, but it fails to recognize the fundamental distinction between Tribal employers and private businesses.

It is our understanding that the IRS views the application of the mandate to Tribal employers similarly to that of non-governmental businesses: essentially as a revenue-driven cost-benefit analysis. This is simply not the case in the Tribal context. Tribes are sovereign, governmental entities that are directly responsible for the health and welfare of their people, and are often the only major employers in Tribal territories. Forcing Tribes to pay millions of dollars in penalties – or, alternatively, to purchase costly insurance for Tribal member employees who are otherwise exempt from the individual mandate and eligible for IHS services – will not just affect Tribal business decisions concerning hiring or expansion, but will directly limit their ability to provide basic social, health, safety, and other governmental services on which their members and other reservation residents rely. Tribes cannot "pass on" the costs of compliance by raising prices on goods or services. Tribal governmental funding is a zero sum game, and any funding used to either comply with the mandate or pay the penalties will necessarily come from coffers used to provide what may be the only constituent services for hundreds of miles.

While it is true that all employers must account for insurance costs when making decisions concerning expansion or hiring, the stakes are comparatively much higher when a Tribe might have to choose between complying with the mandate and funding an adequate reservation police force or other Tribal entity. If applied to Tribal governments, the mandate has the potential to critically undercut Tribal governmental functions.

4. The Internal Revenue Service Should Issue a Regulatory Exemption from the Employer Mandate.

The IRS has previously recognized the burden that the ACA's employer-specific provisions place on Tribal employers: for example, the IRS explicitly excludes "federally recognized Indian tribal governments or . . . any tribally chartered corporation wholly owned by a federally recognized Indian tribal government" from an otherwise-applicable requirement that employers report the cost of coverage under an employer-sponsored group health plan on their employees' W-2 forms.[19] As discussed above, the IRS should similarly exempt Tribes and Tribal organizations from the employer mandate.

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[18] *See generally* 26 C.F.R. §§ 54.4980H–4, H-5.

[19] *See* Internal Revenue Service, "Employer-Provided Health Coverage Informational Reporting Requirements: Questions and Answers," *available at* http://www.irs.gov/uac/Employer-Provided-Health-Coverage-Informational-Reporting-Requirements:-Questions-and-Answers (Dec. 19, 2013).

The IRS has the legal authority to issue such an exemption. The ACA's definition of the "applicable large employers" subject to the mandate does not explicitly include Indian Tribes.[20] Statutes of general applicability that interfere with exclusive issues of self-governance, such as the relationship between Tribal employees and on-reservation businesses, generally require "a clear and plain congressional intent" that they apply to Tribes before they will be so interpreted.[21] Although Congress repeatedly referenced Indian Tribes within the ACA,[22] it did not include any such reference in the employer mandate, therefore indicating that the mandate does not apply of its own force to Tribal employers.[23] Because the sole explicit application of the employer mandate to Tribes is found in IRS regulations,[24] the IRS may accordingly promulgate the following standalone exemption in 26 C.F.R. § 54.4980H–2:

> **26 C.F.R. § 54.4980H–2 Applicable large employer and applicable large employer member.**
> **(a) In general.** Section 4980H applies to an applicable large employer and to all of the applicable large employer members that comprise that applicable large employer.
>
> **(b) Determining applicable large employer status—**
> . . . .
>
> **(5) Indian Tribes and Tribal Entities.** For the purposes of any penalty or assessment under 26 U.S.C. § 4980H or 26 C.F.R. § 54.4980H, the term "applicable large employer" shall not include any Indian tribe, tribal health program, tribal organization, or urban Indian organization (as defined in 25 U.S.C. § 1603).

III. Conclusion.

The ACA employer mandate creates a Hobson's Choice for Tribal governments, forcing them to either pay for the cost of insurance for Tribal member employees who are otherwise exempt from having to obtain coverage, or pay a tax penalty in order to ensure that Tribal member employees qualify for the benefits and protections to which they are entitled. The mandate disincentivizes Tribes from facilitating AI/AN Marketplace enrollment, requires Tribes to pay an individual mandate penalty by proxy on behalf

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[20] *See* 26 U.S.C. § 4980H(c)(2)(A) (defining the term as "with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year").

[21] *E.E.O.C. v. Fond du Lac Heavy Equip. & Const. Co., Inc.*, 986 F.2d 246, 249 (8th Cir. 1993) (Age Discrimination in Employment Act did not apply to employment discrimination action involving member of Indian Tribe, Tribe as employer, and reservation employment); *accord Snyder v. Navajo Nation*, 382 F.3d 892, 896 (9th Cir. 2004) (Fair Labor Standards Act did not apply to dispute between Navajo and non-Navajo Tribal police officers and Navajo Nation over "work [done] on the reservation to serve the interests of the tribe and reservation governance").

[22] *See, e.g.*, Section 1402(d)(2) (referring to health services provided by an Indian Tribe); Section 2901(b) (referring to health programs operated by Indian Tribes); Section 2951(h)(2) (referring to Tribes carrying out early childhood home visitation programs); Section 2953(c)(2)(A) (discussing Tribal eligibility to operate personal responsibility education programs); Section 3503 (discussing Tribal eligibility for quality improvement and technical assistance grant awards).

[23] *See, e.g.*, *Dean v. United States*, 556 U.S. 568, 573 (2009) ("[W]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposeful in the disparate inclusion or exclusion.").

[24] Internal Revenue Service, Shared Responsibility for Employers Regarding Health Coverage; Final Rule, 79 Fed. Reg. 8,544 (Feb. 12, 2014); 26 C.F.R. § 54.4980H–1(a)(23).

of its AI/AN employees, and precludes AI/AN eligibility for tax credits. The mandate also acts as a federal directive that many AI/ANs pay for their health care in circumvention of the trust responsibility. Finally, the mandate is unaffordable for many Tribes, as Tribes will pay for both the penalties and the insurance payments with already-scarce resources that would be far better allocated towards funding direct Tribal services and programs. We therefore ask that the IRS exercise its legal authority to provide categorical relief for Indian Tribes, Tribal organizations, and Urban Indian Organizations from the employer mandate.

Thank you for the opportunity to engage with us on this matter. We stand ready to work with you on any necessary follow up issues and look forward to a continued open dialogue on the employer mandate.

Sincerely,

[[Signatures from various Tribes and Tribal Organizations]]

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Affiliated Tribes of Northwest Indians Worksession in preparation for the Whitehouse Tribal Nations Conference held Kah Nee Ta Resort, Warm Springs, OR November 19, 2014

This document is prepared in partnership with the Affiliated Tribes of Northwest Indians (ATNI) and the Northwest Portland Area Indian Health Board (NPAIHB). It has been prepared in preparation for the ATNI Tribal Leaders meeting to determine northwest health priorities for the White House Tribal Nations Conference to be held on December 2-3, 2014 at the Capital Hilton in Washington D.C.. The health care issues presented in this document represent the views and positions of Portland Area Tribes and are supported by ATNI and NPAIHB resolutions.

Indian Health Service and Tribal Consultation:

Tribal governments have a unique legal and political relationship with the United States. This relationship has been recognized and reinforced by the Constitution, nation-to-nation treaties and executive orders, federal statutes, case law, and other administrative policies. This government-to-government relationship between tribal nations and the United States government has existed since the formation of the United States. This historical and legal foundation has created a fundamental contract between tribal nations and the United States: Tribes ceded millions of acres of land that made the United States what it is today. In return, tribes have the right of continued self-government and the right to exist as distinct peoples on their own lands and in their affairs. This extends to how Tribes decide to participate in Tribal consultation with federal agencies pursuant to Executive Order 13175.

The Indian Health Service (IHS) has taken a position that diminishes Tribal consultation by severely limiting who Tribal governments select to represent them in the tribal consultative process. Northwest Tribes do not feel that the Tribal consultative process with IHS is working. The Agency has claimed this is not the case and that the Federal Advisory Committee Act (FACA) requires the Agency to limit participation in Tribal consultation. Northwest Tribes do not agree with this interpretation and that it is inconsistent with past practice of the Agency and past IHS Directors.

Portland Area Tribes are on record that IHS advisory groups, workgroups, and committees must be compliant with FACA unless the intergovernmental exemption applies and this is not the case. FACA does not apply to these groups as they currently function and this was determined long ago. The IHS has used these groups for decades as a practical means of consulting with Tribes and Tribal organizations b

ecause the courts have interpreted the FACA definition of an "advisory group" narrowly, so as not to include every formal and informal consultation between an agency and a group rendering advice. Portland Area Tribes believe the IHS position is counterproductive to the consultative process despite her priority "to renew and strengthen partnerships with Tribes."

Recommendation: IHS should continue to follow its past practice of consulting with Tribes or their designated representatives.

Indian Health Service Appropriations:

The past year's Indian Health Service (IHS) budgets have experienced a heavy burden of neglect. The IHS budget from FY 2002 to FY 2007 saw less than 2.5 percent increases for health service accounts. A growing population and medical inflation eroded the purchasing power of Indian health programs. Tribes were forced to redirect funding from economic development initiatives to supplement their health programs. Unfortunately, declining Medicaid programs in the wake of state fiscal crisis further eroded resources available for Indian health care programs. There is no denying that a huge and growing resource gap resulted in greater health care disparities between Indian people and the general population over the past ten years.

The Budget Control Act of 2011 (BCA) requires the federal deficit to be reduced by $2.3 trillion over 10 years. The BCA sets spending targets and if they are not met require budget sequestration by the Administration to make across the board spending cuts. This is important for Indian health programs because at least $26.4 billion of the proposed cuts must be made from non-defense discretionary programs. Since the IHS appropriation comes entirely from discretionary funding, the BCA sequestration will have an adverse impact IHS programs. If Congress fails to enact legislation negating the government-wide sequestration in future years, the IHS budget will be subject to across the board spending reductions.

During the FY 2013 sequestration, the Administration and IHS Director reported that IHS programs would be limited to a two percent reduction pursuant to a reference contained in the BCA at, section 256 of the Balanced Budget and Emergency Deficit Control Act of 1985. On September 14, 2012, the Office of Management and Budget (OMB) submitted to Congress a report indicating that the IHS would be subject to a full sequestration which they estimate to be 8.2 percent. **Following the final FY 2013 sequestration, the IHS appropriation of $4.34 billion was reduced by $217 million**. This lost funding will take years for the Administration and Congress to make Tribal governments whole and in turn the AI/AN people they serve.

The BCA disproportionately targets discretionary spending and Tribes underscore to Congress that the IHS appropriations are not "discretionary" by their mere classification in the appropriations process. IHS funding is provided in fulfillment of the United States federal trust responsibility based on treaty obligations that the United States Congress entered into with Indian Tribes. It is important to remind the Administration and Congress that it passed a Declaration of National Indian Health Policy, in which the Congress declares it the policy of the United States—"in fulfillment of its special trust responsibilities and legal obligations to Indians—to ensure the highest possible health status for Indians and urban Indians and *to provide all resources necessary* to effect that policy." [Emphasis added] To reduce IHS

funding would be in contradiction of this policy passed by this Congress and signed by this President and makes it appropriate to exempt IHS programs from sequestration.

Recommendation: Because of the federal trust responsibility and the chronic and severe underfunding of the Indian health system—along with the significant health disparities of Indian people—the Congress and Administration should be exempt the IHS appropriation from discretionary funding budget reductions, and; enact an Amendment to the Budget Control Act of 2011 to fully exempt the IHS budget from sequestration.

IHS Contract Support Costs

The Congress and Administration now agree that Tribes must be paid full contract support costs (CSC). The funding provided to the Indian Health Service (IHS) is still insufficient to fund these requirements. Tribes and the IHS Contract Support Cost Workgroup are working cooperatively with the IHS to develop a solution to short term CSC issues as well as develop an approach to address long term CSC funding issues. Congress has passed a Continuing Resolution (CR) for operation of federal programs through December 11, 2014. It is likely that another CR will be passed to fund the federal government through the beginning of next year.

In September, the IHS identified at the high end an estimated $48 million to fully fund CSC in FY 2014. This amount was adjusted downward for a final figure of $25 million. This was difficult because the amount needed to be reprogrammed at the end of the IHS fiscal year from IHS' remaining discretionary appropriations. The IHS reported that it reprogrammed this out of the IHS Services account – first from Headquarters, then from Area Offices and then from Service Units. Shifting these funds from services to CSC obligations will reduce the funding available for health programs. Given this anomaly, the amount requested in the President's FY 2015 request that Congress is forecasting its budget recommendations on is insufficient to fully fund CSC need for FY 2015 unless additional funding is requested by the Administration.

Short Term Appropriations for CSC:

- Urgent action is needed to ensure that Appropriations made for FY 2014 after December 11th include enough funding to fully fund CSC and avoid reducing any funds for health care services.
- Some Tribes have requested that OMB and Congress consider CSC an "anomaly" for purposes of making the needed full CSC funding available for FY 2014.
- Tribes have also requested that unobligated funds anywhere in the HHS be considered for transfer to fund required CSC.

Long Term Appropriation Solution:

- The Tribes have recommended that the long-term solution to fund CSC is to make it a mandatory, permanent appropriation. This would separate the CSC account and provide sufficient funds to pay these required, mandatory costs, no matter when they are identified during the Fiscal Year.
- However, it is likely that such a solution will take considerable time for Congress to consider and enact, if at all – perhaps years. Tribes will continue their advocacy on this ultimate solution.

CSC **Recommendations**:

- Request the President to support requesting addition funding for a CSC "anomaly" in any FY 2015 Continuing Resolution to pay the FY 2014 shortfall and the additional amount need in FY 2015.
- Request the President to support legislation that would make CSC funding an entitlement (see discussion under legislative priorities).

FY 2016 IHS Budget & Mandatory Costs

The President's FY 2015 budget provides $4.63 billion to IHS programs, which is a respectable increase of $199.6 million (4.5%) over the FY 2014 enacted level. While the President's request may seem respectable in these difficult budget times it simply is not respectable to meet the needs of the federal trust obligation. The House has for the most part has adopted the President's request in its FY 2015 budget mark and provided an additional $7 million. However the Senate has only approved $111 million for the IHS in FY 2015, this amount is $88 million less than the President's request and $96 million less than the House mark. The funding needs for IHS are further exacerbated when the United States' legal responsibility to fund contract support costs (CSC) are factored (see discussion on Contract Support Costs).

In FY 2015, the Northwest Portland Area Indian Health Board (NPAIHB) estimated that the President's request is short by over $287 million to maintain current services. This factored with the liability of the United States to pay contract support costs will require the President's FY 2016 budget request to include enough funding for mandatory costs (inflation, population, growth) and the evolving contract support cost need. If the Senate's FY 2015 marks are adopted by Congress, than the President's request for FY 2016 will also have to fact this effect as well.

Recommendation: Request the President continue to support the IHS and health care needs of AI/AN people by providing adequate funding to "sustain the Indian health system, expand access to care, and continue to improve oversight and accountability" as he reports in the FY 2015 Congressional Justification to Congress. The following are recommendations supported by ATNI, NPAIHB, and embody recommendations from ATNI health committee meetings:

Permanent Funding for Epidemiology Centers
Tribal Epidemiology Center programs were authorized by Congress as a way to provide significant support to multiple Tribes in each of the IHS Areas. The President's requests an increase of $360,000 to cover the increased expense of operating twelve Epidemiology Centers. The twelve Epidemiology Centers provide critical support for tribal efforts in managing local health programs. The Northwest Portland Area Indian Health Board recommends permanent funding for Tribal Epidemiology Centers.

Increase Funding for Substance Abuse in the Mental Health and Alcohol Line Items
The President's budget proposes a $7.4 million increase for alcohol and substance abuse funding programs. More needs to be done to address the behavioral health needs of tribal communities. The circle of violence, depression, and substance abuse continues to plague tribal communities. Methamphetamine use is on the rise resulting in tremendous costs to the Indian health care system.

Currently, there are no Tribal programs in the Northwest that provide for this type of treatment for adults. NPAIHB recommends an additional $17.5 million for the IHS alcohol substance abuse line item.

Increase Mental Health funding due to staffing and new Tribes funding
The President's budget reduces mental health funding by $8.5 million to phase in staffing and fund new Tribes. The reprogramming of mental health funds will result in budgets being reduced for all Tribes because the President's requested increase of $4 million is not sufficient to cover the costs of IHS reprogramming mental health funds.

Health Facilities Construction Funding
Although the IHS is working to improve the Health Facilities Construction Priority System (HFCPS), there are many tribal health facilities that will never be replaced or renovated under the current HFCPS. The Joint Venture (JV) and Small Ambulatory (SAP) Programs are an efficient way to maximize resources of the federal government. The current priority list was developed in 1991 and virtually locks out Tribes from much needed construction dollars unless they are one of the facilities on the current list. If facilities construction continues to be funded, it is recommended that the SAP programs each receive $10 million in FY 2015.

Implementation of the Affordable Care Act

The federal government's duty to provide health care to AI/ANs has historically been carried out through the Indian Health Service (IHS), tribes and tribal organizations, and urban Indian organizations. Collectively, these entities are referred to as "I/T/U". Under provisions of the IHCIA, Medicare and Medicaid have become important additional means through which the resources to fulfill the federal trust responsibility have been made available. Now, with the passage of the Affordable Care Act (ACA) and the assistance to be provided to certain AI/ANs enrolled through an Exchange, an additional mechanism—although not a replacement mechanism—has been put in place to fulfill the federal trust responsibility and achieve the policies set out by Congress. Thus, tribal governments have a special interest to assist the Administration to implement the ACA so that its full benefits of providing health care to Americans can be achieved. In order to assist the Administration and HHS to implement the law we respectfully request the following issues to be addressed:

Indian Definition: The ACA includes three Indian-specific sections that provide special protections and benefits to AI/ANs. The Federal government has ruled that the eligibility standards for the Indian-specific provisions under the ACA are slightly different. To address this key policy issue, the state exchanges and Indian Tribes have requested that uniform operational guidance be issued through HHS and IRS guidance or regulations regarding eligibility determinations for Indian-specific benefits and protections under Medicaid and the ACA. This guidance should rely on the CMS regulations, 42 C.F.R. § 447.50, in order to permit a uniform application across Medicaid, state and federal Exchanges and IRS (for the exemption for AI/ANs from the tax penalty for not maintaining minimum essential coverage).

QHP Contracting & Payments: Indian Health Providers are the Indian Health Service (IHS), Tribes and Tribal Organizations carrying out programs of the IHS, and urban Indian organizations receiving funding from the IHS pursuant to Title V of the IHCIA. To ensure compliance with the Indian-specific provisions of law and simplify administrative interaction of qualified health plans (QHPs) with Indian health providers, the federal government should require the following: (1) require compliance with IHCIA Sections 206 and 408 as a condition of certification and recertification; (2) require QHPs to offer to

contract with all Indian Health Providers in the QHP's service area as in-network providers, and; (3) require QHPs to use the Centers for Medicare and Medicaid Services (CMS) approved "QHP Model Indian Addendum" when contracting with Indian Health Providers. Without such requirements the Indian health system lacks the bargaining power to negotiate with large insurance carriers and will not be included in carrier networks doing business on or near Indian reservations.

Payer of Last Resort: (Title II, Section 2901(c)). The new law makes health programs operated by IHS, tribes/tribal organizations and urban Indian organizations (I/T/Us) the payer of last resort for persons eligible for services through those programs. This key provision removes any doubt that other health coverage - e.g., Medicare, Medicaid, or private insurance - carried by an IHS eligible person is required to pay before IHS or a Tribe is required to pay. ACA rules must be developed so that payer of last resort requirements apply to health plans in the insurance exchanges.

Electronic verification of IHS beneficiaries: Tribal leaders have recommended the use of an Indian Health Service-maintained data base to create an Indian Verification Data Mart in order to conduct real-time electronic data matching for purposes of verifying eligibility for Indian-specific cost-sharing protections under Medicaid and the hardship exemption from purchasing minimum essential coverage. These Indian-specific protections are intended for AI/ANs who meet the definition of Indian established under Medicaid program regulations at 42 CFR § 447.50. This process would provide reliable evidence and provide a less administrative burden and complexity than a paper verification process. The paper verification process is causing delays, adding administrative costs for Tribes and the federal government, and less reliable. HHS has advised Tribes that this process is in the "build schedule" however there is no progress and it continues to be delayed causing Tribal programs valuable resources.

Support for Tribal Public Health Infrastructure

While Tribal health programs have public health and medical care infrastructure it is often underfunded and may lack the capacity to respond effectively to health, natural, and manmade disasters. Too often population density is often a primary consideration in the allocation of emergency preparedness resources, it is important to recognize that public health emergencies and disasters can and do occur on Indian reservations and in rural areas in proximity to Tribes, and that the impact of these emergenies can be felt on all Americans regardless of geography. One need only consider the far reaching impacts of natural disasters, agricultural blight, and infectious diseases to realize the interconnectedness of our reservation, rural and urban citizens.

The recent public health emergencies dealing with the Ebola outbreak in the United States is yet another example. Tribes expressed concerns regarding the cost of deployment of IHS Commisioned Corp officers to combat Ebola, protecting AI/AN communities from exposure to the Ebola virus, and communications with Tribal leadership. While IHS facilities may have established infection control procedures IHS facilities are not equipped to deal with the Ebola virus. IHS and Tribal facilities in most cases do not have isolation rooms, full body protective gear, and other things necessary to contain the Ebola virus.

Recommendation: In order to ensure the readiness of the Tribal governments in times of crisis, an important consideration is that, while the federal and state governments need to be financial partners in this endeavor, resources and implementation must also occur at the local Tribal level.

Legislative Priorities

ACA Indian Definition Fix

The ACA includes three Indian-specific sections that provide special protections and benefits to AI/ANs. The Federal government has ruled that the eligibility standards for the Indian-specific provisions under the ACA are slightly different. To address this key policy issue, the state exchanges and Indian Tribes have requested that uniform operational guidance be issued through HHS and IRS guidance or regulations regarding eligibility determinations for Indian-specific benefits and protections under Medicaid and the ACA. This guidance should rely on the CMS regulations, 42 C.F.R. § 447.50, in order to permit a uniform application across Medicaid, state and federal Exchanges and IRS (for the exemption for AI/ANs from the tax penalty for not maintaining minimum essential coverage).

Make CSC Funding an Entitlement

Tribal leaders have begun to advocate for a change in the manner in which contract support costs (CSC) are appropriated now that the U.S. Supreme Court has affirmed the payment of CSCs under the Indian Self-Determination and Education Assistance Act (ISDEAA) are a legal and binding obligation owed to Tribes carrying out ISDEAA contracts and compacts. The Indian Health Service (IHS) and Bureau of Indian Affairs (BIA) have also begun to pay full CSC payments beginning in FY 2014. The agencies have requested similar action in the President's FY 2015 budget request. Despite the mandatory nature of CSC obligations they are currently paid from annual discretionary appropriations.

Tribal leaders, Indian health advocates and even some Congressional members assert that CSC obligations should be made an entitlement and not funded from discretionary appropriations. The result of CSC obligations in the appropriations process has caused decades of conflict over the underfunding of CSC payments to Tribes. This has resulted in numerous lawsuits between the federal government and Indian Tribes. There are over 1,500 past year's claims filed by Tribes over CSC underfunding that total over one billion dollars. To put this into perspective, the damages that are owed to Tribal governments for unpaid contract support costs are comparable to the recent landmark settlements of the *Cobell, Nez Perce* and *Keepseagle* court cases.

A proposal supported by Tribal leaders to address the fundamental disconnect between the legal binding CSC requirements of the ISDEAA and the appropriations process would be for Congress to pass a simple statutory amendment that would appropriate contract support costs on a permanent, indefinite basis like other legal entitlements. Contract support costs would no longer be pitted against funding for Indian programs and services in the annual budgeting process. It would also help to alleviate the difficulties associated with predicting CSC needs as tribes expand or reduce the scope of their contracts and as indirect cost rates change.

Tribal leaders and other Indian health advocates support changing the contract support cost appropriations process to be into line with the entitlement required in the ISDEAA. Congress recently called for "long-term accounting, budget, and legislative strategies" to address the challenge of full contract support cost funding. This proposal would not solve all of these challenges but it would represent a major step forward to address such issues.

As the Supreme Court has ruled in the 2005 *Cherokee* case and now the recent *Ramah* decision, contract support costs owed under the ISDEAA are "legal obligation[s] of the federal government to make payments" to ISDEAA tribal contractors. As affirmed by the Supreme Court, tribal contractors "have

legal recourse if full payment under the law is not provided." Accordingly, contract support costs are an existing entitlement under substantive law.

The appropriation process has failed to reflect the status of contract support costs as such, however, and that failure is ultimately at the root of the persistent funding problems that have loomed over the otherwise largely successful efforts to diminish "federal domination of Indian service programs" under bold new self-determination and self-governance initiatives. Since contract support costs are already an entitlement under substantive law, Congress should align the appropriation process with the authorizing statute and the *Cherokee* and *Ramah* decisions by appropriating funding for contract support costs on a mandatory basis. Tribal leaders believe this would be a simple and straightforward way to achieve that goal that addresses historical obstacles to full funding of contract support costs with no overall effect on federal spending levels.

Permanent Reauthorization of the SDPI

Congress established the Special Diabetes Program for Indians (SDPI) in the Balanced Budget Act of 1997 to provide for the prevention and treatment services to address the growing problem of diabetes in Indian Country. Congress recently extended the Act through FY 2014 however should permanently extend the Act. The SDPI provides a comprehensive source of funding to address diabetes issues in Tribal communities that successfully provide diabetes prevention and treatment services for AI/ANs and have resulted in short-term, intermediate, and long-term positive outcomes.

Extend Medicare-like Rates to all Medicare providers and suppliers

All Medicare-participating and critical access hospitals that furnish inpatient hospital services are required to provide services to IHS Contract Health Service authorized patients at no more than Medicare-like rates and to accept the CHS reimbursement as payment in full for such items and services. Currently, this Medicare-Like Rate cap applies only to hospital services, which represent only a fraction of the services provided through the CHS system. This means that non-hospital based charges such as radiology, professional and physician fee charges, laboratory fees, and other non-facility based charges are not subject to Medicare-like rates. CHS programs continue to routinely pay full billed charges for non-hospital services. Other federal purchasers of health care like the Department of Defense and Veterans Health Administration (VA) do not pay full billed charges for health care from outside providers. On April 11, 2013, the Government Accountability Office (GAO) issued a groundbreaking report that concluded that the IHS CHS program routinely pays full billed charges for non-hospital services, resulting in needless waste of government and CHS funds. The GAO Report concludes that expanding the Medicare-Like Rate Cap to cover all services purchased under the CHS program would result in hundreds of millions of dollars in savings to CHS programs across Indian Country.

IHS Advance Appropriations

Since FY 1998 there has been only one year (FY 2006) when IHS appropriations have been provided at the beginning of the fiscal year. Late funding results in administrative challenges related to budgeting, recruitment, retention, provision of services, facility maintenance and construction efforts. This affects access to care and the quality of health care provided. Providing sufficient, timely, and predictable funding is needed to ensure the federal government meets its obligation to provide health care for AI/AN people. Healthcare services directly administered by the federal government, such as the Department of Veterans Affairs, are funded by advance appropriations to minimize the impact of late and, at times, inadequate budgets. The decision of Congress to enact advance appropriations for the VA

medical program provides a compelling argument for the effectiveness of advance funding a federally-administered health program which could easily be applied to the IHS. Beyond the efficiency inherent to advance appropriations, providing timely and predictable funding helps to ensure the federal government's Trust responsibility if carried out.

In October 2013, Rep. Don Young (AK) and Rep. Ray Lujan (NM) introduced H.R. 3229; and Senators Lisa Murkowski (AK), Mark Begich (AK), Brian Schatz (HI), and Tom Udall (NM) introduced S. 1570, both bills would amend the Indian Health Care Improvement Act to authorize a two year appropriation fo the Indian Health Service.

Title VI Self-Governance Legislation

When Congress enacted the Self-Governance legislation, it included a provision requiring the HHS to carry out a study of the feasibility of assuming responsibility for non-IHS programs. A Title VI Self-Governance feasibility study found that such a demonstration is feasible for eleven programs. The HHS Secretary should encourage the Administration and Congress to move to enact a non-IHS self-governance demonstration project. HHS should also work with Tribes to design a Self-Governance demonstration for the 11 programs identified in the feasibility study.

Other Health Priorities

Special Appropriation for Northwest Regional Youth Treatment Program

Regional Youth Treatment Centers provide drug and alcohol treatment for adolescents of federally recognized Tribes. AI/AN youth are at higher risk and suffer the effects of alcohol and substance abuse at a higher rate than other non-Indian youth. The Klamath Tribe operates the only dual diagnosis [mental health and drug and alcohol addiction] facility for Indian youth in the United States. The program is located in a 6,500 square foot house that is over 35 years old and in considerable need of repair. It is less than adequate to house youth and for providing services. The tribe has purchased six acres of land for a future building however does not have the capital to build a new facility. NPAIHB requests Congress make a special appropriation of $5 million to the Klamath Tribe for construction of a new facility for the Klamath Alcohol and Drug Abuse program.

Long Term Care (LTC) and Elder Issues

The IHS does not fund long-term care, which is why there are few long-term care services in Indian communities. There are only 15 known tribal nursing homes in the nation. NPAHB supports the study of the long-term care needs of AI/AN people. Tribes need more case management funding and funding to allow Tribes to provide advice on long-term care needs to their elders. Medicare and Medicaid programs could become important sources of funding for long term and home and community based care for elders with support from CMS. The IHS should receive a line-item appropriation to study long-term care programs in Tribal communities. Elder issues and Long Term Care (LTC) are a growing concern for Tribes across the country.

The ACA strengthens and expands the "Money Follows the Person" (MFTP) Program so that more states can participate and rebalance their long-term care systems to transition people with Medicaid from institutions to the community. Today, forty-three states have implemented MFP Programs who are all eligible for a new "MFTP Tribal Initiative (TI) to offer states and Tribes resources to build sustainable

community- based long term services and supports specifically for Indian country. In order for Tribes to be eligible for these resources, states that are current MFTP grantees must apply. There will be federal and state administrative challenges to implementing this new opportunity. We strongly urge CMS and States to continue to consult with Tribes in the development of this new and important program.

Veterans Health Issues

Indian Country has long recognized the growing concerns and frustrations of AI/AN veterans in obtaining health services from the IHS and Veterans Administration (VA). Often there are redundancies in treatment when veterans obtain health services at an IHS or VA facility. AI/AN veterans have advocated that the VA and IHS accept one another's diagnoses without the requirement of additional diagnoses for referrals. These conditions cause an undue burden on veterans when seeking services and are causing unnecessary costs to both the IHS and VA. This stress often serves as a barrier to seeking health care and illness goes untreated. Congress should direct the IHS and VA to identify needs and gaps in services and develop and implement strategies to provide care to AI/AN Veterans. The agencies should work to develop strategies for information sharing of patient records and data exchange so patients do not have to undergo a duplication of service for referrals.

Regional Referral Specialty Care Centers

Portland Area Tribes have been very innovative in developing alternatives for facilities construction. The Portland Area Tribes have recently completed a Pilot Study to evaluate the feasibility of regional referral centers in the IHS system. This effort is consistent with the IHS Directors initiative to bring reform to the IHS. The Pilot Study concludes that the demand for a Regional Specialty Referral Centers, when strategically placed, to offer specialty care, diagnostics, and ambulatory surgery care are economically feasible and should be further explored and funded. This effort demonstrates the viability of Regional Specialty Referral Centers using a "market erosion" methodology that factored user-population data of participating Tribes, reasonable travel distances, health care competitors (providers), and economics of payer groups to derive utilization rates for a regional specialty referral center. The Study further recommends that a demonstration project be completed in the IHS.

Recommendation: Request the appropriations committees include $3.4 million for planning and design of regional referral specialty care center demonstration project in the Portland Area.