MEMORANDUM

DATE: March 22, 2017

TO: Northwest Portland Area Indian Health Board (NPAIHB) Delegates, Tribal Health Directors and Tribal Chairs

FROM: Joe Finkbonner, NPAIHB Executive Director, RPH, and MHA

RE: Weekly NPAIHB "*News and Information*"

**To view a bulletin of interest, click on a title*

NPAIHB Delegates, Tribal Health Directors, Tribal Chairs

- Washington Governor's Response to ACA
- April 11, 2017 Save the date
- April 2017 Outline Agenda
- Draft Agenda 4-11-17 Cancer Coalition
- Draft CMS Region 10 ITU Outreach and Education Event Agenda
- Gov. Inslee Finance Dem Medicaid Letter
- HHS Region 10 Annual Tribal Consultation
- IHS Bill Language
- Letter to Governors and Commissioners
- NPAIHB Funding Opportunities
- Self-Governance Communication & Education Update
- Native Dental Therapy Initiative Spring 2017 Newsletter
- NIHB American Health Care Act's Impact on Tribes
- Northwest Public Health Leadership Institute
- NPAIHB April 2017 QBM flyer
- Senate Finance Attachment
- Senate Finance Committee Response Letter
- Social Security Number Removal Initiative (SSNRI) Update
- TSGAC - Status of CSR Payments
- TSGAC - Status of Individual Mandate
- TSGAC - Timeline of Key ACA-Related Congressional Activities
- TSGAC Brief - CMS Restrictions on Billing Medicaid for Services Outside
- TSGAC Memo - Applicable Percentages Thresholds and Payments for ACA Provs.

- TSGAC Memo - IHS Reimbursement Rates for CY 2017
- TSGAC Memo - ACA in 2017 and Trump-Ryan Health Care Plans
- TSGAC Memo - Comparison House Repub. Plan vs Current Law-ACA
- TSGAC Memo - Net Marketplace Premium Costs Hold or Lower in 2017
- TSGAC Memo - Tribal Sponsorship of Medicare Part B D Premiums

IDAHO Delegates, Tribal Health Directors

- CHILDRENS Traditional vs FDS model Handout
- Idaho Smiles Medicaid Program
- Division of Behavioral Health Update
- DPH Report - Updates and Opportunities
- IDHW Base Benchmark Tribal Notice
- Idaho Medicaid Legal Notice ABPs
- IDHW Tribal Notice for Covered Outpatient Drugs
- IDHW Tribal Notice for A-D Adult DD Waiver renewals
- MCNA Dental Quick Reference Guide Idaho Smiles

OREGON Delegates, Tribal Health Directors

- New Oregon ACA website

STATE OF WASHINGTON

December 9, 2016

The Honorable Kevin McCarthy
Majority Leader
United States House of Representatives
H-107, U.S. Capitol Building
Washington, D.C. 20515

Dear Majority Leader McCarthy:

We want to make clear first and foremost that it would be a moral outrage to repeal the health care policies that are so beneficial to millions of Washingtonians without providing an alternative system to make sure all our families continue to have access to affordable care.

The Affordable Care Act (ACA) has had a profound, positive impact on the residents of our state. It has improved not only the health of our residents but also the strength of our economy and the stability of our state budget. Repealing or significantly undermining the ACA puts hundreds of thousands of our residents at risk of losing their health coverage. Any effort to repeal the law without a viable replacement will seriously undermine our health insurance market and our state's economy.

Under the ACA, our uninsured rate has dropped from 14 percent to an unprecedented 5.8 percent. Nearly 600,000 people have gained coverage through our expansion of Medicaid, and our uncompensated care costs have fallen 50 percent, from $2.3 billion to $1.2 billion. Also as a result of implementing the ACA, Washington State has added 51,000 jobs – most in the private sector. Our GDP has increased by more than $2.7 billion, and we've cut state expenditures by $350 million and increased state revenue. Our state's health care rate of inflation has also been greatly moderated by the law. Our expenditures for health care have increased at about 3 percent per year - well below historic inflation.

Washington has a thriving individual health insurance market, with 13 insurers selling 154 health plans. Enrollment for 2017 through our exchange is up 9 percent from last year with over 160,000 Washingtonians having enrolled in qualified private health plans.

Now that most Washingtonians are covered, we are focusing on additional improvements, including working with health providers and insurers to build performance-based incentives that create real quality improvements, at a lower cost. We are working to integrate mental health and substance use treatment with our physical health system to improve the quality and coordination of care, decrease emergency room use and improve the medical care for our most vulnerable patients. This work is being done in close partnership with private managed care plans that serve the vast majority of Washington's Medicaid enrollees. All of these improvements will not be possible if people lose their health coverage.

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The ACA and our country's health care system need improvements. We ask that when considering proposals, that you first do no harm. Any actions you take must improve the health of our residents and the quality of our health care system, while protecting our state budget and economy. Decisions to cut funding before developing a replacement puts the health of Washingtonians at great risk through undermining and destabilizing their health care.

As statewide elected officials charged with overseeing the health and welfare of our state's residents, we look forward to discussing all proposals that do not cause our people to lose coverage and that will not destabilize our health insurance markets, raise premium or drive up uncompensated care costs.

As the 115th Congress convenes, we also urge you not to undermine the Medicaid, Children's Health Insurance and Medicare programs. They have provided affordable health coverage for millions of people for fifty years. In Washington State, the Medicaid/CHIP and Medicare programs cover approximately 1.79 million and 1.19 million seniors, disabled and low-income children and adults, respectively. Our residents cannot afford any dismantling of these essential federal programs – whether through block grants, per-capita caps, privatization or other means.

On behalf of the people of the state of Washington, we strongly urge Congress to reconsider repealing or undermining the Affordable Care Act. We stand ready to work with you to maintain gains and improve the law so more Americans have access to affordable, quality health care.

Sincerely,

Jay Inslee
Governor

Mike Kreidler
Insurance Commissioner

cc: The Honorable Kevin Brady, Chairman, House Committee on Ways & Means
The Honorable Fred Upton, Chairman, House Committee on Energy & Commerce
The Honorable John Kline, House Committee on Education and the Workforce
The Honorable Greg Walden, Chair-Elect, House Committee on Energy & Commerce
The Honorable Virginia Foxx, House Committee on Education & the Workforce

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Save the Date

Northwest Tribal Cancer Coalition meeting

Tuesday, April 11, 2017

9:30 am to 4:00 pm

Embassy Suites Portland - Washington Square
9000 Southwest Washington Square Road
Tigard, OR 97223
Phone: (503) 644-4000

Please contact Eric Vinson at
evinson@npaihb.org or 503-416-3295
with any questions or comments at the
Northwest Tribal Comprehensive Cancer Program
of the
Northwest Portland Area Indian Health Board.

Online registration:
www.surveymonkey.com/r/April2017NTCC

Northwest Portland Area
Indian Health Board

This meeting is supported by Centers for Disease Control and Prevention, National Cancer Prevention and Control Program Grant # 5 U58 DP003935-5

QUARTERLY BOARD MEETING

Quinault Beach Resort
78 State Route 115
Ocean Shores, WA 98569
April 17-19, 2017

AGENDA

MONDAY APRIL 17, 2017

2:00-5:00 PM	**Tribal Health Director's Meeting**

TUESDAY, APRIL 18, 2017

7:30 AM	**Executive Committee Meeting**
9:00 AM	Call to Order Invocation Welcome Posting of Flags Roll Call
9:15-12:00 PM	PAO Area Directors Report NPAIHB Executive Directors Report Legislative Updates General Session
	LUNCH
12:00 PM	Committee Meetings *(working lunch)* 1. Elders 2. Veterans 3. Public Health 4. Behavioral Health 5. Personnel 6. Legislative/Resolution 7. Youth
1:45 – 4:30 PM	General Session
4:30 PM	Executive Session

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WEDNESDAY APRIL 19, 2017

9:00 AM	Call to Order Invocation
9:15 – 12:00 PM	General Session
12:00 PM	**LUNCH**
1:30 – 5:00 PM	General Session

THURSDAY, APRIL 20, 2017

8:30 AM	Call to Order Invocation
8:45 AM	Chairman's Report
9:00 AM	Committee Reports: 1. Elders 2. Veterans 3. Public Health 4. Behavioral Health 5. Personnel 6. Legislative/Resolution 7. Youth
10:00 -12:00 PM	Unfinished/New Business 1. Approval of Minutes 2. Finance Report 3. Resolutions 4. Future Board Meeting Sites: • *July 18-20, 2017 Joint Meeting w/ CRIHB – Canyonville, OR (Cow Creek)* • *October 17-19, 2017 - TBD* • *April 2018 – TBD* • *April 2018 – TBD* • *July 2018 - TBD*
12:00 PM	Adjourn

Northwest Portland Area Indian Health Board
Northwest Tribal Cancer Coalition meeting

April 11, 2017
9:30 AM to 4:00 PM
Embassy Suites Portland - Washington Square
9000 Southwest Washington Square Road
Tigard, OR 97223 **Phone: (503) 644-4000**

Meeting called by: Judith Charley, Chair **Type of meeting:** Regular Tribal Coalition

Facilitator: Kerri Lopez

----- Agenda Topics -----

Starting Time	Topic	Speaker
9:30 am	Welcome & Agenda Overview	**Judith Charley**, CTWS **Kerri Lopez** NPAIHB
9:45 am	Introductions	All
10:30 am	HPV Immunization Update	**Amanda Bruegl, MD** OHSU
11:30 am	Tribal Program Discussion	**All**
12:00 pm	Working Lunch / Tobacco Fact Sheet Discussion	**Antoinette Aguirre & Ryan Sealy** NPAIHB
1:30 pm	A Native Provider's Journey	**Kathleen Marquart, PA** Tlingit-Haida Central Council
2:30 pm	Breast and Cervical Cancer Screening	**Dee Ann DeRoin, MD** Ioway Tribe of Kansas
3:30 pm	Tribal Screening Programs	**Lanya Rodgers** NARA
		TBD
4:00 pm	Closing Evaluation/Travel Forms	**All**

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The Centers for Medicare & Medicaid Services (CMS) Region 10
Trainings for Indian Health Service, Tribal, and Urban Indian Health Staffs

Agenda

April 4-5, 2017 **Seattle, WA**	**Holiday Inn Seattle Downtown** 211 Dexter Avenue North Seattle, WA 98109 / Phone: 206-728-8123

Day 1- April 4, 2016		
8:30 - 9:00 am	**REGISTRATION**	
9:00	Prayer	Tribal Leader
9:10 -9:45 am	Welcome and Introductions	John Hammarlund, Regional Administrator, CMS Region 10 David Meacham, Division of Medicaid and Children's Health Operations, Region 10
9:45– 10:15 am	Tribal Affairs	Rachel Ryan, Division of Tribal Affairs
10:15 – 11:15am	Office of Inspector General	Kyle T Mitchum, (OIG/OI)
11:15-11:30 am	**BREAK**	
11:30 – 1:00pm	Health Insurance Marketplace and what it means to AI/AN	Rachel Ryan, Division of Tribal Affairs, CMS Kristen Bitsuie, National Indian Health Board
1:00 – 2:15pm	**LUNCH (on your own)**	
2:15 – 3:15 pm	Medicaid 101/CHIP – What you should know.	State Medicaid Liaison (Jesse Dean (HCA) & Longnecker, Michael C. (HCA)
3:15 pm -3:30 pm	**BREAK**	
3:30 – 4:45 pm	**PANEL** Working with the State: State Medicaid Program & State Health Insurance Marketplace	**Idaho: Division of Medicaid/Idaho Department of Health and Welfare** Kinzler, Tiffany, Bureau Chief of Medical Care **Oregon: Oregon Health Authority** Julie Johnson, Tribal Affairs Director **Oregon Health Insurance Marketplace** Rob Smith, Community Partner and Tribal Liaison **Washington Health Benefits Exchange:** Deb Sosa, Tribal Liaison **Governor's Interagency Council on Health Disparities/DSHS:** Marietta Bobba **Washington State Health Care Authority/Tribal Affairs and Analysis:** Jessie Dean, Administrator
4:45 – 5:00 pm	Wrap-up	

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Day 2 - April 5, 2016

7:30-8:00		**REGISTRATION**	
8:30	9:00	Local Welcome	Joe Finkbonner, NPAIHB
9:00	930	Self-Governance	Joe Finkbonner, NPAIHB
9:30 – 10:45 am		Social Security Administration	Kirk Larson, Washington Public Affairs Specialist Social Security Administration
10:45 – 11:00 am		**BREAK**	
11:00 am –2:00 pm		VA Health Benefits and Reimbursement to IHS	Bill Murray, VISN20 Strategic Planner & Tribal Liaison Rob Hard, VBA Seattle Regional Office, External Affairs Manager
12:00 pm – 1:00 pm		**LUNCH (on your own)**	
1:00 - 2:00 pm		Medicare 101, SHIBA/SHIP, Program and Assistance for AI/AN	Sherrill-Wiemer, Vanessa (OIC), Regional Training Consultant, SHIBA Program Washington State Office of the Insurance Commissioner
2:00 – 2:15 pm		**BREAK**	
2:15 - 4:00 pm		Medicare Billing	Tammy Ewers, CPC Part B-Provider Education and Outreach Representative Noridian Healthcare Solutions, LLC Jody Whitten Part A-Provider Outreach and Education Representative Noridian Healthcare Solutions, LLC
4:00 – 4:15 pm		Wrap-up	

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United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510-6200

January 19, 2017

The Honorable Jay Inslee
Governor of Washington
Office of the Governor
P.O. Box 40002
Olympia, WA 98504-0002

Dear Governor Inslee:

As members of the United States Senate Committee on Finance, we have the privilege and responsibility of overseeing Medicaid and the Children's Health Insurance Program (CHIP). Today, Medicaid and CHIP provide coverage to more than 74 million individuals, including more than 36 million children.[1] In light of this responsibility, we are concerned by numerous proposals and statements suggesting plans to radically restructure Medicaid's financing system, resulting in huge permanent cost shifts to states and threatening access to critical health care services for tens of millions of low-income children and families, seniors, and individuals with disabilities.

Enacted in 1965 as a joint state-federal partnership, Medicaid is the nation's largest safety net health program serving as a critical source of comprehensive, affordable health coverage for millions of otherwise uninsured low-income Americans. As part of this essential role in the U.S. health care system, Medicaid along with CHIP provides coverage to one in three children, pays for nearly half of all births nationwide, is the primary payer of long-term care helping to pay for two out of three seniors in nursing homes, serves as the single largest source of public funding for family planning services, and is the nation's largest single payer for all mental health and substance use disorder services.

Medicaid's unique state-federal partnership has allowed it to become a key innovation hub for the nation's health care system. Whether it is transforming the health care delivery system, identifying new approaches to payment reform, or finding new ways to measure quality, Medicaid has demonstrated time and time again its capacity to innovate in order to better serve the nation's most vulnerable, most complex individuals without compromising access to affordable, comprehensive health coverage. Medicaid's current financing structure also allows the program to be responsive to local health care and economic needs by providing timely assistance to states to address public health emergencies, disasters, epidemics and other crises that require quick and immediate action.

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[1] *Centers for Medicare & Medicaid Services, OCTOBER 2016 MEDICAID AND CHIP APPLICATION, ELIGIBILITY DETERMINATION, AND ENROLLMENT REPORT* (Dec. 2016).

The Medicaid expansion is a prime example of how states have leveraged federal resources to better serve low-income individuals in the most effective and efficient manner. With the opioid epidemic ravaging communities across the country, expansion states have been able to provide coverage including access to substance use disorder services to over a million low-income Americans struggling with addiction.[2] In all, nearly a third of low-income adults benefiting from coverage through the Medicaid expansion have either a mental health condition, substance use disorder, or both.[3] Numerous studies show that the Medicaid expansion has resulted in state budget savings, revenue gains, decreased uncompensated care costs, and overall economic growth.[4]

Medicaid is extremely efficient at providing access to affordable, comprehensive benefits uniquely designed to serve a diverse and complex population. Overall, Medicaid's costs per beneficiary are much lower than for privately insured individuals.[5] In addition, these costs have been growing at a slower per-beneficiary rate than for employer-sponsored coverage.[6] As a result, Medicaid has been shown to be the most effective and efficient way to deliver health care coverage to the millions of Americans living below, at, and near the poverty line. The benefits of which can be seen throughout the economy with studies showing that children covered by Medicaid grow up to be healthier, live longer, contribute to the workforce at greater rates, and pay more in taxes[7]—a seriously good return on investment by any measure.

We are concerned this progress is at serious risk. Proposals such as block grants and per capita caps continue to be put forth by some federal policymakers. These proposals would drastically alter Medicaid's current financing structure and result in large cuts to federal funding for state Medicaid programs. An example is Secretary of Health and Human Services Nominee and House Budget Committee Chairman Tom Price's most recent budget proposal. Chairman Price's budget plan for Fiscal Year 2017 proposes over two trillion dollars in cuts to state Medicaid programs over the next ten years with roughly half coming from repeal of the Medicaid expansion and half from converting the underlying Medicaid program to a block grant or per capita cap structure.[8] According to estimates, states would see a reduction in federal funding of almost $170 billion in the tenth year of the plan—a 33 percent cut to state Medicaid budgets.[9]

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[2] STATE HEALTH REFORM ASSISTANCE NETWORK, ISSUE BRIEF: MEDICAID: STATES' MOST POWERFUL TOOL TO COMBAT THE OPIOID CRISIS (July 2016).
[3] SAMHSA, *The CBHQS Report, Short Report: State Participation in the Medicaid Expansion Provision of the Affordable Care Act: Implications for Uninsured Individuals with a Behavioral Health Condition* (Nov. 18, 2015).
[4] LARISA ANTONISSE ET AL., THE EFFECTS OF MEDICAID EXPANSION UNDER THE ACA: FINDINGS FROM A LITERATE REVIEW, KFF.ORG (June 20, 2016).
[5] THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, WHAT DIFFERENCES DOES MEDICAID MAKE? ASSESSING COST EFFECTIVENESS, ACCESS, AND FINANCIAL PROTECTION UNDER MEDICAID FOR LOW-INCOME ADULTS (May 2013).
[6] THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, ISSUE BRIEF: TRENDS IN MEDICAID SPENDING LEADING UP TO ACA IMPLEMENTATION (Feb. 2015) (Figure 9).
[7] ANDREW GOODMAN-BACON, *The Long-Run Effects of Childhood Insurance Coverage: Medicaid Implementation, Adult Health, and Labor Market Outcomes* (Nov. 28, 2016), *available at* http://www-personal.umich.edu/~ajgb/medicaid_longrun_ajgb.pdf.
[8] U.S. HOUSE OF REPRESENTATIVES, COMMITTEE ON THE BUDGET, CHAIRMAN TOM PRICE, A BALANCED BUDGET FOR A STRONGER AMERICA: FISCAL YEAR 2017 BUDGET RESOLUTION (March 2016).
[9] CENTER ON BUDGET AND POLICY PRIORITIES, MEDICAID BLOCK GRANT WOULD SLASH FEDERAL FUNDING, SHIFT COSTS TO STATES, AND LEAVE MILLIONS MORE UNINSURED (Nov. 30, 2016).

This is on top of a trillion dollars in cuts to state budgets by repeal of the Medicaid expansion. In addition, such cuts would be even larger due to factors such as greater than anticipated health care cost growth, the aging of the population, an economic down turn, and other unexpected increases in Medicaid spending such as new high-cost drugs, public health crises, and natural disasters.

Recognizing the importance of the state-federal partnership in the administration of the Medicaid program, we appreciate your feedback in informing federal policymakers on the impacts of these types of proposals on state Medicaid programs and budgets. Accordingly, we kindly request your input on the following questions:

1. How would a 30 plus percent cut in federal financial participation as seen in Chairman Price's fiscal year 2017 budget proposal impact your state Medicaid program?

2. How would repeal of the Medicaid expansion affect health coverage rates in your state?

3. How would repeal of the Medicaid expansion impact your state Medicaid budgets? What would be the impact on other state budget priorities such as education? Would your state be able to raise revenues or otherwise compensate for the loss of this federal funding?

4. How would these levels of cuts impact your ability to meet the needs of an aging baby boomer population expected to require more long-term services and supports, including nursing home care and personal cares services?

5. How would these levels of cuts impact your ability to combat the opioid epidemic and mental health crisis and meet the needs of those with mental health and substance use disorder needs?

6. How would these levels of cuts impact your ability to invest in innovative changes to your health care delivery system?

7. How would these levels of cuts impact your ability to respond to public health crises such as the Zika virus or increases in HIV cases?

8. How would these levels of cuts impact your ability to respond to an economic downturn such as a recession?

9. How would these levels of cuts impact your ability to respond to new high-cost medical breakthroughs such as Sovaldi and other blockbuster drugs?

10. How would these levels of cuts impact your ability to respond to natural and other disasters such as Hurricane Katrina, Superstorm Sandy, and the Flint water crisis?

11. How would these levels of cuts impact your ability to provide affordable family planning services, including contraceptive coverage to low-income women and families?

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12. How would these levels of cuts impact hospital and provider payments? What types of increases in uncompensated care would you expected to see in your state given such cuts?

13. How would these levels of cuts impact localities in your state, such as counties and local jails?

14. What kind of cuts would states have to contemplate under these levels of cuts in federal financing for state Medicaid programs?

15. How else would these levels of cuts impact your state?

Thank you for reviewing this request. In the interest of informing federal policymakers, we respectfully request your response by February 15th, 2017. Written responses can be sent to Medicaid_Responses@finance.senate.gov.

Sincerely,

Senator Ron Wyden

Senator Debbie Stabenow

Senator Maria Cantwell

Senator Bill Nelson

Senator Robert Menendez

Senator Thomas R. Carper

Senator Benjamin L. Cardin

Senator Sherrod Brown

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Senator Michael F. Bennet

Senator Robert P. Casey, Jr.

Senator Mark R. Warner

Senator Claire McCaskill

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PLEASE REGISTER FOR THE HHS REGION 10 ANNUAL TRIBAL CONSULTATION

April 12, 2017

Suquamish Clearwater Casino Resort

Suquamish, WA

The U.S. Department of Health and Human Services (HHS) Region 10 will conduct its annual Tribal Consultation for Tribes in Alaska, Idaho, Oregon, and Washington on **Wednesday April 12, 2017** at the **Suquamish Clearwater Casino Resort, 15347 Suquamish Way NE, Suquamish, WA, 98392**.

We will also hold 1-1 meetings with Tribal Leaders upon request on Tuesday April 11, 2017 at the same location. If you do not request such a meeting, you do not need to attend Day 1.

Outline of Events

Day 1 (Tuesday April 11) - One-on-One Meetings: This short meeting is an opportunity for you to briefly share concerns and information specific to your tribe or tribal organization with federal officials from HHS operating divisions. It is not intended to be a formal consultation. **If you have registered for a one-on-one meeting, please send your issues AS SOON AS POSSIBLE to Nicholson.massie@hhs.gov so we can be prepared to respond.**

The schedule for 1:1 meetings is still being developed based upon requests, but it will probably start by 8:00AM PT and will very likely run until at least 6:00PM PT. **Please register for 1:1 meetings as soon as possible so we can finalize the schedule.**

Day 2 (Wednesday April 12) – Tribal Consultation: The agenda for Day 2 is still in development but will include Opening and Tribal Blessing, Regional Welcome, Tribal Leader Introductions, Open Tribal Leader Comments, and Closing Remarks.

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We anticipate Day 2 will run from 9:00AM PT until 5:00PM PT, but that is subject to change.

To Register for the Consultation follow these 2 simple steps:

Step 1: Respond to the link below to schedule a one-on-one meeting Tuesday April 11 (if you wish to have one) and to attend the Consultation on Wednesday April 12.

http://fluidsurveys.com/surveys/nicholson-massie/2017-tribal-consultation/

Please respond to the survey by Friday March 31, 2017. If you are not scheduling a one-on-one meeting, you do not need to attend on Day 1. There are limited slots for one-on-one meetings; once we finalize a schedule we will confirm the time and location for this meeting.

Step 2: Secure hotel accommodations at the Suquamish Clearwater Casino Resort by Monday, March 20.

Please contact the Suquamish Clearwater Casino Resort reservations at 1 (866) 609-8700 and provide them with our **Group Code 11048**. Please secure your accommodations by **Monday, March 20, 2017** to receive the special rate of $91/night.

Travel from SeaTac Airport by taxi/shuttle/light rail to downtown Seattle, then ferry ride to Bainbridge Island. The Resort has a shuttle that picks-up at the ferry terminal (M-F 9am-12:30am; S/S 5am-12:30am) and will transport you the 7 miles north to the Resort.

If you have any questions about the Consultation session, please contact Nicki Massie at Nicholson.massie@hhs.gov

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112H536

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(Original Signature of Member)

115TH CONGRESS
1ST SESSION

H. R. _____

To amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mr. COLE introduced the following bill; which was referred to the Committee on _____

A BILL

To amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Indian Healthcare Improvement Act of 2017''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

TITLE I—INDIAN HEALTH CARE IMPROVEMENT ACT REAUTHORIZATION AND AMENDMENTS

SEC. 101. REAUTHORIZATION.

(a) IN GENERAL.—Section 825 of the Indian Health Care Improvement Act (25 U.S.C. 1680o) is amended to read as follows:

"SEC. 825. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as are necessary to carry out this Act for fiscal year 2017 and each fiscal year thereafter, to remain available until expended.''.

(b) REPEALS.—The following provisions of the Indian Health Care Improvement Act are repealed:

(1) Section 123 (25 U.S.C. 1616p).

(2) Paragraph (6) of section 209(m) (25 U.S.C. 1621h(m)).

(3) Subsection (g) of section 211 (25 U.S.C. 1621j).

(4) Subsection (e) of section 216 (25 U.S.C. 1621o).

(5) Section 224 (25 U.S.C. 1621w).

(6) Section 309 (25 U.S.C. 1638a).

(7) Section 407 (25 U.S.C. 1647).

(8) Subsection (c) of section 512 (25 U.S.C. 1660b).

(9) Section 514 (25 U.S.C. 1660d).

(10) Section 603 (25 U.S.C. 1663).

(11) Section 805 (25 U.S.C. 1675).

(c) CONFORMING AMENDMENTS.—

(1) Section 204(c)(1) of the Indian Health Care Improvement Act (25 U.S.C. 1621c(c)(1)) is amended by striking ''through fiscal year 2000''.

(2) Section 213 of the Indian Health Care Improvement Act (25 U.S.C. 1621*l*) is amended by striking ''(a) The Secretary'' and inserting ''The Secretary''.

(3) Section 310 of the Indian Health Care Improvement Act (25 U.S.C. 1638b) is amended by striking ''funds provided pursuant to the authorization contained in section 309'' each place it appears and inserting ''funds made available to carry out this title''.

SEC. 102. FINDINGS.

Section 2 of the Indian Health Care Improvement Act (25 U.S.C. 1601) is amended—

(1) by redesignating subsections (a), (b), (c), and (d) as paragraphs (1), (3), (4), and (5), respec-

tively, and indenting the paragraphs appropriately; and

(2) by inserting after paragraph (1) (as so redesignated) the following:

''(2) A major national goal of the United States is 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.''.

SEC. 103. DECLARATION OF NATIONAL INDIAN HEALTH POLICY.

Section 3 of the Indian Health Care Improvement Act (25 U.S.C. 1602) is amended to read as follows:

''SEC. 3. DECLARATION OF NATIONAL INDIAN HEALTH POLICY.

''Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—

''(1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;

''(2) to raise the health status of Indians and urban Indians to at least the levels set forth in the

goals contained within the Healthy People 2010 initiative or successor objectives;

''(3) to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;

''(4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population;

''(5) to require that all actions under this Act shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this Act and the national policy of Indian self-determination;

''(6) to ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and

''(7) to provide funding for programs and facilities operated by Indian tribes and tribal organiza-

tions in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.''.

SEC. 104. DEFINITIONS.

Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603) is amended—

(1) by striking the matter preceding subsection (a) and inserting ''In this Act:'';

(2) in each of subsections (c), (j), (k), and (l), by redesignating the paragraphs contained in the subsections as subparagraphs and indenting the subparagraphs appropriately;

(3) by redesignating subsections (a) through (q) as paragraphs (17), (18), (13), (14), (26), (28), (27), (29), (1), (20), (11), (7), (19), (10), (21), (8), and (9), respectively, indenting the paragraphs appropriately, and moving the paragraphs so as to appear in numerical order;

(4) in each paragraph (as so redesignated), by inserting a heading the text of which is comprised of the term defined in the paragraph;

(5) by inserting ''The term'' after each paragraph heading;

(6) by inserting after paragraph (1) (as redesignated by paragraph (3)) the following:

"(2) BEHAVIORAL HEALTH.—

"(A) IN GENERAL.—The term 'behavioral health' means the blending of substance (alcohol, drugs, inhalants, and tobacco) abuse and mental health disorders prevention and treatment for the purpose of providing comprehensive services.

"(B) INCLUSIONS.—The term 'behavioral health' includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

"(3) CALIFORNIA INDIAN.—The term 'California Indian' means any Indian who is eligible for health services provided by the Service pursuant to section 809.

"(4) COMMUNITY COLLEGE.—The term 'community college' means—

"(A) a tribal college or university; or

"(B) a junior or community college.

"(5) CONTRACT HEALTH SERVICE.—The term 'contract health service' means any health service that is—

"(A) delivered based on a referral by, or at the expense of, an Indian health program; and

"(B) provided by a public or private medical provider or hospital that is not a provider or hospital of the Indian health program.

"(6) DEPARTMENT.—The term 'Department', unless otherwise designated, means the Department of Health and Human Services.";

(7) by striking paragraph (7) (as redesignated by paragraph (3)) and inserting the following:

"(7) DISEASE PREVENTION.—

"(A) IN GENERAL.—The term 'disease prevention' means any activity for—

"(i) the reduction, limitation, and prevention of—

"(I) disease; and

"(II) complications of disease; and

"(ii) the reduction of consequences of disease.

"(B) INCLUSIONS.—The term 'disease prevention' includes an activity for—

"(i) controlling—

"(I) the development of diabetes;

"(II) high blood pressure;

"(III) infectious agents;

"(IV) injuries;

"(V) occupational hazards and disabilities;

"(VI) sexually transmittable diseases; or

"(VII) toxic agents; or

"(ii) providing—

"(I) fluoridation of water; or

"(II) immunizations.";

(8) by striking paragraph (9) (as redesignated by paragraph (3)) and inserting the following:

"(9) FAS.—The term 'fetal alcohol syndrome' or 'FAS' means a syndrome in which, with a history of maternal alcohol consumption during pregnancy, the following criteria are met:

"(A) Central nervous system involvement such as mental retardation, developmental delay, intellectual deficit, microencephaly, or neurologic abnormalities.

"(B) Craniofacial abnormalities with at least 2 of the following: microophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

"(C) Prenatal or postnatal growth delay.";

(9) by striking paragraphs (11) and (12) (as redesignated by paragraph (3)) and inserting the following:

''(11) HEALTH PROMOTION.—The term 'health promotion' means any activity for—

''(A) fostering social, economic, environmental, and personal factors conducive to health, including raising public awareness regarding health matters and enabling individuals to cope with health problems by increasing knowledge and providing valid information;

''(B) encouraging adequate and appropriate diet, exercise, and sleep;

''(C) promoting education and work in accordance with physical and mental capacity;

''(D) making available safe water and sanitary facilities;

''(E) improving the physical, economic, cultural, psychological, and social environment;

''(F) promoting culturally competent care; and

''(G) providing adequate and appropriate programs, including programs for—

''(i) abuse prevention (mental and physical);

"(ii) community health;

"(iii) community safety;

"(iv) consumer health education;

"(v) diet and nutrition;

"(vi) immunization and other methods of prevention of communicable diseases, including HIV/AIDS;

"(vii) environmental health;

"(viii) exercise and physical fitness;

"(ix) avoidance of fetal alcohol spectrum disorders;

"(x) first aid and CPR education;

"(xi) human growth and development;

"(xii) injury prevention and personal safety;

"(xiii) behavioral health;

"(xiv) monitoring of disease indicators between health care provider visits through appropriate means, including Internet-based health care management systems;

"(xv) personal health and wellness practices;

"(xvi) personal capacity building;

"(xvii) prenatal, pregnancy, and infant care;

"(xviii) psychological well-being;

"(xix) reproductive health and family planning;

"(xx) safe and adequate water;

"(xxi) healthy work environments;

"(xxii) elimination, reduction, and prevention of contaminants that create unhealthy household conditions (including mold and other allergens);

"(xxiii) stress control;

"(xxiv) substance abuse;

"(xxv) sanitary facilities;

"(xxvi) sudden infant death syndrome prevention;

"(xxvii) tobacco use cessation and reduction;

"(xxviii) violence prevention; and

"(xxix) such other activities identified by the Service, a tribal health program, or an urban Indian organization to promote achievement of any of the objectives referred to in section 3(2).

"(12) INDIAN HEALTH PROGRAM.—The term 'Indian health program' means—

"(A) any health program administered directly by the Service;

"(B) any tribal health program; and

"(C) any Indian tribe or tribal organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (25 U.S.C. 47) (commonly known as the 'Buy Indian Act').";

(10) by inserting after paragraph (14) (as redesignated by paragraph (3)) the following:

"(15) JUNIOR OR COMMUNITY COLLEGE.—The term 'junior or community college' has the meaning given the term in section 312(e) of the Higher Education Act of 1965 (20 U.S.C. 1058(e)).

"(16) RESERVATION.—

"(A) IN GENERAL.—The term 'reservation' means a reservation, Pueblo, or colony of any Indian tribe.

"(B) INCLUSIONS.—The term 'reservation' includes—

"(i) former reservations in Oklahoma;

"(ii) Indian allotments; and

"(iii) Alaska Native Regions established pursuant to the Alaska Native

Claims Settlement Act (43 U.S.C. 1601 et seq.).'';

(11) by striking paragraph (20) (as redesignated by paragraph (3)) and inserting the following:

''(20) SERVICE UNIT.—The term 'Service unit' means an administrative entity of the Service or a tribal health program through which services are provided, directly or by contract, to eligible Indians within a defined geographic area.'';

(12) by inserting after paragraph (21) (as redesignated by paragraph (3)) the following:

''(22) TELEHEALTH.—The term 'telehealth' has the meaning given the term in section 330K(a) of the Public Health Service Act (42 U.S.C. 254c–16(a)).

''(23) TELEMEDICINE.—The term 'telemedicine' means a telecommunications link to an end user through the use of eligible equipment that electronically links health professionals or patients and health professionals at separate sites in order to exchange health care information in audio, video, graphic, or other format for the purpose of providing improved health care services.

''(24) TRIBAL COLLEGE OR UNIVERSITY.—The term 'tribal college or university' has the meaning

given the term in section 316(b) of the Higher Education Act of 1965 (20 U.S.C. 1059c(b)).

''(25) TRIBAL HEALTH PROGRAM.—The term 'tribal health program' means an Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).''; and

(13) by striking paragraph (26) (as redesignated by paragraph (3)) and inserting the following:

''(26) TRIBAL ORGANIZATION.—The term 'tribal organization' has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).''.

Subtitle A—Indian Health Manpower

SEC. 111. COMMUNITY HEALTH AIDE PROGRAM.

Section 119 of the Indian Health Care Improvement Act (25 U.S.C. 1616*l*) is amended to read as follows:

''SEC. 119. COMMUNITY HEALTH AIDE PROGRAM.

''(a) GENERAL PURPOSES OF PROGRAM.—Pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through

the Service, shall develop and operate a Community Health Aide Program in the State of Alaska under which the Service—

"(1) provides for the training of Alaska Natives as health aides or community health practitioners;

"(2) uses those aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and

"(3) provides for the establishment of teleconferencing capacity in health clinics located in or near those villages for use by community health aides or community health practitioners.

"(b) SPECIFIC PROGRAM REQUIREMENTS.—The Secretary, acting through the Community Health Aide Program of the Service, shall—

"(1) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that those aides and practitioners provide quality health care, health promotion, and disease prevention services to the villages served by the Program;

"(2) in order to provide such training, develop a curriculum that—

"(A) combines education regarding the theory of health care with supervised practical experience in the provision of health care;

"(B) provides instruction and practical experience in the provision of acute care, emergency care, health promotion, disease prevention, and the efficient and effective management of clinic pharmacies, supplies, equipment, and facilities; and

"(C) promotes the achievement of the health status objectives specified in section 3(2);

"(3) establish and maintain a Community Health Aide Certification Board to certify as community health aides or community health practitioners individuals who have successfully completed the training described in paragraph (1) or can demonstrate equivalent experience;

"(4) develop and maintain a system that identifies the needs of community health aides and community health practitioners for continuing education in the provision of health care, including the areas described in paragraph (2)(B), and develop programs that meet the needs for such continuing education;

"(5) develop and maintain a system that provides close supervision of community health aides and community health practitioners;

"(6) develop a system under which the work of community health aides and community health practitioners is reviewed and evaluated to ensure the provision of quality health care, health promotion, and disease prevention services; and

"(7) ensure that—

"(A) pulpal therapy (not including pulpotomies on deciduous teeth) or extraction of adult teeth can be performed by a dental health aide therapist only after consultation with a licensed dentist who determines that the procedure is a medical emergency that cannot be resolved with palliative treatment; and

"(B) dental health aide therapists are strictly prohibited from performing all other oral or jaw surgeries, subject to the condition that uncomplicated extractions shall not be considered oral surgery under this section.

"(c) PROGRAM REVIEW.—

"(1) NEUTRAL PANEL.—

"(A) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a

neutral panel to carry out the study under paragraph (2).

"(B) MEMBERSHIP.—Members of the neutral panel shall be appointed by the Secretary from among clinicians, economists, community practitioners, oral epidemiologists, and Alaska Natives.

"(2) STUDY.—

"(A) IN GENERAL.—The neutral panel established under paragraph (1) shall conduct a study of the dental health aide therapist services provided by the Community Health Aide Program under this section to ensure that the quality of care provided through those services is adequate and appropriate.

"(B) PARAMETERS OF STUDY.—The Secretary, in consultation with interested parties, including professional dental organizations, shall develop the parameters of the study.

"(C) INCLUSIONS.—The study shall include a determination by the neutral panel with respect to—

"(i) the ability of the dental health aide therapist services under this section to

address the dental care needs of Alaska Natives;

"(ii) the quality of care provided through those services, including any training, improvement, or additional oversight required to improve the quality of care; and

"(iii) whether safer and less costly alternatives to the dental health aide therapist services exist.

"(D) CONSULTATION.—In carrying out the study under this paragraph, the neutral panel shall consult with Alaska tribal organizations with respect to the adequacy and accuracy of the study.

"(3) REPORT.—The neutral panel shall submit to the Secretary, the Committee on Indian Affairs of the Senate, and the Committee on Natural Resources of the House of Representatives a report describing the results of the study under paragraph (2), including a description of—

"(A) any determination of the neutral panel under paragraph (2)(C); and

"(B) any comments received from Alaska tribal organizations under paragraph (2)(D).

"(d) NATIONALIZATION OF PROGRAM.—

"(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary, acting through the Service, may establish a national Community Health Aide Program in accordance with the program under this section, as the Secretary determines to be appropriate.

"(2) REQUIREMENT; EXCLUSION.—Subject to paragraphs (3) and (4), in establishing a national program under paragraph (1), the Secretary—

"(A) shall not reduce the amounts provided for the Community Health Aide Program described in subsections (a) and (b); and

"(B) shall exclude dental health aide therapist services from services covered under the program.

"(3) ELECTION OF INDIAN TRIBE OR TRIBAL ORGANIZATION.—

"(A) IN GENERAL.—Subparagraph (B) of paragraph (2) shall not apply in the case of an election made by an Indian tribe or tribal organization located in a State (other than Alaska) in which the use of dental health aide therapist services or midlevel dental health provider serv-

ices is authorized under State law to supply such services in accordance with State law.

''(B) ACTION BY SECRETARY.—On an election by an Indian tribe or tribal organization under subparagraph (A), the Secretary, acting through the Service, shall facilitate implementation of the services elected.

''(4) VACANCIES.—The Secretary shall not fill any vacancy for a certified dentist in a program operated by the Service with a dental health aide therapist.

''(e) EFFECT OF SECTION.—Nothing in this section shall restrict the ability of the Service, an Indian tribe, or a tribal organization to participate in any program or to provide any service authorized by any other Federal law.''.

SEC. 112. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROGRAMS.

Title I of the Indian Health Care Improvement Act (25 U.S.C. 1611 et seq.) (as amended by section 101(b)) is amended by adding at the end the following:

''SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROGRAMS.

''(a) DEMONSTRATION PROGRAMS.—The Secretary, acting through the Service, may fund demonstration pro-

grams for Indian health programs to address the chronic shortages of health professionals.

"(b) PURPOSES OF PROGRAMS.—The purposes of demonstration programs under subsection (a) shall be—

"(1) to provide direct clinical and practical experience within an Indian health program to health profession students and residents from medical schools;

"(2) to improve the quality of health care for Indians by ensuring access to qualified health professionals;

"(3) to provide academic and scholarly opportunities for health professionals serving Indians by identifying all academic and scholarly resources of the region; and

"(4) to provide training and support for alternative provider types, such as community health representatives, and community health aides.

"(c) ADVISORY BOARD.—The demonstration programs established pursuant to subsection (a) shall incorporate a program advisory board, which may be composed of representatives of tribal governments, Indian health programs, and Indian communities in the areas to be served by the demonstration programs.".

SEC. 113. EXEMPTION FROM PAYMENT OF CERTAIN FEES.

Title I of the Indian Health Care Improvement Act (25 U.S.C. 1611 et seq.) (as amended by section 112) is amended by adding at the end the following:

"SEC. 124. EXEMPTION FROM PAYMENT OF CERTAIN FEES.

''Employees of a tribal health program or urban Indian organization shall be exempt from payment of licensing, registration, and any other fees imposed by a Federal agency to the same extent that officers of the commissioned corps of the Public Health Service and other employees of the Service are exempt from those fees.''.

Subtitle B—Health Services

SEC. 121. INDIAN HEALTH CARE IMPROVEMENT FUND.

Section 201 of the Indian Health Care Improvement Act (25 U.S.C. 1621) is amended to read as follows:

"SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.

''(a) USE OF FUNDS.—The Secretary, acting through the Service, is authorized to expend funds, directly or under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), which are appropriated under the authority of this section, for the purposes of—

''(1) eliminating the deficiencies in health status and health resources of all Indian tribes;

''(2) eliminating backlogs in the provision of health care services to Indians;

"(3) meeting the health needs of Indians in an efficient and equitable manner, including the use of telehealth and telemedicine when appropriate;

"(4) eliminating inequities in funding for both direct care and contract health service programs; and

"(5) augmenting the ability of the Service to meet the following health service responsibilities with respect to those Indian tribes with the highest levels of health status deficiencies and resource deficiencies:

"(A) Clinical care, including inpatient care, outpatient care (including audiology, clinical eye, and vision care), primary care, secondary and tertiary care, and long-term care.

"(B) Preventive health, including mammography and other cancer screening.

"(C) Dental care.

"(D) Mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional health care practitioners.

"(E) Emergency medical services.

"(F) Treatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians.

"(G) Injury prevention programs, including data collection and evaluation, demonstration projects, training, and capacity building.

"(H) Home health care.

"(I) Community health representatives.

"(J) Maintenance and improvement.

"(b) NO OFFSET OR LIMITATION.—Any funds appropriated under the authority of this section shall not be used to offset or limit any other appropriations made to the Service under this Act or the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), or any other provision of law.

"(c) ALLOCATION; USE.—

"(1) IN GENERAL.—Funds appropriated under the authority of this section shall be allocated to Service units, Indian tribes, or tribal organizations. The funds allocated to each Indian tribe, tribal organization, or Service unit under this paragraph shall be used by the Indian tribe, tribal organization, or Service unit under this paragraph to improve the health status and reduce the resource deficiency of

each Indian tribe served by such Service unit, Indian tribe, or tribal organization.

"(2) APPORTIONMENT OF ALLOCATED FUNDS.—The apportionment of funds allocated to a Service unit, Indian tribe, or tribal organization under paragraph (1) among the health service responsibilities described in subsection (a)(5) shall be determined by the Service in consultation with, and with the active participation of, the affected Indian tribes and tribal organizations.

"(d) PROVISIONS RELATING TO HEALTH STATUS AND RESOURCE DEFICIENCIES.—For the purposes of this section, the following definitions apply:

"(1) DEFINITION.—The term 'health status and resource deficiency' means the extent to which—

"(A) the health status objectives set forth in sections 3(1) and 3(2) are not being achieved; and

"(B) the Indian tribe or tribal organization does not have available to it the health resources it needs, taking into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances.

"(2) AVAILABLE RESOURCES.—The health resources available to an Indian tribe or tribal organization include health resources provided by the Service as well as health resources used by the Indian tribe or tribal organization, including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.

"(3) PROCESS FOR REVIEW OF DETERMINATIONS.—The Secretary shall establish procedures which allow any Indian tribe or tribal organization to petition the Secretary for a review of any determination of the extent of the health status and resource deficiency of such Indian tribe or tribal organization.

"(e) ELIGIBILITY FOR FUNDS.—Tribal health programs shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

"(f) REPORT.—By no later than the date that is 3 years after the date of enactment of the Indian Healthcare Improvement Act of 2017, the Secretary shall submit to Congress the current health status and resource deficiency report of the Service for each Service unit, including newly

recognized or acknowledged Indian tribes. Such report shall set out—

"(1) the methodology then in use by the Service for determining tribal health status and resource deficiencies, as well as the most recent application of that methodology;

"(2) the extent of the health status and resource deficiency of each Indian tribe served by the Service or a tribal health program;

"(3) the amount of funds necessary to eliminate the health status and resource deficiencies of all Indian tribes served by the Service or a tribal health program; and

"(4) an estimate of—

"(A) the amount of health service funds appropriated under the authority of this Act, or any other Act, including the amount of any funds transferred to the Service for the preceding fiscal year which is allocated to each Service unit, Indian tribe, or tribal organization;

"(B) the number of Indians eligible for health services in each Service unit or Indian tribe or tribal organization; and

"(C) the number of Indians using the Service resources made available to each Service unit, Indian tribe or tribal organization, and, to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.

"(g) INCLUSION IN BASE BUDGET.—Funds appropriated under this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

"(h) CLARIFICATION.—Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs, nor are the provisions of this section intended to discourage the Service from undertaking additional efforts to achieve equity among Indian tribes and tribal organizations.

"(i) FUNDING DESIGNATION.—Any funds appropriated under the authority of this section shall be designated as the 'Indian Health Care Improvement Fund'.".

SEC. 122. CATASTROPHIC HEALTH EMERGENCY FUND.

Section 202 of the Indian Health Care Improvement Act (25 U.S.C. 1621a) is amended to read as follows:

"SEC. 202. CATASTROPHIC HEALTH EMERGENCY FUND.

"(a) ESTABLISHMENT.—There is established an Indian Catastrophic Health Emergency Fund (hereafter in this section referred to as the 'CHEF') consisting of—

"(1) the amounts deposited under subsection (f); and

"(2) the amounts appropriated to CHEF under this section.

"(b) ADMINISTRATION.—CHEF shall be administered by the Secretary, acting through the headquarters of the Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service.

"(c) CONDITIONS ON USE OF FUND.—No part of CHEF or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), nor shall CHEF funds be allocated, apportioned, or delegated on an Area Office, Service Unit, or other similar basis.

"(d) REGULATIONS.—The Secretary shall promulgate regulations consistent with the provisions of this section to—

"(1) establish a definition of disasters and catastrophic illnesses for which the cost of the treatment

provided under contract would qualify for payment from CHEF;

"(2) provide that a Service Unit shall not be eligible for reimbursement for the cost of treatment from CHEF until its cost of treating any victim of such catastrophic illness or disaster has reached a certain threshold cost which the Secretary shall establish at—

"(A) the 2000 level of $19,000; and

"(B) for any subsequent year, not less than the threshold cost of the previous year increased by the percentage increase in the medical care expenditure category of the consumer price index for all urban consumers (United States city average) for the 12-month period ending with December of the previous year;

"(3) establish a procedure for the reimbursement of the portion of the costs that exceeds such threshold cost incurred by—

"(A) Service Units; or

"(B) whenever otherwise authorized by the Service, non-Service facilities or providers;

"(4) establish a procedure for payment from CHEF in cases in which the exigencies of the med-

ical circumstances warrant treatment prior to the authorization of such treatment by the Service; and

"(5) establish a procedure that will ensure that no payment shall be made from CHEF to any provider of treatment to the extent that such provider is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible.

"(e) NO OFFSET OR LIMITATION.—Amounts appropriated to CHEF under this section shall not be used to offset or limit appropriations made to the Service under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), or any other law.

"(f) DEPOSIT OF REIMBURSEMENT FUNDS.—There shall be deposited into CHEF all reimbursements to which the Service is entitled from any Federal, State, local, or private source (including third party insurance) by reason of treatment rendered to any victim of a disaster or catastrophic illness the cost of which was paid from CHEF.".

SEC. 123. DIABETES PREVENTION, TREATMENT, AND CONTROL.

Section 204 of the Indian Health Care Improvement Act (25 U.S.C. 1621c) is amended to read as follows:

"SEC. 204. DIABETES PREVENTION, TREATMENT, AND CONTROL.

"(a) DETERMINATIONS REGARDING DIABETES.—The Secretary, acting through the Service, and in consultation with Indian tribes and tribal organizations, shall determine—

"(1) by Indian tribe and by Service unit, the incidence of, and the types of complications resulting from, diabetes among Indians; and

"(2) based on the determinations made pursuant to paragraph (1), the measures (including patient education and effective ongoing monitoring of disease indicators) each Service unit should take to reduce the incidence of, and prevent, treat, and control the complications resulting from, diabetes among Indian tribes within that Service unit.

"(b) DIABETES SCREENING.—To the extent medically indicated and with informed consent, the Secretary shall screen each Indian who receives services from the Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic and establish a cost-effective approach to ensure ongoing monitoring of disease indicators. Such screening and monitoring may be conducted by a tribal health program and may be conducted through appropriate Internet-based health care management programs.

''(c) DIABETES PROJECTS.—The Secretary shall continue to maintain each model diabetes project in existence on the date of enactment of the Indian Healthcare Improvement Act of 2017, any such other diabetes programs operated by the Service or tribal health programs, and any additional diabetes projects, such as the Medical Vanguard program provided for in title IV of Public Law 108–87, as implemented to serve Indian tribes. tribal health programs shall receive recurring funding for the diabetes projects that they operate pursuant to this section, both at the date of enactment of the Indian Healthcare Improvement Act of 2017 and for projects which are added and funded thereafter.

''(d) DIALYSIS PROGRAMS.—The Secretary is authorized to provide, through the Service, Indian tribes, and tribal organizations, dialysis programs, including the purchase of dialysis equipment and the provision of necessary staffing.

''(e) OTHER DUTIES OF THE SECRETARY.—

''(1) IN GENERAL.—The Secretary shall, to the extent funding is available—

''(A) in each area office, consult with Indian tribes and tribal organizations regarding programs for the prevention, treatment, and control of diabetes;

"(B) establish in each area office a registry of patients with diabetes to track the incidence of diabetes and the complications from diabetes in that area; and

"(C) ensure that data collected in each area office regarding diabetes and related complications among Indians are disseminated to all other area offices, subject to applicable patient privacy laws.

"(2) DIABETES CONTROL OFFICERS.—

"(A) IN GENERAL.—The Secretary may establish and maintain in each area office a position of diabetes control officer to coordinate and manage any activity of that area office relating to the prevention, treatment, or control of diabetes to assist the Secretary in carrying out a program under this section or section 330C of the Public Health Service Act (42 U.S.C. 254c–3).

"(B) CERTAIN ACTIVITIES.—Any activity carried out by a diabetes control officer under subparagraph (A) that is the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), and any funds made avail-

able to carry out such an activity, shall not be divisible for purposes of that Act.''.

SEC. 124. OTHER AUTHORITY FOR PROVISION OF SERVICES; SHARED SERVICES FOR LONG-TERM CARE.

(a) OTHER AUTHORITY FOR PROVISION OF SERVICES.—

(1) IN GENERAL.—Section 205 of the Indian Health Care Improvement Act (25 U.S.C. 1621d) is amended to read as follows:

''SEC. 205. OTHER AUTHORITY FOR PROVISION OF SERVICES.

''(a) DEFINITIONS.—In this section:

''(1) ASSISTED LIVING SERVICE.—The term 'assisted living service' means any service provided by an assisted living facility (as defined in section 232(b) of the National Housing Act (12 U.S.C. 1715w(b))), except that such an assisted living facility—

''(A) shall not be required to obtain a license; but

''(B) shall meet all applicable standards for licensure.

''(2) HOME- AND COMMUNITY-BASED SERVICE.—The term 'home- and community-based serv-

ice' means 1 or more of the services specified in paragraphs (1) through (9) of section 1929(a) of the Social Security Act (42 U.S.C. 1396t(a)) (whether provided by the Service or by an Indian tribe or tribal organization pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) that are or will be provided in accordance with applicable standards.

"(3) HOSPICE CARE.—The term 'hospice care' means—

"(A) the items and services specified in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)); and

"(B) such other services as an Indian tribe or tribal organization determines are necessary and appropriate to provide in furtherance of that care.

"(4) LONG-TERM CARE SERVICES.—The term 'long-term care services' has the meaning given the term 'qualified long-term care services' in section 7702B(c) of the Internal Revenue Code of 1986.

"(b) FUNDING AUTHORIZED.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, may provide funding under this Act to meet the ob-

jectives set forth in section 3 through health care-related services and programs not otherwise described in this Act for the following services:

"(1) Hospice care.

"(2) Assisted living services.

"(3) Long-term care services.

"(4) Home- and community-based services.

"(c) ELIGIBILITY.—The following individuals shall be eligible to receive long-term care services under this section:

"(1) Individuals who are unable to perform a certain number of activities of daily living without assistance.

"(2) Individuals with a mental impairment, such as dementia, Alzheimer's disease, or another disabling mental illness, who may be able to perform activities of daily living under supervision.

"(3) Such other individuals as an applicable tribal health program determines to be appropriate.

"(d) AUTHORIZATION OF CONVENIENT CARE SERVICES.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, may also provide funding under this Act to meet the objectives set forth in section 3 for convenient care services programs pursuant to section 307(c)(2)(A).".

(2) REPEAL.—Section 821 of the Indian Health Care Improvement Act (25 U.S.C. 1680k) is repealed.

(b) SHARED SERVICES FOR LONG-TERM CARE.—Section 822 of the Indian Health Care Improvement Act (25 U.S.C. 1680*l*) is amended to read as follows:

"SEC. 822. SHARED SERVICES FOR LONG-TERM CARE.

''(a) LONG-TERM CARE.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary, acting through the Service, is authorized to provide directly, or enter into contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) with Indian tribes or tribal organizations for, the delivery of long-term care (including health care services associated with long-term care) provided in a facility to Indians.

''(2) INCLUSIONS.—Each agreement under paragraph (1) shall provide for the sharing of staff or other services between the Service or a tribal health program and a long-term care or related facility owned and operated (directly or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) by the Indian tribe or tribal organization.

"(b) CONTENTS OF AGREEMENTS.—An agreement entered into pursuant to subsection (a)—

"(1) may, at the request of the Indian tribe or tribal organization, delegate to the Indian tribe or tribal organization such powers of supervision and control over Service employees as the Secretary determines to be necessary to carry out the purposes of this section;

"(2) shall provide that expenses (including salaries) relating to services that are shared between the Service and the tribal health program be allocated proportionately between the Service and the Indian tribe or tribal organization; and

"(3) may authorize the Indian tribe or tribal organization to construct, renovate, or expand a long-term care or other similar facility (including the construction of a facility attached to a Service facility).

"(c) MINIMUM REQUIREMENT.—Any nursing facility provided for under this section shall meet the requirements for nursing facilities under section 1919 of the Social Security Act (42 U.S.C. 1396r).

"(d) OTHER ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with this section.

''(e) USE OF EXISTING OR UNDERUSED FACILITIES.—The Secretary shall encourage the use of existing facilities that are underused, or allow the use of swing beds, for long-term or similar care.''.

SEC. 125. REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.

Section 206 of the Indian Health Care Improvement Act (25 U.S.C. 1621e) is amended to read as follows:

''SEC. 206. REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.

''(a) RIGHT OF RECOVERY.—Except as provided in subsection (f), the United States, an Indian tribe, or tribal organization shall have the right to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges billed by the Secretary, an Indian tribe, or tribal organization in providing health services through the Service, an Indian tribe, or tribal organization, or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities, to any individual to the same extent that such individual, or any nongovernmental provider of such serv-

ices, would be eligible to receive damages, reimbursement, or indemnification for such charges or expenses if—

''(1) such services had been provided by a non-governmental provider; and

''(2) such individual had been required to pay such charges or expenses and did pay such charges or expenses.

''(b) LIMITATIONS ON RECOVERIES FROM STATES.—Subsection (a) shall provide a right of recovery against any State, only if the injury, illness, or disability for which health services were provided is covered under—

''(1) workers' compensation laws; or

''(2) a no-fault automobile accident insurance plan or program.

''(c) NONAPPLICABILITY OF OTHER LAWS.—No law of any State, or of any political subdivision of a State and no provision of any contract, insurance or health maintenance organization policy, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program entered into or renewed after the date of enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the United States, an Indian tribe, or tribal organization under subsection (a).

"(d) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—No action taken by the United States, an Indian tribe, or tribal organization to enforce the right of recovery provided under this section shall operate to deny to the injured person the recovery for that portion of the person's damage not covered hereunder.

"(e) ENFORCEMENT.—

"(1) IN GENERAL.—The United States, an Indian tribe, or tribal organization may enforce the right of recovery provided under subsection (a) by—

"(A) intervening or joining in any civil action or proceeding brought—

"(i) by the individual for whom health services were provided by the Secretary, an Indian tribe, or tribal organization; or

"(ii) by any representative or heirs of such individual, or

"(B) instituting a separate civil action, including a civil action for injunctive relief and other relief and including, with respect to a political subdivision or local governmental entity of a State, such an action against an official thereof.

"(2) NOTICE.—All reasonable efforts shall be made to provide notice of action instituted under

paragraph (1)(B) to the individual to whom health services were provided, either before or during the pendency of such action.

"(3) RECOVERY FROM TORTFEASORS.—

"(A) IN GENERAL.—In any case in which an Indian tribe or tribal organization that is authorized or required under a compact or contract issued pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) to furnish or pay for health services to a person who is injured or suffers a disease on or after the date of enactment of the Indian Healthcare Improvement Act of 2017 under circumstances that establish grounds for a claim of liability against the tortfeasor with respect to the injury or disease, the Indian tribe or tribal organization shall have a right to recover from the tortfeasor (or an insurer of the tortfeasor) the reasonable value of the health services so furnished, paid for, or to be paid for, in accordance with the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.), to the same extent and under the same circumstances as the United States may recover under that Act.

"(B) TREATMENT.—The right of an Indian tribe or tribal organization to recover under subparagraph (A) shall be independent of the rights of the injured or diseased person served by the Indian tribe or tribal organization.

"(f) LIMITATION.—Absent specific written authorization by the governing body of an Indian tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), the United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe, tribal organization, or urban Indian organization. Where such authorization is provided, the Service may receive and expend such amounts for the provision of additional health services consistent with such authorization.

"(g) COSTS AND ATTORNEY'S FEES.—In any action brought to enforce the provisions of this section, a prevailing plaintiff shall be awarded its reasonable attorney's fees and costs of litigation.

"(h) NONAPPLICABILITY OF CLAIMS FILING REQUIREMENTS.—An insurance company, health mainte-

nance organization, self-insurance plan, managed care plan, or other health care plan or program (under the Social Security Act or otherwise) may not deny a claim for benefits submitted by the Service or by an Indian tribe or tribal organization based on the format in which the claim is submitted if such format complies with the format required for submission of claims under title XVIII of the Social Security Act or recognized under section 1175 of such Act.

''(i) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—The previous provisions of this section shall apply to urban Indian organizations with respect to populations served by such Organizations in the same manner they apply to Indian tribes and tribal organizations with respect to populations served by such Indian tribes and tribal organizations.

''(j) STATUTE OF LIMITATIONS.—The provisions of section 2415 of title 28, United States Code, shall apply to all actions commenced under this section, and the references therein to the United States are deemed to include Indian tribes, tribal organizations, and urban Indian organizations.

''(k) SAVINGS.—Nothing in this section shall be construed to limit any right of recovery available to the United States, an Indian tribe, or tribal organization

under the provisions of any applicable, Federal, State, or tribal law, including medical lien laws.''.

SEC. 126. CREDITING OF REIMBURSEMENTS.

Section 207 of the Indian Health Care Improvement Act (25 U.S.C. 1621f) is amended to read as follows:

''SEC. 207. CREDITING OF REIMBURSEMENTS.

''(a) USE OF AMOUNTS.—

''(1) RETENTION BY PROGRAM.—Except as provided in sections 202(a)(2) and 813, all reimbursements received or recovered under any of the programs described in paragraph (2), including under section 813, by reason of the provision of health services by the Service, by an Indian tribe or tribal organization, or by an urban Indian organization, shall be credited to the Service, such Indian tribe or tribal organization, or such urban Indian organization, respectively, and may be used as provided in section 401. In the case of such a service provided by or through a Service Unit, such amounts shall be credited to such unit and used for such purposes.

''(2) PROGRAMS COVERED.—The programs referred to in paragraph (1) are the following:

''(A) Titles XVIII, XIX, and XXI of the Social Security Act.

''(B) This Act, including section 813.

"(C) Public Law 87–693.

"(D) Any other provision of law.

"(b) NO OFFSET OF AMOUNTS.—The Service may not offset or limit any amount obligated to any Service Unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).".

SEC. 127. BEHAVIORAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS.

Section 209 of the Indian Health Care Improvement Act (25 U.S.C. 1621h) is amended by striking subsection (d) and inserting the following:

"(d) BEHAVIORAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS.—

"(1) STUDY; LIST.—The Secretary, acting through the Service, and the Secretary of the Interior, in consultation with Indian tribes and tribal organizations, shall conduct a study and compile a list of the types of staff positions specified in paragraph (2) whose qualifications include, or should include, training in the identification, prevention, education, referral, or treatment of mental illness, or dysfunctional and self destructive behavior.

"(2) POSITIONS.—The positions referred to in paragraph (1) are—

"(A) staff positions within the Bureau of Indian Affairs, including existing positions, in the fields of—

"(i) elementary and secondary education;

"(ii) social services and family and child welfare;

"(iii) law enforcement and judicial services; and

"(iv) alcohol and substance abuse;

"(B) staff positions within the Service; and

"(C) staff positions similar to those identified in subparagraphs (A) and (B) established and maintained by Indian tribes and tribal organizations (without regard to the funding source).

"(3) TRAINING CRITERIA.—

"(A) IN GENERAL.—The appropriate Secretary shall provide training criteria appropriate to each type of position identified in paragraphs (2)(A) and (2)(B) and ensure that appropriate training has been, or shall be provided to any individual in any such position. With respect to any such individual in a position identified pursuant to paragraph (2)(C), the respective Secre-

taries shall provide appropriate training to, or provide funds to, an Indian tribe or tribal organization for training of appropriate individuals. In the case of positions funded under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the appropriate Secretary shall ensure that such training costs are included in the contract or compact, as the Secretary determines necessary.

"(B) POSITION SPECIFIC TRAINING CRITERIA.—Position specific training criteria shall be culturally relevant to Indians and Indian tribes and shall ensure that appropriate information regarding traditional health care practices is provided.

"(4) COMMUNITY EDUCATION ON MENTAL ILLNESS.—The Service shall develop and implement, on request of an Indian tribe, tribal organization, or urban Indian organization, or assist the Indian tribe, tribal organization, or urban Indian organization to develop and implement, a program of community education on mental illness. In carrying out this paragraph, the Service shall, upon request of an Indian tribe, tribal organization, or urban Indian orga-

nization, provide technical assistance to the Indian tribe, tribal organization, or urban Indian organization to obtain and develop community educational materials on the identification, prevention, referral, and treatment of mental illness and dysfunctional and self-destructive behavior.

''(5) PLAN.—Not later than 90 days after the date of enactment of the Indian Healthcare Improvement Act of 2017, the Secretary shall develop a plan under which the Service will increase the health care staff providing behavioral health services by at least 500 positions within 5 years after the date of enactment of that Act, with at least 200 of such positions devoted to child, adolescent, and family services. The plan developed under this paragraph shall be implemented under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act').''.

SEC. 128. CANCER SCREENINGS.

Section 212 of the Indian Health Care Improvement Act (25 U.S.C. 1621k) is amended by inserting ''and other cancer screenings'' before the period at the end.

SEC. 129. PATIENT TRAVEL COSTS.

Section 213 of the Indian Health Care Improvement Act (25 U.S.C. 1621l) is amended to read as follows:

"SEC. 213. PATIENT TRAVEL COSTS.

"(a) DEFINITION OF QUALIFIED ESCORT.—In this section, the term 'qualified escort' means—

"(1) an adult escort (including a parent, guardian, or other family member) who is required because of the physical or mental condition, or age, of the applicable patient;

"(2) a health professional for the purpose of providing necessary medical care during travel by the applicable patient; or

"(3) other escorts, as the Secretary or applicable Indian Health Program determines to be appropriate.

"(b) PROVISION OF FUNDS.—The Secretary, acting through the Service and Tribal Health Programs, is authorized to provide funds for the following patient travel costs, including qualified escorts, associated with receiving health care services provided (either through direct or contract care or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) under this Act—

"(1) emergency air transportation and non-emergency air transportation where ground transportation is infeasible;

''(2) transportation by private vehicle (where no other means of transportation is available), specially equipped vehicle, and ambulance; and

''(3) transportation by such other means as may be available and required when air or motor vehicle transportation is not available.''.

SEC. 130. EPIDEMIOLOGY CENTERS.

Section 214 of the Indian Health Care Improvement Act (25 U.S.C. 1621m) is amended to read as follows:

''SEC. 214. EPIDEMIOLOGY CENTERS.

''(a) ESTABLISHMENT OF CENTERS.—

''(1) IN GENERAL.—The Secretary shall establish an epidemiology center in each Service area to carry out the functions described in subsection (b).

''(2) NEW CENTERS.—

''(A) IN GENERAL.—Subject to subparagraph (B), any new center established after the date of enactment of the Indian Healthcare Improvement Act of 2017 may be operated under a grant authorized by subsection (d).

''(B) REQUIREMENT.—Funding provided in a grant described in subparagraph (A) shall not be divisible.

''(3) FUNDS NOT DIVISIBLE.—An epidemiology center established under this subsection shall be sub-

ject to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), but the funds for the center shall not be divisible.

''(b) FUNCTIONS OF CENTERS.—In consultation with and on the request of Indian tribes, tribal organizations, and urban Indian organizations, each Service area epidemiology center established under this section shall, with respect to the applicable Service area—

''(1) collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the Service, the Indian tribes, tribal organizations, and urban Indian organizations in the Service area;

''(2) evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health;

''(3) assist Indian tribes, tribal organizations, and urban Indian organizations in identifying highest-priority health status objectives and the services needed to achieve those objectives, based on epidemiological data;

''(4) make recommendations for the targeting of services needed by the populations served;

''(5) make recommendations to improve health care delivery systems for Indians and urban Indians;

"(6) provide requested technical assistance to Indian tribes, tribal organizations, and urban Indian organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

"(7) provide disease surveillance and assist Indian tribes, tribal organizations, and urban Indian communities to promote public health.

"(c) TECHNICAL ASSISTANCE.—The Director of the Centers for Disease Control and Prevention shall provide technical assistance to the centers in carrying out this section.

"(d) GRANTS FOR STUDIES.—

"(1) IN GENERAL.—The Secretary may make grants to Indian tribes, tribal organizations, Indian organizations, and eligible intertribal consortia to conduct epidemiological studies of Indian communities.

"(2) ELIGIBLE INTERTRIBAL CONSORTIA.—An intertribal consortium or Indian organization shall be eligible to receive a grant under this subsection if the intertribal consortium is—

"(A) incorporated for the primary purpose of improving Indian health; and

"(B) representative of the Indian tribes or urban Indian communities residing in the area in which the intertribal consortium is located.

"(3) APPLICATIONS.—An application for a grant under this subsection shall be submitted in such manner and at such time as the Secretary shall prescribe.

"(4) REQUIREMENTS.—An applicant for a grant under this subsection shall—

"(A) demonstrate the technical, administrative, and financial expertise necessary to carry out the functions described in paragraph (5);

"(B) consult and cooperate with providers of related health and social services in order to avoid duplication of existing services; and

"(C) demonstrate cooperation from Indian tribes or urban Indian organizations in the area to be served.

"(5) USE OF FUNDS.—A grant provided under paragraph (1) may be used—

"(A) to carry out the functions described in subsection (b);

"(B) to provide information to, and consult with, tribal leaders, urban Indian community

leaders, and related health staff regarding health care and health service management issues; and

"(C) in collaboration with Indian tribes, tribal organizations, and urban Indian organizations, to provide to the Service information regarding ways to improve the health status of Indians.

"(e) ACCESS TO INFORMATION.—

"(1) IN GENERAL.—An epidemiology center operated by a grantee pursuant to a grant awarded under subsection (d) shall be treated as a public health authority (as defined in section 164.501 of title 45, Code of Federal Regulations (or a successor regulation)) for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1936).

"(2) ACCESS TO INFORMATION.—The Secretary shall grant to each epidemiology center described in paragraph (1) access to use of the data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary.

"(3) REQUIREMENT.—The activities of an epidemiology center described in paragraph (1) shall be

for the purposes of research and for preventing and controlling disease, injury, or disability (as those activities are described in section 164.512 of title 45, Code of Federal Regulations (or a successor regulation)), for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law104–191; 110 Stat. 1936).''.''

SEC. 131. INDIAN YOUTH GRANT PROGRAM.

Section 216(b)(2) of the Indian Health Care Improvement Act (25 U.S.C. 1621o(b)(2)) is amended by striking ''section 209(m)'' and inserting ''section 708(c)''.

SEC. 132. AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.

Section 217 of the Indian Health Care Improvement Act (25 U.S.C. 1621p) is amended to read as follows:

''SEC. 217. AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.

''(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, shall make grants of not more than $300,000 to each of 9 colleges and universities for the purpose of developing and maintaining Indian psychology career recruitment programs as a means of encouraging Indians to enter the behavioral health field. These programs shall be located at various locations throughout the country to maximize their availability to Indian students and

new programs shall be established in different locations from time to time.

''(b) QUENTIN N. BURDICK PROGRAM GRANT.—The Secretary shall provide a grant authorized under subsection (a) to develop and maintain a program at the University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Psychology Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian health programs authorized under section 117(b), the Quentin N. Burdick American Indians Into Nursing Program authorized under section 115(e), and existing university research and communications networks.

''(c) REGULATIONS.—The Secretary shall issue regulations pursuant to this Act for the competitive awarding of grants provided under this section.

''(d) CONDITIONS OF GRANT.—Applicants under this section shall agree to provide a program which, at a minimum—

''(1) provides outreach and recruitment for health professions to Indian communities including elementary, secondary, and accredited and accessible community colleges that will be served by the program;

"(2) incorporates a program advisory board comprised of representatives from the tribes and communities that will be served by the program;

"(3) provides summer enrichment programs to expose Indian students to the various fields of psychology through research, clinical, and experimental activities;

"(4) provides stipends to undergraduate and graduate students to pursue a career in psychology;

"(5) develops affiliation agreements with tribal colleges and universities, the Service, university affiliated programs, and other appropriate accredited and accessible entities to enhance the education of Indian students;

"(6) to the maximum extent feasible, uses existing university tutoring, counseling, and student support services; and

"(7) to the maximum extent feasible, employs qualified Indians in the program.

"(e) ACTIVE DUTY SERVICE REQUIREMENT.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each graduate who receives a stipend described in subsection (d)(4) that is funded under this section. Such obligation shall be met by service—

''(1) in an Indian health program;

''(2) in a program assisted under title V; or

''(3) in the private practice of psychology if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $2,700,000 for fiscal year 2017 and each fiscal year thereafter.''.

SEC. 133. PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES.

Section 218 of the Indian Health Care Improvement Act (25 U.S.C. 1621q) is amended to read as follows:

''SEC. 218. PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES.

''(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, and after consultation with the Centers for Disease Control and Prevention, may make grants available to Indian tribes and tribal organizations for the following:

''(1) Projects for the prevention, control, and elimination of communicable and infectious diseases,

including tuberculosis, hepatitis, HIV, respiratory syncytial virus, hanta virus, sexually transmitted diseases, and H. pylori.

"(2) Public information and education programs for the prevention, control, and elimination of communicable and infectious diseases.

"(3) Education, training, and clinical skills improvement activities in the prevention, control, and elimination of communicable and infectious diseases for health professionals, including allied health professionals.

"(4) Demonstration projects for the screening, treatment, and prevention of hepatitis C virus (HCV).

"(b) APPLICATION REQUIRED.—The Secretary may provide funding under subsection (a) only if an application or proposal for funding is submitted to the Secretary.

"(c) COORDINATION WITH HEALTH AGENCIES.—Indian tribes and tribal organizations receiving funding under this section are encouraged to coordinate their activities with the Centers for Disease Control and Prevention and State and local health agencies.

"(d) TECHNICAL ASSISTANCE; REPORT.—In carrying out this section, the Secretary—

''(1) may, at the request of an Indian tribe or tribal organization, provide technical assistance; and

''(2) shall prepare and submit a report to Congress biennially on the use of funds under this section and on the progress made toward the prevention, control, and elimination of communicable and infectious diseases among Indians and urban Indians.''.

SEC. 134. METHODS TO INCREASE CLINICIAN RECRUITMENT AND RETENTION ISSUES.

(a) LICENSING.—Section 221 of the Indian Health Care Improvement Act (25 U.S.C. 1621t) is amended to read as follows:

''SEC. 221. LICENSING.

''Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).''.

(b) CONTINUING EDUCATION ALLOWANCES.—Section 106 of the Indian Health Care Improvement Act (25 U.S.C. 1615) is amended to read as follows:

"SEC. 106. CONTINUING EDUCATION ALLOWANCES.

"In order to encourage scholarship and stipend recipients under sections 104, 105, and 115 and health professionals, including community health representatives and emergency medical technicians, to join or continue in an Indian health program and to provide services in the rural and remote areas in which a significant portion of Indians reside, the Secretary, acting through the Service, may—

"(1) provide programs or allowances to transition into an Indian health program, including licensing, board or certification examination assistance, and technical assistance in fulfilling service obligations under sections 104, 105, and 115; and

"(2) provide programs or allowances to health professionals employed in an Indian health program to enable those professionals, for a period of time each year prescribed by regulation of the Secretary, to take leave of the duty stations of the professionals for professional consultation, management, leadership, and refresher training courses.".

SEC. 135. LIABILITY FOR PAYMENT.

Section 222 of the Indian Health Care Improvement Act (25 U.S.C. 1621u) is amended to read as follows:

"SEC. 222. LIABILITY FOR PAYMENT.

"(a) NO PATIENT LIABILITY.—A patient who receives contract health care services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.

"(b) NOTIFICATION.—The Secretary shall notify a contract care provider and any patient who receives contract health care services authorized by the Service that such patient is not liable for the payment of any charges or costs associated with the provision of such services not later than 5 business days after receipt of a notification of a claim by a provider of contract care services.

"(c) NO RECOURSE.—Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 220(b), the provider shall have no further recourse against the patient who received the services.".

SEC. 136. OFFICES OF INDIAN MEN'S HEALTH AND INDIAN WOMEN'S HEALTH.

Section 223 of the Indian Health Care Improvement Act (25 U.S.C. 1621v) is amended—

(1) by striking the section designation and heading and all that follows through "oversee efforts of the Service to" and inserting the following:

"SEC. 223. OFFICES OF INDIAN MEN'S HEALTH AND INDIAN WOMEN'S HEALTH.

"(a) OFFICE OF INDIAN MEN'S HEALTH.—

"(1) ESTABLISHMENT.—The Secretary may establish within the Service an office, to be known as the 'Office of Indian Men's Health'.

"(2) DIRECTOR.—

"(A) IN GENERAL.—The Office of Indian Men's Health shall be headed by a director, to be appointed by the Secretary.

"(B) DUTIES.—The director shall coordinate and promote the health status of Indian men in the United States.

"(3) REPORT.—Not later than 2 years after the date of enactment of theIndian Healthcare Improvement Act of 2017, the Secretary, acting through the Service, shall submit to Congress a report describing—

"(A) any activity carried out by the director as of the date on which the report is prepared; and

"(B) any finding of the director with respect to the health of Indian men.

"(b) OFFICE OF INDIAN WOMEN'S HEALTH.—The Secretary, acting through the Service, shall establish an

office, to be known as the 'Office of Indian Women's Health', to''; and

(2) in subsection (b) (as so redesignated) by inserting ''(including urban Indian women)'' before ''of all ages''.

SEC. 137. CONTRACT HEALTH SERVICE ADMINISTRATION AND DISBURSEMENT FORMULA.

Title II of the Indian Health Care Improvement Act (25 U.S.C. 1621 et seq.) is amended by adding at the end the following:

''SEC. 226. CONTRACT HEALTH SERVICE ADMINISTRATION AND DISBURSEMENT FORMULA.

''(a) SUBMISSION OF REPORT.—As soon as practicable after the date of enactment of the Indian Healthcare Improvement Act of 2017, the Comptroller General of the United States shall submit to the Secretary, the Committee on Indian Affairs of the Senate, and the Committee on Natural Resources of the House of Representatives, and make available to each Indian tribe, a report describing the results of the study of the Comptroller General regarding the funding of the contract health service program (including historic funding levels and a recommendation of the funding level needed for the program) and the administration of the contract health service program (including the distribution of funds pur-

suant to the program), as requested by Congress in March 2009, or pursuant to section 830.

"(b) CONSULTATION WITH TRIBES.—On receipt of the report under subsection (a), the Secretary shall consult with Indian tribes regarding the contract health service program, including the distribution of funds pursuant to the program—

"(1) to determine whether the current distribution formula would require modification if the contract health service program were funded at the level recommended by the Comptroller General;

"(2) to identify any inequities in the current distribution formula under the current funding level or inequitable results for any Indian tribe under the funding level recommended by the Comptroller General;

"(3) to identify any areas of program administration that may result in the inefficient or ineffective management of the program; and

"(4) to identify any other issues and recommendations to improve the administration of the contract health services program and correct any unfair results or funding disparities identified under paragraph (2).

''(c) SUBSEQUENT ACTION BY SECRETARY.—If, after consultation with Indian tribes under subsection (b), the Secretary determines that any issue described in subsection (b)(2) exists, the Secretary may initiate procedures under subchapter III of chapter 5 of title 5, United States Code, to negotiate or promulgate regulations to establish a disbursement formula for the contract health service program funding.''.

Subtitle C—Health Facilities

SEC. 141. HEALTH CARE FACILITY PRIORITY SYSTEM.

Section 301 of the Indian Health Care Improvement Act (25 U.S.C. 1631) is amended—

(1) by redesignating subsection (d) as subsection (h); and

(2) by striking subsection (c) and inserting the following:

''(c) HEALTH CARE FACILITY PRIORITY SYSTEM.—

''(1) IN GENERAL.—

''(A) PRIORITY SYSTEM.—The Secretary, acting through the Service, shall maintain a health care facility priority system, which—

''(i) shall be developed in consultation with Indian tribes and tribal organizations;

''(ii) shall give Indian tribes' needs the highest priority;

"(iii)(I) may include the lists required in paragraph (2)(B)(ii); and

"(II) shall include the methodology required in paragraph (2)(B)(v); and

"(III) may include such health care facilities, and such renovation or expansion needs of any health care facility, as the Service may identify; and

"(iv) shall provide an opportunity for the nomination of planning, design, and construction projects by the Service, Indian tribes, and tribal organizations for consideration under the priority system at least once every 3 years, or more frequently as the Secretary determines to be appropriate.

"(B) NEEDS OF FACILITIES UNDER ISDEAA AGREEMENTS.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Service facilities operated under contracts or compacts in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully and equitably

integrated into the health care facility priority system.

"(C) CRITERIA FOR EVALUATING NEEDS.—For purposes of this subsection, the Secretary, in evaluating the needs of facilities operated under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), shall use the criteria used by the Secretary in evaluating the needs of facilities operated directly by the Service.

"(D) PRIORITY OF CERTAIN PROJECTS PROTECTED.—The priority of any project established under the construction priority system in effect on the date of enactment of the Indian Healthcare Improvement Act of 2017 shall not be affected by any change in the construction priority system taking place after that date if the project—

"(i) was identified in the fiscal year 2008 Service budget justification as—

"(I) 1 of the 10 top-priority inpatient projects;

"(II) 1 of the 10 top-priority outpatient projects;

"(III) 1 of the 10 top-priority staff quarters developments; or

"(IV) 1 of the 10 top-priority Youth Regional Treatment Centers;

"(ii) had completed both Phase I and Phase II of the construction priority system in effect on the date of enactment of such Act; or

"(iii) is not included in clause (i) or (ii) and is selected, as determined by the Secretary—

"(I) on the initiative of the Secretary; or

"(II) pursuant to a request of an Indian tribe or tribal organization.

"(2) REPORT; CONTENTS.—

"(A) INITIAL COMPREHENSIVE REPORT.—

"(i) DEFINITIONS.—In this subparagraph:

"(I) FACILITIES APPROPRIATION ADVISORY BOARD.—The term 'Facilities Appropriation Advisory Board' means the advisory board, comprised of 12 members representing Indian tribes and 2 members representing

the Service, established at the discretion of the Director—

"(aa) to provide advice and recommendations for policies and procedures of the programs funded pursuant to facilities appropriations; and

"(bb) to address other facilities issues.

"(II) FACILITIES NEEDS ASSESSMENT WORKGROUP.—The term 'Facilities Needs Assessment Workgroup' means the workgroup established at the discretion of the Director—

"(aa) to review the health care facilities construction priority system; and

"(bb) to make recommendations to the Facilities Appropriation Advisory Board for revising the priority system.

"(ii) INITIAL REPORT.—

"(I) IN GENERAL.—Not later than 1 year after the date of enactment of the Indian Healthcare Im-

provement Act of 2017, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes the comprehensive, national, ranked list of all health care facilities needs for the Service, Indian tribes, and tribal organizations (including inpatient health care facilities, outpatient health care facilities, specialized health care facilities (such as for long-term care and alcohol and drug abuse treatment), wellness centers, and staff quarters, and the renovation and expansion needs, if any, of such facilities) developed by the Service, Indian tribes, and tribal organizations for the Facilities Needs Assessment Workgroup and the Facilities Appropriation Advisory Board.

''(II) INCLUSIONS.—The initial report shall include—

''(aa) the methodology and criteria used by the Service in de-

termining the needs and establishing the ranking of the facilities needs; and

"(bb) such other information as the Secretary determines to be appropriate.

"(iii) UPDATES OF REPORT.—Beginning in calendar year 2017, the Secretary shall—

"(I) update the report under clause (ii) not less frequently that once every 5 years; and

"(II) include the updated report in the appropriate annual report under subparagraph (B) for submission to Congress under section 801.

"(B) ANNUAL REPORTS.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report which sets forth the following:

"(i) A description of the health care facility priority system of the Service established under paragraph (1).

"(ii) Health care facilities lists, which may include—

"(I) the 10 top-priority inpatient health care facilities;

"(II) the 10 top-priority outpatient health care facilities;

"(III) the 10 top-priority specialized health care facilities (such as long-term care and alcohol and drug abuse treatment); and

"(IV) the 10 top-priority staff quarters developments associated with health care facilities.

"(iii) The justification for such order of priority.

"(iv) The projected cost of such projects.

"(v) The methodology adopted by the Service in establishing priorities under its health care facility priority system.

"(3) REQUIREMENTS FOR PREPARATION OF REPORTS.—In preparing the report required under paragraph (2), the Secretary shall—

"(A) consult with and obtain information on all health care facilities needs from Indian tribes and tribal organizations; and

"(B) review the total unmet needs of all Indian tribes and tribal organizations for health care facilities (including staff quarters), including needs for renovation and expansion of existing facilities.

"(d) REVIEW OF METHODOLOGY USED FOR HEALTH FACILITIES CONSTRUCTION PRIORITY SYSTEM.—

"(1) IN GENERAL.—Not later than 1 year after the establishment of the priority system under subsection (c)(1)(A), the Comptroller General of the United States shall prepare and finalize a report reviewing the methodologies applied, and the processes followed, by the Service in making each assessment of needs for the list under subsection (c)(2)(A)(ii) and developing the priority system under subsection (c)(1), including a review of—

"(A) the recommendations of the Facilities Appropriation Advisory Board and the Facilities Needs Assessment Workgroup (as those terms are defined in subsection (c)(2)(A)(i)); and

"(B) the relevant criteria used in ranking or prioritizing facilities other than hospitals or clinics.

"(2) SUBMISSION TO CONGRESS.—The Comptroller General of the United States shall submit the report under paragraph (1) to—

"(A) the Committees on Indian Affairs and Appropriations of the Senate;

"(B) the Committees on Natural Resources and Appropriations of the House of Representatives; and

"(C) the Secretary.

"(e) FUNDING CONDITION.—All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), for the planning, design, construction, or renovation of health facilities for the benefit of 1 or more Indian Tribes shall be subject to the provisions of section 102 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450f) or sections 504 and 505 of that Act (25 U.S.C. 458aaa–3, 458aaa–4).

"(f) DEVELOPMENT OF INNOVATIVE APPROACHES.—The Secretary shall consult and cooperate with Indian tribes and tribal organizations, and confer with urban Indian organizations, in developing innovative approaches to

address all or part of the total unmet need for construction of health facilities, that may include—

"(1) the establishment of an area distribution fund in which a portion of health facility construction funding could be devoted to all Service areas;

"(2) approaches provided for in other provisions of this title; and

"(3) other approaches, as the Secretary determines to be appropriate.".

SEC. 142. PRIORITY OF CERTAIN PROJECTS PROTECTED.

Section 301 of the Indian Health Care Improvement Act (25 U.S.C. 1631) (as amended by section 141) is amended by adding at the end the following:

"(g) PRIORITY OF CERTAIN PROJECTS PROTECTED.—The priority of any project established under the construction priority system in effect on the date of enactment of this Indian Healthcare Improvement Act of 2017 shall not be affected by any change in the construction priority system taking place after that date if the project—

"(1) was identified in the fiscal year 2008 Service budget justification as—

"(A) 1 of the 10 top-priority inpatient projects;

"(B) 1 of the 10 top-priority outpatient projects;

"(C) 1 of the 10 top-priority staff quarters developments; or

"(D) 1 of the 10 top-priority Youth Regional Treatment Centers;

"(2) had completed both Phase I and Phase II of the construction priority system in effect on the date of enactment of such Act; or

"(3) is not included in clause (i) or (ii) and is selected, as determined by the Secretary—

"(A) on the initiative of the Secretary; or

"(B) pursuant to a request of an Indian tribe or tribal organization.".

SEC. 143. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.

Section 307 of the Indian Health Care Improvement Act (25 U.S.C. 1637) is amended to read as follows:

"SEC. 307. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.

"(a) PURPOSE AND GENERAL AUTHORITY.—

"(1) PURPOSE.—The purpose of this section is to encourage the establishment of demonstration projects that meet the applicable criteria of this section to be carried out by the Secretary, acting

through the Service, or Indian tribes or tribal organizations acting pursuant to contracts or compacts under the Indian Self Determination and Education Assistance Act (25 U.S.C. 450 et seq.)—

"(A) to test alternative means of delivering health care and services to Indians through facilities; or

"(B) to use alternative or innovative methods or models of delivering health care services to Indians (including primary care services, contract health services, or any other program or service authorized by this Act) through convenient care services (as defined in subsection (c)), community health centers, or cooperative agreements or arrangements with other health care providers that share or coordinate the use of facilities, funding, or other resources, or otherwise coordinate or improve the coordination of activities of the Service, Indian tribes, or tribal organizations, with those of the other health care providers.

"(2) AUTHORITY.—The Secretary, acting through the Service, is authorized to carry out, or to enter into contracts or compacts under the Indian Self-Determination and Education Assistance Act

(25 U.S.C. 450 et seq.) with Indian tribes or tribal organizations to carry out, health care delivery demonstration projects that—

"(A) test alternative means of delivering health care and services to Indians through facilities; or

"(B) otherwise carry out the purposes of this section.

"(b) USE OF FUNDS.—The Secretary, in approving projects pursuant to this section—

"(1) may authorize such contracts for the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services; and

"(2) is authorized—

"(A) to waive any leasing prohibition;

"(B) to permit use and carryover of funds appropriated for the provision of health care services under this Act (including for the purchase of health benefits coverage, as authorized by section 402(a));

"(C) to permit the use of other available funds, including other Federal funds, funds from third-party collections in accordance with sections 206, 207, and 401, and non-Federal

funds contributed by State or local governmental agencies or facilities or private health care providers pursuant to cooperative or other agreements with the Service, 1 or more Indian tribes, or tribal organizations;

"(D) to permit the use of funds or property donated or otherwise provided from any source for project purposes;

"(E) to provide for the reversion of donated real or personal property to the donor; and

"(F) to permit the use of Service funds to match other funds, including Federal funds.

"(c) HEALTH CARE DEMONSTRATION PROJECTS.—

"(1) DEFINITION OF CONVENIENT CARE SERVICE.—In this subsection, the term 'convenient care service' means any primary health care service, such as urgent care services, nonemergent care services, prevention services and screenings, and any service authorized by section 203 or 205(d), that is offered—

"(A) at an alternative setting; or

"(B) during hours other than regular working hours.

"(2) GENERAL PROJECTS.—

"(A) CRITERIA.—The Secretary may approve under this section demonstration projects that meet the following criteria:

"(i) There is a need for a new facility or program, such as a program for convenient care services, or an improvement in, increased efficiency at, or reorientation of an existing facility or program.

"(ii) A significant number of Indians, including Indians with low health status, will be served by the project.

"(iii) The project has the potential to deliver services in an efficient and effective manner.

"(iv) The project is economically viable.

"(v) For projects carried out by an Indian tribe or tribal organization, the Indian tribe or tribal organization has the administrative and financial capability to administer the project.

"(vi) The project is integrated with providers of related health or social services (including State and local health care agencies or other health care providers)

and is coordinated with, and avoids duplication of, existing services in order to expand the availability of services.

"(B) PRIORITY.—In approving demonstration projects under this paragraph, the Secretary shall give priority to demonstration projects, to the extent the projects meet the criteria described in subparagraph (A), located in any of the following Service units:

"(i) Cass Lake, Minnesota.

"(ii) Mescalero, New Mexico.

"(iii) Owyhee and Elko, Nevada.

"(iv) Schurz, Nevada.

"(v) Ft. Yuma, California.

"(3) INNOVATIVE HEALTH SERVICES DELIVERY DEMONSTRATION PROJECT.—

"(A) APPLICATION OR REQUEST.—On receipt of an application or request from an Indian tribe, a consortium of Indian tribes, or a tribal organization within a Service area, the Secretary shall take into consideration alternative or innovated methods to deliver health care services within the Service area (or a portion of, or facility within, the Service area) as described in the application or request, includ-

ing medical, dental, pharmaceutical, nursing, clinical laboratory, contract health services, convenient care services, community health centers, or any other health care services delivery models designed to improve access to, or efficiency or quality of, the health care, health promotion, or disease prevention services and programs under this Act.

"(B) APPROVAL.—In addition to projects described in paragraph (2), in any fiscal year, the Secretary is authorized under this paragraph to approve not more than 10 applications for health care delivery demonstration projects that meet the criteria described in subparagraph (C).

"(C) CRITERIA.—The Secretary shall approve under subparagraph (B) demonstration projects that meet all of the following criteria:

"(i) The criteria set forth in paragraph (2)(A).

"(ii) There is a lack of access to health care services at existing health care facilities, which may be due to limited hours of operation at those facilities or other factors.

"(iii) The project—

"(I) expands the availability of services; or

"(II) reduces—

"(aa) the burden on Contract Health Services; or

"(bb) the need for emergency room visits.

"(d) TECHNICAL ASSISTANCE.—On receipt of an application or request from an Indian tribe, a consortium of Indian tribes, or a tribal organization, the Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with this section, including information regarding the Service unit budget and available funding for carrying out the proposed demonstration project.

"(e) SERVICE TO INELIGIBLE PERSONS.—Subject to section 813, the authority to provide services to persons otherwise ineligible for the health care benefits of the Service, and the authority to extend hospital privileges in Service facilities to non-Service health practitioners as provided in section 813, may be included, subject to the terms of that section, in any demonstration project approved pursuant to this section.

''(f) EQUITABLE TREATMENT.—For purposes of subsection (c), the Secretary, in evaluating facilities operated under any contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), shall use the same criteria that the Secretary uses in evaluating facilities operated directly by the Service.

''(g) EQUITABLE INTEGRATION OF FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Service facilities that are the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) for health services are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.''.

SEC. 144. TRIBAL MANAGEMENT OF FEDERALLY OWNED QUARTERS.

Title III of the Indian Health Care Improvement Act (as amended by section 101(b)) is amended by inserting after section 308 (25 U.S.C. 1638) the following:

''SEC. 309. TRIBAL MANAGEMENT OF FEDERALLY OWNED QUARTERS.

''(a) RENTAL RATES.—

''(1) ESTABLISHMENT.—Notwithstanding any other provision of law, a tribal health program that

operates a hospital or other health facility and the federally owned quarters associated with such a facility pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) may establish the rental rates charged to the occupants of those quarters, on providing notice to the Secretary.

''(2) OBJECTIVES.—In establishing rental rates under this subsection, a tribal health program shall attempt—

''(A) to base the rental rates on the reasonable value of the quarters to the occupants of the quarters; and

''(B) to generate sufficient funds to prudently provide for the operation and maintenance of the quarters, and at the discretion of the tribal health program, to supply reserve funds for capital repairs and replacement of the quarters.

''(3) EQUITABLE FUNDING.—A federally owned quarters the rental rates for which are established by a tribal health program under this subsection shall remain eligible to receive improvement and repair funds to the same extent that all federally

owned quarters used to house personnel in programs of the Service are eligible to receive those funds.

"(4) NOTICE OF RATE CHANGE.—A tribal health program that establishes a rental rate under this subsection shall provide occupants of the federally owned quarters a notice of any change in the rental rate by not later than the date that is 60 days notice before the effective date of the change.

"(5) RATES IN ALASKA.—A rental rate established by a tribal health program under this section for a federally owned quarters in the State of Alaska may be based on the cost of comparable private rental housing in the nearest established community with a year-round population of 1,500 or more individuals.

"(b) DIRECT COLLECTION OF RENT.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, and subject to paragraph (2), a tribal health program may collect rent directly from Federal employees who occupy federally owned quarters if the tribal health program submits to the Secretary and the employees a notice of the election of the tribal health program to collect rents directly from the employees.

"(2) ACTION BY EMPLOYEES.—On receipt of a notice described in paragraph (1)—

"(A) the affected Federal employees shall pay rent for occupancy of a federally owned quarters directly to the applicable tribal health program; and

"(B) the Secretary shall not have the authority to collect rent from the employees through payroll deduction or otherwise.

"(3) USE OF PAYMENTS.—The rent payments under this subsection—

"(A) shall be retained by the applicable tribal health program in a separate account, which shall be used by the tribal health program for the maintenance (including capital repairs and replacement) and operation of the quarters, as the tribal health program determines to be appropriate; and

"(B) shall not be made payable to, or otherwise be deposited with, the United States.

"(4) RETROCESSION OF AUTHORITY.—If a tribal health program that elected to collect rent directly under paragraph (1) requests retrocession of the authority of the tribal health program to collect that

rent, the retrocession shall take effect on the earlier of—

''(A) the first day of the month that begins not less than 180 days after the tribal health program submits the request; and

''(B) such other date as may be mutually agreed on by the Secretary and the tribal health program.''.

SEC. 145. OTHER FUNDING, EQUIPMENT, AND SUPPLIES FOR FACILITIES.

Title III of the Indian Health Care Improvement Act (25 U.S.C. 1631 et seq.) is amended by adding at the end the following:

''SEC. 311. OTHER FUNDING, EQUIPMENT, AND SUPPLIES FOR FACILITIES.

''(a) AUTHORIZATION.—

''(1) AUTHORITY TO TRANSFER FUNDS.—The head of any Federal agency to which funds, equipment, or other supplies are made available for the planning, design, construction, or operation of a health care or sanitation facility may transfer the funds, equipment, or supplies to the Secretary for the planning, design, construction, or operation of a health care or sanitation facility to achieve—

''(A) the purposes of this Act; and

"(B) the purposes for which the funds, equipment, or supplies were made available to the Federal agency.

"(2) AUTHORITY TO ACCEPT FUNDS.—The Secretary may—

"(A) accept from any source, including Federal and State agencies, funds, equipment, or supplies that are available for the construction or operation of health care or sanitation facilities; and

"(B) use those funds, equipment, and supplies to plan, design, , construct, and operate health care or sanitation facilities for Indians, including pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

"(3) EFFECT OF RECEIPT.—Receipt of funds by the Secretary under this subsection shall not affect any priority established under section 301.

"(b) INTERAGENCY AGREEMENTS.—The Secretary may enter into interagency agreements with Federal or State agencies and other entities, and accept funds, equipment, or other supplies from those entities, to provide for the planning, design, construction, and operation of health

care or sanitation facilities to be administered by Indian health programs to achieve—

"(1) the purposes of this Act; and

"(2) the purposes for which the funds were appropriated or otherwise provided."

"(c) ESTABLISHMENT OF STANDARDS.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall establish, by regulation, standards for the planning, design, construction, and operation of health care or sanitation facilities serving Indians under this Act.

"(2) OTHER REGULATIONS.—Notwithstanding any other provision of law, any other applicable regulations of the Department shall apply in carrying out projects using funds transferred under this section.

"(d) DEFINITION OF SANITATION FACILITY.—In this section, the term 'sanitation facility' means a safe and adequate water supply system, sanitary sewage disposal system, or sanitary solid waste system (including all related equipment and support infrastructure).".

SEC. 146. INDIAN COUNTRY MODULAR COMPONENT FACILITIES DEMONSTRATION PROGRAM.

Title III of the Indian Health Care Improvement Act (25 U.S.C. 1631 et seq.) (as amended by section 145) is amended by adding at the end the following:

"SEC. 312. INDIAN COUNTRY MODULAR COMPONENT FACILITIES DEMONSTRATION PROGRAM.

"(a) DEFINITION OF MODULAR COMPONENT HEALTH CARE FACILITY.—In this section, the term 'modular component health care facility' means a health care facility that is constructed—

"(1) off-site using prefabricated component units for subsequent transport to the destination location; and

"(2) represents a more economical method for provision of health care facility than a traditionally constructed health care building.

"(b) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a demonstration program under which the Secretary shall award no less than 3 grants for purchase, installation and maintenance of modular component health care facilities in Indian communities for provision of health care services.

"(c) SELECTION OF LOCATIONS.—

"(1) PETITIONS.—

"(A) SOLICITATION.—The Secretary shall solicit from Indian tribes petitions for location of the modular component health care facilities in the Service areas of the petitioning Indian tribes.

"(B) PETITION.—To be eligible to receive a grant under this section, an Indian tribe or tribal organization must submit to the Secretary a petition to construct a modular component health care facility in the Indian community of the Indian tribe, at such time, in such manner, and containing such information as the Secretary may require.

"(2) SELECTION.—In selecting the location of each modular component health care facility to be provided under the demonstration program, the Secretary shall give priority to projects already on the Indian Health Service facilities construction priority list and petitions which demonstrate that erection of a modular component health facility—

"(A) is more economical than construction of a traditionally constructed health care facility;

"(B) can be constructed and erected on the selected location in less time than traditional construction; and

"(C) can adequately house the health care services needed by the Indian population to be served.

"(3) EFFECT OF SELECTION.—A modular component health care facility project selected for participation in the demonstration program shall not be eligible for entry on the facilities construction priorities list entitled 'IHS Health Care Facilities FY 2011 Planned Construction Budget' and dated May 7, 2009 (or any successor list).

"(d) ELIGIBILITY.—

"(1) IN GENERAL.—An Indian tribe may submit a petition under subsection (c)(1)(B) regardless of whether the Indian tribe is a party to any contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

"(2) ADMINISTRATION.—At the election of an Indian tribe or tribal organization selected for participation in the demonstration program, the funds provided for the project shall be subject to the provi-

sions of the Indian Self-Determination and Education Assistance Act.

''(e) REPORTS.—Not later than 1 year after the date on which funds are made available for the demonstration program and annually thereafter, the Secretary shall submit to Congress a report describing—

''(1) each activity carried out under the demonstration program, including an evaluation of the success of the activity; and

''(2) the potential benefits of increased use of modular component health care facilities in other Indian communities.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $50,000,000 to carry out the demonstration program under this section for the first 5 fiscal years, and such sums as may be necessary to carry out the program in subsequent fiscal years.''.

SEC. 147. MOBILE HEALTH STATIONS DEMONSTRATION PROGRAM.

Title III of the Indian Health Care Improvement Act (25 U.S.C. 1631 et seq.) (as amended by section 146) is amended by adding at the end the following:

''SEC. 313. MOBILE HEALTH STATIONS DEMONSTRATION PROGRAM.

''(a) DEFINITIONS.—In this section:

"(1) ELIGIBLE TRIBAL CONSORTIUM.—The term 'eligible tribal consortium' means a consortium composed of 2 or more Service units between which a mobile health station can be transported by road in up to 8 hours. A Service unit operated by the Service or by an Indian tribe or tribal organization shall be equally eligible for participation in such consortium.

"(2) MOBILE HEALTH STATION.—The term 'mobile health station' means a health care unit that—

"(A) is constructed, maintained, and capable of being transported within a semi-trailer truck or similar vehicle;

"(B) is equipped for the provision of 1 or more specialty health care services; and

"(C) can be equipped to be docked to a stationary health care facility when appropriate.

"(3) SPECIALTY HEALTH CARE SERVICE.—

"(A) IN GENERAL.—The term 'specialty health care service' means a health care service which requires the services of a health care professional with specialized knowledge or experience.

"(B) INCLUSIONS.—The term 'specialty health care service' includes any service relating to—

"(i) dialysis;

"(ii) surgery;

"(iii) mammography;

"(iv) dentistry; or

"(v) any other specialty health care service.

"(b) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a demonstration program under which the Secretary shall provide at least 3 mobile health station projects.

"(c) PETITION.—To be eligible to receive a mobile health station under the demonstration program, an eligible tribal consortium shall submit to the Secretary, a petition at such time, in such manner, and containing—

"(1) a description of the Indian population to be served;

"(2) a description of the specialty service or services for which the mobile health station is requested and the extent to which such service or services are currently available to the Indian population to be served; and

"(3) such other information as the Secretary may require.

"(d) USE OF FUNDS.—The Secretary shall use amounts made available to carry out the demonstration program under this section—

"(1)(A) to establish, purchase, lease, or maintain mobile health stations for the eligible tribal consortia selected for projects; and

"(B) to provide, through the mobile health station, such specialty health care services as the affected eligible tribal consortium determines to be necessary for the Indian population served;

"(2) to employ an existing mobile health station (regardless of whether the mobile health station is owned or rented and operated by the Service) to provide specialty health care services to an eligible tribal consortium; and

"(3) to establish, purchase, or maintain docking equipment for a mobile health station, including the establishment or maintenance of such equipment at a modular component health care facility (as defined in section 312(a)), if applicable.

"(e) REPORTS.—Not later than 1 year after the date on which the demonstration program is established under subsection (b) and annually thereafter, the Secretary, act-

ing through the Service, shall submit to Congress a report describing—

"(1) each activity carried out under the demonstration program including an evaluation of the success of the activity; and

"(2) the potential benefits of increased use of mobile health stations to provide specialty health care services for Indian communities.

"(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $5,000,000 per year to carry out the demonstration program under this section for the first 5 fiscal years, and such sums as may be needed to carry out the program in subsequent fiscal years.".

Subtitle D—Access to Health Services

SEC. 151. TREATMENT OF PAYMENTS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.

Section 401 of the Indian Health Care Improvement Act (25 U.S.C. 1641) is amended to read as follows:

"SEC. 401. TREATMENT OF PAYMENTS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.

"(a) DISREGARD OF MEDICARE, MEDICAID, AND CHIP PAYMENTS IN DETERMINING APPROPRIATIONS.—Any payments received by an Indian health program or by an urban Indian organization under title XVIII, XIX,

or XXI of the Social Security Act for services provided to Indians eligible for benefits under such respective titles shall not be considered in determining appropriations for the provision of health care and services to Indians.

"(b) NONPREFERENTIAL TREATMENT.—Nothing in this Act authorizes the Secretary to provide services to an Indian with coverage under title XVIII, XIX, or XI of the Social Security Act in preference to an Indian without such coverage.

"(c) USE OF FUNDS.—

"(1) SPECIAL FUND.—

"(A) 100 PERCENT PASS-THROUGH OF PAYMENTS DUE TO FACILITIES.—Notwithstanding any other provision of law, but subject to paragraph (2), payments to which a facility of the Service is entitled by reason of a provision of title XVIII or XIX of the Social Security Act shall be placed in a special fund to be held by the Secretary. In making payments from such fund, the Secretary shall ensure that each Service unit of the Service receives 100 percent of the amount to which the facilities of the Service, for which such Service unit makes collections, are entitled by reason of a provision of either such title.

"(B) USE OF FUNDS.—Amounts received by a facility of the Service under subparagraph (A) by reason of a provision of title XVIII or XIX of the Social Security Act shall first be used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the programs of the Service operated by or through such facility which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of such respective title. Any amounts so received that are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to consultation with the Indian tribes being served by the Service unit, be used for reducing the health resource deficiencies (as determined in section 201(c)) of such Indian tribes, including the provision of services pursuant to section 205.

"(2) DIRECT PAYMENT OPTION.—Paragraph (1) shall not apply to a tribal health program upon the election of such program under subsection (d) to receive payments directly. No payment may be made out of the special fund described in such paragraph

with respect to reimbursement made for services provided by such program during the period of such election.

"(d) DIRECT BILLING.—

"(1) IN GENERAL.—Subject to complying with the requirements of paragraph (2), a tribal health program may elect to directly bill for, and receive payment for, health care items and services provided by such program for which payment is made under title XVIII, XIX, or XXI of the Social Security Act or from any other third party payor.

"(2) DIRECT REIMBURSEMENT.—

"(A) USE OF FUNDS.—Each tribal health program making the election described in paragraph (1) with respect to a program under a title of the Social Security Act shall be reimbursed directly by that program for items and services furnished without regard to subsection (c)(1), except that all amounts so reimbursed shall be used by the tribal health program for the purpose of making any improvements in facilities of the tribal health program that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to such items and services under the

program under such title and to provide additional health care services, improvements in health care facilities and tribal health programs, any health care-related purpose (including coverage for a service or service within a contract health service delivery area or any portion of a contract health service delivery area that would otherwise be provided as a contract health service), or otherwise to achieve the objectives provided in section 3 of this Act.

''(B) AUDITS.—The amounts paid to a tribal health program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act shall be subject to all auditing requirements applicable to the program under such title, as well as all auditing requirements applicable to programs administered by an Indian health program. Nothing in the preceding sentence shall be construed as limiting the application of auditing requirements applicable to amounts paid under title XVIII, XIX, or XXI of the Social Security Act.

''(C) IDENTIFICATION OF SOURCE OF PAYMENTS.—Any tribal health program that re-

ceives reimbursements or payments under title XVIII, XIX, or XXI of the Social Security Act shall provide to the Service a list of each provider enrollment number (or other identifier) under which such program receives such reimbursements or payments.

"(3) EXAMINATION AND IMPLEMENTATION OF CHANGES.—

"(A) IN GENERAL.—The Secretary, acting through the Service and with the assistance of the Administrator of the Centers for Medicare & Medicaid Services, shall examine on an ongoing basis and implement any administrative changes that may be necessary to facilitate direct billing and reimbursement under the program established under this subsection, including any agreements with States that may be necessary to provide for direct billing under a program under title XIX or XXI of the Social Security Act.

"(B) COORDINATION OF INFORMATION.—The Service shall provide the Administrator of the Centers for Medicare & Medicaid Services with copies of the lists submitted to the Service under paragraph (2)(C), enrollment data re-

garding patients served by the Service (and by tribal health programs, to the extent such data is available to the Service), and such other information as the Administrator may require for purposes of administering title XVIII, XIX, or XXI of the Social Security Act.

''(4) WITHDRAWAL FROM PROGRAM.—A tribal health program that bills directly under the program established under this subsection may withdraw from participation in the same manner and under the same conditions that an Indian tribe or tribal organization may retrocede a contracted program to the Secretary under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). All cost accounting and billing authority under the program established under this subsection shall be returned to the Secretary upon the Secretary's acceptance of the withdrawal of participation in this program.

''(5) TERMINATION FOR FAILURE TO COMPLY WITH REQUIREMENTS.—The Secretary may terminate the participation of a tribal health program or in the direct billing program established under this subsection if the Secretary determines that the program has failed to comply with the requirements of

paragraph (2). The Secretary shall provide a tribal health program with notice of a determination that the program has failed to comply with any such requirement and a reasonable opportunity to correct such noncompliance prior to terminating the program's participation in the direct billing program established under this subsection.

''(e) RELATED PROVISIONS UNDER THE SOCIAL SECURITY ACT.—For provisions related to subsections (c) and (d), see sections 1880, 1911, and 2107(e)(1)(D) of the Social Security Act.''.

SEC. 152. PURCHASING HEALTH CARE COVERAGE.

Section 402 of the Indian Health Care Improvement Act (25 U.S.C. 1642) is amended to read as follows:

''SEC. 402. PURCHASING HEALTH CARE COVERAGE.

''(a) IN GENERAL.—Insofar as amounts are made available under law (including a provision of the Social Security Act, the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), or other law, other than under section 404) to Indian tribes, tribal organizations, and urban Indian organizations for health benefits for Service beneficiaries, Indian tribes, tribal organizations, and urban Indian organizations may use such amounts to purchase health benefits coverage (including coverage for a service, or service within a contract health

service delivery area, or any portion of a contract health service delivery area that would otherwise be provided as a contract health service) for such beneficiaries in any manner, including through—

"(1) a tribally owned and operated health care plan;

"(2) a State or locally authorized or licensed health care plan;

"(3) a health insurance provider or managed care organization;

"(4) a self-insured plan; or

"(5) a high deductible or health savings account plan.

"(b) FINANCIAL NEED.—The purchase of coverage under subsection (a) by an Indian tribe, tribal organization, or urban Indian organization may be based on the financial needs of such beneficiaries (as determined by the 1 or more Indian tribes being served based on a schedule of income levels developed or implemented by such 1 ore more Indian tribes).

"(c) EXPENSES FOR SELF-INSURED PLAN.—In the case of a self-insured plan under subsection (a)(4), the amounts may be used for expenses of operating the plan, including administration and insurance to limit the financial risks to the entity offering the plan.

"(d) CONSTRUCTION.—Nothing in this section shall be construed as affecting the use of any amounts not referred to in subsection (a).".

SEC. 153. GRANTS TO AND CONTRACTS WITH THE SERVICE, INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS TO FACILITATE OUTREACH, ENROLLMENT, AND COVERAGE OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS AND OTHER HEALTH BENEFITS PROGRAMS.

Section 404 of the Indian Health Care Improvement Act (25 U.S.C. 1644) is amended to read as follows:

"SEC. 404. GRANTS TO AND CONTRACTS WITH THE SERVICE, INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS TO FACILITATE OUTREACH, ENROLLMENT, AND COVERAGE OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS AND OTHER HEALTH BENEFITS PROGRAMS.

"(a) INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—The Secretary, acting through the Service, shall make grants to or enter into contracts with Indian tribes and tribal organizations to assist such tribes and tribal organizations in establishing and administering programs on or near reservations and trust lands, including pro-

grams to provide outreach and enrollment through video, electronic delivery methods, or telecommunication devices that allow real-time or time-delayed communication between individual Indians and the benefit program, to assist individual Indians—

"(1) to enroll for benefits under a program established under title XVIII, XIX, or XXI of the Social Security Act and other health benefits programs; and

"(2) with respect to such programs for which the charging of premiums and cost sharing is not prohibited under such programs, to pay premiums or cost sharing for coverage for such benefits, which may be based on financial need (as determined by the Indian tribe or tribes or tribal organizations being served based on a schedule of income levels developed or implemented by such tribe, tribes, or tribal organizations).

"(b) CONDITIONS.—The Secretary, acting through the Service, shall place conditions as deemed necessary to effect the purpose of this section in any grant or contract which the Secretary makes with any Indian tribe or tribal organization pursuant to this section. Such conditions shall include requirements that the Indian tribe or tribal organization successfully undertake—

"(1) to determine the population of Indians eligible for the benefits described in subsection (a);

"(2) to educate Indians with respect to the benefits available under the respective programs;

"(3) to provide transportation for such individual Indians to the appropriate offices for enrollment or applications for such benefits; and

"(4) to develop and implement methods of improving the participation of Indians in receiving benefits under such programs.

"(c) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—

"(1) IN GENERAL.—The provisions of subsection (a) shall apply with respect to grants and other funding to urban Indian organizations with respect to populations served by such organizations in the same manner they apply to grants and contracts with Indian tribes and tribal organizations with respect to programs on or near reservations.

"(2) REQUIREMENTS.—The Secretary shall include in the grants or contracts made or provided under paragraph (1) requirements that are—

"(A) consistent with the requirements imposed by the Secretary under subsection (b);

"(B) appropriate to urban Indian organizations and urban Indians; and

"(C) necessary to effect the purposes of this section.

"(d) FACILITATING COOPERATION.—The Secretary, acting through the Centers for Medicare & Medicaid Services, shall develop and disseminate best practices that will serve to facilitate cooperation with, and agreements between, States and the Service, Indian tribes, tribal organizations, or urban Indian organizations with respect to the provision of health care items and services to Indians under the programs established under title XVIII, XIX, or XXI of the Social Security Act.

"(e) AGREEMENTS RELATING TO IMPROVING ENROLLMENT OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.—For provisions relating to agreements of the Secretary, acting through the Service, for the collection, preparation, and submission of applications by Indians for assistance under the Medicaid and children's health insurance programs established under titles XIX and XXI of the Social Security Act, and benefits under the Medicare program established under title XVIII of such Act, see subsections (a) and (b) of section 1139 of the Social Security Act.

''(f) DEFINITION OF PREMIUMS AND COST SHARING.—In this section:

''(1) PREMIUM.—The term 'premium' includes any enrollment fee or similar charge.

''(2) COST SHARING.—The term 'cost sharing' includes any deduction, deductible, copayment, coinsurance, or similar charge.''.

SEC. 154. SHARING ARRANGEMENTS WITH FEDERAL AGENCIES.

Section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645) is amended to read as follows:

''SEC. 405. SHARING ARRANGEMENTS WITH FEDERAL AGENCIES.

''(a) AUTHORITY.—

''(1) IN GENERAL.—The Secretary may enter into (or expand) arrangements for the sharing of medical facilities and services between the Service, Indian tribes, and tribal organizations and the Department of Veterans Affairs and the Department of Defense.

''(2) CONSULTATION BY SECRETARY REQUIRED.—The Secretary may not finalize any arrangement between the Service and a Department described in paragraph (1) without first consulting

with the Indian tribes which will be significantly affected by the arrangement.

''(b) LIMITATIONS.—The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of title 38, United States Code, which would impair—

''(1) the priority access of any Indian to health care services provided through the Service and the eligibility of any Indian to receive health services through the Service;

''(2) the quality of health care services provided to any Indian through the Service;

''(3) the priority access of any veteran to health care services provided by the Department of Veterans Affairs;

''(4) the quality of health care services provided by the Department of Veterans Affairs or the Department of Defense; or

''(5) the eligibility of any Indian who is a veteran to receive health services through the Department of Veterans Affairs.

''(c) REIMBURSEMENT.—The Service, Indian tribe, or tribal organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through

the Service, an Indian tribe, or a tribal organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

''(d) CONSTRUCTION.—Nothing in this section may be construed as creating any right of a non-Indian veteran to obtain health services from the Service.''.

SEC. 155. ELIGIBLE INDIAN VETERAN SERVICES.

Title IV of the Indian Health Care Improvement Act (25 U.S.C. 1641 et seq.) (as amended by section 101(b)) is amended by adding at the end the following:

''SEC. 407. ELIGIBLE INDIAN VETERAN SERVICES.

''(a) FINDINGS; PURPOSE.—

''(1) FINDINGS.—Congress finds that—

''(A) collaborations between the Secretary and the Secretary of Veterans Affairs regarding the treatment of Indian veterans at facilities of the Service should be encouraged to the maximum extent practicable; and

''(B) increased enrollment for services of the Department of Veterans Affairs by veterans who are members of Indian tribes should be encouraged to the maximum extent practicable.

''(2) PURPOSE.—The purpose of this section is to reaffirm the goals stated in the document entitled 'Memorandum of Understanding Between the VA/

Veterans Health Administration And HHS/Indian Health Service' and dated February 25, 2003 (relating to cooperation and resource sharing between the Veterans Health Administration and Service).

"(b) DEFINITIONS.—In this section:

"(1) ELIGIBLE INDIAN VETERAN.—The term 'eligible Indian veteran' means an Indian or Alaska Native veteran who receives any medical service that is—

"(A) authorized under the laws administered by the Secretary of Veterans Affairs; and

"(B) administered at a facility of the Service (including a facility operated by an Indian tribe or tribal organization through a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) pursuant to a local memorandum of understanding.

"(2) LOCAL MEMORANDUM OF UNDERSTANDING.—The term 'local memorandum of understanding' means a memorandum of understanding between the Secretary (or a designee, including the director of any area office of the Service) and the Secretary of Veterans Affairs (or a designee) to implement the document entitled 'Memorandum of Un-

derstanding Between the VA/Veterans Health Administration And HHS/Indian Health Service' and dated February 25, 2003 (relating to cooperation and resource sharing between the Veterans Health Administration and Indian Health Service).

''(c) ELIGIBLE INDIAN VETERANS EXPENSES.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall provide for veteran-related expenses incurred by eligible Indian veterans as described in subsection (b)(1)(B).

''(2) METHOD OF PAYMENT.—The Secretary shall establish such guidelines as the Secretary determines to be appropriate regarding the method of payments to the Secretary of Veterans Affairs under paragraph (1).

''(d) TRIBAL APPROVAL OF MEMORANDA.—In negotiating a local memorandum of understanding with the Secretary of Veterans Affairs regarding the provision of services to eligible Indian veterans, the Secretary shall consult with each Indian tribe that would be affected by the local memorandum of understanding.

''(e) FUNDING.—

''(1) TREATMENT.—Expenses incurred by the Secretary in carrying out subsection (c)(1) shall not

be considered to be Contract Health Service expenses.

''(2) USE OF FUNDS.—Of funds made available to the Secretary in appropriations Acts for the Service (excluding funds made available for facilities, Contract Health Services, or contract support costs), the Secretary shall use such sums as are necessary to carry out this section.''.

SEC. 156. NONDISCRIMINATION UNDER FEDERAL HEALTH CARE PROGRAMS IN QUALIFICATIONS FOR REIMBURSEMENT FOR SERVICES.

Title IV of the Indian Health Care Improvement Act (25 U.S.C. 1641 et seq.) (as amended by section 155) is amended by adding at the end the following:

''SEC. 408. NONDISCRIMINATION UNDER FEDERAL HEALTH CARE PROGRAMS IN QUALIFICATIONS FOR REIMBURSEMENT FOR SERVICES.

''(a) REQUIREMENT TO SATISFY GENERALLY APPLICABLE PARTICIPATION REQUIREMENTS.—

''(1) IN GENERAL.—A Federal health care program must accept an entity that is operated by the Service, an Indian tribe, tribal organization, or urban Indian organization as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as

any other provider qualified to participate as a provider of health care services under the program if the entity meets generally applicable State or other requirements for participation as a provider of health care services under the program.

"(2) SATISFACTION OF STATE OR LOCAL LICENSURE OR RECOGNITION REQUIREMENTS.—Any requirement for participation as a provider of health care services under a Federal health care program that an entity be licensed or recognized under the State or local law where the entity is located to furnish health care services shall be deemed to have been met in the case of an entity operated by the Service, an Indian tribe, tribal organization, or urban Indian organization if the entity meets all the applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such State or local law. In accordance with section 221, the absence of the licensure of a health professional employed by such an entity under the State or local law where the entity is located shall not be taken into account for purposes of determining whether the entity meets such standards, if the professional is licensed in another State.

"(b) APPLICATION OF EXCLUSION FROM PARTICIPATION IN FEDERAL HEALTH CARE PROGRAMS.—

"(1) EXCLUDED ENTITIES.—No entity operated by the Service, an Indian tribe, tribal organization, or urban Indian organization that has been excluded from participation in any Federal health care program or for which a license is under suspension or has been revoked by the State where the entity is located shall be eligible to receive payment or reimbursement under any such program for health care services furnished to an Indian.

"(2) EXCLUDED INDIVIDUALS.—No individual who has been excluded from participation in any Federal health care program or whose State license is under suspension shall be eligible to receive payment or reimbursement under any such program for health care services furnished by that individual, directly or through an entity that is otherwise eligible to receive payment for health care services, to an Indian.

"(3) FEDERAL HEALTH CARE PROGRAM DEFINED.—In this subsection, the term, 'Federal health care program' has the meaning given that term in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f)), except that, for purposes

of this subsection, such term shall include the health insurance program under chapter 89 of title 5, United States Code.

''(c) RELATED PROVISIONS.—For provisions related to nondiscrimination against providers operated by the Service, an Indian tribe, tribal organization, or urban Indian organization, see section 1139(c) of the Social Security Act (42 U.S.C. 1320b–9(c)).''.

SEC. 157. ACCESS TO FEDERAL INSURANCE.

Title IV of the Indian Health Care Improvement Act (25 U.S.C. 1641 et seq.) (as amended by section 156) is amended by adding at the end the following:

''SEC. 409. ACCESS TO FEDERAL INSURANCE.

''Notwithstanding the provisions of title 5, United States Code, Executive order, or administrative regulation, an Indian tribe or tribal organization carrying out programs under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) or an urban Indian organization carrying out programs under title V of this Act shall be entitled to purchase coverage, rights, and benefits for the employees of such Indian tribe or tribal organization, or urban Indian organization, under chapter 89 of title 5, United States Code, and chapter 87 of such title if necessary employee deductions and agency contributions in payment for the coverage, rights, and ben-

efits for the period of employment with such Indian tribe or tribal organization, or urban Indian organization, are currently deposited in the applicable Employee's Fund under such title.''.

SEC. 158. GENERAL EXCEPTIONS.

Title IV of the Indian Health Care Improvement Act (25 U.S.C. 1641 et seq.) (as amended by section 157) is amended by adding at the end the following:

''SEC. 410. GENERAL EXCEPTIONS.

''The requirements of this title shall not apply to any excepted benefits described in paragraph (1)(A) or (3) of section 2791(c) of the Public Health Service Act (42 U.S.C. 300gg–91).''.

SEC. 159. NAVAJO NATION MEDICAID AGENCY FEASIBILITY STUDY.

Title IV of the Indian Health Care Improvement Act (25 U.S.C. 1641 et seq.) (as amended by section 158) is amended by adding at the end the following:

''SEC. 411. NAVAJO NATION MEDICAID AGENCY FEASIBILITY STUDY.

''(a) STUDY.—The Secretary shall conduct a study to determine the feasibility of treating the Navajo Nation as a State for the purposes of title XIX of the Social Security Act, to provide services to Indians living within the boundaries of the Navajo Nation through an entity estab-

lished having the same authority and performing the same functions as single-State medicaid agencies responsible for the administration of the State plan under title XIX of the Social Security Act.

"(b) CONSIDERATIONS.—In conducting the study, the Secretary shall consider the feasibility of—

"(1) assigning and paying all expenditures for the provision of services and related administration funds, under title XIX of the Social Security Act, to Indians living within the boundaries of the Navajo Nation that are currently paid to or would otherwise be paid to the State of Arizona, New Mexico, or Utah;

"(2) providing assistance to the Navajo Nation in the development and implementation of such entity for the administration, eligibility, payment, and delivery of medical assistance under title XIX of the Social Security Act;

"(3) providing an appropriate level of matching funds for Federal medical assistance with respect to amounts such entity expends for medical assistance for services and related administrative costs; and

"(4) authorizing the Secretary, at the option of the Navajo Nation, to treat the Navajo Nation as a State for the purposes of title XIX of the Social Se-

curity Act (relating to the State children's health insurance program) under terms equivalent to those described in paragraphs (2) through (4).

''(c) REPORT.—Not later then 3 years after the date of enactment of the Indian Healthcare Improvement Act of 2017, the Secretary shall submit to the Committee on Indian Affairs and Committee on Finance of the Senate and the Committee on Natural Resources and Committee on Energy and Commerce of the House of Representatives a report that includes—

''(1) the results of the study under this section;

''(2) a summary of any consultation that occurred between the Secretary and the Navajo Nation, other Indian Tribes, the States of Arizona, New Mexico, and Utah, counties which include Navajo Lands, and other interested parties, in conducting this study;

''(3) projected costs or savings associated with establishment of such entity, and any estimated impact on services provided as described in this section in relation to probable costs or savings; and

''(4) legislative actions that would be required to authorize the establishment of such entity if such entity is determined by the Secretary to be feasible.''.

Subtitle E—Health Services for Urban Indians

SEC. 161. FACILITIES RENOVATION.

Section 509 of the Indian Health Care Improvement Act (25 U.S.C. 1659) is amended by inserting ''or construction or expansion of facilities'' after ''renovations to facilities''.

SEC. 162. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

Section 512 of the Indian Health Care Improvement Act (25 U.S.C. 1660b) is amended to read as follows:

''SEC. 512. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

''Notwithstanding any other provision of law, the Tulsa Clinic and Oklahoma City Clinic demonstration projects shall—

''(1) be permanent programs within the Service's direct care program;

''(2) continue to be treated as Service units and operating units in the allocation of resources and coordination of care; and

''(3) continue to meet the requirements and definitions of an urban Indian organization in this Act, and shall not be subject to the provisions of the

Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).''.

SEC. 163. REQUIREMENT TO CONFER WITH URBAN INDIAN ORGANIZATIONS.

(a) CONFERRING WITH URBAN INDIAN ORGANIZATIONS.—Title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) (as amended by section 101(b)) is amended by adding at the end the following:

''SEC. 514. CONFERRING WITH URBAN INDIAN ORGANIZATIONS.

''(a) DEFINITION OF CONFER.—In this section, the term 'confer' means to engage in an open and free exchange of information and opinions that—

''(1) leads to mutual understanding and comprehension; and

''(2) emphasizes trust, respect, and shared responsibility.

''(b) REQUIREMENT.—The Secretary shall ensure that the Service confers, to the maximum extent practicable, with urban Indian organizations in carrying out this Act.''.

(b) CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS.—Section 502 of the Indian Health Care Improvement Act (25 U.S.C. 1652) is amended to read as follows:

"SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS.

"(a) IN GENERAL.—Pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, shall enter into contracts with, or make grants to, urban Indian organizations to assist the urban Indian organizations in the establishment and administration, within urban centers, of programs that meet the requirements of this title.

"(b) CONDITIONS.—Subject to section 506, the Secretary, acting through the Service, shall include such conditions as the Secretary considers necessary to effect the purpose of this title in any contract into which the Secretary enters with, or in any grant the Secretary makes to, any urban Indian organization pursuant to this title.".

SEC. 164. EXPANDED PROGRAM AUTHORITY FOR URBAN INDIAN ORGANIZATIONS.

Title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) (as amended by section 163(a)) is amended by adding at the end the following:

"SEC. 515. EXPANDED PROGRAM AUTHORITY FOR URBAN INDIAN ORGANIZATIONS.

"Notwithstanding any other provision of this Act, the Secretary, acting through the Service, is authorized to establish programs, including programs for awarding grants, for urban Indian organizations that are identical to any

programs established pursuant to sections 218, 702, and 708(g).''.

SEC. 165. COMMUNITY HEALTH REPRESENTATIVES.

Title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) (as amended by section 164) is amended by adding at the end the following:

''SEC. 516. COMMUNITY HEALTH REPRESENTATIVES.

''The Secretary, acting through the Service, may enter into contracts with, and make grants to, urban Indian organizations for the employment of Indians trained as health service providers through the Community Health Representative Program under section 107 in the provision of health care, health promotion, and disease prevention services to urban Indians.''.

SEC. 166. USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY; HEALTH INFORMATION TECHNOLOGY.

Title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) (as amended by section 165) is amended by adding at the end the following:

''SEC. 517. USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY.

''(a) IN GENERAL.—The Secretary may permit an urban Indian organization that has entered into a contract or received a grant pursuant to this title, in carrying out

the contract or grant, to use, in accordance with such terms and conditions for use and maintenance as are agreed on by the Secretary and the urban Indian organizations—

"(1) any existing facility under the jurisdiction of the Secretary;

"(2) all equipment contained in or pertaining to such an existing facility; and

"(3) any other personal property of the Federal Government under the jurisdiction of the Secretary.

"(b) DONATIONS.—Subject to subsection (d), the Secretary may donate to an urban Indian organization that has entered into a contract or received a grant pursuant to this title any personal or real property determined to be excess to the needs of the Service or the General Services Administration for the purposes of carrying out the contract or grant.

"(c) ACQUISITION OF PROPERTY.—The Secretary may acquire excess or surplus personal or real property of the Federal Government for donation, subject to subsection (d), to an urban Indian organization that has entered into a contract or received a grant pursuant to this title if the Secretary determines that the property is appropriate for use by the urban Indian organization for purposes of the contract or grant.

''(d) PRIORITY.—If the Secretary receives from an urban Indian organization or an Indian tribe or tribal organization a request for a specific item of personal or real property described in subsection (b) or (c), the Secretary shall give priority to the request for donation to the Indian tribe or tribal organization, if the Secretary receives the request from the Indian tribe or tribal organization before the earlier of—

''(1) the date on which the Secretary transfers title to the property to the urban Indian organization; and

''(2) the date on which the Secretary transfers the property physically to the urban Indian organization.

''(e) EXECUTIVE AGENCY STATUS.—For purposes of section 501(a) of title 40, United States Code, an urban Indian organization that has entered into a contract or received a grant pursuant to this title may be considered to be an Executive agency in carrying out the contract or grant.

''SEC. 518. HEALTH INFORMATION TECHNOLOGY.

''The Secretary, acting through the Service, may make grants to urban Indian organizations under this title for the development, adoption, and implementation of health information technology (as defined in section 3000

of the Public Health Service Act (42 U.S.C. 300jj)), telemedicine services development, and related infrastructure.''.

Subtitle F—Organizational Improvements

SEC. 171. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

Section 601 of the Indian Health Care Improvement Act (25 U.S.C. 1661) is amended to read as follows:

''SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian tribes, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department the Indian Health Service.

''(2) DIRECTOR.—The Service shall be administered by a Director, who shall be appointed by the President, by and with the advice and consent of the

Senate. The Director shall report to the Secretary. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 2008, the term of service of the Director shall be 4 years. A Director may serve more than 1 term.

''(3) INCUMBENT.—The individual serving in the position of Director of the Service on the day before the date of enactment of the Indian Healthcare Improvement Act of 2017 shall serve as Director.

''(4) ADVOCACY AND CONSULTATION.—The position of Director is established to, in a manner consistent with the government-to-government relationship between the United States and Indian Tribes—

''(A) facilitate advocacy for the development of appropriate Indian health policy; and

''(B) promote consultation on matters relating to Indian health.

''(b) AGENCY.—The Service shall be an agency within the Public Health Service of the Department, and shall not be an office, component, or unit of any other agency of the Department.

''(c) DUTIES.—The Director shall—

''(1) perform all functions that were, on the day before the date of enactment of the Indian

Healthcare Improvement Act of 2017, carried out by or under the direction of the individual serving as Director of the Service on that day;

"(2) perform all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians, including by ensuring that all agency directors, managers, and chief executive officers have appropriate and adequate training, experience, skill levels, knowledge, abilities, and education (including continuing training requirements) to competently fulfill the duties of the positions and the mission of the Service;

"(3) administer all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including programs under—

"(A) this Act;

"(B) the Act of November 2, 1921 (25 U.S.C. 13);

"(C) the Act of August 5, 1954 (42 U.S.C. 2001 et seq.);

"(D) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.); and

"(E) the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.);

"(4) administer all scholarship and loan functions carried out under title I;

"(5) directly advise the Secretary concerning the development of all policy- and budget-related matters affecting Indian health;

"(6) collaborate with the Assistant Secretary for Health concerning appropriate matters of Indian health that affect the agencies of the Public Health Service;

"(7) advise each Assistant Secretary of the Department concerning matters of Indian health with respect to which that Assistant Secretary has authority and responsibility;

"(8) advise the heads of other agencies and programs of the Department concerning matters of Indian health with respect to which those heads have authority and responsibility;

"(9) coordinate the activities of the Department concerning matters of Indian health; and

"(10) perform such other functions as the Secretary may designate.

"(d) AUTHORITY.—

"(1) IN GENERAL.—The Secretary, acting through the Director, shall have the authority—

"(A) except to the extent provided for in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;

"(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

"(C) to manage, expend, and obligate all funds appropriated for the Service.

"(2) PERSONNEL ACTIONS.—Notwithstanding any other provision of law, the provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472), shall apply to all personnel actions taken with respect to new positions created within the Service as a result of its establishment under subsection (a).".

SEC. 172. OFFICE OF DIRECT SERVICE TRIBES.

Title VI of the Indian Health Care Improvement Act (25 U.S.C. 1661 et seq.) (as amended by section 101(b)) is amended by adding at the end the following:

"SEC. 603. OFFICE OF DIRECT SERVICE TRIBES.

"(a) ESTABLISHMENT.—There is established within the Service an office, to be known as the 'Office of Direct Service Tribes'.

"(b) TREATMENT.—The Office of Direct Service Tribes shall be located in the Office of the Director.

"(c) DUTIES.—The Office of Direct Service Tribes shall be responsible for—

"(1) providing Service-wide leadership, guidance and support for direct service tribes to include strategic planning and program evaluation;

"(2) ensuring maximum flexibility to tribal health and related support systems for Indian beneficiaries;

"(3) serving as the focal point for consultation and participation between direct service tribes and organizations and the Service in the development of Service policy;

"(4) holding no less than biannual consultations with direct service tribes in appropriate locations to gather information and aid in the development of health policy; and

"(5) directing a national program and providing leadership and advocacy in the development of health policy, program management, budget formu-

lation, resource allocation, and delegation support for direct service tribes.''.

SEC. 173. NEVADA AREA OFFICE.

Title VI of the Indian Health Care Improvement Act (25 U.S.C. 1661 et seq.) (as amended by section 172) is amended by adding at the end the following:

''SEC. 604. NEVADA AREA OFFICE.

''(a) IN GENERAL.—Not later than 1 year after the date of enactment of this section, in a manner consistent with the tribal consultation policy of the Service, the Secretary shall submit to Congress a plan describing the manner and schedule by which an area office, separate and distinct from the Phoenix Area Office of the Service, can be established in the State of Nevada.

''(b) FAILURE TO SUBMIT PLAN.—

''(1) DEFINITION OF OPERATIONS FUNDS.—In this subsection, the term 'operations funds' means only the funds used for—

''(A) the administration of services, including functional expenses such as overtime, personnel salaries, and associated benefits; or

''(B) related tasks that directly affect the operations described in subparagraph (A).

''(2) WITHHOLDING OF FUNDS.—If the Secretary fails to submit a plan in accordance with sub-

section (a), the Secretary shall withhold the operations funds reserved for the Office of the Director, subject to the condition that the withholding shall not adversely impact the capacity of the Service to deliver health care services.

''(3) RESTORATION.—The operations funds withheld pursuant to paragraph (2) may be restored, at the discretion of the Secretary, to the Office of the Director on achievement by that Office of compliance with this section.''.

Subtitle G—Behavioral Health Programs

SEC. 181. BEHAVIORAL HEALTH PROGRAMS.

Title VII of the Indian Health Care Improvement Act (25 U.S.C. 1665 et seq.) is amended to read as follows:

''TITLE VII—BEHAVIORAL HEALTH PROGRAMS

''Subtitle A—General Programs

''SEC. 701. DEFINITIONS.

''In this subtitle:

''(1) ALCOHOL-RELATED NEURODEVELOPMENTAL DISORDERS; ARND.—The term 'alcohol-related neurodevelopmental disorders' or 'ARND' means, with a history of maternal alcohol consumption during pregnancy, central nervous

system abnormalities, which may range from minor intellectual deficits and developmental delays to mental retardation. ARND children may have behavioral problems, learning disabilities, problems with executive functioning, and attention disorders. The neurological defects of ARND may be as severe as FAS, but facial anomalies and other physical characteristics are not present in ARND, thus making diagnosis difficult.

''(2) ASSESSMENT.—The term 'assessment' means the systematic collection, analysis, and dissemination of information on health status, health needs, and health problems.

''(3) BEHAVIORAL HEALTH AFTERCARE.—The term 'behavioral health aftercare' includes those activities and resources used to support recovery following inpatient, residential, intensive substance abuse, or mental health outpatient or outpatient treatment. The purpose is to help prevent or deal with relapse by ensuring that by the time a client or patient is discharged from a level of care, such as outpatient treatment, an aftercare plan has been developed with the client. An aftercare plan may use such resources as a community-based therapeutic group, transitional living facilities, a 12-step spon-

sor, a local 12-step or other related support group, and other community-based providers.

"(4) DUAL DIAGNOSIS.—The term 'dual diagnosis' means coexisting substance abuse and mental illness conditions or diagnosis. Such clients are sometimes referred to as mentally ill chemical abusers (MICAs).

"(5) FETAL ALCOHOL SPECTRUM DISORDERS.—

"(A) IN GENERAL.—The term 'fetal alcohol spectrum disorders' includes a range of effects that can occur in an individual whose mother drank alcohol during pregnancy, including physical, mental, behavioral, and/or learning disabilities with possible lifelong implications.

"(B) INCLUSIONS.—The term 'fetal alcohol spectrum disorders' may include—

"(i) fetal alcohol syndrome (FAS);

"(ii) partial fetal alcohol syndrome (partial FAS);

"(iii) alcohol-related birth defects (ARBD); and

"(iv) alcohol-related neurodevelopmental disorders (ARND).

"(6) FAS OR FETAL ALCOHOL SYNDROME.—The term 'FAS' or 'fetal alcohol syndrome' means a syndrome in which, with a history of maternal alcohol consumption during pregnancy, the following criteria are met:

"(A) Central nervous system involvement, such as mental retardation, developmental delay, intellectual deficit, microencephaly, or neurological abnormalities.

"(B) Craniofacial abnormalities with at least 2 of the following:

"(i) Microophthalmia.

"(ii) Short palpebral fissures.

"(iii) Poorly developed philtrum.

"(iv) Thin upper lip.

"(v) Flat nasal bridge.

"(vi) Short upturned nose.

"(C) Prenatal or postnatal growth delay.

"(7) REHABILITATION.—The term 'rehabilitation' means medical and health care services that—

"(A) are recommended by a physician or licensed practitioner of the healing arts within the scope of their practice under applicable law;

"(B) are furnished in a facility, home, or other setting in accordance with applicable standards; and

"(C) have as their purpose any of the following:

"(i) The maximum attainment of physical, mental, and developmental functioning.

"(ii) Averting deterioration in physical or mental functional status.

"(iii) The maintenance of physical or mental health functional status.

"(8) SUBSTANCE ABUSE.—The term 'substance abuse' includes inhalant abuse.

"SEC. 702. BEHAVIORAL HEALTH PREVENTION AND TREATMENT SERVICES.

"(a) PURPOSES.—The purposes of this section are as follows:

"(1) To authorize and direct the Secretary, acting through the Service, Indian tribes, and tribal organizations, to develop a comprehensive behavioral health prevention and treatment program which emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs.

"(2) To provide information, direction, and guidance relating to mental illness and dysfunction and self-destructive behavior, including child abuse and family violence, to those Federal, tribal, State, and local agencies responsible for programs in Indian communities in areas of health care, education, social services, child and family welfare, alcohol and substance abuse, law enforcement, and judicial services.

"(3) To assist Indian tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior.

"(4) To provide authority and opportunities for Indian tribes and tribal organizations to develop, implement, and coordinate with community-based programs which include identification, prevention, education, referral, and treatment services, including through multidisciplinary resource teams.

"(5) To ensure that Indians, as citizens of the United States and of the States in which they reside, have the same access to behavioral health services to which all citizens have access.

"(6) To modify or supplement existing programs and authorities in the areas identified in paragraph (2).

"(b) PLANS.—

"(1) DEVELOPMENT.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, shall encourage Indian tribes and tribal organizations to develop tribal plans, and urban Indian organizations to develop local plans, and for all such groups to participate in developing areawide plans for Indian Behavioral Health Services. The plans shall include, to the extent feasible, the following components:

"(A) An assessment of the scope of alcohol or other substance abuse, mental illness, and dysfunctional and self-destructive behavior, including suicide, child abuse, and family violence, among Indians, including—

"(i) the number of Indians served who are directly or indirectly affected by such illness or behavior; or

"(ii) an estimate of the financial and human cost attributable to such illness or behavior.

"(B) An assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward

achieving the availability of the full continuum of care described in subsection (c).

"(C) An estimate of the additional funding needed by the Service, Indian tribes, tribal organizations, and urban Indian organizations to meet their responsibilities under the plans.

"(2) NATIONAL CLEARINGHOUSE.—The Secretary, acting through the Service, shall coordinate with existing national clearinghouses and information centers to include at the clearinghouses and centers plans and reports on the outcomes of such plans developed by Indian tribes, tribal organizations, urban Indian organizations, and Service areas relating to behavioral health. The Secretary shall ensure access to these plans and outcomes by any Indian tribe, tribal organization, urban Indian organization, or the Service.

"(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian tribes, tribal organizations, and urban Indian organizations in preparation of plans under this section and in developing standards of care that may be used and adopted locally.

"(c) PROGRAMS.—The Secretary, acting through the Service, shall provide, to the extent feasible and if funding is available, programs including the following:

"(1) COMPREHENSIVE CARE.—A comprehensive continuum of behavioral health care which provides—

"(A) community-based prevention, intervention, outpatient, and behavioral health aftercare;

"(B) detoxification (social and medical);

"(C) acute hospitalization;

"(D) intensive outpatient/day treatment;

"(E) residential treatment;

"(F) transitional living for those needing a temporary, stable living environment that is supportive of treatment and recovery goals;

"(G) emergency shelter;

"(H) intensive case management;

"(I) diagnostic services; and

"(J) promotion of healthy approaches to risk and safety issues, including injury prevention.

"(2) CHILD CARE.—Behavioral health services for Indians from birth through age 17, including—

"(A) preschool and school age fetal alcohol spectrum disorder services, including assessment and behavioral intervention;

"(B) mental health and substance abuse services (emotional, organic, alcohol, drug, inhalant, and tobacco);

"(C) identification and treatment of co-occurring disorders and comorbidity;

"(D) prevention of alcohol, drug, inhalant, and tobacco use;

"(E) early intervention, treatment, and aftercare;

"(F) promotion of healthy approaches to risk and safety issues; and

"(G) identification and treatment of neglect and physical, mental, and sexual abuse.

"(3) ADULT CARE.—Behavioral health services for Indians from age 18 through 55, including—

"(A) early intervention, treatment, and aftercare;

"(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;

"(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

"(D) promotion of healthy approaches for risk-related behavior;

"(E) treatment services for women at risk of giving birth to a child with a fetal alcohol spectrum disorder; and

"(F) sex specific treatment for sexual assault and domestic violence.

"(4) FAMILY CARE.—Behavioral health services for families, including—

"(A) early intervention, treatment, and aftercare for affected families;

"(B) treatment for sexual assault and domestic violence; and

"(C) promotion of healthy approaches relating to parenting, domestic violence, and other abuse issues.

"(5) ELDER CARE.—Behavioral health services for Indians 56 years of age and older, including—

"(A) early intervention, treatment, and aftercare;

"(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;

"(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

"(D) promotion of healthy approaches to managing conditions related to aging;

"(E) sex specific treatment for sexual assault, domestic violence, neglect, physical and mental abuse and exploitation; and

"(F) identification and treatment of dementias regardless of cause.

"(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

"(1) ESTABLISHMENT.—The governing body of any Indian tribe, tribal organization, or urban Indian organization may adopt a resolution for the establishment of a community behavioral health plan providing for the identification and coordination of available resources and programs to identify, prevent, or treat substance abuse, mental illness, or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members or its service population. This plan should include

behavioral health services, social services, intensive outpatient services, and continuing aftercare.

"(2) TECHNICAL ASSISTANCE.—At the request of an Indian tribe, tribal organization, or urban Indian organization, the Bureau of Indian Affairs and the Service shall cooperate with and provide technical assistance to the Indian tribe, tribal organization, or urban Indian organization in the development and implementation of such plan.

"(3) FUNDING.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, may make funding available to Indian tribes and tribal organizations which adopt a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community behavioral health plan and to provide administrative support in the implementation of such plan.

"(e) COORDINATION FOR AVAILABILITY OF SERVICES.—The Secretary, acting through the Service, shall coordinate behavioral health planning, to the extent feasible, with other Federal agencies and with State agencies, to encourage comprehensive behavioral health services for Indians regardless of their place of residence.

"(f) MENTAL HEALTH CARE NEED ASSESSMENT.—Not later than 1 year after the date of enactment of the

Indian Healthcare Improvement Act of 2017, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

"SEC. 703. MEMORANDA OF AGREEMENT WITH THE DEPARTMENT OF INTERIOR.

"(a) CONTENTS.—Not later than 1 year after the date of enactment of the Indian Healthcare Improvement Act of 2017, the Secretary, acting through the Service, and the Secretary of the Interior shall develop and enter into a memoranda of agreement, or review and update any existing memoranda of agreement, as required by section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411) under which the Secretaries address the following:

"(1) The scope and nature of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians.

"(2) The existing Federal, tribal, State, local, and private services, resources, and programs avail-

able to provide behavioral health services for Indians.

''(3) The unmet need for additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1).

''(4)(A) The right of Indians, as citizens of the United States and of the States in which they reside, to have access to behavioral health services to which all citizens have access.

''(B) The right of Indians to participate in, and receive the benefit of, such services.

''(C) The actions necessary to protect the exercise of such right.

''(5) The responsibilities of the Bureau of Indian Affairs and the Service, including mental illness identification, prevention, education, referral, and treatment services (including services through multidisciplinary resource teams), at the central, area, and agency and Service unit, Service area, and headquarters levels to address the problems identified in paragraph (1).

''(6) A strategy for the comprehensive coordination of the behavioral health services provided by the Bureau of Indian Affairs and the Service to meet

the problems identified pursuant to paragraph (1), including—

"(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and Indian tribes and tribal organizations (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2401 et seq.)) with behavioral health initiatives pursuant to this Act, particularly with respect to the referral and treatment of dually diagnosed individuals requiring behavioral health and substance abuse treatment; and

"(B) ensuring that the Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services.

"(7) Directing appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and Service unit levels, to cooperate fully with tribal requests made pursuant to community behavioral health plans adopted under section 702(c) and section 4206 of the Indian Alcohol and

Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2412).

"(8) Providing for an annual review of such agreement by the Secretaries which shall be provided to Congress and Indian tribes and tribal organizations.

"(b) SPECIFIC PROVISIONS REQUIRED.—The memoranda of agreement updated or entered into pursuant to subsection (a) shall include specific provisions pursuant to which the Service shall assume responsibility for—

"(1) the determination of the scope of the problem of alcohol and substance abuse among Indians, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human cost;

"(2) an assessment of the existing and needed resources necessary for the prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse; and

"(3) an estimate of the funding necessary to adequately support a program of prevention of alcohol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

''(c) PUBLICATION.—Each memorandum of agreement entered into or renewed (and amendments or modifications thereto) under subsection (a) shall be published in the Federal Register. At the same time as publication in the Federal Register, the Secretary shall provide a copy of such memoranda, amendment, or modification to each Indian tribe, tribal organization, and urban Indian organization.

''SEC. 704. COMPREHENSIVE BEHAVIORAL HEALTH PREVENTION AND TREATMENT PROGRAM.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall provide a program of comprehensive behavioral health, prevention, treatment, and aftercare, which may include, if feasible and appropriate, systems of care, and shall include—

''(A) prevention, through educational intervention, in Indian communities;

''(B) acute detoxification, psychiatric hospitalization, residential, and intensive outpatient treatment;

''(C) community-based rehabilitation and aftercare;

''(D) community education and involvement, including extensive training of health

care, educational, and community-based personnel;

"(E) specialized residential treatment programs for high-risk populations, including pregnant and postpartum women and their children; and

"(F) diagnostic services.

"(2) TARGET POPULATIONS.—The target population of such programs shall be members of Indian tribes. Efforts to train and educate key members of the Indian community shall also target employees of health, education, judicial, law enforcement, legal, and social service programs.

"(b) CONTRACT HEALTH SERVICES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, may enter into contracts with public or private providers of behavioral health treatment services for the purpose of carrying out the program required under subsection (a).

"(2) PROVISION OF ASSISTANCE.—In carrying out this subsection, the Secretary shall provide assistance to Indian tribes and tribal organizations to develop criteria for the certification of behavioral health service providers and accreditation of service

facilities which meet minimum standards for such services and facilities.

"SEC. 705. MENTAL HEALTH TECHNICIAN PROGRAM.

"(a) IN GENERAL.—Pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary shall establish and maintain a mental health technician program within the Service which—

"(1) provides for the training of Indians as mental health technicians; and

"(2) employs such technicians in the provision of community-based mental health care that includes identification, prevention, education, referral, and treatment services.

"(b) PARAPROFESSIONAL TRAINING.—In carrying out subsection (a), the Secretary, acting through the Service, shall provide high-standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

"(c) SUPERVISION AND EVALUATION OF TECHNICIANS.—The Secretary, acting through the Service, shall

supervise and evaluate the mental health technicians in the training program.

''(d) TRADITIONAL HEALTH CARE PRACTICES.—The Secretary, acting through the Service, shall ensure that the program established pursuant to this section involves the use and promotion of the traditional health care practices of the Indian tribes to be served.

''SEC. 706. LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.

''(a) IN GENERAL.—Subject to section 221, and except as provided in subsection (b), any individual employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under this Act is required to be licensed as a psychologist, social worker, or marriage and family therapist, respectively.

''(b) TRAINEES.—An individual may be employed as a trainee in psychology, social work, or marriage and family therapy to provide mental health care services described in subsection (a) if such individual—

''(1) works under the direct supervision of a licensed psychologist, social worker, or marriage and family therapist, respectively;

''(2) is enrolled in or has completed at least 2 years of course work at a post-secondary, accredited

education program for psychology, social work, marriage and family therapy, or counseling; and

''(3) meets such other training, supervision, and quality review requirements as the Secretary may establish.

''SEC. 707. INDIAN WOMEN TREATMENT PROGRAMS.

''(a) GRANTS.—The Secretary, consistent with section 702, may make grants to Indian tribes, tribal organizations, and urban Indian organizations to develop and implement a comprehensive behavioral health program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the cultural, historical, social, and child care needs of Indian women, regardless of age.

''(b) USE OF GRANT FUNDS.—A grant made pursuant to this section may be used—

''(1) to develop and provide community training, education, and prevention programs for Indian women relating to behavioral health issues, including fetal alcohol spectrum disorders;

''(2) to identify and provide psychological services, counseling, advocacy, support, and relapse prevention to Indian women and their families; and

''(3) to develop prevention and intervention models for Indian women which incorporate tradi-

tional health care practices, cultural values, and community and family involvement.

''(c) CRITERIA.—The Secretary, in consultation with Indian tribes and tribal organizations, shall establish criteria for the review and approval of applications and proposals for funding under this section.

''(d) ALLOCATION OF FUNDS FOR URBAN INDIAN ORGANIZATIONS.—20 percent of the funds appropriated pursuant to this section shall be used to make grants to urban Indian organizations.

''SEC. 708. INDIAN YOUTH PROGRAM.

''(a) DETOXIFICATION AND REHABILITATION.—The Secretary, acting through the Service, consistent with section 702, shall develop and implement a program for acute detoxification and treatment for Indian youths, including behavioral health services. The program shall include regional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian tribes or tribal organizations at the local level under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). Regional centers shall be integrated with the intake and rehabilitation programs based in the referring Indian community.

"(b) ALCOHOL AND SUBSTANCE ABUSE TREATMENT CENTERS OR FACILITIES.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The Secretary, acting through the Service, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth regional treatment center or treatment network in each area under the jurisdiction of an area office.

"(B) AREA OFFICE IN CALIFORNIA.—For the purposes of this subsection, the area office in California shall be considered to be 2 area offices, 1 office whose jurisdiction shall be considered to encompass the northern area of the State of California, and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California for the purpose of implementing California treatment networks.

"(2) FUNDING.—For the purpose of staffing and operating such centers or facilities, funding shall be pursuant to the Act of November 2, 1921 (25 U.S.C. 13).

"(3) LOCATION.—A youth treatment center constructed or purchased under this subsection shall

be constructed or purchased at a location within the area described in paragraph (1) agreed upon (by appropriate tribal resolution) by a majority of the Indian tribes to be served by such center.

"(4) SPECIFIC PROVISION OF FUNDS.—

"(A) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary may, from amounts authorized to be appropriated for the purposes of carrying out this section, make funds available to—

"(i) the Tanana Chiefs Conference, Incorporated, for the purpose of leasing, constructing, renovating, operating, and maintaining a residential youth treatment facility in Fairbanks, Alaska; and

"(ii) the Southeast Alaska Regional Health Corporation to staff and operate a residential youth treatment facility without regard to the proviso set forth in section 4(*l*) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(*l*)).

"(B) PROVISION OF SERVICES TO ELIGIBLE YOUTHS.—Until additional residential youth treatment facilities are established in

Alaska pursuant to this section, the facilities specified in subparagraph (A) shall make every effort to provide services to all eligible Indian youths residing in Alaska.

"(c) INTERMEDIATE ADOLESCENT BEHAVIORAL HEALTH SERVICES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, may provide intermediate behavioral health services, which may , if feasible and appropriate, incorporate systems of care, to Indian children and adolescents, including—

"(A) pretreatment assistance;

"(B) inpatient, outpatient, and aftercare services;

"(C) emergency care;

"(D) suicide prevention and crisis intervention; and

"(E) prevention and treatment of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence.

"(2) USE OF FUNDS.—Funds provided under this subsection may be used—

"(A) to construct or renovate an existing health facility to provide intermediate behavioral health services;

"(B) to hire behavioral health professionals;

"(C) to staff, operate, and maintain an intermediate mental health facility, group home, sober housing, transitional housing or similar facilities, or youth shelter where intermediate behavioral health services are being provided;

"(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units; and

"(E) for intensive home- and community-based services.

"(3) CRITERIA.—The Secretary, acting through the Service, shall, in consultation with Indian tribes and tribal organizations, establish criteria for the review and approval of applications or proposals for funding made available pursuant to this subsection.

"(d) FEDERALLY OWNED STRUCTURES.—

"(1) IN GENERAL.—The Secretary, in consultation with Indian tribes and tribal organizations, shall—

"(A) identify and use, where appropriate, federally owned structures suitable for local residential or regional behavioral health treatment for Indian youths; and

"(B) establish guidelines for determining the suitability of any such federally owned structure to be used for local residential or regional behavioral health treatment for Indian youths.

"(2) TERMS AND CONDITIONS FOR USE OF STRUCTURE.—Any structure described in paragraph (1) may be used under such terms and conditions as may be agreed upon by the Secretary and the agency having responsibility for the structure and any Indian tribe or tribal organization operating the program.

"(e) REHABILITATION AND AFTERCARE SERVICES.—

"(1) IN GENERAL.—The Secretary, Indian tribes, or tribal organizations, in cooperation with the Secretary of the Interior, shall develop and implement within each Service unit, community-based rehabilitation and follow-up services for Indian youths who are having significant behavioral health problems, and require long-term treatment, community reintegration, and monitoring to support the In-

dian youths after their return to their home community.

"(2) ADMINISTRATION.—Services under paragraph (1) shall be provided by trained staff within the community who can assist the Indian youths in their continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff may include alcohol and substance abuse counselors, mental health professionals, and other health professionals and paraprofessionals, including community health representatives.

"(f) INCLUSION OF FAMILY IN YOUTH TREATMENT PROGRAM.—In providing the treatment and other services to Indian youths authorized by this section, the Secretary, acting through the Service, shall provide for the inclusion of family members of such youths in the treatment programs or other services as may be appropriate. Not less than 10 percent of the funds appropriated for the purposes of carrying out subsection (e) shall be used for outpatient care of adult family members related to the treatment of an Indian youth under that subsection.

"(g) MULTIDRUG ABUSE PROGRAM.—The Secretary, acting through the Service, shall provide, consistent with section 702, programs and services to prevent and treat

the abuse of multiple forms of substances, including alcohol, drugs, inhalants, and tobacco, among Indian youths residing in Indian communities, on or near reservations, and in urban areas and provide appropriate mental health services to address the incidence of mental illness among such youths.

''(h) INDIAN YOUTH MENTAL HEALTH.—The Secretary, acting through the Service, shall collect data for the report under section 801 with respect to—

''(1) the number of Indian youth who are being provided mental health services through the Service and tribal health programs;

''(2) a description of, and costs associated with, the mental health services provided for Indian youth through the Service and tribal health programs;

''(3) the number of youth referred to the Service or tribal health programs for mental health services;

''(4) the number of Indian youth provided residential treatment for mental health and behavioral problems through the Service and tribal health programs, reported separately for on- and off-reservation facilities; and

''(5) the costs of the services described in paragraph (4).

"SEC. 709. INPATIENT AND COMMUNITY-BASED MENTAL HEALTH FACILITIES DESIGN, CONSTRUCTION, AND STAFFING.

"Not later than 1 year after the date of enactment of theIndian Healthcare Improvement Act of 2017, the Secretary, acting through the Service, may provide, in each area of the Service, not less than 1 inpatient mental health care facility, or the equivalent, for Indians with behavioral health problems. For the purposes of this subsection, California shall be considered to be 2 area offices, 1 office whose location shall be considered to encompass the northern area of the State of California and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California. The Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

"SEC. 710. TRAINING AND COMMUNITY EDUCATION.

"(a) PROGRAM.—The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement or assist Indian tribes and tribal organizations to develop and implement, within each Service unit or tribal program, a program of community education and involvement which shall be designed to provide concise and timely information to the community leadership of each tribal community. Such program shall include education about behavioral

health issues to political leaders, tribal judges, law enforcement personnel, members of tribal health and education boards, health care providers including traditional practitioners, and other critical members of each tribal community. Such program may also include community-based training to develop local capacity and tribal community provider training for prevention, intervention, treatment, and aftercare.

''(b) INSTRUCTION.—The Secretary, acting through the Service, shall provide instruction in the area of behavioral health issues, including instruction in crisis intervention and family relations in the context of alcohol and substance abuse, child sexual abuse, youth alcohol and substance abuse, and the causes and effects of fetal alcohol spectrum disorders to appropriate employees of the Bureau of Indian Affairs and the Service, and to personnel in schools or programs operated under any contract with the Bureau of Indian Affairs or the Service, including supervisors of emergency shelters and halfway houses described in section 4213 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2433).

''(c) TRAINING MODELS.—In carrying out the education and training programs required by this section, the Secretary, in consultation with Indian tribes, tribal organi-

zations, Indian behavioral health experts, and Indian alcohol and substance abuse prevention experts, shall develop and provide community-based training models. Such models shall address—

"(1) the elevated risk of alcohol abuse and other behavioral health problems faced by children of alcoholics;

"(2) the cultural, spiritual, and multigenerational aspects of behavioral health problem prevention and recovery; and

"(3) community-based and multidisciplinary strategies for preventing and treating behavioral health problems.

"SEC. 711. BEHAVIORAL HEALTH PROGRAM.

"(a) INNOVATIVE PROGRAMS.—The Secretary, acting through the Service, consistent with section 702, may plan, develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

"(b) AWARDS; CRITERIA.—The Secretary may award a grant for a project under subsection (a) to an Indian tribe or tribal organization and may consider the following criteria:

"(1) The project will address significant unmet behavioral health needs among Indians.

''(2) The project will serve a significant number of Indians.

''(3) The project has the potential to deliver services in an efficient and effective manner.

''(4) The Indian tribe or tribal organization has the administrative and financial capability to administer the project.

''(5) The project may deliver services in a manner consistent with traditional health care practices.

''(6) The project is coordinated with, and avoids duplication of, existing services.

''(c) EQUITABLE TREATMENT.—For purposes of this subsection, the Secretary shall, in evaluating project applications or proposals, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

''SEC. 712. FETAL ALCOHOL SPECTRUM DISORDERS PROGRAMS.

''(a) PROGRAMS.—

''(1) ESTABLISHMENT.—The Secretary, consistent with section 702, acting through the Service, Indian Tribes, and Tribal Organizations, is authorized to establish and operate fetal alcohol spectrum disorders programs as provided in this section for

the purposes of meeting the health status objectives specified in section 3.

"(2) USE OF FUNDS.—

"(A) IN GENERAL.—Funding provided pursuant to this section shall be used for the following:

"(i) To develop and provide for Indians community and in-school training, education, and prevention programs relating to fetal alcohol spectrum disorders.

"(ii) To identify and provide behavioral health treatment to high-risk Indian women and high-risk women pregnant with an Indian's child.

"(iii) To identify and provide appropriate psychological services, educational and vocational support, counseling, advocacy, and information to fetal alcohol spectrum disorders-affected Indians and their families or caretakers.

"(iv) To develop and implement counseling and support programs in schools for fetal alcohol spectrum disorders-affected Indian children.

"(v) To develop prevention and intervention models which incorporate practitioners of traditional health care practices, cultural values, and community involvement.

"(vi) To develop, print, and disseminate education and prevention materials on fetal alcohol spectrum disorders.

"(vii) To develop and implement, in consultation with Indian Tribes and Tribal Organizations, and in conference with urban Indian Organizations, culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol spectrum disorders clinics for use in Indian communities and urban Centers.

"(viii) To develop and provide training on fetal alcohol spectrum disorders to professionals providing services to Indians, including medical and allied health practitioners, social service providers, educators, and law enforcement, court officials and corrections personnel in the juvenile and criminal justice systems.

"(B) ADDITIONAL USES.—In addition to any purpose under subparagraph (A), funding provided pursuant to this section may be used for 1 or more of the following:

"(i) Early childhood intervention projects from birth on to mitigate the effects of fetal alcohol spectrum disorders among Indians.

"(ii) Community-based support services for Indians and women pregnant with Indian children.

"(iii) Community-based housing for adult Indians with fetal alcohol spectrum disorders.

"(3) CRITERIA FOR APPLICATIONS.—The Secretary shall establish criteria for the review and approval of applications for funding under this section.

"(b) SERVICES.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall—

"(1) develop and provide services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol spectrum disorders in Indian communities; and

"(2) provide supportive services, including services to meet the special educational, vocational,

school-to-work transition, and independent living needs of adolescent and adult Indians with fetal alcohol spectrum disorders.

''(c) APPLIED RESEARCH PROJECTS.—The Secretary, acting through the Substance Abuse and Mental Health Services Administration, shall make grants to Indian Tribes, Tribal Organizations, and urban Indian Organizations for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat, or provide rehabilitation and behavioral health aftercare for Indians and urban Indians affected by fetal alcohol spectrum disorders.

''(d) FUNDING FOR URBAN INDIAN ORGANIZATIONS.—Ten percent of the funds appropriated pursuant to this section shall be used to make grants to urban Indian Organizations funded under title V.

''SEC. 713. CHILD SEXUAL ABUSE PREVENTION AND TREATMENT PROGRAMS.

''(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish, consistent with section 702, in every Service area, programs involving treatment for—

''(1) victims of sexual abuse who are Indian children or children in an Indian household; and

"(2) other members of the household or family of the victims described in paragraph (1).

"(b) USE OF FUNDS.—Funding provided pursuant to this section shall be used for the following:

"(1) To develop and provide community education and prevention programs related to sexual abuse of Indian children or children in an Indian household.

"(2) To identify and provide behavioral health treatment to victims of sexual abuse who are Indian children or children in an Indian household, and to their family members who are affected by sexual abuse.

"(3) To develop prevention and intervention models which incorporate traditional health care practices, cultural values, and community involvement.

"(4) To develop and implement culturally sensitive assessment and diagnostic tools for use in Indian communities and urban centers.

"(c) COORDINATION.—The programs established under subsection (a) shall be carried out in coordination with programs and services authorized under the Indian Child Protection and Family Violence Prevention Act (25 U.S.C. 3201 et seq.).

"SEC. 714. DOMESTIC AND SEXUAL VIOLENCE PREVENTION AND TREATMENT.

"(a) IN GENERAL.—The Secretary, in accordance with section 702, is authorized to establish in each Service area programs involving the prevention and treatment of—

"(1) Indian victims of domestic violence or sexual abuse; and

"(2) other members of the household or family of the victims described in paragraph (1).

"(b) USE OF FUNDS.—Funds made available to carry out this section shall be used—

"(1) to develop and implement prevention programs and community education programs relating to domestic violence and sexual abuse;

"(2) to provide behavioral health services, including victim support services, and medical treatment (including examinations performed by sexual assault nurse examiners) to Indian victims of domestic violence or sexual abuse;

"(3) to purchase rape kits; and

"(4) to develop prevention and intervention models, which may incorporate traditional health care practices.

"(c) TRAINING AND CERTIFICATION.—

"(1) IN GENERAL.—Not later than 1 year after the date of enactment of the Indian Healthcare Improvement Act of 2017, the Secretary shall establish appropriate protocols, policies, procedures, standards of practice, and, if not available elsewhere, training curricula and training and certification requirements for services for victims of domestic violence and sexual abuse.

"(2) REPORT.—Not later than 18 months after the date of enactment of the Indian Healthcare Improvement Act of 2017, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes the means and extent to which the Secretary has carried out paragraph (1).

"(d) COORDINATION.—

"(1) IN GENERAL.—The Secretary, in coordination with the Attorney General, Federal and tribal law enforcement agencies, Indian health programs, and domestic violence or sexual assault victim organizations, shall develop appropriate victim services and victim advocate training programs—

"(A) to improve domestic violence or sexual abuse responses;

"(B) to improve forensic examinations and collection;

"(C) to identify problems or obstacles in the prosecution of domestic violence or sexual abuse; and

"(D) to meet other needs or carry out other activities required to prevent, treat, and improve prosecutions of domestic violence and sexual abuse.

"(2) REPORT.—Not later than 2 years after the date of enactment of the Indian Healthcare Improvement Act of 2017, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes, with respect to the matters described in paragraph (1), the improvements made and needed, problems or obstacles identified, and costs necessary to address the problems or obstacles, and any other recommendations that the Secretary determines to be appropriate.

"SEC. 715. BEHAVIORAL HEALTH RESEARCH.

"(a) IN GENERAL.—The Secretary, in consultation with appropriate Federal agencies, shall make grants to, or enter into contracts with, Indian tribes, tribal organiza-

tions, and urban Indian organizations or enter into contracts with, or make grants to appropriate institutions for, the conduct of research on the incidence and prevalence of behavioral health problems among Indians served by the Service, Indian tribes, or tribal organizations and among Indians in urban areas. Research priorities under this section shall include—

''(1) the multifactorial causes of Indian youth suicide, including—

''(A) protective and risk factors and scientific data that identifies those factors; and

''(B) the effects of loss of cultural identity and the development of scientific data on those effects;

''(2) the interrelationship and interdependence of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

''(3) the development of models of prevention techniques.

''(b) EMPHASIS.—The effect of the interrelationships and interdependencies referred to in subsection (a)(2) on children, and the development of prevention techniques under subsection (a)(3) applicable to children, shall be emphasized.

"Subtitle B—Indian Youth Suicide Prevention

"SEC. 721. FINDINGS AND PURPOSE.

''(a) FINDINGS.—Congress finds that—

''(1)(A) the rate of suicide of American Indians and Alaska Natives is 1.9 times higher than the national average rate; and

''(B) the rate of suicide of Indian and Alaska Native youth aged 15 through 24 is—

''(i) 3.5 times the national average rate; and

''(ii) the highest rate of any population group in the United States;

''(2) many risk behaviors and contributing factors for suicide are more prevalent in Indian country than in other areas, including—

''(A) history of previous suicide attempts;

''(B) family history of suicide;

''(C) history of depression or other mental illness;

''(D) alcohol or drug abuse;

''(E) health disparities;

''(F) stressful life events and losses;

''(G) easy access to lethal methods;

"(H) exposure to the suicidal behavior of others;

"(I) isolation; and

"(J) incarceration;

"(3) according to national data for 2005, suicide was the second-leading cause of death for Indians and Alaska Natives of both sexes aged 10 through 34;

"(4)(A) the suicide rates of Indian and Alaska Native males aged 15 through 24 are—

"(i) as compared to suicide rates of males of any other racial group, up to 4 times greater; and

"(ii) as compared to suicide rates of females of any other racial group, up to 11 times greater; and

"(B) data demonstrates that, over their lifetimes, females attempt suicide 2 to 3 times more often than males;

"(5)(A) Indian tribes, especially Indian tribes located in the Great Plains, have experienced epidemic levels of suicide, up to 10 times the national average; and

"(B) suicide clustering in Indian country affects entire tribal communities;

"(6) death rates for Indians and Alaska Natives are statistically underestimated because many areas of Indian country lack the proper resources to identify and monitor the presence of disease;

"(7)(A) the Indian Health Service experiences health professional shortages, with physician vacancy rates of approximately 17 percent, and nursing vacancy rates of approximately 18 percent, in 2007;

"(B) 90 percent of all teens who die by suicide suffer from a diagnosable mental illness at time of death;

"(C) more than ½ of teens who die by suicide have never been seen by a mental health provider; and

"(D) ⅓ of health needs in Indian country relate to mental health;

"(8) often, the lack of resources of Indian tribes and the remote nature of Indian reservations make it difficult to meet the requirements necessary to access Federal assistance, including grants;

"(9) the Substance Abuse and Mental Health Services Administration and the Service have established specific initiatives to combat youth suicide in Indian country and among Indians and Alaska Natives throughout the United States, including the

National Suicide Prevention Initiative of the Service, which has worked with Service, tribal, and urban Indian health programs since 2003;

"(10) the National Strategy for Suicide Prevention was established in 2001 through a Department of Health and Human Services collaboration among—

"(A) the Substance Abuse and Mental Health Services Administration;

"(B) the Service;

"(C) the Centers for Disease Control and Prevention;

"(D) the National Institutes of Health; and

"(E) the Health Resources and Services Administration; and

"(11) the Service and other agencies of the Department of Health and Human Services use information technology and other programs to address the suicide prevention and mental health needs of Indians and Alaska Natives.

"(b) PURPOSES.—The purposes of this subtitle are—

"(1) to authorize the Secretary to carry out a demonstration project to test the use of telemental

health services in suicide prevention, intervention, and treatment of Indian youth, including through—

"(A) the use of psychotherapy, psychiatric assessments, diagnostic interviews, therapies for mental health conditions predisposing to suicide, and alcohol and substance abuse treatment;

"(B) the provision of clinical expertise to, consultation services with, and medical advice and training for frontline health care providers working with Indian youth;

"(C) training and related support for community leaders, family members, and health and education workers who work with Indian youth;

"(D) the development of culturally relevant educational materials on suicide; and

"(E) data collection and reporting;

"(2) to encourage Indian tribes, tribal organizations, and other mental health care providers serving residents of Indian country to obtain the services of predoctoral psychology and psychiatry interns; and

"(3) to enhance the provision of mental health care services to Indian youth through existing grant

programs of the Substance Abuse and Mental Health Services Administration.

"SEC. 722. DEFINITIONS.

"In this subtitle:

"(1) ADMINISTRATION.—The term 'Administration' means the Substance Abuse and Mental Health Services Administration.

"(2) DEMONSTRATION PROJECT.—The term 'demonstration project' means the Indian youth telemental health demonstration project authorized under section 723(a).

"(3) TELEMENTAL HEALTH.—The term 'telemental health' means the use of electronic information and telecommunications technologies to support long-distance mental health care, patient and professional-related education, public health, and health administration.

"SEC. 723. INDIAN YOUTH TELEMENTAL HEALTH DEMONSTRATION PROJECT.

"(a) AUTHORIZATION.—

"(1) IN GENERAL.—The Secretary, acting through the Service, is authorized to carry out a demonstration project to award grants for the provision of telemental health services to Indian youth who—

"(A) have expressed suicidal ideas;

"(B) have attempted suicide; or

"(C) have behavioral health conditions that increase or could increase the risk of suicide.

"(2) ELIGIBILITY FOR GRANTS.—Grants under paragraph (1) shall be awarded to Indian tribes and tribal organizations that operate 1 or more facilities—

"(A) located in an area with documented disproportionately high rates of suicide;

"(B) reporting active clinical telehealth capabilities; or

"(C) offering school-based telemental health services to Indian youth.

"(3) GRANT PERIOD.—The Secretary shall award grants under this section for a period of up to 4 years.

"(4) MAXIMUM NUMBER OF GRANTS.—Not more than 5 grants shall be provided under paragraph (1), with priority consideration given to Indian tribes and tribal organizations that—

"(A) serve a particular community or geographic area in which there is a demonstrated need to address Indian youth suicide;

"(B) enter into collaborative partnerships with Service or other tribal health programs or facilities to provide services under this demonstration project;

"(C) serve an isolated community or geographic area that has limited or no access to behavioral health services; or

"(D) operate a detention facility at which Indian youth are detained.

"(5) CONSULTATION WITH ADMINISTRATION.—In developing and carrying out the demonstration project under this subsection, the Secretary shall consult with the Administration as the Federal agency focused on mental health issues, including suicide.

"(b) USE OF FUNDS.—

"(1) IN GENERAL.—An Indian tribe or tribal organization shall use a grant received under subsection (a) for the following purposes:

"(A) To provide telemental health services to Indian youth, including the provision of—

"(i) psychotherapy;

"(ii) psychiatric assessments and diagnostic interviews, therapies for mental health conditions predisposing to suicide, and treatment; and

"(iii) alcohol and substance abuse treatment.

"(B) To provide clinician-interactive medical advice, guidance and training, assistance in diagnosis and interpretation, crisis counseling and intervention, and related assistance to Service or tribal clinicians and health services providers working with youth being served under the demonstration project.

"(C) To assist, educate, and train community leaders, health education professionals and paraprofessionals, tribal outreach workers, and family members who work with the youth receiving telemental health services under the demonstration project, including with identification of suicidal tendencies, crisis intervention and suicide prevention, emergency skill development, and building and expanding networks among those individuals and with State and local health services providers.

"(D) To develop and distribute culturally appropriate community educational materials regarding—

"(i) suicide prevention;

"(ii) suicide education;

"(iii) suicide screening;

"(iv) suicide intervention; and

"(v) ways to mobilize communities with respect to the identification of risk factors for suicide.

"(E) To conduct data collection and reporting relating to Indian youth suicide prevention efforts.

"(2) TRADITIONAL HEALTH CARE PRACTICES.—In carrying out the purposes described in paragraph (1), an Indian tribe or tribal organization may use and promote the traditional health care practices of the Indian tribes of the youth to be served.

"(c) APPLICATIONS.—

"(1) IN GENERAL.—Subject to paragraph (2), to be eligible to receive a grant under subsection (a), an Indian tribe or tribal organization shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

"(A) a description of the project that the Indian tribe or tribal organization will carry out using the funds provided under the grant;

"(B) a description of the manner in which the project funded under the grant would—

"(i) meet the telemental health care needs of the Indian youth population to be served by the project; or

"(ii) improve the access of the Indian youth population to be served to suicide prevention and treatment services;

"(C) evidence of support for the project from the local community to be served by the project;

"(D) a description of how the families and leadership of the communities or populations to be served by the project would be involved in the development and ongoing operations of the project;

"(E) a plan to involve the tribal community of the youth who are provided services by the project in planning and evaluating the behavioral health care and suicide prevention efforts provided, in order to ensure the integration of community, clinical, environmental, and cultural components of the treatment; and

"(F) a plan for sustaining the project after Federal assistance for the demonstration project has terminated.

"(2) EFFICIENCY OF GRANT APPLICATION PROCESS.—The Secretary shall carry out such measures as the Secretary determines to be necessary to maximize the time and workload efficiency of the process by which Indian tribes and tribal organizations apply for grants under paragraph (1).

"(d) COLLABORATION.—The Secretary, acting through the Service, shall encourage Indian tribes and tribal organizations receiving grants under this section to collaborate to enable comparisons regarding best practices across projects.

"(e) ANNUAL REPORT.—Each grant recipient shall submit to the Secretary an annual report that—

"(1) describes the number of telemental health services provided; and

"(2) includes any other information that the Secretary may require.

"(f) REPORTS TO CONGRESS.—

"(1) INITIAL REPORT.—

"(A) IN GENERAL.—Not later than 2 years after the date on which the first grant is awarded under this section, the Secretary shall sub-

mit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources and the Committee on Energy and Commerce of the House of Representatives a report that—

"(i) describes each project funded by a grant under this section during the preceding 2-year period, including a description of the level of success achieved by the project; and

"(ii) evaluates whether the demonstration project should be continued during the period beginning on the date of termination of funding for the demonstration project under subsection (g) and ending on the date on which the final report is submitted under paragraph (2).

"(B) CONTINUATION OF DEMONSTRATION PROJECT.—On a determination by the Secretary under clause (ii) of subparagraph (A) that the demonstration project should be continued, the Secretary may carry out the demonstration project during the period described in that clause using such sums otherwise made

available to the Secretary as the Secretary determines to be appropriate.

''(2) FINAL REPORT.—Not later than 270 days after the date of termination of funding for the demonstration project under subsection (g), the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources and the Committee on Energy and Commerce of the House of Representatives a final report that—

''(A) describes the results of the projects funded by grants awarded under this section, including any data available that indicate the number of attempted suicides;

''(B) evaluates the impact of the telemental health services funded by the grants in reducing the number of completed suicides among Indian youth;

''(C) evaluates whether the demonstration project should be—

''(i) expanded to provide more than 5 grants; and

''(ii) designated as a permanent program; and

"(D) evaluates the benefits of expanding the demonstration project to include urban Indian organizations.

"(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $1,500,000 for each of fiscal years 2017 through 2019.

"SEC. 724. SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION GRANTS.

"(a) GRANT APPLICATIONS.—

"(1) EFFICIENCY OF GRANT APPLICATION PROCESS.—The Secretary, acting through the Administration, shall carry out such measures as the Secretary determines to be necessary to maximize the time and workload efficiency of the process by which Indian tribes and tribal organizations apply for grants under any program administered by the Administration, including by providing methods other than electronic methods of submitting applications for those grants, if necessary.

"(2) PRIORITY FOR CERTAIN GRANTS.—

"(A) IN GENERAL.—To fulfill the trust responsibility of the United States to Indian tribes, in awarding relevant grants pursuant to a program described in subparagraph (B), the Secretary shall take into consideration the

needs of Indian tribes or tribal organizations, as applicable, that serve populations with documented high suicide rates, regardless of whether those Indian tribes or tribal organizations possess adequate personnel or infrastructure to fulfill all applicable requirements of the relevant program.

"(B) DESCRIPTION OF GRANT PROGRAMS.—A grant program referred to in subparagraph (A) is a grant program—

"(i) administered by the Administration to fund activities relating to mental health, suicide prevention, or suicide-related risk factors; and

"(ii) under which an Indian tribe or tribal organization is an eligible recipient.

"(3) CLARIFICATION REGARDING INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—Notwithstanding any other provision of law, in applying for a grant under any program administered by the Administration, no Indian tribe or tribal organization shall be required to apply through a State or State agency.

"(4) REQUIREMENTS FOR AFFECTED STATES.—

"(A) DEFINITIONS.—In this paragraph:

"(i) AFFECTED STATE.—The term 'affected State' means a State—

"(I) the boundaries of which include 1 or more Indian tribes; and

"(II) the application for a grant under any program administered by the Administration of which includes statewide data.

"(ii) INDIAN POPULATION.—The term 'Indian population' means the total number of residents of an affected State who are Indian.

"(B) REQUIREMENTS.—As a condition of receipt of a grant under any program administered by the Administration, each affected State shall—

"(i) describe in the grant application—

"(I) the Indian population of the affected State; and

"(II) the contribution of that Indian population to the statewide data used by the affected State in the application; and

"(ii) demonstrate to the satisfaction of the Secretary that—

"(I) of the total amount of the grant, the affected State will allocate for use for the Indian population of the affected State an amount equal to the proportion that—

"(aa) the Indian population of the affected State; bears to

"(bb) the total population of the affected State; and

"(II) the affected State will take reasonable efforts to collaborate with each Indian tribe located within the affected State to carry out youth suicide prevention and treatment measures for members of the Indian tribe.

"(C) REPORT.—Not later than 1 year after the date of receipt of a grant described in subparagraph (B), an affected State shall submit to the Secretary a report describing the measures carried out by the affected State to ensure compliance with the requirements of subparagraph (B)(ii).

"(b) NO NON-FEDERAL SHARE REQUIREMENT.—Notwithstanding any other provision of law, no Indian tribe or tribal organization shall be required to provide a non-Federal share of the cost of any project or activity carried out using a grant provided under any program administered by the Administration.

"(c) OUTREACH FOR RURAL AND ISOLATED INDIAN TRIBES.—Due to the rural, isolated nature of most Indian reservations and communities (especially those reservations and communities in the Great Plains region), the Secretary shall conduct outreach activities, with a particular emphasis on the provision of telemental health services, to achieve the purposes of this subtitle with respect to Indian tribes located in rural, isolated areas.

"(d) PROVISION OF OTHER ASSISTANCE.—

"(1) IN GENERAL.—The Secretary, acting through the Administration, shall carry out such measures (including monitoring and the provision of required assistance) as the Secretary determines to be necessary to ensure the provision of adequate suicide prevention and mental health services to Indian tribes described in paragraph (2), regardless of whether those Indian tribes possess adequate personnel or infrastructure—

"(A) to submit an application for a grant under any program administered by the Administration, including due to problems relating to access to the Internet or other electronic means that may have resulted in previous obstacles to submission of a grant application; or

"(B) to fulfill all applicable requirements of the relevant program.

"(2) DESCRIPTION OF INDIAN TRIBES.—An Indian tribe referred to in paragraph (1) is an Indian tribe—

"(A) the members of which experience—

"(i) a high rate of youth suicide;

"(ii) low socioeconomic status; and

"(iii) extreme health disparity;

"(B) that is located in a remote and isolated area; and

"(C) that lacks technology and communication infrastructure.

"(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as the Secretary determines to be necessary to carry out this subsection.

"(e) EARLY INTERVENTION AND ASSESSMENT SERVICES.—

''(1) DEFINITION OF AFFECTED ENTITY.—In this subsection, the term 'affected entity' means any entity—

''(A) that receives a grant for suicide intervention, prevention, or treatment under a program administered by the Administration; and

''(B) the population to be served by which includes Indian youth.

''(2) REQUIREMENT.—The Secretary, acting through the Administration, shall ensure that each affected entity carrying out a youth suicide early intervention and prevention strategy described in section 520E(c)(1) of the Public Health Service Act (42 U.S.C. 290bb–36(c)(1)), or any other youth suicide-related early intervention and assessment activity, provides training or education to individuals who interact frequently with the Indian youth to be served by the affected entity (including parents, teachers, coaches, and mentors) on identifying warning signs of Indian youth who are at risk of committing suicide.

''SEC. 725. USE OF PREDOCTORAL PSYCHOLOGY AND PSYCHIATRY INTERNS.

''The Secretary shall carry out such activities as the Secretary determines to be necessary to encourage Indian

tribes, tribal organizations, and other mental health care providers to obtain the services of predoctoral psychology and psychiatry interns—

''(1) to increase the quantity of patients served by the Indian tribes, tribal organizations, and other mental health care providers; and

''(2) for purposes of recruitment and retention.

''SEC. 726. INDIAN YOUTH LIFE SKILLS DEVELOPMENT DEMONSTRATION PROGRAM.

''(a) PURPOSE.—The purpose of this section is to authorize the Secretary, acting through the Administration, to carry out a demonstration program to test the effectiveness of a culturally compatible, school-based, life skills curriculum for the prevention of Indian and Alaska Native adolescent suicide, including through—

''(1) the establishment of tribal partnerships to develop and implement such a curriculum, in cooperation with—

''(A) behavioral health professionals, with a priority for tribal partnerships cooperating with mental health professionals employed by the Service;

''(B) tribal or local school agencies; and

''(C) parent and community groups;

"(2) the provision by the Administration or the Service of—

"(A) technical expertise; and

"(B) clinicians, analysts, and educators, as appropriate;

"(3) training for teachers, school administrators, and community members to implement the curriculum;

"(4) the establishment of advisory councils composed of parents, educators, community members, trained peers, and others to provide advice regarding the curriculum and other components of the demonstration program;

"(5) the development of culturally appropriate support measures to supplement the effectiveness of the curriculum; and

"(6) projects modeled after evidence-based projects, such as programs evaluated and published in relevant literature.

"(b) DEMONSTRATION GRANT PROGRAM.—

"(1) DEFINITIONS.—In this subsection:

"(A) CURRICULUM.—The term 'curriculum' means the culturally compatible, school-based, life skills curriculum for the prevention of Indian and Alaska Native adolescent

suicide identified by the Secretary under paragraph (2)(A).

"(B) ELIGIBLE ENTITY.—The term 'eligible entity' means—

"(i) an Indian tribe;

"(ii) a tribal organization;

"(iii) any other tribally authorized entity; and

"(iv) any partnership composed of 2 or more entities described in clause (i), (ii), or (iii).

"(2) ESTABLISHMENT.—The Secretary, acting through the Administration, may establish and carry out a demonstration program under which the Secretary shall—

"(A) identify a culturally compatible, school-based, life skills curriculum for the prevention of Indian and Alaska Native adolescent suicide;

"(B) identify the Indian tribes that are at greatest risk for adolescent suicide;

"(C) invite those Indian tribes to participate in the demonstration program by—

"(i) responding to a comprehensive program requirement request of the Secretary; or

"(ii) submitting, through an eligible entity, an application in accordance with paragraph (4); and

"(D) provide grants to the Indian tribes identified under subparagraph (B) and eligible entities to implement the curriculum with respect to Indian and Alaska Native youths who—

"(i) are between the ages of 10 and 19; and

"(ii) attend school in a region that is at risk of high youth suicide rates, as determined by the Administration.

"(3) REQUIREMENTS.—

"(A) TERM.—The term of a grant provided under the demonstration program under this section shall be not less than 4 years.

"(B) MAXIMUM NUMBER.—The Secretary may provide not more than 5 grants under the demonstration program under this section.

"(C) AMOUNT.—The grants provided under this section shall be of equal amounts.

"(D) CERTAIN SCHOOLS.—In selecting eligible entities to receive grants under this section, the Secretary shall ensure that not less than 1 demonstration program shall be carried out at each of—

"(i) a school operated by the Bureau of Indian Education;

"(ii) a Tribal school; and

"(iii) a school receiving payments under section 8002 or 8003 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7702, 7703).

"(4) APPLICATIONS.—To be eligible to receive a grant under the demonstration program, an eligible entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

"(A) an assurance that, in implementing the curriculum, the eligible entity will collaborate with 1 or more local educational agencies, including elementary schools, middle schools, and high schools;

"(B) an assurance that the eligible entity will collaborate, for the purpose of curriculum

development, implementation, and training and technical assistance, with 1 or more—

"(i) nonprofit entities with demonstrated expertise regarding the development of culturally sensitive, school-based, youth suicide prevention and intervention programs; or

"(ii) institutions of higher education with demonstrated interest and knowledge regarding culturally sensitive, school-based, life skills youth suicide prevention and intervention programs;

"(C) an assurance that the curriculum will be carried out in an academic setting in conjunction with at least 1 classroom teacher not less frequently than twice each school week for the duration of the academic year;

"(D) a description of the methods by which curriculum participants will be—

"(i) screened for mental health at-risk indicators; and

"(ii) if needed and on a case-by-case basis, referred to a mental health clinician for further assessment and treatment and with crisis response capability; and

"(E) an assurance that supportive services will be provided to curriculum participants identified as high-risk participants, including referral, counseling, and follow-up services for—

"(i) drug or alcohol abuse;

"(ii) sexual or domestic abuse; and

"(iii) depression and other relevant mental health concerns.

"(5) USE OF FUNDS.—An Indian tribe identified under paragraph (2)(B) or an eligible entity may use a grant provided under this subsection—

"(A) to develop and implement the curriculum in a school-based setting;

"(B) to establish an advisory council—

"(i) to advise the Indian tribe or eligible entity regarding curriculum development; and

"(ii) to provide support services identified as necessary by the community being served by the Indian tribe or eligible entity;

"(C) to appoint and train a school- and community-based cultural resource liaison, who will act as an intermediary among the Indian tribe or eligible entity, the applicable school ad-

ministrators, and the advisory council established by the Indian tribe or eligible entity;

"(D) to establish an on-site, school-based, MA- or PhD-level mental health practitioner (employed by the Service, if practicable) to work with tribal educators and other personnel;

"(E) to provide for the training of peer counselors to assist in carrying out the curriculum;

"(F) to procure technical and training support from nonprofit or State entities or institutions of higher education identified by the community being served by the Indian tribe or eligible entity as the best suited to develop and implement the curriculum;

"(G) to train teachers and school administrators to effectively carry out the curriculum;

"(H) to establish an effective referral procedure and network;

"(I) to identify and develop culturally compatible curriculum support measures;

"(J) to obtain educational materials and other resources from the Administration or other appropriate entities to ensure the success of the demonstration program; and

"(K) to evaluate the effectiveness of the curriculum in preventing Indian and Alaska Native adolescent suicide.

"(c) EVALUATIONS.—Using such amounts made available pursuant to subsection (e) as the Secretary determines to be appropriate, the Secretary shall conduct, directly or through a grant, contract, or cooperative agreement with an entity that has experience regarding the development and operation of successful culturally compatible, school-based, life skills suicide prevention and intervention programs or evaluations, an annual evaluation of the demonstration program under this section, including an evaluation of—

"(1) the effectiveness of the curriculum in preventing Indian and Alaska Native adolescent suicide;

"(2) areas for program improvement; and

"(3) additional development of the goals and objectives of the demonstration program.

"(d) REPORT TO CONGRESS.—

"(1) IN GENERAL.—Subject to paragraph (2), not later than 180 days after the date of termination of the demonstration program, the Secretary shall submit to the Committee on Indian Affairs and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Natural

Resources and the Committee on Education and Labor of the House of Representatives a final report that—

"(A) describes the results of the program of each Indian tribe or eligible entity under this section;

"(B) evaluates the effectiveness of the curriculum in preventing Indian and Alaska Native adolescent suicide;

"(C) makes recommendations regarding—

"(i) the expansion of the demonstration program under this section to additional eligible entities;

"(ii) designating the demonstration program as a permanent program; and

"(iii) identifying and distributing the curriculum through the Suicide Prevention Resource Center of the Administration; and

"(D) incorporates any public comments received under paragraph (2).

"(2) PUBLIC COMMENT.—The Secretary shall provide a notice of the report under paragraph (1) and an opportunity for public comment on the re-

port for a period of not less than 90 days before submitting the report to Congress.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $1,000,000 for each of fiscal years 2017 through 2020.''.

Subtitle H—Miscellaneous

SEC. 191. CONFIDENTIALITY OF MEDICAL QUALITY ASSURANCE RECORDS; QUALIFIED IMMUNITY FOR PARTICIPANTS.

Title VIII of the Indian Health Care Improvement Act (as amended by section 101(b)) is amended by inserting after section 804 (25 U.S.C. 1674) the following:

''SEC. 805. CONFIDENTIALITY OF MEDICAL QUALITY ASSURANCE RECORDS; QUALIFIED IMMUNITY FOR PARTICIPANTS.

''(a) DEFINITIONS.—In this section:

''(1) HEALTH CARE PROVIDER.—The term 'health care provider' means any health care professional, including community health aides and practitioners certified under section 119, who is—

''(A) granted clinical practice privileges or employed to provide health care services at—

''(i) an Indian health program; or

''(ii) a health program of an urban Indian organization; and

"(B) licensed or certified to perform health care services by a governmental board or agency or professional health care society or organization.

"(2) MEDICAL QUALITY ASSURANCE PROGRAM.—The term 'medical quality assurance program' means any activity carried out before, on, or after the date of enactment of the Indian Healthcare Improvement Act of 2017 by or for any Indian health program or urban Indian organization to assess the quality of medical care, including activities conducted by or on behalf of individuals, Indian health program or urban Indian organization medical or dental treatment review committees, or other review bodies responsible for quality assurance, credentials, infection control, patient safety, patient care assessment (including treatment procedures, blood, drugs, and therapeutics), medical records, health resources management review, and identification and prevention of medical or dental incidents and risks.

"(3) MEDICAL QUALITY ASSURANCE RECORD.—The term 'medical quality assurance record' means the proceedings, records, minutes, and reports that—

"(A) emanate from quality assurance program activities described in paragraph (2); and

"(B) are produced or compiled by or for an Indian health program or urban Indian organization as part of a medical quality assurance program.

"(b) CONFIDENTIALITY OF RECORDS.—Medical quality assurance records created by or for any Indian health program or a health program of an urban Indian organization as part of a medical quality assurance program are confidential and privileged. Such records may not be disclosed to any person or entity, except as provided in subsection (d).

"(c) PROHIBITION ON DISCLOSURE AND TESTIMONY.—

"(1) IN GENERAL.—No part of any medical quality assurance record described in subsection (b) may be subject to discovery or admitted into evidence in any judicial or administrative proceeding, except as provided in subsection (d).

"(2) TESTIMONY.—An individual who reviews or creates medical quality assurance records for any Indian health program or urban Indian organization who participates in any proceeding that reviews or creates such records may not be permitted or re-

quired to testify in any judicial or administrative proceeding with respect to such records or with respect to any finding, recommendation, evaluation, opinion, or action taken by such person or body in connection with such records except as provided in this section.

''(d) AUTHORIZED DISCLOSURE AND TESTIMONY.—

''(1) IN GENERAL.—Subject to paragraph (2), a medical quality assurance record described in subsection (b) may be disclosed, and an individual referred to in subsection (c) may give testimony in connection with such a record, only as follows:

''(A) To a Federal agency or private organization, if such medical quality assurance record or testimony is needed by such agency or organization to perform licensing or accreditation functions related to any Indian health program or to a health program of an urban Indian organization to perform monitoring, required by law, of such program or organization.

''(B) To an administrative or judicial proceeding commenced by a present or former Indian health program or urban Indian organization provider concerning the termination, sus-

pension, or limitation of clinical privileges of such health care provider.

"(C) To a governmental board or agency or to a professional health care society or organization, if such medical quality assurance record or testimony is needed by such board, agency, society, or organization to perform licensing, credentialing, or the monitoring of professional standards with respect to any health care provider who is or was an employee of any Indian health program or urban Indian organization.

"(D) To a hospital, medical center, or other institution that provides health care services, if such medical quality assurance record or testimony is needed by such institution to assess the professional qualifications of any health care provider who is or was an employee of any Indian health program or urban Indian organization and who has applied for or been granted authority or employment to provide health care services in or on behalf of such program or organization.

"(E) To an officer, employee, or contractor of the Indian health program or urban Indian

organization that created the records or for which the records were created. If that officer, employee, or contractor has a need for such record or testimony to perform official duties.

"(F) To a criminal or civil law enforcement agency or instrumentality charged under applicable law with the protection of the public health or safety, if a qualified representative of such agency or instrumentality makes a written request that such record or testimony be provided for a purpose authorized by law.

"(G) In an administrative or judicial proceeding commenced by a criminal or civil law enforcement agency or instrumentality referred to in subparagraph (F), but only with respect to the subject of such proceeding.

"(2) IDENTITY OF PARTICIPANTS.—With the exception of the subject of a quality assurance action, the identity of any person receiving health care services from any Indian health program or urban Indian organization or the identity of any other person associated with such program or organization for purposes of a medical quality assurance program that is disclosed in a medical quality assurance record described in subsection (b) shall be deleted

from that record or document before any disclosure of such record is made outside such program or organization.

"(e) DISCLOSURE FOR CERTAIN PURPOSES.—

"(1) IN GENERAL.—Nothing in this section shall be construed as authorizing or requiring the withholding from any person or entity aggregate statistical information regarding the results of any Indian health program or urban Indian organization's medical quality assurance programs.

"(2) WITHHOLDING FROM CONGRESS.—Nothing in this section shall be construed as authority to withhold any medical quality assurance record from a committee of either House of Congress, any joint committee of Congress, or the Government Accountability Office if such record pertains to any matter within their respective jurisdictions.

"(f) PROHIBITION ON DISCLOSURE OF RECORD OR TESTIMONY.—An individual or entity having possession of or access to a record or testimony described by this section may not disclose the contents of such record or testimony in any manner or for any purpose except as provided in this section.

"(g) EXEMPTION FROM FREEDOM OF INFORMATION ACT.—Medical quality assurance records described in sub-

section (b) may not be made available to any person under section 552 of title 5, United States Code.

''(h) LIMITATION ON CIVIL LIABILITY.—An individual who participates in or provides information to a person or body that reviews or creates medical quality assurance records described in subsection (b) shall not be civilly liable for such participation or for providing such information if the participation or provision of information was in good faith based on prevailing professional standards at the time the medical quality assurance program activity took place.

''(i) APPLICATION TO INFORMATION IN CERTAIN OTHER RECORDS.—Nothing in this section shall be construed as limiting access to the information in a record created and maintained outside a medical quality assurance program, including a patient's medical records, on the grounds that the information was presented during meetings of a review body that are part of a medical quality assurance program.

''(j) REGULATIONS.—The Secretary, acting through the Service, shall promulgate regulations pursuant to section 802.

''(k) CONTINUED PROTECTION.—Disclosure under subsection (d) does not permit redisclosure except to the extent such further disclosure is authorized under sub-

section (d) or is otherwise authorized to be disclosed under this section.

''(l) INCONSISTENCIES.—To the extent that the protections under part C of title IX of the Public Health Service Act (42 U.S.C. 229b–21 et seq.) (as amended by the Patient Safety and Quality Improvement Act of 2005 (Public Law 109–41; 119 Stat. 424)) and this section are inconsistent, the provisions of whichever is more protective shall control.

''(m) RELATIONSHIP TO OTHER LAW.—This section shall continue in force and effect, except as otherwise specifically provided in any Federal law enacted after the date of enactment of the Indian Healthcare Improvement Act of 2017.''.

SEC. 192. LIMITATION ON USE OF FUNDS APPROPRAITED TO THE INDIAN HEALTH SERVICE.

Section 806 of the Indian Health Care Improvement Act is amended—

(1) by striking ''Any limitation'' and inserting the following:

''(a) HHS APPROPRIATIONS.—Any limitation''; and

(2) by adding at the end the following:

''(b) LIMITATIONS PURSUANT TO OTHER FEDERAL LAW.—Any limitation pursuant to other Federal laws on the use of Federal funds appropriated to the Service shall

apply with respect to the performance or coverage of abortions.''.

SEC. 193. ARIZONA, NORTH DAKOTA, AND SOUTH DAKOTA AS CONTRACT HEALTH SERVICE DELIVERY AREAS; ELIGIBILITY OF CALIFORNIA INDIANS.

Title VIII of the Indian Health Care Improvement Act is amended—

(1) by striking section 808 (25 U.S.C. 1678) and inserting the following:

''SEC. 808. ARIZONA AS CONTRACT HEALTH SERVICE DELIVERY AREA.

''(a) IN GENERAL.—The State of Arizona shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of Indian tribes in the State of Arizona.

''(b) MAINTENANCE OF SERVICES.—The Service shall not curtail any health care services provided to Indians residing on reservations in the State of Arizona if the curtailment is due to the provision of contract services in that State pursuant to the designation of the State as a contract health service delivery area by subsection (a).'';

(2) by inserting after section 808 (25 U.S.C. 1678) the following:

"SEC. 808A. NORTH DAKOTA AND SOUTH DAKOTA AS CONTRACT HEALTH SERVICE DELIVERY AREA.

"(a) IN GENERAL.—The States of North Dakota and South Dakota shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of Indian tribes in the States of North Dakota and South Dakota.

"(b) MAINTENANCE OF SERVICES.—The Service shall not curtail any health care services provided to Indians residing on any reservation, or in any county that has a common boundary with any reservation, in the State of North Dakota or South Dakota if the curtailment is due to the provision of contract services in those States pursuant to the designation of the States as a contract health service delivery area by subsection (a)."; and

(3) by striking section 809 (25 U.S.C. 1679) and inserting the following:

"SEC. 809. ELIGIBILITY OF CALIFORNIA INDIANS.

"(a) IN GENERAL.—The following California Indians shall be eligible for health services provided by the Service:

"(1) Any member of a federally recognized Indian tribe.

"(2) Any descendant of an Indian who was residing in California on June 1, 1852, if such descendant—

"(A) is a member of the Indian community served by a local program of the Service; and

"(B) is regarded as an Indian by the community in which such descendant lives.

"(3) Any Indian who holds trust interests in public domain, national forest, or reservation allotments in California.

"(4) Any Indian of California who is listed on the plans for distribution of the assets of rancherias and reservations located within the State of California under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

"(b) CLARIFICATION.—Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.".

SEC. 194. METHODS TO INCREASE ACCESS TO PROFESSIONALS OF CERTAIN CORPS.

Section 812 of the Indian Health Care Improvement Act (25 U.S.C. 1680b) is amended to read as follows:

"SEC. 812. NATIONAL HEALTH SERVICE CORPS.

"(a) NO REDUCTION IN SERVICES.—The Secretary shall not remove a member of the National Health Service Corps from an Indian health program or urban Indian or-

ganization or withdraw funding used to support such a member, unless the Secretary, acting through the Service, has ensured that the Indians receiving services from the member will experience no reduction in services.

''(b) TREATMENT OF INDIAN HEALTH PROGRAMS.—At the request of an Indian health program, the services of a member of the National Health Service Corps assigned to the Indian health program may be limited to the individuals who are eligible for services from that Indian health program.''.

SEC. 195. HEALTH SERVICES FOR INELIGIBLE PERSONS.

Section 813 of the Indian Health Care Improvement Act (25 U.S.C. 1680c) is amended to read as follows:

''SEC. 813. HEALTH SERVICES FOR INELIGIBLE PERSONS.

''(a) CHILDREN.—Any individual who—

''(1) has not attained 19 years of age;

''(2) is the natural or adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian; and

''(3) is not otherwise eligible for health services provided by the Service,

shall be eligible for all health services provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs

of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until 1 year after the date of a determination of competency.

''(b) SPOUSES.—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but is not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all such spouses or spouses who are married to members of each Indian tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian tribe or tribal organization providing such services. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

''(c) HEALTH FACILITIES PROVIDING HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary is authorized to provide health services under this subsection through health facilities operated directly by the Service to individuals who reside within the Service

unit and who are not otherwise eligible for such health services if—

"(A) the Indian tribes served by such Service unit requests such provision of health services to such individuals, and

"(B) the Secretary and the served Indian tribes have jointly determined that the provision of such health services will not result in a denial or diminution of health services to eligible Indians.

"(2) ISDEAA PROGRAMS.—In the case of health facilities operated under a contract or compact entered into under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the governing body of the Indian tribe or tribal organization providing health services under such contract or compact is authorized to determine whether health services should be provided under such contract or compact to individuals who are not eligible for such health services under any other subsection of this section or under any other provision of law. In making such determinations, the governing body of the Indian tribe or tribal organization shall take into account the consideration described in paragraph (1)(B). Any services provided by the In-

dian tribe or tribal organization pursuant to a determination made under this subparagraph shall be deemed to be provided under the agreement entered into by the Indian tribe or tribal organization under the Indian Self-Determination and Education Assistance Act. The provisions of section 314 of Public Law 101–512 (104 Stat. 1959), as amended by section 308 of Public Law 103–138 (107 Stat. 1416), shall apply to any services provided by the Indian tribe or tribal organization pursuant to a determination made under this subparagraph.

''(3) PAYMENT FOR SERVICES.—

''(A) IN GENERAL.—Persons receiving health services provided by the Service under this subsection shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Notwithstanding section 207 of this Act or any other provision of law, amounts collected under this subsection, including Medicare, Medicaid, or children's health insurance program reimbursements under titles XVIII, XIX, and XXI of the Social

Security Act (42 U.S.C. 1395 et seq.), shall be credited to the account of the program providing the service and shall be used for the purposes listed in section 401(d)(2) and amounts collected under this subsection shall be available for expenditure within such program.

"(B) INDIGENT PEOPLE.—Health services may be provided by the Secretary through the Service under this subsection to an indigent individual who would not be otherwise eligible for such health services but for the provisions of paragraph (1) only if an agreement has been entered into with a State or local government under which the State or local government agrees to reimburse the Service for the expenses incurred by the Service in providing such health services to such indigent individual.

"(4) REVOCATION OF CONSENT FOR SERVICES.—

"(A) SINGLE TRIBE SERVICE AREA.—In the case of a Service Area which serves only 1 Indian tribe, the authority of the Secretary to provide health services under paragraph (1) shall terminate at the end of the fiscal year succeeding the fiscal year in which the governing

body of the Indian tribe revokes its concurrence to the provision of such health services.

"(B) MULTITRIBAL SERVICE AREA.—In the case of a multitribal Service Area, the authority of the Secretary to provide health services under paragraph (1) shall terminate at the end of the fiscal year succeeding the fiscal year in which at least 51 percent of the number of Indian tribes in the Service Area revoke their concurrence to the provisions of such health services.

"(d) OTHER SERVICES.—The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other provision of law in order to—

"(1) achieve stability in a medical emergency;

"(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard;

"(3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through postpartum; or

"(4) provide care to immediate family members of an eligible individual if such care is directly related to the treatment of the eligible individual.

"(e) HOSPITAL PRIVILEGES FOR PRACTITIONERS.—

"(1) IN GENERAL.—Hospital privileges in health facilities operated and maintained by the Service or operated under a contract or compact pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) may be extended to non-Service health care practitioners who provide services to individuals described in subsection (a), (b), (c), or (d). Such non-Service health care practitioners may, as part of the privileging process, be designated as employees of the Federal Government for purposes of section 1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible individuals as a part of the conditions under which such hospital privileges are extended.

"(2) DEFINITION.—For purposes of this subsection, the term 'non-Service health care practitioner' means a practitioner who is not—

"(A) an employee of the Service; or

"(B) an employee of an Indian tribe or tribal organization operating a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et

seq.) or an individual who provides health care services pursuant to a personal services contract with such Indian tribe or tribal organization.

''(f) ELIGIBLE INDIAN.—For purposes of this section, the term 'eligible Indian' means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section.''.

SEC. 196. ANNUAL BUDGET SUBMISSION.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) is amended by adding at the end the following:

''SEC. 826. ANNUAL BUDGET SUBMISSION.

''Effective beginning with the submission of the annual budget request to Congress for fiscal year 2017, the President shall include, in the amount requested and the budget justification, amounts that reflect any changes in—

''(1) the cost of health care services, as indexed for United States dollar inflation (as measured by the Consumer Price Index); and

''(2) the size of the population served by the Service.''.

SEC. 197. PRESCRIPTION DRUG MONITORING.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) (as amended by section 195) is amended by adding at the end the following:

"SEC. 827. PRESCRIPTION DRUG MONITORING.

"(a) MONITORING.—

"(1) ESTABLISHMENT.—The Secretary, in coordination with the Secretary of the Interior and the Attorney General, shall establish a prescription drug monitoring program, to be carried out at health care facilities of the Service, tribal health care facilities, and urban Indian health care facilities.

"(2) REPORT.—Not later than 18 months after the date of enactment of the Indian Healthcare Improvement Act of 2017, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes—

"(A) the needs of the Service, tribal health care facilities, and urban Indian health care facilities with respect to the prescription drug monitoring program under paragraph (1);

"(B) the planned development of that program, including any relevant statutory or administrative limitations; and

"(C) the means by which the program could be carried out in coordination with any State prescription drug monitoring program.

"(b) ABUSE.—

"(1) IN GENERAL.—The Attorney General, in conjunction with the Secretary and the Secretary of the Interior, shall conduct—

"(A) an assessment of the capacity of, and support required by, relevant Federal and tribal agencies—

"(i) to carry out data collection and analysis regarding incidents of prescription drug abuse in Indian communities; and

"(ii) to exchange among those agencies and Indian health programs information relating to prescription drug abuse in Indian communities, including statutory and administrative requirements and limitations relating to that abuse; and

"(B) training for Indian health care providers, tribal leaders, law enforcement officers, and school officials regarding awareness and prevention of prescription drug abuse and strategies for improving agency responses to ad-

dressing prescription drug abuse in Indian communities.

"(2) REPORT.—Not later than 18 months after the date of enactment of the Indian Healthcare Improvement Act of 2017, the Attorney General shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes—

"(A) the capacity of Federal and tribal agencies to carry out data collection and analysis and information exchanges as described in paragraph (1)(A);

"(B) the training conducted pursuant to paragraph (1)(B);

"(C) infrastructure enhancements required to carry out the activities described in paragraph (1), if any; and

"(D) any statutory or administrative barriers to carrying out those activities.".

SEC. 198. TRIBAL HEALTH PROGRAM OPTION FOR COST SHARING.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) (as amended by section 196) is amended by adding at the end the following:

"SEC. 828. TRIBAL HEALTH PROGRAM OPTION FOR COST SHARING.

"(a) IN GENERAL.—Nothing in this Act limits the ability of a tribal health program operating any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in, a compact with the Service pursuant to title V of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 458aaa et seq.) to charge an Indian for services provided by the tribal health program.

"(b) SERVICE.—Nothing in this Act authorizes the Service—

"(1) to charge an Indian for services; or

"(2) to require any tribal health program to charge an Indian for services.".

SEC. 199. DISEASE AND INJURY PREVENTION REPORT.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) (as amended by section 197) is amended by adding at the end the following:

"SEC. 829. DISEASE AND INJURY PREVENTION REPORT.

"Not later than 18 months after the date of enactment of the Indian Healthcare Improvement Act of 2017, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committees on Natural Resources and Energy and Commerce of the House of Representatives describing—

''(1) all disease and injury prevention activities conducted by the Service, independently or in conjunction with other Federal departments and agencies and Indian tribes; and

''(2) the effectiveness of those activities, including the reductions of injury or disease conditions achieved by the activities.''.

SEC. 200. OTHER GAO REPORTS.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) (as amended by section 198) is amended by adding at the end the following:

''SEC. 830. OTHER GAO REPORTS.

''(a) COORDINATION OF SERVICES.—

''(1) STUDY AND EVALUATION.—The Comptroller General of the United States shall conduct a study, and evaluate the effectiveness, of coordination of health care services provided to Indians—

''(A) through Medicare, Medicaid, or SCHIP;

''(B) by the Service; or

''(C) using funds provided by—

''(i) State or local governments; or

''(ii) Indian tribes.

''(2) REPORT.—Not later than 18 months after the date of enactment of the Indian Healthcare Im-

provement Act of 2017, the Comptroller General shall submit to Congress a report—

"(A) describing the results of the evaluation under paragraph (1); and

"(B) containing recommendations of the Comptroller General regarding measures to support and increase coordination of the provision of health care services to Indians as described in paragraph (1).

"(b) PAYMENTS FOR CONTRACT HEALTH SERVICES.—

"(1) IN GENERAL.—The Comptroller General shall conduct a study on the use of health care furnished by health care providers under the contract health services program funded by the Service and operated by the Service, an Indian tribe, or a tribal organization.

"(2) ANALYSIS.—The study conducted under paragraph (1) shall include an analysis of—

"(A) the amounts reimbursed under the contract health services program described in paragraph (1) for health care furnished by entities, individual providers, and suppliers, including a comparison of reimbursement for that

health care through other public programs and in the private sector;

"(B) barriers to accessing care under such contract health services program, including barriers relating to travel distances, cultural differences, and public and private sector reluctance to furnish care to patients under the program;

"(C) the adequacy of existing Federal funding for health care under the contract health services program;

"(D) the administration of the contract health service program, including the distribution of funds to Indian health programs pursuant to the program; and

"(E) any other items determined appropriate by the Comptroller General.

"(3) REPORT.—Not later than 18 months after the date of enactment of the Indian Healthcare Improvement Act of 2017, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations regarding—

"(A) the appropriate level of Federal funding that should be established for health care

under the contract health services program described in paragraph (1);

''(B) how to most efficiently use that funding; and

''(C) the identification of any inequities in the current distribution formula or inequitable results for any Indian tribe under the funding level, and any recommendations for addressing any inequities or inequitable results identified.

''(4) CONSULTATION.—In conducting the study under paragraph (1) and preparing the report under paragraph (3), the Comptroller General shall consult with the Service, Indian tribes, and tribal organizations.''.

SEC. 201. TRADITIONAL HEALTH CARE PRACTICES.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) (as amended by section 199) is amended by adding at the end the following:

''SEC. 831. TRADITIONAL HEALTH CARE PRACTICES.

''Although the Secretary may promote traditional health care practices, consistent with the Service standards for the provision of health care, health promotion, and disease prevention under this Act, the United States is not liable for any provision of traditional health care practices pursuant to this Act that results in damage, in-

jury, or death to a patient. Nothing in this subsection shall be construed to alter any liability or other obligation that the United States may otherwise have under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) or this Act.''.

SEC. 202. DIRECTOR OF HIV/AIDS PREVENTION AND TREATMENT.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) (as amended by section 199A) is amended by adding at the end the following:

''SEC. 832. DIRECTOR OF HIV/AIDS PREVENTION AND TREATMENT.

''(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish within the Service the position of the Director of HIV/AIDS Prevention and Treatment (referred to in this section as the 'Director').

''(b) DUTIES.—The Director shall—

''(1) coordinate and promote HIV/AIDS prevention and treatment activities specific to Indians;

''(2) provide technical assistance to Indian tribes, tribal organizations, and urban Indian organizations regarding existing HIV/AIDS prevention and treatment programs; and

''(3) ensure interagency coordination to facilitate the inclusion of Indians in Federal HIV/AIDS

research and grant opportunities, with emphasis on the programs operated under the Ryan White Comprehensive Aids Resources Emergency Act of 1990 (Public Law 101–381; 104 Stat. 576) and the amendments made by that Act.

''(c) REPORT.—Not later than 2 years after the date of enactment of the Indian Healthcare Improvement Act of 2017, and not less frequently than once every 2 years thereafter, the Director shall submit to Congress a report describing, with respect to the preceding 2-year period—

''(1) each activity carried out under this section; and

''(2) any findings of the Director with respect to HIV/AIDS prevention and treatment activities specific to Indians.''.

TITLE II—AMENDMENTS TO OTHER ACTS AND MISCELLANEOUS PROVISIONS

SEC. 201. ELIMINATION OF SUNSET FOR REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

(a) REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.—Section 1880(e)(1)(A) of the Social Secu-

rity Act (42 U.S.C. 1395qq(e)(1)(A)) is amended by striking ''during the 5-year period beginning on'' and inserting ''on or after''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items or services furnished on or after January 1, 2017.

SEC. 202. INCLUDING COSTS INCURRED BY AIDS DRUG ASSISTANCE PROGRAMS AND INDIAN HEALTH SERVICE IN PROVIDING PRESCRIPTION DRUGS TOWARD THE ANNUAL OUT-OF-POCKET THRESHOLD UNDER PART D.

(a) IN GENERAL.—Section 1860D–2(b)(4)(C) of the Social Security Act (42 U.S.C. 1395w-102(b)(4)(C)) is amended—

(1) in clause (i), by striking ''and'' at the end;

(2) in clause (ii)—

(A) by striking ''such costs shall be treated as incurred only if'' and inserting ''subject to clause (iii), such costs shall be treated as incurred only if'';

(B) by striking '', under section 1860D–14, or under a State Pharmaceutical Assistance Program''; and

(C) by striking the period at the end and inserting ''; and''; and

(3) by inserting after clause (ii) the following new clause:

"(iii) such costs shall be treated as incurred and shall not be considered to be reimbursed under clause (ii) if such costs are borne or paid—

"(I) under section 1860D–14;

"(II) under a State Pharmaceutical Assistance Program;

"(III) by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or

"(IV) under an AIDS Drug Assistance Program under part B of title XXVI of the Public Health Service Act.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to costs incurred on or after January 1, 2017.

SEC. 203. PROHIBITION OF USE OF FEDERAL FUNDS FOR ABORTION.

No funds authorized or appropriated by this Act (or an amendment made by this Act) may be used to pay for

any abortion or to cover any part of the costs of any health plan that includes coverage of abortion, except in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself, or unless the pregnancy is the result of an act of rape or incest.

SEC. 204. REAUTHORIZATION OF NATIVE HAWAIIAN HEALTH CARE PROGRAMS.

(a) REAUTHORIZATION.—The Native Hawaiian Health Care Act of 1988 (42 U.S.C. 11701 et seq.) is amended by striking ''2001'' each place it appears in sections 6(h)(1), 7(b), and 10(c) (42 U.S.C. 11705(h)(1), 11706(b), 11709(c)) and inserting ''2019''.

(b) HEALTH AND EDUCATION.—

(1) IN GENERAL.—Section 6(c) of the Native Hawaiian Health Care Act of 1988 (42 U.S.C. 11705) is amended by adding at the end the following:

''(4) HEALTH AND EDUCATION.—In order to enable privately funded organizations to continue to supplement public efforts to provide educational programs designed to improve the health, capability,

and well-being of Native Hawaiians and to continue to provide health services to Native Hawaiians, notwithstanding any other provision of Federal or State law, it shall be lawful for the private educational organization identified in section 7202(16) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7512(16)) to continue to offer its educational programs and services to Native Hawaiians (as defined in section 7207 of that Act (20 U.S.C. 7517)) first and to others only after the need for such programs and services by Native Hawaiians has been met.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect on December 5, 2006.

(c) DEFINITION OF HEALTH PROMOTION.—Section 12(2) of the Native Hawaiian Health Care Act of 1988 (42 U.S.C. 11711(2)) is amended—

(1) in subparagraph (F), by striking ''and'' at the end;

(2) in subparagraph (G), by striking the period at the end and inserting '', and''; and

(3) by adding at the end the following:

''(H) educational programs with the mission of improving the health, capability, and well-being of Native Hawaiians.''.

Congress of the United States
Washington, DC 20515

December 2, 2016

Dear Governors and Commissioners:

As Obamacare continues to saddle patients with less choice, higher costs, and mountains of mandates, it is clear that major health care reforms must be made to strengthen and improve health care for all Americans. In the coming months, Congress will begin debating and implementing needed legislation. Lawmakers, Governors, and state insurance commissioners have a tremendous opportunity to achieve our shared goal of enacting health care reforms that lower costs, improve quality, empower states and individuals, and bring our health care system into the 21st Century.

Through our efforts to reach consensus on *A Better Way* for health care, House Republicans gave a lot of thought to policies that would help put health care spending on a more sustainable path, improve innovation, cut costs, empower patients, and increase choices. And we need your ideas too. That is why we are seeking input and recommendations based on your experience overseeing the health insurance markets and Medicaid programs within your state, for both expansion and non-expansion states. Governors and state insurance commissioners play an integral role in the health system and will be invaluable partners as we tackle these important changes together. In fact, we expect that health care officials in your state have already begun deliberative and thorough discussions on what local and unique priorities must be achieved in your upcoming legislative session. Working together, we are hopeful our joint efforts can help your state make fiscally sustainable reforms and give all patients a fair shot at quality, affordable health care.

To begin an ongoing and open dialogue, we would appreciate if you and your staff would take time to provide answers to the following questions:

1. What changes should Congress consider to grant more flexibility to states to provide insurance options that expand choices and lower premiums?
2. What legislative and regulatory reforms should Congress and the incoming administration consider to stabilize your individual, small group, and large group health insurance markets?
3. What are key administrative, regulatory, or legislative changes you believe would help you reduce costs and improve health outcomes in your Medicaid program, while still delivering high quality care for the most vulnerable?
4. What can Congress do to preserve employer-sponsored insurance coverage and reduce costs for the millions of Americans who receive health coverage through their jobs?
5. What key long-term reforms would improve affordability for patients?
6. Does your state currently have or plan to enact authority to utilize a Section 1332 Waivers for State Innovation beginning January 1, 2017?
    a. If allowed, would your state utilize a coordinated waiver application process for both 1115 Medicaid and 1332 State Innovation Waivers for benefit year 2017?

b. If allowed, would your state utilize a model waiver for expedited review and approval similar to the Medicare Part D transition[1] and assistance for Hurricane Katrina evacuees?[2]
c. If allowed, which requirements would your state seek to waive under a 1332 waiver?
d. If allowed—and if applicable— what changes would be necessary to current guidance to accelerate your state's ability to pursue a 1332 waiver?

7. As part of returning more choice, control and access to the states and your constituents, would your state pursue the establishment of a high-risk pool if federal law were changed to allow one?
8. What timing issues, such as budget deadlines, your legislative calendar, and any consumer notification and insurance rate and form review requirements, should we consider while making changes?
9. Has your state adopted any of the 2010 federal reforms into state law? If so, which ones? What impact would repeal have on these state law changes?

Please provide responses by Friday, January 6, 2017. Please submit all written comments to https://www.majorityleader.gov/**state-healthcare-recommendations**/. Along with your submission, please identify a staffer we can work with to coordinate feedback and meetings.
Additionally, we would be honored if you would join us in Washington early next year to discuss your ideas and better inform the work of Congress. We will invite the Governor and insurance commissioner of every state to attend this meeting.

The American people deserve more patient-oriented solutions driven by innovative thinking that takes into consideration the unique needs of a diverse country. This means more state choices and fewer federal mandates. Our values, based on the principles of Federalism, drive a philosophy that States should have the freedom and flexibility to create options that are best for patients. Insurers should compete for consumer business and treat patients fairly. And Americans should have access to the best life-saving treatments in the world. Working as a team, with your help and creative ideas, we can achieve our mutual goal of putting patients first.

Sincerely,

Kevin McCarthy
House Majority Leader

Kevin Brady
Chairman
House Committee on Ways and Means

Fred Upton
Chairman
House Committee on Energy and Commerce

John Kline
Chairman
House Committee on Education and the Workforce

[1] Centers for Medicare and Medicaid Services. "State Reimbursement for Medicare Part D Transition." January 24, 2006. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2006-Fact-sheets-items/2006-01-24.html.
[2] Centers for Medicare and Medicaid Services. "Disaster Relief for Hurricane Katrina Evacuees in Texas." September 15, 2005. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2005-Fact-sheets-items/2005-09-15.html.

Greg Walden
Chair-Elect
House Committee on Energy and Commerce

Virginia Foxx
Chair-Elect
House Committee on Education and the Workforce

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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

$$$ ~ Weekly Funding Opportunities Report ~$$$

Friday, March 17, 2017

To: Idaho Delegates, Oregon Delegates, Washington Delegates, Tribal Chairs and Tribal Health Directors

Greetings! The NPAIHB - Funding Opportunity is provided on the basis that when there is pertinent announces that we are made aware of, received and researched for as part of our commitment to the health and well-being of our tribal members it is posted here for you. Every Friday, new posts will be available (unless there is nothing **"New" Funding Opportunity Information (is provided in this color code).**

If you have a specific targeted goal, or urgent community needs and find yourself not knowing where to start looking our assistance is available anytime, and we would be very excited to assist you. Also, at the end of this announcement there are several funding organizations that do not have deadlines and do accept proposals all year round. Thank you for your time, please do not hesitate to contact me:

Tara Fox, Grant Specialist
E-mail: tfox@npaihb.org
Office Phone: (503) 416-3274

Community Approaches to Reducing Sexually Transmitted Diseases (CARS)

Department of Health and Human Services/Centers for Disease Control - NCHHSTP

DEADLINE: Apr 01, 2017 Electronically submitted applications must be submitted no later than 5:00 p.m., ET, on the listed application due date.

AMOUNT: $312,500

DESCRIPTION: The Centers for Disease Control and Prevention (CDC) announces the availability of Fiscal Year (FY) 2017 funds fora cooperative agreement with organizations with demonstrated experience and capacity of implementing community engagement methods (e.g. community-based participatory research) and multi-sector partnerships to promote sexual health, advance community wellness, influence sexual health behavior and practices, and reduce STI disparities. In accordance with the Healthy People 2020 Goals for the nation, this FOA focuses on reducing the proportion of adolescents and young adults with Chlamydia trachomatis infections, reducing Chlamydia rates among females aged 15-44 years, reducing gonorrhea rates, reducing sustained domestic transmission of primary

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and secondary syphilis, congenital syphilis, GC incidence, and reducing the proportion of young adults with genital herpes infection due to herpes simplex type 2. The new FOA provides support in five focus areas. These focus areas are: (1) implementation of community engagement methods (e.g. community-based participatory research) to achieve health equity; (2) identification and implementation of systems and environmental change strategies that (a) promote sexual health and support healthy behaviors and (b) facilitate community-clinical linkages to build support for interventions to prevent and reduce STI disparities; (3) enhancement and sustainability of partnerships; (4) support for communication strategies to promote STD program successes and leverage additional resources for STI control and prevention; and (5) evaluation of the efficacy of this approach and intervention implementation. Measureable outcomes are: 1. Community Engagement: Community members actively participate in and are satisfied with Community Advisory Board (CAB); perceived power among CAB members; community social determinants of health priority are identified; community involved in design of interventions to reduce STD disparities; increased linkages with and access to target groups. 2. Identification and implementation of system and environmental strategies: Existing clinical resources identified; community priorities and effective community-designed interventions are implemented, evaluated, and sustained; positivity and treatment rates from community events and STD screenings are documented; decrease in exposure to social disorder (e.g., presence of trash, lack of community cooperation); decrease in risky sexual behavior; decrease in STD disparities; 3. Multi-sectorial partnerships: New and stable partnerships are formed; partner resources and influence are used to implement, evaluate, and community-designed interventions; 4. Communication: Increased awareness of STD disparities and sexual health issues through mixed-modal communication methods including social media; increased access to and use of community health resources and support services by target groups most impacted by STD disparities; increased access to and use of educational opportunities by target groups; implementation of effective health equity and sexual health communication methods. This FOA is designed to begin on September 30, 2017 and replaces FOA PS14-1406

WEBSITE/LINK: **http://www.grants.gov/web/grants/view-opportunity.html?oppId=290103**

The Substance Abuse and HIV Prevention Navigator Program for Racial/Ethnic Minorities Ages 13-24 Cooperative Agreement

DEADLINE: Monday, April 17, 2017

AMOUNT: Up to $200,000 per year X 5 years.

DESCRIPTION: The purpose of this program is to provide services to those at highest risk for HIV and substance use disorders, especially racial/ethnic males ages 13-24 at risk for HIV/AIDS including males who have sex with other males (MSM). The program will place a particular emphasis on those individuals who are not in stable housing in communities with high incidence and prevalence rates of substance misuse and HIV infection. It will provide opportunities to enhance outreach to the population of focus and assist them in receiving HIV medical care. The program proposes to use a navigation approach (Community Health Workers, Neighborhood Navigators, and Peer Support Specialists) to expedite services for these populations. Community-based organizations will be provided the opportunity to deliver comprehensive HIV/AIDS-related support services and

transition assistance (substance misuse prevention and HIV medical care, housing, employment, family, education and prescription drug assistance services) that will reduce morbidity and mortality for this high risk group.

WEBSITE/LINK: **https://www.samhsa.gov/grants/grant-announcements/sp-17-004**

Services Grant Program for Residential Treatment for Pregnant and Postpartum Women

DEADLINE: Monday, April 17, 2017

AMOUNT: Up to $524,000 per year x 5 years.

DESCRIPTION: The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) is accepting applications for fiscal year (FY) 2017 Residential Treatment for Pregnant and Postpartum Women (PPW) grant program. The purpose of this program is to expand comprehensive treatment, prevention and recovery support services for women and their children in residential substance use treatment facilities, including services for non-residential family members of both the women and children.

The populations of focus are low-income (according to federal poverty guidelines) women, age 18 and over, who are pregnant, postpartum (the period after childbirth up to 12 months), and their minor children, age 17 and under, who have limited access to quality health services. SAMHSA has identified traditionally underserved populations, especially racial and ethnic minority women, as a population of focus. SAMHSA is particularly concerned about the high morbidity and mortality rates of pregnant women and their infants among African Americans. Services should be extended, when deemed appropriate, to fathers of the children, partners of the women, and other family members of the women and children who do not reside in the residential treatment facility.

WEBSITE/LINK: **https://www.samhsa.gov/grants/grant-announcements/ti-17-007**

Grants for the Benefit of Homeless Individuals

DEADLINE: Tuesday, April 25, 2017

AMOUNT: Up to $400,000 per year X 5 years.

DESCRIPTION: The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), is accepting applications for fiscal year (FY) 2017 Grants for the Benefit of Homeless Individuals (Short Title: GBHI). The purpose of this program is to support the development and/or expansion of local implementation of a community infrastructure that integrates behavioral health treatment and services for substance use disorders (SUD) and co-occurring mental and substance use disorders (COD), permanent housing, and other critical services for individuals (including youth) and families experiencing homelessness.

WEBSITE/LINK: **https://www.samhsa.gov/grants/grant-announcements/ti-17-009**

Targeted Capacity Expansion-HIV Program: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS

DEADLINE: Wednesday, May 3, 2017

AMOUNT: Up to $500,000 per year X 5 years.

ELIGIBILITY: Eligibility is restricted to local-level public and private nonprofit entities that provide substance use and co-occurring services, and have established linkages to primary HIV services including:

Local governments,

Federally recognized American Indian/Alaska Native (AI/AN) tribes and tribal organizations,

Urban Indian organizations (UIOs),

Public or private universities and colleges, and

Community- and faith-based organizations.

Tribal organization means the recognized body of any AI/AN tribe; any legally established organization of AI/ANs which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of AIs/ANs in all phases of its activities. Consortia of tribes or tribal organizations are eligible to apply, but each participating entity must indicate its approval. A single tribe in the consortium must be the legal applicant, the recipient of the award, and the entity legally responsible for satisfying the grant requirements.

UIO (as identified by the Office of Indian Health Service Urban Indian Health Programs through active Title V grants/contracts) means a non-profit corporate body situated in an urban center governed by an urban Indian-controlled board of directors, and providing for the maximum participation of all interested individuals and groups, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in 25 U.S.C. 1653(a). UIOs are not tribes or tribal governments and do not have the same consultation rights or trust relationship with the federal government.

Applicants must demonstrate partnership with primary HIV treatment and care providers. Applicants must document this partnership, which can be demonstrated by letters of commitment and MOAs from partnering organizations in Attachment 1 of the application.

Given the focus on local service provision, SAMHSA is limiting these awards to direct treatment service providers and local governments. Therefore, states are not eligible to apply. Also, in an effort to impact the second prong of the 90-90-90 goal by allowing for expansion to a number of new organizations and additional communities receiving TCE-HIV grant awards, grantees that received an award under the following FOAs are not eligible to apply: TI-15-006 Targeted Capacity Expansion: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High-Risk for HIV/AIDS and TI-16-011 Targeted Capacity Expansion HIV: Substance Use Disorder Treatment for Racial/Ethnic Minority Women at High Risk for HIV/AIDS.

DESCRIPTION: The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) is accepting applications for fiscal year (FY) 2017 Targeted Capacity Expansion-HIV Program: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High-Risk for HIV/AIDS (Short Title: TCE-HIV: High Risk Populations) cooperative agreements. The purpose of this program is to increase engagement in care for racial and ethnic minority individuals with substance use disorders (SUD) and/or co-occurring substance use and mental disorders (COD) who are at risk for HIV or HIV positive that receive HIV services/treatment. The program also aims to contribute to the nation's achievement of the 90-90-90 goals regarding HIV status and treatment.

This program will focus on high risk populations including racial/ethnic minority populations, such as black young men who have sex with men (YMSM) (ages 18-29), and other high-risk populations such as Latino YMSM and men who have sex with men (MSM) (ages 30 years and older), and gay, bisexual, and transgender individuals who have a SUD or COD who are HIV positive or at risk for HIV/AIDS. This cooperative agreement will support the following activities: linkage to care for racial and ethnic minority individuals with SUD and/or COD treatment needs who are HIV positive or at high risk for HIV, including SUD and/or COD treatment and recovery support services; HIV/AIDS testing and case management services, including linkage and provision of HIV care and treatment; Hepatitis testing, vaccination, and referral/linkage for treatment and case management; housing support services; outreach; and enhancement and expansion of infrastructure and capacity to retain clients in SUD/COD and HIV/AIDS care.

The expected outcomes for the program include increasing the number of individuals with SUD/COD who are HIV positive that are on antiretroviral therapy (ART) and linked to HIV care, reducing the impact of behavioral health problems, reducing HIV risk and incidence, reducing trauma related conditions, and increasing access to and retention in treatment for individuals with co-existing behavioral health, HIV, and hepatitis conditions. This program will ensure that individuals who have been diagnosed with a SUD and/or COD and who are HIV positive or most at risk for HIV/AIDS have access to and receive appropriate behavioral health services. Cooperative agreement funds must be used to serve people diagnosed with a SUD as their primary condition.

WEBSITE/LINK: **https://www.samhsa.gov/grants/grant-announcements/ti-17-011**

Evidence-Based Falls Prevention Programs Financed Solely by 2017 Prevention and Health Funds (PPHF-2017) DHHS/Administration for Community Living

DEADLINE: May 13, 2017 Electronically submitted applications must be submitted no later than 11:59 p.m., ET, on the listed application due date.

AMOUNT: $600,000 x 3 years.

DESCRIPTION: The Administration on Aging (AoA) within the Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS) forecasts the possible availability of Fiscal Year (FY) 2017 funds to make three-year grants to approximately 6-8 entities to bring to scale and sustain evidence-based falls prevention programs that will reduce the number of falls, fear of falling, and fall-related injuries in older adults and adults with disabilities. Goal 1: Significantly increase the number of older adults and adults with disabilities at risk of falls who participate in evidence-based

community programs to reduce falls and falls risks; and Goal 2: Implement innovative funding arrangements (e.g. contracts with integrated health care systems) to support community-based falls prevention programs beyond the grant period, while embedding the programs into an integrated, sustainable evidence-based prevention program network.

WEBSITE/LINK: https://www.grants.gov/web/grants/view-opportunity.html?oppId=290900

FY2017 AmeriCorps Indian Tribes Grants

DEADLINE: CNCS strongly encourages applicants to submit a Notification of Intent to Apply by Wednesday, April 19, 2017 by using this link:
https://www.surveymonkey.com/r/2017ACTribesIntent

The deadline for applications to the 2017 Notice of Funding is Wednesday, May 10, 2017 at 5:00 p.m. Eastern Time.

CNCS expects that successful applicants will be notified no later than July 11, 2017.

AMOUNT: CNCS expects a highly competitive AmeriCorps grant competition. CNCS reserves the right to prioritize providing funding to existing awards over making new awards. The actual level of funding will be subject to the availability of annual appropriations. Grant awards have two components: operating funds and AmeriCorps member positions. Grant award amounts vary – both in the level of operating funds and in the type and amount of AmeriCorps member positions – as determined by the scope of the projects.

DESCRIPTION: The mission of CNCS is to improve lives, strengthen communities, and foster civic participation through service and volunteering. Through AmeriCorps, Senior Corps, the Social Innovation Fund, and the Volunteer Generation Fund, CNCS has helped to engage millions of citizens in meeting community and national challenges through service and volunteer action.

AmeriCorps grants are awarded to eligible organizations (see Eligible Applicants section) proposing to engage AmeriCorps members in evidence-based or evidence-informed interventions to strengthen communities. An AmeriCorps member is an individual who engages in community service through an approved national service position. Members may receive a living allowance and other benefits while serving. Upon successful completion of their service, members earn a Segal AmeriCorps Education Award from the National Service Trust that members can use to pay for higher education expenses or apply to qualified student loans.

WEBSITE/LINK: https://www.nationalservice.gov/build-your-capacity/grants/funding-opportunities/2017/fy2017-americorps-indian-tribes-grants%20

Disaster Assistance for State Units on Aging (SUAs) and Tribal Organizations in National Disasters Declared by the President – DHHS/Administration for Community Living

DEADLINE: Sep 15, 2017 Electronically submitted applications must be submitted no later than 11:59 p.m., ET, on the listed application due date.

AMOUNT: $40,000

DESCRIPTION: Grants awarded under this announcement are to provide disaster reimbursement and assistance funds to those State Units on Aging (SUAs) and federally recognized Tribal Organizations who are currently receiving a grant under Title VI of the Older Americans Act (OAA), as amended. These funds only become available when the President declares a National Disaster and may only be used in those areas designated in the Disaster Declaration issued by the President of the United States. Eligible SUAs and Title VI grantees should discuss all disaster applications with ACL/AoA Regional staff before submitting a formal application. The amount of funds requested should be discussed with Regional staff before the application is completed. Providing a draft of the narrative justification for the application will help expedite the processing of an award. Applicants should talk with the State and local Emergency Managers to determine what funds may be available through other resources before applying for OAA funding. State Units on Aging (SUAs) and federally recognized Tribal Organizations currently receiving a grant under Title VI of the Older Americans Act must submit proposals electronically via http://www.grants.gov . At http://www.grants.gov, you will be able to download a copy of the application packet, complete it off-line, and then upload and submit the application via the Grants.gov website.

WEBSITE/LINK: **https://www.grants.gov/web/grants/view-opportunity.html?oppId=289875**

U.S. Tobacco Control Policies to Reduce Health Disparities (R21) – DHHS/NIH

DEADLINE: May 24, 2017. Letter of Intent Due Date(s) - 30 days prior to the application due date.

AMOUNT: $200,000

DESCRIPTION: The purpose of this Funding Opportunity Announcement (FOA) is to support observational or intervention research focused on reducing health disparities in tobacco use in the United States. Specifically, this FOA is intended to stimulate scientific inquiry focused on innovative tobacco control policies including, but not limited to, those addressing health economics (e.g. tax and pricing policies, insurance coverage for tobacco dependence treatment). Applicants may propose projects in which the primary outcome of interest is on reducing tobacco use health disparities in vulnerable populations by utilizing tobacco prevention and control strategies. The long-term goal of this FOA is to reduce health disparities in health outcomes thereby reducing the excess disease burden of tobacco use within these groups. This FOA provides funding for up to 2-years for research planning, intervention delivery, dissemination and implementation. Applicants submitting proposals related to health economics are encouraged to consult NOT-OD-16-025 to ensure that proposals align with NIH mission priorities in health economics research.

WEBSITE/LINK: **https://grants.nih.gov/grants/guide/pa-files/PAR-17-218.html**

Marijuana, Prescription Opioid, or Prescription Benzodiazepine Drug Use Among Older Adults (R01) - Department of Health and Human Services/National Institutes of Health

DEADLINE: June, 5, 2017

AMOUNT: See announcement web link.

DESCRIPTION: Despite significant scientific advancements made in substance use disorder research over the last century, the causes and consequences of drug use in later life remain poorly understood. The intent of this funding opportunity announcement is to support innovative research that examines aspects of marijuana and prescription opioid and benzodiazepine use in adults aged 50 and older. This FOA encourages research that examines the determinants of these types of drug use and/or characterizes the resulting neurobiological alterations, associated behaviors, and public health consequences. This initiative will focus on two distinct populations of older adults: individuals with earlier onset of drug use who are now entering this stage of adult development or individuals who initiate drug use after the age of 50. Applications are encouraged to utilize broad methodologies ranging from basic science, clinical, and epidemiological approaches. The insights gleaned from this initiative are critical to our understanding of the determinants of drug use in later life, as well as its consequences in the aging brain and on behavior. This knowledge may have the potential to identify risk factors and to guide clinical practices in older populations.

WEBSITE/LINK: **https://grants.nih.gov/grants/guide/pa-files/PA-17-196.html**

Hearing Health Care for Adults: Improving Access and Affordability (R01)- Department of Health and Human Services/National Institutes of Health

DEADLINE: June 5, 2017

AMOUNT:

DESCRIPTION: This FOA encourages on hearing loss and hearing health care in adults in support of improving access and affordability. Further research is needed to strengthen the evidence base with a goal of delivering better hearing health care outcomes in adults. These goals are highlighted in the NIDCD Strategic Research Plan: **https://www.nidcd.nih.gov/about/strategic-plan/2012-2016/2012-2016-nidcd-strategic-plan** This FOA encourages applications addressing the research recommendations in the 2009 NIDCD research workshop on AAHHC and the 2016 NASEM report "Hearing Health Care for Adults: Priorities for Improving Access and Affordability".

WEBSITE/LINK: **https://grants.nih.gov/grants/guide/pa-files/PA-17-202.html**

Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs Financed Solely by 2017 Prevention and Public Health Funds (PPHF-2017) -Department of Health and Human Services/Administration for Community Living

DEADLINE: May 12, 2017 Electronically submitted applications must be submitted no later than 11:59 p.m., ET, on the listed application due date.

AMOUNT: $900,000 X 8 awards

DESCRIPTION: The Administration on Aging (AoA) within the Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS) forecasts the possible availability of Fiscal Year (FY) 2017 funds to make three-year grants to approximately 6-8 entities to bring to scale and sustain evidence-based programs that empower older adults and adults with disabilities to better manage their chronic conditions. Goal 1: Significantly increase the number of older adults and adults with disabilities who participate in evidence-based self-management programs to empower them to better manage their chronic conditions; and Goal 2: Implement innovative funding arrangements (e.g. contracts with integrated health care systems) to support the CDSME programs beyond the grant period, while embedding the programs into an integrated, sustainable evidence-based prevention program network.

WEBSITE/LINK: **https://www.grants.gov/web/grants/view-opportunity.html?oppId=290899**

Alzheimer's Disease Supportive Services Program (ADSSP): Creating and Sustaining Dementia-Capable Service Systems for People with Dementia and their Family Caregivers - Department of Health and Human Services/Administration for Community Living

DEADLINE: May 12, 2017 Electronically submitted applications must be submitted no later than 11:59 p.m., ET, on the listed application due date.

AMOUNT: $650,000 X 7 awards.

DESCRIPTION: (See state eligibility announcement.) The objective of the Alzheimer's disease Supportive Services Program (ADSSP) is to expand the availability of dementia-capable support services for persons with Alzheimers Disease and Related Dementias (ADRD), their families and their caregivers. This goal will be achieved by: 1) enhancing the ability of state systems and programs to embed dementia-capability in their service networks; and 2) by delivering dementia-capable supportive services using evidence-based and/or evidence-informed interventions to support persons with dementia and their caregivers. The grantees receive targeted technical assistance provided by the National Alzheimer's and Dementia Resource Center.

WEBSITE/LINK: **https://www.grants.gov/web/grants/view-opportunity.html?oppId=291743**

2017 MARCH

NIJ FY17 Research and Evaluation on Violence Against Women: Teen Dating Violence, Sexual Violence, and Intimate Partner Violence Department of Justice National Institute of Justice

DEADLINE: Mar 20, 2017

AMOUNT: $5,000,000

DESCRIPTION: Violence Against Women research and evaluation is one of the major foci of NIJ's Violence and Victimization Research Division. The goals of the Violence Against Women program of research are to improve knowledge and understanding of teen dating violence, intimate partner violence, stalking, and sexual violence. NIJ strives to support objective and independent knowledge and validated tools to reduce violence against women and girls, and promote justice for victims of crime.

WEBSITE/LINK: **http://www.grants.gov/web/grants/view-opportunity.html?oppId=291274**

CDC's Collaboration with Academia to Strengthen Public Health Workforce Capacity Department of Health and Human Services Centers for Disease Control - CSELS

DEADLINE: Mar 31, 2017 Electronically submitted applications must be submitted no later than 11:59 p.m., EST, on the listed application due date.

AMOUNT: $1,000,000

DESCRIPTION: The purpose of this FOA is to advance the educational preparation of public health, medical, and baccalaureate and higher degree nursing students and provide opportunities that strengthen population health and public health practice competencies through innovative approaches which include, but are not limited to: 1) improved integration of public/population health concepts into health profession education, 2) hands-on experience for students and emerging health professionals, as well as faculty development opportunities, working with communities, professionals from related disciplines, and public health partners to address the leading causes of death and illness, 3) specific additional projects funded by CDC programs that provide workforce development opportunities in academic or public health practice settings or that introduce public health careers, and 4) programs that provide fellowships and rotational assignments at CDC's domestic offices, state, tribal, local, and territorial health departments, or in other community-based settings. The overall goal is to create the opportunities for academia to develop qualified, knowledgeable and experienced students and emerging health professionals suitably prepared to serve in governmental public health practice, or able to apply public health concepts in various healthcare or other settings, to collectively meet the challenge of improving the populations health.

WEBSITE/LINK: **http://www.grants.gov/web/grants/view-opportunity.html?oppId=291425**

Partnerships to Achieve Health Equity (Partnership)

DEADLINE: March 31, 2017 by 5 p.m. Eastern Time

AMOUNT: $400,000

DESCRIPTION: The Office of Minority Health (OMH), located within the Office of the Secretary of the United States Department of Health and Human Services (HHS or

Department), announces the anticipated availability of funds for Fiscal Year (FY) 2017 for grant awards for the Partnerships to Achieve Health Equity (Partnership program) under the authority of 42 U.S.C. § 300u-6 (Public Health Service Act § 1707). This notice solicits applications for the Partnership program.

The Partnership program is intended to demonstrate that partnerships between Federal agencies and organizations with a nationwide or regional reach, focus or impact can efficiently and effectively do one of the following: (1) improve access to and utilization of care by racial and ethnic minority and/or disadvantaged populations; (2) develop innovative models for managing multiple chronic conditions including health promotion and disease prevention for individuals with multiple chronic conditions that disparately affect racial and ethnic minorities and affect morbidity; (3) increase the diversity of the health workforce including health professionals, health researchers and health scientists through programs at the high school or 4 undergraduate level that focus on racial and ethnic health disparities and health equity, and which include mentoring as a core component; or (4) increase data availability and utilization of data that increases the knowledge base regarding health disparities and facilitates the development, implementation and assessment of health equity activities, including but not limited to the creation of new linked datasets, using longitudinal and/or linked data sets, design and test innovative models that explore the independent and interactive influences of social determinants of health on a) health behaviors, b) utilization of health services, and c) health conditions, such that causal relationships are demonstrated, and training and technical support in data use for community-based and/or public health partners engaged in health equity efforts.

Partnership projects' strategies should include innovative multi- partner collaboration, address social determinants of health, and incorporate the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). 1

WEBSITE/LINK:
https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=58588 http://www.grants.gov/web/grants/view-opportunity.html?oppId=289362

NOT HEALTH RELATED:

The Cross-Jurisdictional Sharing Small Grants Program

DEADLINE: Applications will be considered on a rolling basis from January 2 until March 31, 2017, or until all five small grants are awarded, whichever comes first.

AMOUNT: Awards will be up to $10,000 for a project period of up to six months.

DESCRIPTION: The Center for Sharing Public Health Services (the "Center") is offering up to five small grants to organizations that wish to explore, plan, implement or improve some aspects of cross-jurisdictional sharing (CJS) in public health. This opportunity is available for 1) public health agencies, 2) organizations representing policymakers with the authority to enter into CJS agreements, or 3) their designated agents. Proposals must fall into one of two categories: 1) Proposals focused on the implementation of a specific CJS arrangement among multiple jurisdictions, or 2) Proposals that are not linked to a specific CJS arrangement but otherwise contribute to the achievement of the Center's goals described in this document.

WEBSITE/LINK: http://phsharing.org/wp-content/uploads/2016/12/Small-Grant-Program-2017.pdf

2017 APRIL

FAHS-BECK FUND FOR RESEARCH AND EXPERIMENTATION A Fund Established with The New York Community Trust

DEADLINE: April 1 and November 1 – 5 p.m. eastern time.

AMOUNT: Grants of up to $20,000 are available to help support the research of faculty members or post-doctoral researchers affiliated with non-profit human service organizations in the United States and Canada.

DESCRIPTION: Areas of interest to the Fund are: studies to develop, refine, evaluate, or disseminate innovative interventions designed to prevent or ameliorate major social, psychological, behavioral or public health problems affecting children, adults, couples, families, or communities, or studies that have the potential for adding significantly to knowledge about such problems. The research for which funding is requested must focus on the United States and/or Canada or on a comparison between the United States and/or Canada and one or more other countries.

Who May Apply

Faculty members of accredited colleges or universities or individuals affiliated with accredited non-profit human service organizations in the United States or Canada are eligible to apply. The applicant organization must agree to accept administrative responsibility for the project and submit required financial forms and reports to the Fund.

The principal investigator (PI) must have an earned doctorate in a relevant discipline and relevant experience. The PI must be in full control of the research and be the principal author of the final report.

Service Component of Proposed Research

If there is a service component of the proposed research, it must be provided by an organization or individual that has the appropriate accreditation, certification, or licensure.

WEBSITE/LINK:
http://www.fahsbeckfund.org/pdf_files/Post_Doctoral_Guidelines.pdf

Massage Therapy Foundation Invites Applications for Community Service Grants

DEADLINE: APRIL 3, 2017

AMNOUNT: Grants of up to $5,000 will be awarded to nonprofit organizations that provide massage therapy to people who currently have little or no access to such services.

DESCRIPTION: The Massage Therapy Foundation advances the knowledge and practice of massage therapy through support for scientific research, education, and community service. To that end, the foundation is accepting applications for its 2015 Community Service grants program.

The program is designed to promote working partnerships between the massage therapy profession and community-based organizations. To be eligible, applicants must be a nonprofit 501(c)(3) organization or affiliate of an organization that has been in existence for at least a year and currently provides some therapeutic or other service programs to the community.

WEBSITE/LINK: http://massagetherapyfoundation.org/grants-and-contests/community-service-grants

Breast Reconstruction Awareness Fund Public Awareness Grants - The Plastic Surgery Foundation (The PSF)

DEADLINE: April 5, 2017

AMOUNT: Breast Reconstruction Awareness Fund Public Awareness Grants, up to $10,000, are awarded to U.S. based tax-exempt public 501(c)(3) charities with a demonstrated commitment to developing and implementing projects and programs for the purpose of raising the awareness of breast reconstruction surgery options in the community.

DESCRIPTION: The Plastic Surgery Foundation (The PSF) is committed to supporting organizations that focus on increasing breast reconstruction surgery awareness and education to women and their family members.

Through The PSF's Breast Reconstruction Awareness Fund, The PSF awards a limited number of Breast Reconstruction Surgery Public Awareness Grants to U.S. based, tax-exempt public 501(c)(3) charities that have demonstrated a commitment to increasing the awareness of breast reconstruction surgery.

WEBSITE/LINK: http://www.thepsf.org/humanitarian/breast-reconstruction-awareness-fund/public-awareness-grants.htm

Runnerclick Scholarship

DEADLINE: No later than April 30, 2017

AMOUNT: $2000

DESCRIPTION: First a little about Runnerclick. We aim to bring you reviews on the latest and greatest from brands such as Brooks, Asics, Adidas, Nike, Saucony and many others. We also review and blog about a lot more than just running shoes, such as GPS watches, shoes made for walking, trails, standing or zumba – the list goes on.

We also offer a growing running blog with contributions from sport familiar writers, where you will find great pointers on how to successfully achieve a healthy, get rid of plantar fasciitis and active lifestyle, as well as further enhance the one you may already lead. Although our content is mostly aimed at runners of all experience levels, we believe that the information that our writers provide could be helpful to all, in general.

We feel that maintaining a healthy lifestyle, and remaining active in sports as well as other outdoor activities can be beneficial in building a strong mind and good character through sportsmanship. That is why we are proud to announce the Runnerclick scholarship, awarded to three qualified applicants each year, for an amount of $2000 (two thousand U.S. Dollars) to each of the three winners.

We are happy to help with the growth and education that will turn out more healthy and productive members of our society, also keeping alive an athletic and competitive traditions as we develop.

We encourage anyone who is interested to apply, however there are a few necessary requirements that must be fulfilled in order to be seriously considered for one of the three annual awards. Below you will find a more specific breakdown of the scholarship details, as well as the requirements for eligibility and guidelines for your essay. If you decide to apply, you'll just need to completely follow the steps below to submit your application.

Good luck!

WEBSITE/LINK: http://runnerclick.com/runnerclick-scholarship/

Yale LGBT Studies Research Fellowship

DEADLINE: The application deadline for the 2017-2018 Fellowship is April 21, 2017.

AMNOUNT: The fellowship provides an award of $4,000, which is intended to pay for travel to and from New Haven and act as a living allowance.

DESCRIPTION: Lesbian, Gay, Bisexual, and Transgender Studies at Yale University is proud to announce the second annual Yale LGBT Studies Research Fellowship. The Fellowship is offered annually, and is designed to provide access to Yale resources in LGBT Studies for scholars who live outside the greater New Haven area.

Scholars from across the country and around the world are invited to apply for the Yale LGBT Studies Research Fellowship. This fellowship supports scholars from any field pursuing research in lesbian, gay, bisexual, transgender, and/or queer studies at Yale

University, utilizing the vast faculty resources, manuscript archives, and library collections available at Yale. Graduate students conducting dissertation research, independent scholars, and all faculty are invited to apply. Scholars residing within 100 miles of New Haven are ineligible. Granted for one month, the fellowship must be taken up between September 1, 2017 and April 30, 2018. The recipient is expected to be in residence for a minimum of twenty days during the period of their award and is encouraged to participate in the activities of Yale University, including programs organized by Lesbian, Gay, Bisexual, & Transgender Studies, Women's, Gender, & Sexuality Studies, and the Yale Research Initiative on the History of Sexualities.

WEBSITE/LINK: http://lgbts.yale.edu/research

Domestic Violence Shelter Grant Program

DEADLINE: Domestic violence shelter grant applications are available from this web site or from The Mary Kay Foundation from January 15 to April 30 each year. We announce grant recipients in the fall to coincide with National Domestic Violence Awareness Month in October.

AMOUNT: Funds awarded by the foundation may be used for the operating budget of the applicant, with the exception of staff travel. The foundation will award a grant to at least one domestic violence shelter in every state. Any remaining funds will be distributed based on state population.

In 2016, the foundation awarded grants of $20,000 to more than a hundred and fifty women's domestic violence shelters across the nation.

DESCRIPTION: The goal of the Mary Kay Foundation is to eliminate domestic violence. As part of this effort, the foundation makes grants to organizations in the United States that operate emergency shelters for victims of domestic violence. The grants are announced each October in observance of National Domestic Violence Awareness Month.

WEBSITE/LINK:
http://www.marykayfoundation.org/Pages/ShelterGrantProgram.aspx

2017- MAY

Interventions for Health Promotion and Disease prevention in Native American Populations (R01)

DEADLINE: May 12, 2017, by 5:00 PM local time of applicant organization.

AMOUNT: Application budgets are not limited, but need to reflect the actual needs of the proposed project. The project period is limited to five years.

DESCRIPTION: The purpose of this funding opportunity announcement (FOA) is to develop, adapt, and test the effectiveness of health promotion and disease prevention interventions in Native American (NA) populations. NA populations are exposed to considerable risk factors that significantly increase their likelihood of chronic disease, substance abuse, mental illness, oral diseases, and HIV-infection. The intervention program should be culturally appropriate and promote the adoption of healthy lifestyles, improve behaviors and social conditions and/or improve environmental conditions related to

chronic diseases, the consumption of tobacco, alcohol and other drugs, mental illness, oral disease, or HIV-infection. The intervention program should be designed so that it could be sustained within the entire community within existing resources, and, if successful, disseminated in other Native American communities. The long-term goal of this FOA is to reduce mortality and morbidity in NA communities. For the purposes of this FOA Native Americans include the following populations: Alaska Native, American Indian, and Native Hawaiian. The term 'Native Hawaiian' means any individual any of whose ancestors were natives, prior to 1778, of the area which now comprises the State of Hawaii.

WEBSITE/LINK: **http://grants.nih.gov/grants/guide/pa-files/PAR-14-260.html**

Food Protection Task Force (FPTF) and Integrated Food Safety System (IFSS) Project Grant Program (R18) - Department of Health and Human Services Food and Drug Administration

DEADLINE: May 16, 2017

AMOUNT: $10,000 x 20

DESCRIPTION: This Funding Opportunity Announcement (FOA), issued by the Food and Drug Administration under the support for Research Demonstration and Dissemination Projects (R18), is to solicit applications from organizations that propose to develop, test, and evaluate food safety and food defense health service activities and to foster the application of existing knowledge for the control of categorical and food related diseases and illnesses. Grantees will also organize Food Protection Task Force meetings and support related research activities, foster communication, cooperation and collaboration within the States among federal, state, local, tribal and territorial food protection, public health, agriculture, and regulatory agencies.

WEBSITE/LINK: **http://www.grants.gov/web/grants/view-opportunity.html?oppId=283029**

Future of Work – The Russell Sage Foundation

DEADLINE:
Letter of Inquiry Deadline -May 31, 2017 (11am PT)
Invited Proposal Deadline - August 15, 2017 (11am PT)
Funding Decision - November 2017

AMOUNT: Awards are available for research assistance, data acquisition, data analysis, and investigator time for conducting research and writing up results. Applications should limit budget requests to no more than a two-year period, with a maximum of $150,000 (including overhead) per project. Presidential Awards, with a maximum budget of $35,000 (no overhead allowed) are also available. Our website lists upcoming deadlines and provides detailed information about submitting letters of inquiry, proposals and budgets.

DESCRIPTION: The Russell Sage Foundation's program on the Future of Work supports innovative research on the causes and consequences of changes in the quality of jobs for less- and moderately-skilled workers and their families. We seek investigator-initiated research proposals that will broaden our understanding of the role of changes in employer practices, the nature of the labor market and public policies on the employment, earnings,

and the quality of jobs of workers. We are especially interested in proposals that address important questions about the interplay of market and non-market forces in shaping the wellbeing of workers, today and in the future. Funding is available for secondary analysis of data or for original data collection. We are especially interested in novel uses of existing data, as well as analyses of new or under-utilized data. Proposals to conduct laboratory or field experiments, in-depth qualitative interviews, and ethnographies are also encouraged. Smaller projects might consist of exploratory fieldwork, a pilot study, or the analysis of existing data.

The Foundation encourages methodological variety and inter-disciplinary collaboration. All proposed projects must have well-developed conceptual frameworks and research designs. Analytical models must be specified and research questions and hypotheses (where applicable) must be clearly stated.

A brief letter of inquiry (4 pages max. excluding references) must precede a full proposal to determine whether the proposed project is in line with the Foundation's program priorities and available funds. All applications must be submitted through the Foundation's online submission system. If you still have questions after reviewing the information on our website, please contact Aixa Cintrón-Vélez, Program Director, at programs@rsage.org.

WEBSITE/LINK:

http://www.rwjf.org/en/library/funding-opportunities/2017/coordinating-efforts-to-enhance-hospitals-role-in-population-health.html

2017 JUNE

Innovations in Mechanisms and Interventions to Address Mental Health in HIV Prevention and Care Continuum (R01) Department of Health and Human Services National Institutes of Health

DEADLINE: June 5

AMOUNT: See application.

DESCRIPTION: This Funding Opportunity Announcement (FOA) encourages applications focused on 1) advancing understanding of mechanisms by which mental health affects HIV prevention and treatment in order to identify modifiable intervention targets; and 2) developing and testing expanded interventions to improve both mental health and HIV outcomes along the entire HIV care continuum (from HIV testing to viral suppression). PA-17-136 uses the R01 grant mechanism while PA-17-137 uses the R21 mechanism. High risk/high payoff projects that lack preliminary data or utilize existing data may be most appropriate for the R21 mechanism, while applicants with preliminary data and/or include longitudinal analysis may wish to apply using the R01 mechanism.

WEBSITE/LINK: http://www.grants.gov/web/grants/view-opportunity.html?oppId=291442

Regional Partnership Grants to Increase the Well-Being of, and to Improve the Permanency Outcomes for, Children Affected by Substance Abuse in American

Indian/Alaska Native Communities \Department of Health and Human Services Administration for Children and Families - ACYF/CB

DEADLINE: Jun 06, 2017 Electronically submitted applications must be submitted no later than 11:59 p.m., ET, on the listed application due date.

AMOUNT: $600,000 X 6 awards

DESCRIPTION: The purpose of this forecasted funding opportunity announcement (FOA) is to provide competitive grant funds for projects of up to 5 years, authorized by the Child and Family Services Improvement and Innovation Act (Pub. L. 112-34). This Act includes a targeted grants program (section 437(f)) that directs the Secretary of Health and Human Services to reserve funds for regional partnership grants (RPGs) to improve the well-being of children affected by substance abuse. These targeted grants will be awarded to regional partnerships that provide, through interagency collaboration and integration of programs and services and activities that are designed to increase the well-being of, improve permanency outcomes for, and enhance the safety of children who are in out-of-home placements or are at risk of entering out-of-home placements as a result of a parent's or caretaker's substance abuse. Native communities face service delivery issues that are complicated by several barriers such as, lack of early intervention for American Indian/Alaska Native (AI/AN) communities, distances to services, and lack of access to programs and services. The goal of the program, services, and activities supported by these funds is to improve the well-being of children and families affected by parental substance abuse in AI/AN communities. Per the legislative requirements, RPGs are required to select and report on performance indicators and evaluation measures to increase the knowledge that can be gained from the program. Partnerships will: Use specific, well-defined, and evidence-based programs and/or promising practices that are also trauma-informed and targeted to the identified population; Conduct an evaluation that is sufficiently rigorous to contribute to the evidence base on service delivery, outcomes and costs associated with the project's chosen interventions; Participate in the national cross-site evaluation, which includes an implementation and partnership study, an outcomes study, and an impact study. PLEASE SEE ALSO FORECAST FOR REGIONAL PARTNERSHIP GRANTS TO INCREASE THE WELL-BEING OF, AND TO IMPROVE THE PERMANENCY OUTCOMES FOR, CHILDREN AFFECTED BY SUBSTANCE ABUSE.

WEBSITE/LINK: **http://www.grants.gov/web/grants/view-opportunity.html?oppId=288214**

Public Policy Effects on Alcohol-, Marijuana-, and Other Substance-Related Behaviors and Outcomes (R03) Department of Health and Human Services National Institutes of Health

DEADLINE: June 16

AMOUNT: See application.

DESCRIPTION: This Funding Opportunity Announcement (FOA) encourages applications to conduct research on the effects of public policies on health-related behaviors and outcomes associated with alcohol, marijuana, and other substances. The purpose of the FOA is to advance understanding of how public policy may serve as a tool for improving public health and welfare through its effects on behaviors and outcomes pertaining to

alcohol and other drugs. This FOA is intended to support innovative research to examine policy effects that have the potential to lead to meaningful changes in public health. Research projects that may be supported by this FOA include, but are not necessarily limited to: causal analyses of the effects of one or multiple public policies; evaluations of the effectiveness of specific public policies as tools for improving public health through their effects on alcohol-, marijuana-, and other substance-related behaviors and outcomes; and research to advance methods and measurement used in studying relationships between public policies and alcohol-, marijuana-, and other substance-related behaviors and outcomes. The R03 Small Research Grant Program supports discrete, well-defined projects that realistically can be completed in two years and that require limited levels of funding. This program supports different types of projects including (but not limited to) pilot or feasibility studies; secondary analysis of existing data; small, self-contained research projects; and development of research methodology.

WEBSITE/LINK: http://www.grants.gov/web/grants/view-opportunity.html?oppId=291415

2017 JULY

Hospice and Palliative Nurses Foundation

DEADLINE: July 1, 2017

AMOUNT: A single grant of up to $15,000 will be awarded.

DESCRIPTION: The Hospice and Palliative Nurses Foundation, the charitable arm of the Hospice and Palliative Nurses Association, is accepting applications for its Certification Research Grant program.

The HPNF Certification Research Grant is intended to provide investigators with resources to conduct exploratory, pilot, or feasibility studies that will lead to larger scale projects linking certification with patient outcomes. Examples include collecting preliminary data about the distribution of certification qualifications among staff of different types of organizations or examining datasets from healthcare systems for patterns of staffing and outcomes. To be eligible, the principal investigator must be actively involved in some aspect of hospice and palliative care practice, education, or research; hold a master's or doctoral degree or be enrolled in a doctoral program; and have a project that is consistent with the purpose of the research grant. Preference will be given to HPNA members.

For complete program guidelines and application instructions, see the HPNF website.

WEBSITE/LINK: http://hpnf.advancingexpertcare.org/research/research-grant-opportunities/

National Lupus Outreach and Clinical Trial Education Program (Lupus Program)

DEADLINE: July 1, 2017

AMOUNT: $250,000-$325,000 for Priority A; $450,000-$550,000 for Priority B

DESCRIPTION: The Office of Minority Health (OMH) at the United States Department of Health and Human Services announces the availability of Fiscal Year 2017 grant funds for

the National Lupus Outreach and Clinical Trial Education Program (Lupus Program). The Lupus Program seeks to reduce lupus related health disparities among racial and ethnic minority populations disproportionately affected by this disease by: (1) implementing a national health education program on lupus (Priority A); and (2) developing, piloting and assessing clinical trial education interventions for health care providers and paraprofessionals focusing on improving recruitment and retention rates in clinical trials for racial and ethnic minority populations affected by lupus (Priority B).

WEBSITE/LINK: **http://www.grants.gov/web/grants/view-opportunity.html?oppId=289374**

Global Infectious Disease Research Training Program (D43)

DEADLINE: Letter of Intent Due Date(s) -30 days prior to the application due date. July, 27, 2017

AMOUNT: Applications budgets are limited to $230,000 per year for new awards and $276,000 per year for renewal awards (total direct costs). The maximum project period is up to 5 years.

DESCRIPTION: This Funding Opportunity Announcement (FOA) encourages applications for the Global Infectious Disease Research Training program from U.S. and LMIC research institutions. The application should propose a collaborative research training program that will strengthen the capacity of a LMIC institution to conduct infectious disease research that focuses on 1) major endemic or life-threatening emerging infectious diseases 2) neglected tropical diseases 3) infections that frequently occur as co-infections in HIV infected individuals or 4) infections associated with non-communicable disease conditions of public health importance in LMICs. FIC will support innovative research training programs that are designed to build sustainable infectious disease research capacity at an institution in an endemic LMIC. Sustainable infectious disease research capacity is known to require a critical mass of scientists and health research professionals with in-depth scientific expertise and complementary leadership skills that enable the institution to conduct independent, internationally-recognized infectious disease research relevant to the health priorities of their country.

WEBSITE/LINK: **http://grants.nih.gov/grants/guide/pa-files/PAR-17-057.html**

NO DEADLINE – GRANT RESOURCE INFORMATION:

Evidence for Action: Investigator-Initiated Research to Build a Culture of Health

DEADLINE:

Informational Web Conferences:

Lessons Learned from a Year of Evidence for Action Grant Reviews

February 18, 2016 from 1:30-2:30 p.m. ET (10:30-11:30 a.m. PT)

Registration is required.

Archived Web Conferences

Informational Web Conferences were scheduled for June 3, 2015 and July 22, 2015 Recordings for both events are now available.

June 3, 2015 web conference recording available here.

July 22, 2015 web conference recording available here.

Timing: Since applications are accepted on a rolling basis, there is no deadline for submission. Generally, applicants can expect to be notified within 6-8 weeks of their LOI submission. Applicants invited to the full proposal stage will have 2 months to submit their proposal once they receive notification. Full proposal funding decisions will generally be made within 6-8 weeks of the submission deadline.

AMOUNT: Approximately $2.2 million will be awarded annually. We expect to fund between five and 12 grants each year for periods of up to 30 months. We anticipate that this funding opportunity will remain open for at least a period of three years; however, decisions about modifications to the program and the duration of the program will be made by RWJF at its sole discretion.

DESCRIPTION: Evidence for Action: Investigator-Initiated Research to Build a Culture of Health is a national program of RWJF that supports the Foundation's commitment to building a Culture of Health in the United States. The program aims to provide individuals, organizations, communities, policymakers, and researchers with the empirical evidence needed to address the key determinants of health encompassed in the Culture of Health Action Framework. In addition, Evidence for Action will also support efforts to assess outcomes and set priorities for action. It will do this by encouraging and supporting creative, rigorous research on the impact of innovative programs, policies and partnerships on health and well-being, and on novel approaches to measuring health determinants and outcomes.

WEBSITE: http://www.rwjf.org/en/library/funding-opportunities/2015/evidence-for-action-investigator-initiated-research-to-build-a-culture-of-health.html?rid=3uOaFeLLcJROtLce2ecBeg&et_cid=469879

Changes in Health Care Financing and Organization: Small Grants

DEADLINE: Grants are awarded on a rolling basis; proposals may be submitted at any time.

AMOUNT: This solicitation is for small grants of $100,000 or less.

DESCRIPTION: Changes in Health Care Financing and Organization (HCFO) supports research, policy analysis and evaluation projects that provide policy leaders timely information on health care policy, financing and organization issues. Supported projects include:

examining significant issues and interventions related to health care financing and organization and their effects on health care costs, quality and access; and

exploring or testing major new ways to finance and organize health care that have the potential to improve access to more affordable and higher quality health services.

Eligibility and Selection Criteria

Researchers, as well as practitioners and public and private policy-makers working with researchers, are eligible to submit proposals through their organizations. Projects may be initiated from within many disciplines, including health services research, economics, sociology, political science, public policy, public health, public administration, law and business administration. RWJF encourages proposals from organizations on behalf of researchers who are just beginning their careers, who can serve either individually as principal investigators or as part of a project team comprising researchers or other collaborators with more experience. Only organizations and government entities are eligible to receive funding under this program.

Preference will be given to applicants that are either public entities or nonprofit organizations that are tax-exempt under Section 501(c) (3) of the Internal Revenue Code and are not private foundations as defined under Section 509(a).

Complete selection criteria can be found in the Call for Proposals.

WEBSITE: **http://www.rwjf.org/en/grants/funding-opportunities/2011/changes-in-health-care-financing-and-organization--small-grants.html**

The National Children's Alliance

Deadline: **http://www.nationalchildrensalliance.org/**

Amount: See website

Description: The National Children's Alliance has a Request for proposals to help support the development of CACs and Multidisciplinary Teams. NACA encourages all tribal communities to apply. They can offer FREE technical support to help you with your application.

- **Common Wealth Fund**

The Commonwealth Fund encourages and accepts unsolicited requests on an ongoing basis. The Fund strongly prefers grant applicants to submit letters of inquiry using the online application form. Applicants who choose to submit letters of inquiry by regular mail or fax should provide the information outlined in a two- to three-page document.

They fund:

- **Delivery System Innovation and Improvement**
- **Health Reform Policy**

- **Health System Performance Assessment and Tracking**

http://www.commonwealthfund.org/Grants-and-Programs/Letter-of-Inquiry.aspx

- **Kaboom! Invites Grant Applications to Open Previously Unavailable Playgrounds**

Deadline: KaBOOM! is inviting grant applications from communities anywhere in the United States working to establish joint use agreements to re-open playground and

recreational facilities previously unavailable due to safety and upkeep concerns. (No specific deadline.)

Amount: Let's Play Land Use grants of $15,000 and $30,000 will support creation of joint-use agreements between local governments and school districts that address cost concerns related to safety, vandalism, maintenance, and liability issues to re-open previously unavailable playgrounds and recreational facilities.

The $15,000 grants will support the opening of at least four playgrounds in cities with populations of less than 100,000 people. The $30,000 grants will support the opening of at least eight playgrounds in larger communities.

Description: Grants can be used for training and technical assistance, utilities and other building related to the extra use of the facility, legal fees, contract security

services, and marketing campaigns related to the joint-use agreement. Grant recipients must commit to opening the playgrounds within twelve months of the grant decision.

Complete grant application guidelines are available on the KaBOOM! website:

http://kaboom.org/about_kaboom/programs/grants?utm_source=direct&utm_medium=surl

- **Meyer Memorial Trust**

Deadline: Monthly (Except January, April and August)

Amount: Range generally from $40,001 to $300,000 with grant periods from one to two (and occasionally three) years.

Description: Responsive Grants are awarded for a wide array of activities in the areas of human services, health, affordable housing, community development, conservation and environment, public affairs, arts and culture and education. There are two stages of consideration before Responsive Grants are awarded. Initial Inquires are accepted at any time through MMT's online grants application. Applicants that pass initial approval are invited to submit full proposals. The full two-step proposal investigation usually takes five to seven months. **http://www.mmt.org/program/responsive-grants**

- **Kellogg Foundation Invites Applications for Programs that Engage Youth and Communities in Learning Opportunities**

Deadline: No Deadline

Amount: No Amount Specified

Description: The W.K. Kellogg Foundation is accepting applications from nonprofit organizations working to promote new ideas about how to engage children and youth in learning and ways to bring together community-based systems that promote learning. The

foundation will consider grants in four priority areas: Educated Kids; Healthy Kids; Secure Families; and Civic Engagement.

Educated Kids: To ensure that all children get the development and education they need as a basis for independence and success, the foundation seeks opportunities to invest in early child development (ages zero to eight) leading to reading proficiency by third grade, graduation from high school, and pathways to meaningful employment.

Healthy Kids: The foundation supports programs that work to ensure that all children grow and reach optimal well-being by having access to fresh, healthy food, physical activity, quality health care, and strong family supports.

Secure Families: The foundation supports programs that build economic security for vulnerable children and their families through sustained income and asset accumulation.

Civic Engagement: The foundation partners with organizations committed to inclusion, impact, and innovation in solving public problems and meeting the needs of children and families who are most vulnerable.

See the Kellogg Foundation Web site for eligibility and application guidelines.
http://foundationcenter.org/pnd/rfp/rfp_item.jhtml?id=411900024#sthash.8WbcfJRk.dpuf

• W.K. Kellogg Foundation

Deadline: The Kellogg Foundation does not have any submission deadlines. Grant applications are accepted throughout the year and are reviewed at their headquarters in Battle Creek, Michigan, or in our regional office in Mexico (for submissions focused within their region).

Amount: NO LIMIT (Please read restrictions/What they won't fund.)

Description: What to Expect Once they receive your completed online application, an automated response, which includes your WKKF reference number, will be sent to you acknowledging its receipt. Their goal is to review your application and email their initial response to you within 45 days. Your grant may be declined or it may be selected for further development.

As part of review process you may be asked to submit your organization's financial reports and/or IRS Form 990. While this information may be required, it is not intended to be the overall determining factor for any funding. You will not be asked to provide any financial reports or detailed budget information during this initial submission. They will only request this information later if needed as part of the proposal development.

If you would like to speak with someone personally, please contact the Central Proposal Processing department at (269) 969-2329. http://www.wkkf.org/

- **AHRQ Research and Other Activities Relevant to American Indians and Alaska Natives**

http://www.ahrq.gov/research/findings/factsheets/minority/amindbrf/index.html

Community Grant Program- WALMART

DEADLINE: The 2016 grant cycle begins Feb. 1, 2016 and the application deadline to apply is Dec. 31, 2016. **Application may be submitted at any time during this funding cycle. Please note that applications will only remain pending in our system for 90 days.**

AMOUNT: Awarded grants range from $250 to $2,500.

DESCRIPTION: Through the Community Grant Program, our associates are proud to support the needs of their communities by providing grants to local organizations.

WEBSITE: http://giving.walmart.com/apply-for-grants/local-giving

SCHOLARSHIP:

The Meyerhoff Adaptation Project -

The Meyerhoff Scholars Program is open to all high-achieving high school seniors who have an interest in pursuing doctoral study in the sciences or engineering, and who are interested in the advancement of minorities in the sciences and related fields. Students must be nominated for the program and are most typically nominated by their high school administrators, guidance counselors, and teachers. Awards range from $5,000 – $22,000 per year for four years.

The Meyerhoff Selection Committee considers students academic performance, standardized test scores, recommendation letters, and commitment to community service. Scholars are selected for their interests in the sciences, engineering, mathematics, or computer science, as well as their plans to pursue a Ph.D. or combined M.D./Ph.D. in the sciences or engineering. Reviewing the freshman class profile may provide an idea of the kinds of students who are admitted to UMBC and the Meyerhoff Scholars Program.

Applicants are expected to have completed a strong college preparatory program of study from an accredited high school. The minimum program of study should include:

English: four years

Social Science/History: three years

Mathematics*: three years

Science: three years

Language other than English: two years

*Students are strongly recommended to have completed four years of mathematics, including trigonometry, pre-calculus, and/or calculus.

Eligibility Criteria

To be considered for the Meyerhoff Scholars Program, prospective students must have at least a "B" average in high school science or math courses, and many applicants have completed a year or more of calculus. Preference is given to those who have taken advanced placement courses in math and science, have research experience, and have strong references from science or math instructors. In recent years, a strong preference has been given to those students interested in the Ph.D. or M.D./Ph.D. (over the M.D.).

Students must meet all eligibility requirements:

Minimum of 600 on the Math component of the SAT

Cumulative High School GPA of a 3.0 or above

Aspire to obtain a Ph.D. or M.D./Ph.D. in Math, Science, Computer Science, or Engineering

Display commitment to community service

Must be a citizen or permanent resident of the United States

WEBSITE:
http://meyerhoff.umbc.edu/how-to-apply/benefits-and-eligibility/

~ONLY FOR WASHINGTON STATE UNIVERSITY~

First Scholars – The Suder Foundation

DEADLINE:

AMOUNT: The goal of the First Scholars program is to help first-generation college students succeed in school, graduate, and have a life complete with self-awareness, success and significance. Scholars receive personalized support, including a four-year renewable scholarship of $5,000. The program is open to incoming first-time, full-time freshmen whose parents have no more than two years of education beyond high school and no post-secondary degree.

DESCRIPTION: The First Scholars™ Program is available to incoming first-time, full-time freshmen whose parents have no more than two years of education beyond high school and no post-secondary degree. Participation in First Scholars™ includes a four-year renewable scholarship, half disbursed in the fall semester and half disbursed in the spring semester. Students can receive the award depending on eligibility requirements for a total of 4 years if program requirements are met.

This scholarship is open to Washington residents who enroll at Washington State University - Pullman full-time during the 2016-2017 academic year. The program requires that the recipients live on campus in a specified residence hall for the 2016-2017 academic year, and outside of the family home the following three academic years in order to renew the scholarship.

First-generation students represent a cross-section of America and college campus demographics. First Scholars come from diverse cultural, socioeconomic, geographic and family backgrounds and experiences. First-gen students are found in all departments and colleges of virtually every major public university across the country. Our affiliate

universities have an average 30-50% first-gen enrollment and the number keeps rising. However, the average national graduation rate for first-generation students is only 34%, compared with 55% for the general student population.

WEBSITE: **http://firstscholars.wsu.edu/**

Education Award Applications –The American College of Psychiatrists

DEADLINE: June 30

AMOUNT: (SEE WEBSITE)

DESCRIPTION: The Award for Creativity in Psychiatric Education is open to any creative/innovative program for psychiatric education that has been in operation for at least two years, and has been a part of a U.S. or Canadian approved psychiatric residency training program. Trainees may include: medical students, residents, other physicians, allied mental health professionals, or members of the community. The Committee selects an awardee in the fall; all applicants are notified of the Committee's decision by November 15.

WEBSITE: **http://www.acpsych.org/awards/education-award-applications-deadline-december-1**

VETERANS

- **VFW Accepting Applications From Veterans for Emergency Financial Assistance**

DEADLINE: Open

AMOUNT: Grants of up to $5,000 will be awarded to active and discharged military service members who have been deployed in the last six years and have run into unexpected financial difficulties as a result of deployment or other military-related activity or natural disaster....

DESCRIPTION: As the nation's largest organization of combat veterans, we understand the challenges veterans, service members and military families can face and believe that experiencing financial difficulties should not be one of them. That's the premise behind the VFW's Unmet Needs program.

Unmet Needs is there to help America's service members who have been deployed in the last six years and have run into unexpected financial difficulties as a result of deployment or other military-related activity. The program provides financial aid of up to $5,000 to assist with basic life needs in the form of a grant -not a loan- so no repayment is required. To further ease the burden, we pay the creditor directly.

Since the program's inception, Unmet Needs has distributed over $5 million in assistance to qualified military families, with nearly half of those funds going directly toward basic housing needs.

The needs of our veterans, service members and their families should never go unmet. Let us offer you a hand up when you need it!

Please review the Unmet Needs eligibility criteria to see if you or someone you know qualifies for a grant through the Unmet Needs program**.**

WEBSITE:
http://www.vfw.org/UnmetNeeds/?gclid=CjwKEAiAhPCyBRCtwMDS5tzT03gSJADZ8VjRw5RxJw1br5NTowrY1NFzylowGtdvOagXa3LHyYK_PRoCB4Hw_wcB

RWJF: Submit a Pioneering Idea Brief Proposal - Throughout the year, we welcome Pioneering Ideas Brief Proposals that can help us anticipate the future and consider new and unconventional perspectives and approaches to building a Culture of Health.

DEADLINE: Open

AMOUNT: See site

DESCRIPTION: The goal of the Pioneering Ideas Brief Proposal funding opportunity is to explore; to look into the future and put health first as we design for changes in how we live, learn, work and play; to wade into uncharted territory in order to better understand what new trends, opportunities and breakthrough ideas can enable everyone in America to live the healthiest life possible.

While improving the status quo is vital to the health and well-being of millions of Americans now, the Pioneering Ideas Brief Proposal opportunity reaches beyond incremental changes to explore the ideas and trends that will influence the trajectory and future of health. Ultimately, we support work that will help us learn what a Culture of Health can look like—and how we can get there.

What is a Pioneering Idea?

Good question! We don't want to provide a checklist that limits your thinking—or ours. We do want to give you as clear a picture as we can about the kinds of proposals we hope to see, so you can best assess whether submitting an idea through our Pioneering Ideas Brief Proposal process is the right next step for you. Our application form allows you to introduce your idea; if it seems to be a fit for our portfolio we will reach out for more information.

We share some examples below of Pioneering Ideas we have funded in the past to give you a sense of where we've been. Keep in mind that ultimately, we need you to challenge us, and to tell us where we should be going and what ideas have the most potential to transform the way we think about health. As you review the examples below, you may notice some shared themes or characteristics which:

Challenge assumptions or long-held cultural practices.

Take an existing idea and give it a new spin—or a novel application.

Offer a new take or perspective on a long-running, perplexing problem.

Apply cutting-edge ideas from other fields to health.

Explore the potential for emerging trends to impact our ability to build a Culture of Health.

WEBSITE/LINK: **http://www.rwjf.org/en/how-we-work/submit-a-proposal.html?rid=CR0RfoW1kVrIxFKudcSYjlL9Zh7yWU63VdhdaVE2UAc&et_cid=639126**

IDAHO & WASHINGTON - ONLY

ASPCA Northern Tier Shelter Initiative Coalition Grants

DEADLINE: No Deadline

AMOUNT: Grant amounts will vary depending on project. A site visit may be required as part of the review process or as a condition of receiving the grant funds. Consultation services may be offered as part of a grant package.

DESCRIPTION: Priority will be given to coalitions working toward long-term, systemic, and sustainable community/regional improvements in animal welfare services. This may include (but not limited to) programs that:

Increase capacity to provide quality animal care and services by:

Improving protocols around vaccination on intake, disease spread prevention, decreased length of stay, physical and behavioral care of sheltered pets

Improving capacity to provide basic health services including spay/neuter and vaccines for animals at risk in the community.

Increase coalition live release rate via:

Fee-waived adoption programs and policies

High-volume adoption events

Foster programs

Relocation initiatives within the seven Northern Tier target states

Decrease shelter intake via:

Lost and found programs

Return to owner in the field

Pet retention assistance, such as safety net programs

Re-homing assistance

WEBSITE: http://aspcapro.org/grant/2016/05/06/aspca-northern-tier-shelter-initiative-coalition-grants

Healthy Native Babies Outreach Stipend Application

DEADLINE: Applications will be accepted on a rolling basis as funds are available.

AMOUNT: $1500

DESCRIPTION: The Healthy Native Babies Project, a project of the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), has created culturally appropriate materials with safe infant sleep messages for American Indian and Alaska Native communities. These materials can be tailored for local communities by selecting various photos, graphic designs, and phrases in Native languages from the Healthy Native Babies Project Toolkit Disk. Outreach stipends are available for printing customized outreach materials to disseminate in your community. Recipients must be from one of the following Indian Health Service (IHS) Areas: Alaska, Bemidji, Billings, Great Plains, and Portland. Information on IHS Areas can be found at: **https://www.ihs.gov/locations/.**

WEBSITE/LINK: http://files.constantcontact.com/913a319f001/8e50ceae-d3be-462e-be3d-3216455225bc.pdf?ver=1470849886000

Good Sports Accepting Applications for Sports Equipment Program

DEADLINE: *ROLLING FUNDING*

AMOUNT: While the equipment, apparel, and footwear received through the program are free, recipients are expected to pay shipping and handling costs, which amount to roughly 10 percent of the donation value, with a maximum fee of $1,500.

DESCRIPTION: Good Sports helps lay the foundation for healthy, active lifestyles by providing athletic equipment, footwear, and apparel to disadvantaged young people nationwide. By working closely with teams, coaches, and community leaders across the United States, the organization is able to focus on the respective needs of each individual program and help offset the main factors causing the greatest challenges.

Good Sports is accepting applications from organizations and schools for equipment, apparel, and footwear for a wide range of sports. Organizations that are approved will have access to equipment, apparel, and footwear inventory for a two-year period. During that time, organizations can make up to six separate donation requests — as long as need is well documented, donations will be granted. There is no need to resubmit a full application again during the two-year period.

To be eligible, applicants must directly serve youth between the ages of 3 and 18; serve youth in an economically disadvantaged area; be located in North America (the U.S. and Canada); and operate an organized sport, recreational activity, or fitness program that offers consistent and structured opportunity for play to large groups of children. Schools must apply as a whole; applications for individual programs within a school will not be considered. Donation requests for short-term events such as sports camps and tournaments or to individual athletes will not be considered.

Applications are reviewed on a rolling basis. It is recommended, however, that organizations apply at least eight weeks prior to the start of their particular season or program to ensure the desired equipment can be accessed and shipped on time.

WEBSITE/LINK: https://www.goodsports.org/apply/

Good Sports Accepting Applications for Athletic Equipment Grants

DEADLINE: *ROLLING FUNDING*

AMOUNT: You will be required to sign a release form and pay a shipping and handling fee with each donation. This will always equal 10% of the total retail value of the items; for example, if the total value of your items equals $2,000, you will be asked to provide $200, etc.

DESCRIPTION: Good Sports in Quincy, Massachusetts, is a nonprofit whose mission is to increase youth participation in sports, recreation, and fitness activities.

To that end, the organization provides sports equipment, apparel, and footwear to youth organizations offering sports, fitness, and recreational programs to youth in need.

To be eligible, organizations must directly serve youth between the ages of 3 and 18 in an economically disadvantaged area; be located in North America (U.S. and Canada); and operate an organized sport, recreational activity, or fitness program that offers consistent and structured opportunity for play to large groups of children. Winning organizations may make up to six equipment requests within a two-year period. Winners will be responsible for operational costs, including equipment shipping, up to $1,500.

WEBSITE/LINK: http://www.goodsports.org/apply/

Voya Foundation Grants

DEADLINE: Grant requests are reviewed throughout the year. Grant applicants should check the online system for quarterly deadlines, which are subject to change.

AMOUNT: Value of grant requests must be a minimum of $2,500.

DESCRIPTION: The Voya Foundation, the philanthropic arm of Voya Financial, works to ensure that youth are equipped with science, technology, engineering, and math (STEM) expertise and financial knowledge necessary to compete in the twenty-first century workforce and make smart financial decisions that lead to a secure retirement.

To that end, Voya is accepting applications from organizations that provide innovative and experiential K-8 STEM learning opportunities that promote an early interest in STEM career fields and improve teachers' capabilities in STEM; or that provide financial education curriculum to grade 9-12 students focused on navigating major financial milestones such as student debt, credit, home ownership, financial products and services/financial capability, and family needs.

1) STEM Education: The foundation supports organizations that fund high-quality experiential STEM learning opportunities for children in grades K-8. Programs are evaluated based on improvements in covered STEM concepts and increased interest in STEM careers generated over the course of the program.

2) Financial Literacy: Voya's financial literacy grants support organizations that provide financial literacy curriculum to students in high school (grades 9-12). Programs must cover student debt, credit, home ownership, investing, and understanding of financial products and services (financial capability), and family financial planning.

To be eligible, applicants must be considered tax exempt under Section 501(c)(3) of the Internal Revenue Code.

WEBSITE/LINK: http://corporate.voya.com/corporate-responsibility/investing-communities/voya-foundation-grants

NATIVE DENTAL THERAPY INITIATIVE

A project of the Northwest Portland Area Indian Health Board

News and Updates

March 2017

DENTAL THERAPY FOR WASHINGTON TRIBES: FIRST LAW SIGNED BY GOVERNOR IN 2017

On February 22, Washington Governor Jay Inslee signed SSB 5079 recognizing Tribal Dental Health Aide Therapists (DHAT) and securing access to federal funding needed to sustain clinics that use this mid-level provider. SSB 5079 sailed through this year's legislative session with bi-partisan support —its 4th year.

Senator John McCoy, D-Tulalip, first started working on this issue after the Alaska DHAT program started 12 years ago, and is the prime sponsor of the bill that was signed today.

Brian Cladoosby, Chairman of the Swinomish Indian Tribal Community, and President of the National Congress of American Indians stated, "This bill is first and foremost about sovereignty—the right and responsibility of tribal governments to take care of their people, including oral health. DHAT programs are a proven, tribal solution to the oral health crisis in Indian Country that increases and improves access, increases the number of native oral health providers, and reduces costs."

One year ago, the Swinomish Indian Tribal Community hired DHAT Daniel Kennedy, who became the first tribally-licensed DHAT in the lower-48. Because Swinomish created their own licensing board under their innate sovereign authority, the state had no role in approving or denying the license. *continued next page…*

QUICK LINKS!

Enrolled SSB 5079

SSB 5079 History and Sponsors

Frequently Asked Questions

Washington Tribes Broad Support for SSB 5079 Letter

In the News!

The Omak-Okanogan County Chronicle: LAW AIMS TO IMPROVE TRIBAL DENTAL CARE

KNKX—NPR: TRIBES PLANNING NEXT STEPS NOW THAT DENTAL THERAPY BILL IS LAW

indianz.com: MARK TRAHANT: A VICTORY ON INDIAN HEALTH IN WASHINGTON STATE

The Olympian: LONG-SOUGHT BILL TO HELP DENTAL CARE ON TRIBAL LAND FIRST TO PASS LEGISLATURE

Lewis County Chronicle: BILL IMPROVING DENTAL CARE ON RESERVATIONS INTRODUCED

Indian Country Media Network: OVERCOMING BARRIERS TO DENTAL CARE ONE KID AT A TIME

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Northwest Portland Area Indian Health Board is honored and excited to welcome the Native American Rehabilitation Association of the Northwest (NARA) as our newest site participating in the Tribal Dental Health Aide Therapist Pilot Project. Founded in 1970, NARA is an Indian-owned, Indian-operated, non-profit agency in Portland, OR that operates a residential family treatment center, an outpatient treatment center, a child and family services center, two primary health care clinic, several adult mental health locations, a dental clinic, and transitional housing for AI/AN women and children. The dental clinic is the newest clinic and opened in May of 2016. In the first 5 months they saw 799 new patients.

WELCOME NARA NW!

NARA provides dental services primarily to AI/ANs—60% of their patient base, representing 259 different tribes—and Medicaid eligible and uninsured clients. NARA does outreach to the 9 tribes in Oregon and currently has a waiting list because they do not have enough providers to see all of the patients they have.

Integrating DHATs into their dental team will allow NARA to focus on important long term goals: increase the number of completed treatment plans, shorten waiting lists to make both basic services and more advanced services available in a timely manner to patients, and increase oral health education through community outreach.

NARA plans to send a student to the ANTHC DHAT Education Program this summer.

DENTAL THERAPY FOR WA TRIBES continued…

However, for Tribes that have fewer resources and infrastructure to license their own providers, this new law recognizes the authority of a tribal government to hire federally-certified DHATs.

Mel Tonasket, Vice Chair of the Confederated Tribes of the Colville Reservation, and former Washington State Board of Health Commissioner added, “Our Tribe has 9000 members and a reservation that stretches over 1.3 million acres of remote NE Washington. Like every other part of rural Washington, we have challenges to recruit, hire, and retain dental providers. We need providers that come from our community and want to serve our community.”

Importantly, the law directs the Washington Health Care Authority to work with the Centers for Medicare and Medicaid Services to allow for Medicaid reimbursement and clears the way for an expansion of DHATs in Washington.

Questions or comments? Contact Pam Johnson, Native Dental Therapy Initiative, pjohnson@npaihb.org, 206-755-4309

Follow us on:

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LEGISLATIVE UPDATES

Senate Committee on Indian Affairs to Host Roundtable Discussion on Infrastructure
Today, Wednesday, March 15, 2017 the Senate Committee on Indian Affairs will host a Roundtable Discussion, "Building Native America Together: Infrastructure Innovation and Improvements for the New Administration and Indian Country."

Panels for the Roundtable are as follows:
Panel 1:

- Mr. Delbert Rexford, Special Assistant and Advisor to the President, Ukpeaġvik Iñupiat Corporation (UIC), Barrow, AK
- The Honorable Edward Manuel, Chairman, Tohono O'odham Nation, Sells, AZ
- The Honorable Leslie Shakespeare, Councilman, Eastern Shoshone Tribe of the Wind River Reservation, Fort Washakie, WY

Panel 2:

- Mr. William Rudnicki, Tribal Administrator, Shakopee Mdewakanton Sioux Community of Minnesota, Prior Lake, MN
- The Honorable James Floyd, Principal Chief, Muscogee (Creek) Nation, Okmulgee, OK
- Mr. Ryan Rusche, Tribal Attorney, Confederated Salish and Kootenai Tribes of the Flathead Reservation, Pablo, MT

Panel 3:

- Ms. Belinda Nelson, Chairperson, Gila River Telecommunications, Inc., Chandler, AZ
- Mr. Derek Dyson, Attorney (Duncan, Weinberg, Genzer, & Pembroke), Navajo Tribal Utility Authority, Washington, DC
- Mr. Godfrey Enjady, General Manager, Mescalero Apache Telecom, Inc., Mescalero, NM

Panel 4:

- Mr. Jon Whirlwind Horse, Facilities Manager, Oglala Sioux Tribe Education Agency, Kyle, SD
- Mr. Jeff Seidel, Senior Vice President, Dougherty & Company, LLC, Minneapolis, MN
- Mr. Stephen Hockins, Strategic Planner, Mississippi Band of Choctaw Indians, Choctaw, MS
- The Honorable Darrell Shay, Vice Chairman, Shoshone-Bannock Tribes, Fort Hall, ID

Click here to listen to the Roundtable at **2:00 PM Eastern**.

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Congressional Budget Office Scores American Health Care Act
On Monday, March 13, 2017, the Congressional Budget Office (CBO), the nonpartisan, independent office tasked to analyze budget and economic issues related to proposed legislation, provided its findings regarding the impact of the American Health Care Act (AHCA). CBO found that the ACHA would decrease the deficit by $337 billion over a decade. While the CBO projected that the number of people without health insurance would grow by 14 million in 2018 under the AHCA, with that number rising to 24 million in a decade mostly due to proposed changes to Medicaid.

Other findings in the report include:

- Premiums would decrease an average of 10 percent by 2026 after an initial increase of 15 percent to 20 percent due to the repeal of the ACA requirement to purchase coverage.
- The AHCA tax credits would provide 50 percent less financial help in affording coverage than those under the ACA by 2026.
- Elimination of the individual mandate would prompt fewer healthy people to sign up for insurance, which could cause premium costs to increase 15 percent to 20 percent in 2018 and 2019.
- Starting in 2020, the increase in average premiums would be offset by a number of provisions in the AHCA plan: grants to states, a younger mix of enrollees, and the elimination of some insurer requirements.
- The AHCA would substantially reduce premiums for younger people while raising them for older people, mostly because of a provision that would allow insurers to charge older people more.
- The cuts to Medicaid would be sharp, with 14 million fewer enrollees and 25 percent less spending by 2026. Those cuts to Medicaid could be concerning for many governors.
- By 2026, premiums in the individual market for a 21-year-old would be 20 percent to 25 percent lower, but premiums for a 64-year-old would be 20 percent to 25 percent higher.
- Overall, by 2026, average premiums for single policyholders in the individual market would be about 10 percent lower than under the ACA.

Click here to read the CBO's full report.

AGENCY UPDATES

Governmental Accounting Standards Board (GASB) Requests Comments to Improve Financial Reporting Model
The GASB issued an Invitation to Comment (ITC), *Financial Reporting Model Improvements-Governmental Funds*, on January 4, 2017. The ITC is intended to obtain feedback from stakeholders at an early stage of the Board's financial reporting model reexamination project. Interested parties are asked to review and provide input on the ITC by **March 31, 2017**.

To learn more about the ITC, **click here**.

ADVISORY COMMITTEE UPDATES

TSGAC is Seeking Committee Nominations

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TSGAC is seeking multiple nominations for IHS Committees, Workgroups, and the Advisory Committee.

1. **Information Systems Advisory Committee (ISAC)**. ISAC guides the development of Indian health information infrastructure and information systems. The goal of ISAC is to assure the creation of flexible and dynamic information systems that assist in the management and delivery of health care and contribute to the elevation of the health status of Indian people. ISAC will assist in insuring that information systems are available, accessible, useful, cost effective, and user friendly for local level providers, while continuing to create standardized aggregate data that supports advocacy for Indian health programs at the national level. The Committee meets via teleconference two-three times a year and in person once a year.
2. Community Health Aide Program (CHAP) workgroup. During the recent January Quarterly meeting TSGAC learned that IHS will likely establish a workgroup to further develop CHAP. The workgroup will implement Tribal comments and recommendations that were made in response to the **Dear Tribal Leader Letter** released by IHS. It will be critical for Self-Governance to have a Tribal leader and technical representative. Further information will be provided as IHS makes announcements regarding the workgroup.
3. TSGAC Representatives. TSGAC provides information, education, advocacy, and policy guidance for implementation of Self-Governance within the Indian Health Service. TSGAC is seeking nominations for Tribal representatives for Bemidji (Primary and Alternate), Great Plains (Primary and Alternate), and Phoenix (Alternate). You can learn more about the role, responsibilities, and eligibility for TSGAC representatives **here**.

If you are interested in submitting a nomination for either ISAC, the CHAP workgroup, or TSGAC, please e-mail Terra Branson at **terrab@tribalselfgov.org**.

TRIBAL CONSULTATION AND COMMENT REQUESTS

HHS Annual Tribal Budget Consultation
The 19th U.S. Department of Health and Human Services (HHS) Annual Tribal Budget Consultation (ATBC) will take place March 29-30, 2017, at the Hubert H. Humphrey Building at 200 Independence Avenue, SW, Washington, DC.

The consultation session will provide a forum for Tribes to collectively share their views and priorities with HHS officials on national health and human services funding priorities and make recommendations for the Department's FY 2019 budget request. The consultation also will provide a venue for a two-way conversation between Tribal leaders and HHS officials on program issues and concerns that will lead to recommendations for action. The schedule for this year's consultation is as follows:

One-on-one meetings with HHS Divisions: Wednesday, March 29th, 2017
Tribes may schedule one-on-one meetings to share their specific health and human service issues with HHS officials. Various HHS agencies will be available to listen and contribute to the conversation. Please note that the amount of time allotted to meet with individual HHS officials will be determined by the volume of requests. **All requests for one-on-one meetings must be received through pre-registration by COB Friday, March 24th, 2017**.

Tribes can register for one-on-one meetings **here**.

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Annual Budget Consultation: Thursday, March 30th, 2017
At 9 AM on Thursday, March 30th, HHS will begin the consultation session. The Department will also determine topics for consultation prior to the session and share a draft agenda soon.

To pre-register for the ATBC and request one-on-one meetings, **click here**.

2017 Annual Regional Tribal Consultations (RTC)
In addition to the ATBC, HHS will again host Regional Tribal consultation sessions to address how the Department can continue to improve outreach and coordination and to discuss programmatic issues and overall concerns with Tribes. Regional sessions will include one-on-one time with the regional leadership. Additional details are included in the enclosure. Below are the dates for the Regional Tribal consultations.

Dates and Locations:
April 11-12, Seattle, WA (Region 10)
May 9, Syracuse, NY (Region 2)
May 16-17, Las Vegas, NV (Region 9)
May 17-18, Boston, MA (Region 1)
May 17-18, Kansas City, MO (Region 7)
June 15-16, New Buffalo, MI (Region 5)
May 23-24, Oklahoma City, OK (Region 6)
May 23-24, Denver, CO (Region 8)
TBA Washington, DC (Region 3)
TBA Nashville, TN (Region 4)
TBA Window Rock, AZ (Navajo)

Click here to read the full Dear Tribal Leader Letter and contact Elizabeth Carr, Associate Director of Tribal Affairs, at **consultation@hhs.gov** with any questions.

Department of the Interior (DOI) Requests Guidance on Proposal to Update Business Operation Regulations
DOI is requesting Tribal input on the Department's proposal to comprehensively update the regulations governing trade occurring within Indian Country. DOI published an advance notice of proposed rulemaking (ANPRM) to solicit comments on whether and how the Department should update 25 CFR part 140, including how the Indian Trader regulations might be updated to govern who trades on Indian land and how the regulations can better promote Tribal self-determination regarding trade on Indian lands.

Feedback to the Department is due **April 10, 2017** to **www.regulations.gov.** **Click here** to review the specific questions posed in this ANPRM.

UPCOMING EVENTS

March 21-23, 2017: Tribal Interior Budget Council
The mission of the TIBC is: to provide an advisory government-to-government forum and process for Tribes and the Department to develop budgets that allow for the fulfillment of Tribes' self-determination, self-governance, sovereignty, and treaty rights, as well as, sufficient levels of funding to address the needs of Tribes and their Tribal citizens.

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Click here to learn more about the upcoming meeting.

March 21, 2017: National Health Service Corps Virtual Job Fair
The virtual job fair will provide an opportunity to highlight career opportunities at specific clinics, hospitals, or health departments to primary care providers across the country. The virtual job fair is voluntary and free for interested facilities to register and present their employment opportunities.

Registration is limited. To register, **click here.**

For more information, **click here.**

March 28-30, 2017: TSGAC and SGAC to Host Quarterly Meetings
The Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC) and Department of the Interior (DOI) Self-Governance Advisory Committee (SGAC) will meet in March to confer, discuss, and reach consensus on specific self-governance issues and provide verbal and written advice about self-governance issues to IHS and DOI. Anyone is welcome to participate in Committee meetings or contact their representative to review agenda topics and recent discussions.

The meeting will be held at the Washington DC Convention Center Embassy Suite, 900 10th Street NW, Washington, DC 20001.

IHS TSGAC: March 28-29, 2017
DOI SGAC: March 29-30, 2017

To register or review the draft agendas for the meeting, **click here.**

FUNDING OPPORTUNITIES

Tribal Transit Program 2017
Due: March 20, 2017

The Federal Transit Administration (FTA) announces the availability of approximately $5 million in funding provided by the Public Transportation on Indian Reservations Program (Tribal Transit Program (TTP)), as authorized by 49 U.S.C. 5311(c)(1)(A), as amended by the Fixing America's Surface Transportation (FAST) Act , Public Law 114-94 (December 4, 2015). This is a national solicitation for project proposals and includes the selection criteria and program eligibility information for Fiscal Year 2017 projects. The primary purpose of these competitively selected grants is to support planning, capital, and, in limited circumstances, operating assistance for Tribal public transit services. Funds distributed to Indian Tribes under the TTP should not replace or reduce funds that Indian Tribes receive from states through FTA's Section 5311 program.

To learn more and apply, **click here**.

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FY17 Historic Preservation Fund Tribal Heritage Grants
Due: March 24, 2017

The National Historic Preservation Act of 1966 authorizes grants to Federally recognized Indian Tribes for cultural and historic preservation projects. These grants assist Indian Tribes, Alaskan Natives, and Native Hawaiian Organizations in protecting and promoting their unique cultural heritage and traditions.

To learn more and apply, **click here**.

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National Indian Health Board

Indian Health Care Improvement Act Not Targeted in House Health Reform Plan

On Monday night, House Republican leadership of two key committees, Energy & Commerce and Ways & Means, each released legislation to reform the nation's healthcare systems and change many aspects of the Affordable Care Act.

Crucially, neither committee's draft legislation included repeal of the Indian Healthcare Improvement Act (IHCIA), which was passed in 2010 as part of the ACA but remains unrelated to the main structure of the law's healthcare reforms. Other Indian-specific pieces of the ACA are also left intact.

The bill would make significant changes to the private insurance system: the tax penalty for individuals not purchasing and employers not offering healthcare would be $0, effectively repealing the individual and employer mandates.

- However, to incentivize coverage, insurance companies would be allowed to surcharge premiums by 30% for one year for individuals who go without insurance coverage for 63 days or more.

To provide assistance to Americans who struggle to purchase health insurance, the bill creates refundable tax credits based on income and age.

- These credits replace subsidies in the ACA for those with incomes below 400% of the poverty level.
- The credits are most generous to Americans with income below $75,000 and are gradually phased out as income rises.
- The credits to older Americans are more generous than the credits to younger Americans, but not by enough to close the gap between the higher premiums older Americans pay and the less expensive premiums the

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younger pay.

The taxes currently financing the ACA would be repealed starting in 2018, except for the "Cadillac Tax" on high-cost insurance plans, which would take effect in 2025. It is unclear at this time if the proposed reforms are sufficient to cover the cost of the bill.

Medicaid Expansion is preserved as is until 2020, after which federal funds stop going to the states to fund the expansion and states are no longer allowed to offer the program to the expansion population. The legislation also includes $15 billion dollars in annual grants through 2026 to states for a "Patient and State Stability Fund" to assist in covering uninsured populations.

Medicaid is reformed to a per capita system, capping the program's overall spending. The bill would also eliminate the mandate for state Medicaid programs to offer "essential services." The 100% federal reimbursement rate for American Indians and Alaska Natives remains in place.

Due to the vital role the Medicaid program plays in fulfilling the federal trust responsibility, NIHB is extremely concerned about the changes the bill enacts to Medicaid Expansion.

Both the House Ways and Means Committee and House Energy and Commerce Committee will mark up the legislation tomorrow morning. You can read the text of the Ways and Means legislation here and the section by section here. You can read the Energy and Commerce text here and the section by section here.

Indian Healthcare Improvement Act Introduced

Also last night, Congressman Tom Cole (R-OK) introduced H.R. 1369 which would include the text of the IHCIA as enacted as part of the Affordable Care Act (except for date changes). His office said that they do not expect that IHCIA would be repealed, but wanted to have this legislation as a safeguard should anything unexpected occur.

If you have any questions about the American Health Care Act or H.R. 1369 please contact NIHB's Director of Congressional Relations, Caitrin Shuy at cshuy@nihb.orgor (202) 507-4085.

Founded in 1972, NIHB is a 501(c) 3 not for profit, charitable organization providing health care advocacy services, facilitating Tribal budget consultation and providing timely information, and other services to all Tribal

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governments. NIHB also conducts research, provides policy analysis, program assessment and development, national and regional meeting planning, training, technical assistance, program and project management. NIHB presents the Tribal perspective while monitoring, reporting on and responding to federal legislation and regulations. It also serves as conduit to open opportunities for the advancement of American Indian and Alaska Native health care with other national and international organizations, foundations corporations and others in its quest to build support for, and advance, Indian health care issues.

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On Monday night, House Republican leadership of two key committees, Energy & Commerce and Ways & Means, each released legislation to reform the nation's healthcare systems and change many aspects of the Affordable Care Act.

Crucially, neither committee's draft legislation included repeal of the Indian Healthcare Improvement Act (IHCIA), which was passed in 2010 as part of the ACA but remains unrelated to the main structure of the law's healthcare reforms. Other Indian-specific pieces of the ACA are also left intact.

The bill would make significant changes to the private insurance system: the tax penalty for individuals not purchasing and employers not offering healthcare would be $0, effectively repealing the individual and employer mandates.

- However, to incentivize coverage, insurance companies would be allowed to surcharge premiums by 30% for one year for individuals who go without insurance coverage for 63 days or more.

To provide assistance to Americans who struggle to purchase health insurance, the bill creates refundable tax credits based on income and age.

- These credits replace subsidies in the ACA for those with incomes below 400% of the poverty level.
- The credits are most generous to Americans with income below $75,000 and are gradually phased out as income rises.
- The credits to older Americans are more generous than the credits to younger Americans, but not by enough to close the gap between the higher premiums older Americans pay and the less expensive premiums the younger pay.

The taxes currently financing the ACA would be repealed starting in 2018, except for the "Cadillac Tax" on high-cost insurance plans, which would take effect in 2025. It is unclear at this time if the proposed reforms are sufficient to cover the cost of the bill.

Medicaid Expansion is preserved as is until 2020, after which federal funds stop going to the states to fund the expansion and states are no longer allowed to offer the program to the expansion population. The legislation also includes $15 billion dollars in annual grants through 2026 to states for a "Patient and State Stability Fund" to assist in covering uninsured populations.

Medicaid is reformed to a per capita system, capping the program's overall spending. The bill would also eliminate the mandate for state Medicaid programs to offer "essential services." The 100% federal reimbursement rate for American Indians and Alaska Natives remains in place.

Due to the vital role the Medicaid program plays in fulfilling the federal trust

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responsibility, NIHB is extremely concerned about the changes the bill enacts to Medicaid Expansion.

Both the House Ways and Means Committee and House Energy and Commerce Committee will mark up the legislation tomorrow morning. You can read the text of the Ways and Means legislation here and the section by section here. You can read the Energy and Commerce text here and the section by section here.

Indian Healthcare Improvement Act Introduced

Also last night, Congressman Tom Cole (R-OK) introduced H.R. 1369 which would include the text of the IHCIA as enacted as part of the Affordable Care Act (except for date changes). His office said that they do not expect that IHCIA would be repealed, but wanted to have this legislation as a safeguard should anything unexpected occur.

If you have any questions about the American Health Care Act or H.R. 1369 please contact NIHB's Director of Congressional Relations, Caitrin Shuy at cshuy@nihb.org or (202) 507-4085.

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If you have any questions, please contact Lisa Griggs, Executive Administrative Assistant at (503) 416-3269 or email lgriggs@npaihb.org

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Answers to questions in response to letter of January 19, 2017

1. How would a 30 plus percent cut to federal financial participation as seen in Chairman Price's fiscal year 2017 budget proposal impact your state Medicaid program?
From our calculations, the increased liability to the state from cutting the federal financial participation by 30 percent in Medicaid would result in a loss of $1.55 billion to the state annually. This is a number that would undermine our overall Medicaid program and would cause many seniors to get fewer needed long-term care services for long-term care and undermine the economy of most of our rural communities by severely underpaying for the high rate of low-income people living in those communities. Most of our rural hospitals would be forced to severely downscale, limit access and potentially go out of business. Without a rural hospital, the economy of rural communities is severely affected and no new businesses will move into a community with limited health services. Other impacts related to severe cuts or if growth is limited below real-cost growth through block grants are listed below.

2. How would repeal of the Medicaid expansion affect health coverage rates in your state?
Cutting Medicaid expansion would result in large increases to the ranks of the uninsured in the state. Our estimates are that an additional 528,000 people would become uninsured. This would be an increase in the rate of uninsured of about 8 percent. This is a net impact as some people who were excluded would be able to get insurance in other ways.

However, the people who did enter the individual market would be a higher risk and more-costly population. We have real world experience in Washington; in the 1990s, shortsighted legislators cut coverage and a mandate resulted in our insurance market imploding so no one in the state could buy individual insurance for almost two years until we put a stabilizing fix in place. This partial fix excluded about a third of all people with pre-existing conditions. These people remained uninsured – a very inadequate result that was damaging to tens of thousands of working families who were applying for insurance and willing to pay average prices.

3. How would repeal of the Medicaid expansion impact your state Medicaid Budgets? What would be the impact on other state priorities such as education? Would your state be able to raise revenues or further compensate for this loss in federal funding?
Based on our 2016 Medicaid forecast, the state will lose $2.6 billion in FY18 and $2.8 billion in FY19 if the ACA is repealed and Medicaid Expansion is repealed. The state would lose and additional $400 million per fiscal year for exchange subsidies.

Washington State is facing a $4 billion biennial budget shortfall. This is due to ongoing operational costs, court-mandated educational funding and CMS-mandated – and needed – improvements to our mental health system. Adding $6 billion – the replacement cost for the ACA funding – to that deficit would be impossible and unsustainable.

4. How would these levels of cuts impact your ability to meet the needs of an aging baby boomer population?
There are a number of impacts of these cuts for the aging population. Early retirees or older adults working without health insurance through their employer are a large proportion of our state. Over 90,000 people in the 50-64 age range depend on Medicaid and the subsidized

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products through the exchange. This is a population that has more medical problems than younger beneficiaries and removing their insurance puts their health, employment, and their families at risk of bankruptcy more than any other group.

Many of the elderly on Medicare depend on the ACA to pay for medications. They depend on the 1:3 rate banding that makes health insurance affordable. And they depend on the ACA and Medicaid for long-term care services.

The elderly and disabled people we care for are a very vulnerable population and require long-term support services. National data show that 70 percent of the people who reach 65 will need these services. By 2035, the population age 75 and above will have risen by roughly 150 percent. The number of Medicaid beneficiaries with complex cognitive challenges will also increase dramatically by 2040 relative to 2010: a 181 percent increase in Medicaid beneficiaries over age 65 with Alzheimer's, a 152 percent increase in Medicaid beneficiaries over age 70 with dementia, and a 152 percent increase in the number of Medicaid beneficiaries over age 75 with serious cognitive difficulties. These are the most expensive patients we care for and a majority of them are on Medicaid. Limiting the growth of the Medicaid program shifts all of these increased costs directly onto the back of the state. A rough calculation is that our long-term care costs would increase by about 50 percent above normal inflation, resulting in new state expenditures of $600 million (in 2017 dollars) for the state share. If there were a decrease in the federal match rate or a block grant, the cost to the state would potentially be $1.2 billion that would be borne by the state annually above current expenditures.

5. How would these levels of cuts impact your ability to combat the opioid epidemic and mental health crisis and meet the needs of those with mental health and substance use disorder needs?

The opioid epidemic is a crisis in most states, as it is in Washington. We have instituted support for better treatment in the community, better training for our front-line providers, and have expanded our medically-assisted treatment programs. We now spend over $10 million per year in the latter, financed through the Medicaid system. Medicaid expansion has enabled us to better treat and actively manage the thousands of patients affected. Capping Medicaid limits our ability to flex our programs and meet the escalating need.

We have also begun a large effort to improve our mental health and substance use treatment system – a change that is needed and encouraged by all parties. Before we began this process, only 40 percent of people with known mental health problems were getting care. Also, only 20 percent of substance users were getting any care. Because of the expansion, we can now design integrated systems of care, provide needed services to those previously outside the system, develop active management for all low-income people with these problems, and intervene earlier, preventing people from progressing into disability. This is a work in progress. Our effectiveness in addressing these problems will be muted with repeal.

6. How would this level of cuts impact your ability to invest in innovative changes to your health care delivery system?

There are major impacts to innovation in our health care system based on the ACA. The first is that having all people potentially covered allows us to more aggressively innovate in our

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management through quality improvement, performance incentives and behavioral integration. We are able to align our payment system with the delivery system as needed to better manage. We now have almost all lower-income people within the health care system and providers can develop effective front-line innovative services for all patients not worrying if a service for a patient will be paid for or if a patient will buy a medication. Also, we have the ability to innovate in our health payment system developing performance measures, collecting usable information that can aid in choice and structuring payments that incentivize improved quality and better outcomes for patients.

Eliminating the expansion population moves the state back to the traditional Medicaid population with no chance to identify and intervene early in opioid addiction and mental health problems and no chance to identify and prevent many other diseases that are missed when low-income people are uninsured.

7. How would these levels of cuts impact your ability to respond to public health crises such as Zika virus or increases in HIV?
Our essential public health services are not funded to a level that would enable us to handle many types of crises. We are looking to increase our disease monitoring and rapid response this year – an essential now that antibiotics are becoming less effective and diseases like ZIKA can move around the world with rapidity. Removing another 528,000 people from coverage will make the treatment and management of these diseases much harder and more expensive for the state and local health departments.

8. How would these levels of cuts impact your ability to respond to an economic downturn such as a recession?
Our best estimate is our response in the last recession, during which, Washington State made the following changes to Medicaid:

- Maternal Support Services – we reduced the number of hours for low to medium-risk pregnancies
- Adult preventive dental services – cut all dental services except for emergency services (extractions for pain & infection) for all adults except for DD adults who were pregnant, COPES and in a nursing home
- Hearing aid benefit for adults – eliminated benefit for adults
- Breast & Cervical cancer program – reduced because the remainder was rolled into the ACA transition
- School based medical – the schools had to put forward more of the state match for the IGT
- Disproportionate Share Grants – low-income, urban indigent and small rural each reduced by 40 percent
- Prior Authorization for Advanced Imaging and Surgical Procedures – an increase in medical necessity reviews resulted in 20 percent reduction in costs
- ER Utilization – reduction for non-medically necessary ER utilization
- Hospital Rates - cut 8 percent inpatient and 7 percent Outpatient (non-governmental, non-rural hospitals)
- Adult Vision – no longer pay for adult eyeglasses – clients will be able to purchase at discount from Department of Corrections

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- DME/Wheelchairs – established limits on diabetic supplies, and discontinued coverage on bath equipment, BP monitors, and enteral nutrition for adults
- Podiatric physician reimbursement – only reimbursed for adult care when medically necessary to treat acute conditions or non-acute for at-risk clients
- Therapies – the benefits was reduced to the 12 visits for either OT, ST or PT
- FQHC Payment methodology – new payment methodology to revert to lower, national measure of medical inflation

These changes were implemented for a reduction not as severe as the one contemplated in the above questions. We would expect many more changes that are not beneficial for the patients involved who do not have incomes high enough to afford any replacement. All people in our expansion population earn less than $15,000 per year. Covering rent, food and bus fare leaves them with no available money for extras.

9. How would these levels of cuts impact your ability to respond to new high-cost medical breakthroughs such as Solvaldi and other blockbuster drugs?
These cuts would severely impact the state's ability to respond to new needed and medically-helpful specialty drugs like Solvaldi. Our cost for the few drugs in this category was $112 million in CY16, which is about 14 percent of our total Medicaid Rx budget. These costs have not been predictable due to timing of releases and court cases that have required us to use the medication with no limits. If we had a cut in our Medicaid budget, or worse a block grant/per capita cap that limited our total funds, the state would have to pay all the costs for these medications if they bumped us over our cap. Also, since many of the people now being treated would no longer be covered, screening would be delayed and treatment would be less successful. Eventually these people would be eligible for Medicaid, but we would lose our ability to intervene early, cure as many and eradicate this as a disease. From a budget perspective, in a block grant scenario we would potentially pay 100 percent of the cost and in a repeal situation; we would pay 50 percent of the cost.

10. How would these levels of cuts impact your ability to respond to natural and other disasters such as Hurricane Katrina, Superstorm Sandy, and the Flint water crisis?
Our responses to past natural disasters have cost the state significant funds. Given our budget limits as listed above, in a disaster situation, we will be limited in our ability to respond. Most specifically, if there are health-related emergencies – e.g., injuries or exposures – treating the injured will result in the state and providers having significant unfunded liabilities. Also, the extent of a highly likely event – a Cascade Subduction earthquake and tsunami – would destroy local health facilities in western Washington and would wipe out most health facilities and providers in the inundation zone. The health impact, both immediate and long-term, would be devastating to the communities affected and without a strong health services system, coverage for the people in the region and the infrastructure that can support their care. We would expect a large immediate loss of life in the short-run and a need for ongoing health services available to all people in the region. Experience in the recent Japanese earthquake and tsunami of 2011 found that this ongoing care is critical for the population's health moving forward. Our system relies on coverage to finance prevention and care – both acute and chronic. Without this coverage, this population will suffer long after a major event. In the region potentially affected, more than 20 percent of the adult population has gotten affordable insurance through the Affordable Care Act.

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Below is a summary of the costs incurred in our 2001 earthquake to give you a taste of the problems and costs of these disasters. Having a partial and underfunded health system will increase our financial liability and remove the needed infrastructure in these communities to meet at the immediate and long-term effects.

In 2001, Washington State experienced the natural disaster with the largest economic impact to date – the Nisqually Earthquake. Estimates put the cost of the damages at $2 billion. In addition, numerous seismic upgrades were implemented after the quake, including a 300 percent increase in seismic monitoring stations, 400 stations installed with global positioning equipment to monitor quakes and assess potential hazards, seismic upgrades and repairs on the Capitol campus, and the retrofitting of approximately 500 of the 880 highway bridges in the Puget Sound region.[1] Notwithstanding these damages and costs, the Pacific Northwest faces an even greater threat from a long anticipated magnitude 9.0 earthquake. Estimates from the Cascadia Region Earthquake Workgroup put the estimated economic impact of a 9.0 earthquake at $49 billion for Washington State.[2]

11. How would these levels of cuts impact your ability to provide affordable family planning services, including contraceptive coverage to low-income women and families?
Family planning is crucial to the well-being of families throughout the state. Families are more stable, economically more successful and better able to educate the next generation if they can choose when to have children. Cutting the expansion of Medicaid would mean that 274,000 women of childbearing age would not have access to affordable contraception. Women who have good coverage for contraceptives or have the funds to pay for them control their fertility so abortions are decreased and their families are more stable. These expansion-population women do not have the funds to buy very expensive contraceptives (LARC) that have proven efficacy. We would expect more economic hardship and significantly more abortions in the state.

12. How would these levels of cuts impact hospital and provider payments? What types of increases in uncompensated care would you expect to see in your state given such cuts?
Hospitals would be hard hit. Cutting the expansion population would result in a $1.0 billion cut in payments to hospitals. Rural hospitals alone would lose $89 million. This would undermine some very fragile hospitals.

Costs for people who are uninsured would dramatically increase. Uncompensated care (charity plus bad debt) fell from $2.0 billion in 2013 to $0.9 billion in 2015. During that same time period, charity care fell from $1.4 billion to $0.5 billion, and bad debt fell from $0.9 billion to $0.4 billion.[3] Eliminating the expansion would result in more people foregoing needed care because of costs.

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[1] http://www.theolympian.com/news/state/washington/article25286947.html
[2] http://file.dnr.wa.gov/publications/ger_ic116_csz_scenario_update.pdf. See page 9.
[3] Charity Care in Washington Hospitals, DOH, email correspondence

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13. How would these levels of cuts impact localities in your state, such as counties and local jails?
Health departments large enough to have Behavioral Risk Factor Surveillance System (BRFSS) data available are reporting significant increases in routine preventative checkups and decreases in adults foregoing care due to costs. This would be expected to reverse if Medicaid were reduced.

The problem of incarcerating people with mental health and substance use problems is widespread in Washington as it is in the rest of the country. We have been able to enroll people who are in the justice system in Medicaid due to expansion, which allows us to divert them from jail to treatment and ensure that, if incarcerated, they are able to transition out into needed care and not fall through the cracks. Within jails, enrollment in Medicaid increased from 31 percent in 2013 to 58 percent in 2014, and this trend is expected to continue if the ACA is retained.[4] Among those released from the state prisons in 2015, 6,066 of the 7,888 releasees (77%) were enrolled in Medicaid coverage. Almost all of these releasees were enrolled under the Medicaid expansion program (5,634 of the 7,888, or 71% of the total releases).[5]

14. What kinds of cuts would states have to contemplate under these levels of cuts in federal financing for state Medicaid programs?
Washington State is facing a $4 billion biennial budget shortfall. We are **$1.5 billion** short due to ongoing operational costs, court-mandated educational funding and CMS-mandated – and needed – improvements to our mental health system make up the rest. Adding $6 billion – the replacement cost for the ACA funding – to that deficit would be impossible and unsustainable.

15. How else would these levels of cuts impact your state?
Cutting Medicaid expansion in our state would be bad for our economy, employment, the stability of the private insurance market, medical insurance premium inflation, pharmaceutical costs for our most vulnerable seniors, not to speak of the hundreds of people who would literally die (estimated at about 400/year) due to being uninsured. Our economy would contract. Currently, we are adding about $3 billion to the economy from the ACA. Removing those funds would have a significant effect. We have gained 51,000 jobs that would probably be lost. Health insurance premiums for all lines of insurance (like employer-based insurance) have declined from an average of 8.1 percent per year for the decade before the ACA to 3.2 percent since passage. Changes in the individual insurance rates have been more dramatic.

The average premium change for the three years before the ACA was 18.5 percent. In the three years after implementation, the inflation rate was 6.7 percent per year. Clearly, repealing the ACA will have an impact on many working people and employers if we revert to the previous situation and the higher inflation rate. Of interest, states that did not fully embrace the ACA did not have our experience and saw continued high inflation. There are good reasons for this difference that should not be underestimated.

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[4] Joplin L., Sihler A, "Jail Diversion for People with Mental Illness in Washington State – A study conducted for the state of Washington Office of Financial Management", November 2018
[5] DSHS Research and Data Analysis, personal correspondence

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JAY INSLEE
Governor

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February 15, 2017

United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Dear Sens. Wyden, Stabenow, Cantwell, Nelson, Menendez, Carper, Cardin, Brown, Bennet, Casey, Warner, and McCaskill:

I appreciate the opportunity to provide vital information to the Finance Committee and the people of the United States about the potential impact of the proposed reductions in federal support for our safety net programs. Many people are either unaware of the importance of these programs for their own communities or are playing politics with people's lives. I trust it is the former, and I hope this document and the attachment help in informing you and them of the value of the safety net – in particular the essential federal Medicaid program – and its relationship to the economies, jobs and safety of our state and communities.

The programs financed through Medicaid support people in all parts of Washington State – more in rural communities and mostly in working families. Our beneficiaries are a cross-section of our communities – most are white, but many are minorities. Almost all are low-income. Most in the working-age population do work. For our elderly, blind and disabled people, Medicaid is the backbone of the safety net providing long-term care services, care management, health and supportive services. And, Medicaid ensures children have a healthy beginning and can learn and grow and enter school ready to succeed.

The truth is that the Affordable Care Act (ACA) has been good for the vast majority of people in our state – overall and especially for those in the individual market. Cost shifting (costs that we all pay for people without insurance) in our state is down from $2.38 billion in 2013 to $1.1 billion in 2014 – the first year of implementation of the ACA. We have seen 51,000 more people employed in Washington State due to the ACA. And, we all have the knowledge and comfort of knowing that we can start new businesses, change jobs and retire early knowing there is affordable health insurance available for our families.

If the discussion in Washington, DC is truly about improving the health system, we must continue to provide needed and appreciated coverage and services for the working families in our communities, in addition to the traditional Medicaid populations. It means that these people

should have affordable care so the promise of access is real. It also means that we continue to share the burden between the federal and state budgets as we have since the inception of the program. Undoubtedly, there are ways to improve on the ACA, but the system needs to work for all people. The insurance market needs to be stable, as it is now in Washington State. And the federal government should not expect the states to bear more of the cost or the future risk for the health system alone.

I appreciate your interest in understanding the impact of the potential health care policy changes being considered in Congress. Attached are answers to the questions you posed. I stand ready to assist you in this process. Most importantly, I strongly urge Congress not to repeal the ACA, and especially not to do so without first identifying a sufficient replacement that ensures that 30 million Americans and 750,000 Washingtonians do not lose their affordable health coverage.

Very truly yours,

Jay Inslee
Governor

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Webinar

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Wednesday
March 22, 2017

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1:00 – 2:30 p.m. ET

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Social Security Number Removal Initiative (SSNRI) Update

Dear Tribal Leaders, and Tribal and Urban Indian Health Organizations:

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 (Public Law 114-10) requires CMS to remove social security numbers (SSN) from all Medicare cards by April 2019. Starting in April 2018, CMS will issue new cards with Medicare Beneficiary Identifiers (MBI). MBIs are randomly generated numbers that do not include SSNs.

SSNRI is designed to decrease Medicare beneficiaries' vulnerability to identity theft, with minimal disruption to Medicare operations, and minimal burden for providers and beneficiaries.

CMS is actively educating the provider community about this initiative, including Tribal and Urban health care programs and facilities operated by the Indian Health Service (IHS).

CMS has held conference calls with IHS and the CMS Tribal Technical Advisory Group. This letter will be one communication of many to ensure that Tribal and Urban Indian health facilities are aware of CMS' SSNRI implementation efforts. Beginning in January 2018, CMS will also conduct intensive education and outreach to Medicare beneficiaries and their agents about the upcoming changes to Medicare beneficiary cards.

As Tribal and Urban Indian health programs, you will need to prepare for this change by determining how using new MBI numbers will impact Tribal and Urban facilities' systems, business practices, and any entity

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with whom you currently exchange information using a SSN-based Health Insurance Claim Number (HICN). Any required system and business changes must be made before April 2018. Providers should test their software to see if it currently requires the HICN format, and reach out to their vendor if changes related to MBI implementation are needed. Providers using clearinghouses should contact them and ask if they will be prepared for MBI implementation by April 2018.

Providers will be able to use either the MBI or the SSN-based HICN through the transition period from April 2018 through December 2019. After the transition period, only the MBI will be used for transactions with very limited exceptions.

CMS will be hosting a webinar on SSNRI. Please save the date for this important webinar.

More information on SSNRI.

If you have questions, please submit them to the SSNRI team at SSNRemoval@cms.hhs.gov.

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

Republicans Take Step to Maintain Cost-Sharing Reduction Payments Under the Affordable Care Act, at Least Temporarily[1]

December 29, 2016

This brief provides an update to Tribes on a recent action by House Republicans to continue cost-sharing reduction (CSR) payments by the federal government to health insurance issuers under the Affordable Care Act (ACA) as a means of protecting the individual health insurance market. The move came as part of a lawsuit that House Republicans filed in 2014 in an effort to end the CSR payments. Now that Republicans are expected to "repeal" the ACA stemming from the November election results, Congressional Republicans and the Trump White House appear to want to hold the ACA together long enough to enact and implement a "replacement" in 2 – 3 years.

In November 2016, House Republicans filed a motion to delay temporarily the proceedings in the lawsuit, and a U.S. appeals court granted the motion on December 5, 2016. This latest development in the lawsuit maintains the current status of the CSR payments—at least temporarily—which have continued since the lower court issued its decision. But, the incoming Trump Administration will have an important decision to make. If the incoming Trump Administration drops the appeal to a lower-court ruling filed by the Obama Administration, the CSR payments likely would be halted immediately.

Background

Under the ACA, individuals who meet the definition of Indian and enroll in a qualified health plan (QHP) through the Marketplace qualify for comprehensive CSRs.[2] Non-Indians who have an income that does not exceed 250% of the federal poverty level (FPL) qualify for general CSRs, provided that they enroll in a silver-level plan.[3] The federal government makes advance CSR payments to QHP issuers to reimburse them for the CSR amounts that they provide to eligible Marketplace enrollees. Currently, more than six million Marketplace enrollees receive general CSRs, and approximately 26,000 American Indians and Alaska Natives residing in 38 states for which data are available receive the comprehensive Indian-specific CSRs.[4]

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[1] This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Doneg McDonough, TSGAC Technical Advisor, at DonegMcD@Outlook.com.

[2] See 45 CFR 155.350(a) and (b) and 156.420(b). Individuals who meet the definition of Indian can enroll in either a zero or limited cost-sharing plan, depending on their income level. Eligible individuals who have an income of 100-300% FPL can enroll in a zero cost-sharing plan, and all others can enroll in a limited cost-sharing plan. Under both plan variations, enrollees pay no deductibles, coinsurance, or copayments when receiving essential health benefits (EHBs) from Indian health care providers (IHCPs) or through non-IHCPs.

[3] See 45 CFR 155.305(g).

[4] Center for Medicare and Medicaid Services, for Federally-Facilitated Marketplace enrollment as of May 23, 2016.

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Potential Implications

House Republicans sought the delay in the lawsuit to allow the incoming Trump administration and new Republican Congress time to take action on their health care proposals without disrupting the individual health insurance market, and associated federal financial assistance, that was fashioned under the ACA. Although President-Elect Donald Trump and Republican congressional leaders have promised to "repeal and replace" the ACA, the sudden elimination of $9 billion in CSR payments in 2017 likely would require health insurance to issuers to raise premiums dramatically or exit the Marketplace. According to one health policy expert, the "reasonable course for Congress at this time is to appropriate funds to cover the cost-sharing reduction payments for 2017 (and 2018 to avoid a collapse of the marketplaces at the end of 2017), and then to negotiate with the Trump administration the withdrawal of the appeal and the vacating of the district court's order with the administration."[5]

Lawsuit History

House Republicans initially filed the lawsuit in 2014, seeking to end the CSR payments on constitutional grounds. The lawsuit, *House v. Burwell*, argued that Congress authorized but never appropriated funding for the CSR payments and that the Obama administration improperly funded the payments without congressional approval. In May 2016, U.S. District Court Judge Rosemary Collyer ruled in favor of House Republicans but allowed the CSR payments to continue pending the resolution of an appeal filed by the Obama Administration.

House Republicans in November 2016 filed a motion to hold in abeyance all briefings in the appeal of the lawsuit. A three-judge panel of the U.S. Court of Appeals for the District of Columbia Circuit in early December 2016 granted the motion and ordered the parties to file motions governing further proceedings in the appeal by February 21, 2017. By that time, the incoming Trump administration will have become the defendant in the case and will decide next steps with the House Republican plaintiffs. The decision of the Trump Administration, in conjunction with Congressional Republicans, will indicate whether Republicans intend to maintain the functioning of the ACA insurance coverage options until a replacement can be enacted into law and implemented.[6]

[5] Timothy Jost, "Court Stays Cost-Sharing Reduction Payment Case, Giving Control to New Administration and Congress (Updated)," *Health Affairs Blog* (Washington, DC), December 5, 2016. See http://healthaffairs.org/blog/2016/12/05/court-stays-cost-sharing-reduction-payment-case-giving-control-to-new-administration-and-congress/.

[6] https://www.washingtonpost.com/national/health-science/trump-could-quickly-doom-aca-cost-sharing-subsidies-for-millions-of-americans/2016/12/21/05349066-c2fc-11e6-9a51-cd56ea1c2bb7_story.html?utm_term=.674c7fb665b2

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Did the Trump Administration Eliminate the Individual Shared Responsibility Payment Requirement Under the Affordable Care Act?[1]

February 27, 2017

This brief provides an update to Tribes on a recent action taken by the Internal Revenue Service (IRS) to ease the regulatory burden associated with the individual mandate under the Affordable Care Act (ACA). On January 20, 2017, President Trump issued an Executive Order that directed the heads of federal departments and agencies with authorities and responsibilities under the ACA to "take all actions consistent with law to minimize the unwarranted economic and regulatory burdens" of the law.[2] In response to this order, the IRS earlier this month posted a notice of a change in policy regarding the 2017 tax filing process.[3] This notice, however, did not modify or eliminate the individual shared responsibility payment requirement, meaning that individuals who were subject to a requirement to secure insurance or make a payment to the federal government are still required to do so. And, eligible American Indians and Alaska Natives (AI/ANs) continue to be exempt from the requirement to make shared responsibility payments.

Background

Section 5000A of the Internal Revenue Code, as added by the ACA, requires individuals to have qualifying health insurance coverage (minimum essential coverage) each month, or obtain an exemption, to avoid making a "shared responsibility payment" when filing their federal income tax return. Under the ACA, members of a federally-recognized Tribe, including shareholders in an Alaska Native regional or village corporation, as well as individuals eligible for services through an Indian health care provider, qualify for an exemption from the shared responsibility payment. **It is important to note that the IRS notice has no impact on the ability of eligible AI/ANs to obtain an exemption from the shared responsibility payment**. Likewise, family members of AI/ANs who were not previously eligible for an exemption might continue to be subject to the requirements.

IRS Notice

The IRS notice rescinded recent system changes that would have automatically rejected electronic and paper tax returns during the filing process this year if taxpayers did not provide information on their health insurance coverage status, effectively retaining the policy from the 2016 tax filing season.[4] As part of the tax filing process, individuals who had minimum essential coverage for all 12 months of the prior tax year can check the "Full-year coverage" box on their tax return and make no shared responsibility payment. Individuals who did not have coverage for all 12 months either must claim an exemption, if eligible, by attaching Form 8965 or make a shared responsibility payment. **AI/AN taxpayers should continue to file their tax returns as they have in the past, either indicating that they had minimum essential coverage for all 12 months of the tax year or, if eligible, claiming an exemption**.

[1] This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Doneg McDonough, TSGAC Technical Advisor, at DonegMcD@Outlook.com.

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[2] "Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal," White House Office of the Press Secretary, Jan. 20, 2017. See https://www.whitehouse.gov/the-press-office/2017/01/2/executive-order-minimizing-economic-burden-patient-protection-and.

[3] IRS, "Individual Shared Responsibility Provision," IRS Web site. https://www.irs.gov/affordable-care-act/individuals-and-families/individual-shared-responsibility-provision (accessed Feb. 24, 2017).

[4] Similar to previous years, if the IRS has questions about a tax return, the taxpayer might receive follow-up questions and correspondence at a future date, after the completion of the filing process.

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Current Understanding of --

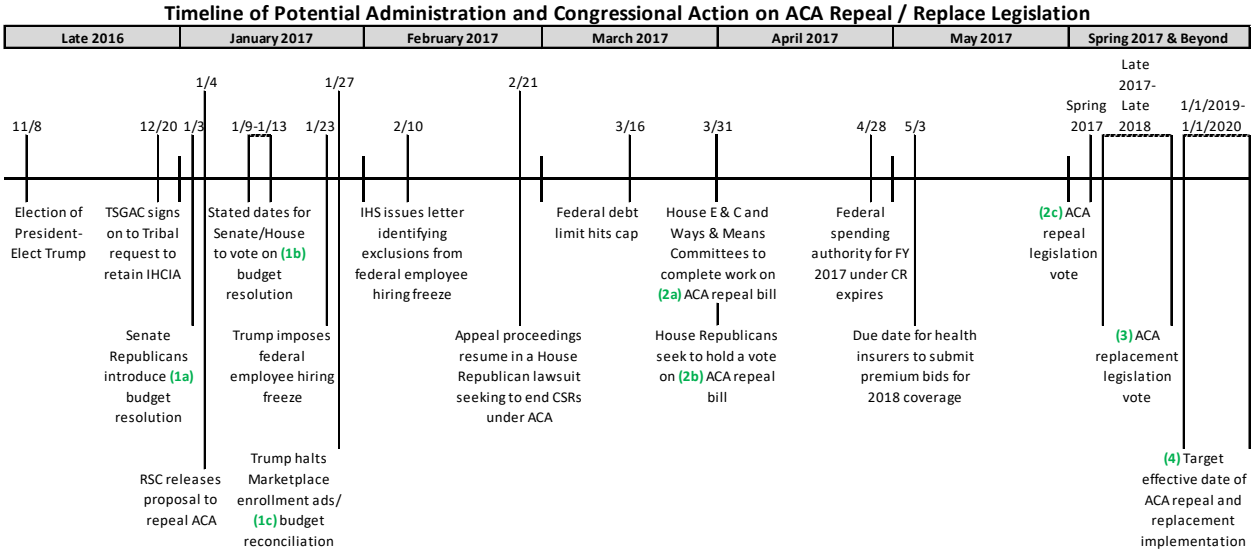
Timeline of Potential Administration and Congressional Action on ACA Repeal / Replace Legislation; Other Key Dates; and Activities of Tribes[1]

As of: February 13, 2017

This brief provides a timeline on potential / completed congressional, Trump Administration, and Tribal organization actions regarding repealing and replacing the Affordable Care Act (ACA). *Activities and dates are updated according to on-going press reports.*

Congressional / Administration actions appear in black; Tribal organization actions appear in red.

Timeline of Potential Administration and Congressional Action on ACA Repeal / Replace Legislation



Date	Administration / Congressional Action	Tribal Action
11/8/2016	Donald Trump elected President; lead health care policy priority is to: "Repeal and replace Obamacare with Health Savings Accounts (HSAs)" and "maximize flexibility for states via block grants …" (Trump Web site as of 1/7/2017, see https://www.donaldjtrump.com/policies/health-care/)	See related TSGAC memo titled "Affordable Care Act and IHCIA in 2017; Trump, Ryan and Price Health Insurance Approaches; State of Indiana Medicaid Expansion Plan" at http://www.tribalselfgov.org/wp-content/uploads/2016/12/TSGAC-memo-2017-ACA-IHCIA-Trump-Ryan-Price-Health-Care-Plans-2016-12-04b.pdf.

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12/20/2016	**TSGAC signs on to Tribal organization letter to Congress requesting preservation of the Indian Healthcare Improvement Act, Indian-specific provisions under Medicaid, and other health-related provisions "unrelated to the overall healthcare reform legislation."** The letter is available at https://www.tribalselfgov.org/wp.../Tribal-organization-IHCIA-Support-Letter.pdf.
1/3/2017	Senate Republicans **(1a)** introduce a budget resolution (S. Con. Res. 3). Four Congressional committees **(1b)** to draft "reconciliation instructions" by 1/27/2017 that will include provisions to repeal parts of ACA. S. Con. Res. 3 is available at https://www.congress.gov/bill/115th-congress/senate-concurrent-resolution/3. See related CRS memo titled "The Budget Reconciliation Process: Timing of Legislative Action" at https://fas.org/sgp/crs/misc/RL30458.pdf.
1/4/2017	The Republican Study Committee releases a proposal to repeal ACA by 1/1/2018, with no timeline set for a replacement. The Republican Study Committee proposal is available at http://rsc.walker.house.gov/#AHCRA.
1/9/2017-1/13/2017	• Stated dates for the Senate to vote on the budget resolution. • Stated dates for the House to vote on the (Senate version of) budget resolution.
1/23/2017	Trump issues presidential memorandum that ordered an immediate freeze on the hiring of all federal civilian employees, except in certain circumstances. The memo is available at https://www.whitehouse.gov/the-press-office/2017/01/23/presidential-memorandum-regarding-hiring-freeze.
1/27/2017	**TSGAC submits letter to acting HHS secretary and acting IHS director in support of an exemption from the federal employee hiring freeze for certain staff and contracted positions at the IHS**. The letter is available at http://www.tribalselfgov.org/wp-content/uploads/2017/01/2017.01.27-TSGAC-Request-Exemption-from-Hiring-Freeze-for-IHS.pdf.
1/27/2017	• Trump halts federally-sponsored advertising and outreach aimed at encouraging enrollment in Marketplace coverage. • **(1c)** Senate and House "reconciliation instructions" are due from committees under S. Con. Res. 3. Date is likely to slip (possibly to early March).
2/10/2017	IHS issues a Dear Tribal Leader Letter indicating that agency "positions involved in direct patient care and a number of ancillary mission critical support positions without which patient care providers and facilities could not function are now exempt" from the federal employee hiring freeze. The letter is available at: https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/2017_Letters/DTLL_UIOLL-HiringFreeze_02102017.pdf.
2/21/2017	Appeal proceedings will resume in a House Republican lawsuit seeking to end cost-sharing reductions under ACA. [**See TSGAC memo on TSG website" "Republicans Take Steps to..."** http://www.tribalselfgov.org/wp-content/uploads/2017/01/TSGAC-Status-of-CSR-Payments-2017-1-6a.pdf]
3/16/2017	Federal debt limit hits cap; additional borrowing authority needed to prevent inability to make payments on government obligations.
3/31/2017	• As part of "budget reconciliation process," **(2a)** House Energy & Commerce and Ways & Means Committees plan to complete work on ACA repeal legislation by the end of March 2017. Legislation likely will not fully repeal ACA but anticipated to eliminate many major provisions, including Medicaid expansion, premium tax credits, individual/employer mandates, and financing provisions. • House Republicans seek to **(2b)** hold a vote on ACA repeal legislation ([XXX] Reconciliation Act) by 3/31/2017.
4/28/2017	Federal spending authority for FY2017 under continuing resolution expires; extension of spending authority needed to prevent government shut down.

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Spring 2017	ACA repeal legislation ([XXX] Reconciliation Act) to be voted on. • The Senate is expected to **(2c)** consider ACA repeal legislation, either through the committee process or a direct floor vote. • Once passed in the Senate, the House and Senate would work to resolve any differences in the ACA repeal legislation and approve a final bill. • President Trump is expected to sign the ACA repeal legislation into law, although there are differences in opinion on whether "replace" legislation should be enacted simultaneously with "repeal".
5/3/2017	Due date for health insurers to submit premium bids for 2018 coverage. Date could be delayed.
Late 2017 – late 2018	ACA replacement legislation voted on. • **(3)** Congressional Republicans plan to develop ACA replacement legislation, either at the time of "repeal" (which would delay the "repeal" vote); within 2017 but after repeal; and possibly after the midterm elections (11/2018).
1/1/2019 – 1/1/2020	Target effective date of **(4)** ACA repeal and replacement implementation. • Potential date ranges Congressional Republicans have indicated that they might establish for the completion of the transition from the ACA to a replacement.

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Clarification on Federal Policy and Next Steps for Tribal Health Care Facilities Billing Medicaid for Clinic Services Provided Outside of Their "Four Walls"[1]

February 14, 2017

This brief seeks to provide guidance to Indian health care providers (IHCPs), specifically those operated by a Tribe or Tribal organization, on a recent clarification of federal policy under which CMS will phase-in enforcement of a policy indicating that IHCPs enrolled in Medicaid as clinics cannot bill the program for "clinic services"[2] provided outside the "four walls" of their facilities, except for services provided to homeless individuals. In addition, this brief outlines steps that affected Tribal health care facilities enrolled as providers of clinic services can take in their state to continue to receive Medicaid payments at the facility rate (usually the "OMB encounter rate" or the "IHS All-Inclusive" outpatient rate) for services provided outside the four walls of their facilities.

Background

On February 26, 2016, the federal Centers for Medicare and Medicaid Services (CMS) issued a State Health Official (SHO) Letter[3] to inform state Medicaid agencies and other state health officials about an update in payment policy affecting federal funding for services received by American Indians and Alaska Natives (AI/ANs) through IHCPs. CMS, in the process of implementing the SHO Letter, realized that some IHCPs have billed Medicaid for clinic services provided outside the four walls of their facilities. On January 18, 2017, CMS issued a document[4] clarifying that "clinic services" include only services that are within the scope of the "clinic services" benefit and that are either furnished within the four walls of an enrolled Medicaid clinic or are furnished off-site to homeless individuals by clinic personnel. Consequently, after the grace period provided for in the CMS revised policy, IHCPs enrolled in Medicaid as clinics cannot bill for off-site services as "clinic services," and therefore cannot be paid for them at their facility rate (unless the patient is homeless). Instead, services that are provided off-site to persons who are not homeless may only be billed and paid for as an assigned claim from the off-site provider who furnished the service, for example, as a covered physician service paid for under the physician fee schedule.

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[1] This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Doneg McDonough, TSGAC Technical Advisor, at DonegMcD@Outlook.com.

[2] Defined at 42 CFR 440.90 as "preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients."

[3] See CMS, "SHO #16-002: Federal Funding for Services 'Received Through' an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives," at https://www.medicaid.gov/federal-policy-guidance/downloads/SHO022616.pdf.

[4] See CMS, "Frequently Asked Questions (FAQs): Federal Funding for Services 'Received Through' an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives (SHO #16-002)," at http://www.tribalselfgov.org/wp-content/uploads/2017/02/01-faq11817.pdf.

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Impact of Policy

As mentioned above, the policy applies only to services provided outside of the four walls of IHCPs enrolled in Medicaid as clinics. The policy does not apply to the following:

- Clinic services provided within the four walls of a clinic;
- Clinic services provided by clinic personnel to homeless individuals outside the four walls of a clinic;
- On-site and off-site services of facilities that are enrolled and paid as outpatient hospital departments, including hospital-based clinics in States that offer that enrollment option;
- Services delivered by an outside provider, which is billed as an assigned claim at that provider's reimbursement rate; and
- Covered services of Federally Qualified Health Centers, whether provided on-site or off-site.

Possible Relief for Affected Tribal Health Care Facilities

Change in Designation to FQHC

For Tribal health care facilities affected by the policy, CMS has suggested re-designating as a Federally Qualified Health Center (FHQC) [5] as a means of continuing to bill Medicaid for services provided outside the four walls of their facilities, as FQHCs are not subject to the same "four wall" restrictions as clinics. Under section 1905(l)(2)(B) of the Social Security Act (Act), outpatient health care facilities operated by a Tribe or Tribal organization under the Indian Self-Determination Act are by definition FQHCs. Tribal health care facilities thus have to option to enroll in Medicaid programs as FQHCs. Tribal health care facilities currently enrolled in Medicaid as a clinic need only to inform the state of their desire to change their designation to an FQHC; they do not have to re-enroll in the program.

Change in Medicaid Payment Rate

Tribal FQHCs typically receive Medicaid payments based on a rate determined by the state using the Prospective Payment System (PPS) methodology, rather than the encounter rate (aka the "OMB Rate" or "IHS All-Inclusive Rate"). However, under section 1902(bb)(6) of the Act, states and FQHCs have the ability to agree to use an Alternative Payment Methodology (APM) in determining Medicaid payment rates, meaning that states can use the encounter rate, rather than the PPS rate, to set payments for Tribal FQHCs, as long as the APM rate is higher than the FQHC payment rate. States must submit a state plan amendment (SPA) to set Medicaid payments for Tribal FQHCs at the encounter rate, and must annually determine that the encounter rate is higher than the FQHC PPS rate that would otherwise apply. (This means States will have to calculate the FQHC PPS rate each year, but CMS says tribal facilities will not be required to submit cost reports in connection with that process.)

[5] Health care facilities enrolling as an FQHC under Medicaid generally do not have to meet the requirements for enrolling as an FQHC under Medicare.

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Other differences between Medicaid FQHC services and Medicaid clinic services.

There are other important differences between Medicaid "clinic services" and "FQHC services." The scope of coverage is not necessarily the same, and it may vary from state to state. States may impose different service caps or limitations on the two types of services. Supervision, staffing, documentation, and billing requirements may also be different. There may be both advantages and disadvantages to switching to FQHC enrollment. Affected facilities should work with their State Medicaid agencies to identify the differences, and evaluate them carefully, before deciding whether to make the change.

Grace Period

CMS has provided a grace period to allow affected Tribal health care facilities time to evaluate their options, re-designate as FQHCs under Medicaid, and negotiate with states to use the encounter rate rather than the PPS rate for payment. According to CMS, the agency will not review Medicaid claims for clinic services provided outside the four walls of tribal health care facilities before January 30, 2021. CMS indicated, however, that tribal health care facilities seeking to re-designate as an FQHC under Medicaid should notify the state of their intention to do so by January 18, 2018.

Next Steps

Affected Tribal health care facilities should consider taking the following steps:

1. Begin working immediately with your state to identify all the differences between clinic and FQHC status, including scope of coverage, staffing, supervision, documentation, billing, and other requirements.
2. Evaluate the financial and programmatic pros and cons of making the change, beyond the ability to bill for off-site services at the encounter rate.
3. If you decide the change would be advantageous, notify the state no later than January 18, 2018 that you intend to change your Medicaid enrollment status from a clinic to an FQHC;
4. Reach an agreement with the state to use the encounter rate, rather than the PPS rate, in setting Medicaid payments for Tribal FQHCs;
5. Work with the state in drafting and submitting to CMS a state plan amendment to set Medicaid payments for Tribal FQHCs at the encounter rate. The state plan amendment should be submitted by the state to CMS no later than March 31, 2021, in order to be able to be in effect on January 1, 2021.

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Applicable Percentages, Thresholds, and Payments: Indexing Adjustments Related to Certain Affordable Care Act Provisions for 2015-2018[1]

Revised October 30, 2016

This brief seeks to provide guidance to Tribes on indexing adjustments associated with the Patient Protection and Affordable Care Act (ACA) provisions for calculating the amount of premium tax credit (PTCs), determining whether individuals qualify for an income-based exemption from the shared responsibility payment, determining whether employer-sponsored health insurance is considered affordable, determining the amount of any shared responsibility payment owed by individuals or employers, and establishing the maximum out-of-pocket amounts for individuals and families.

Applicable Percentage Contribution (for Premium Tax Credit Calculations)

Under ACA, individuals who have an income between 100 percent and 400 percent of the federal poverty level (FPL) and meet other requirements can obtain PTCs to help pay for Marketplace coverage. Section 36B of the Internal Revenue Code (Code) (as added by ACA) set the required household income

Table 1: Applicable Percentage Contribution for CY 2014 Through CY 2017

	2014		2015		2016		2017	
Household Income (as a % of FPL)	Low End of Range	Top End of Range	Low End of Range	Top End of Range	Low End of Range	Top End of Range	Low End of Range	Top End of Range
< 133%	2.0	2.0	2.01 (+0.5)	2.01 (+0.5)	2.03 (+1.0)	2.03 (+1.0)	2.04 (+0.5)	2.04 (+0.5)
133% to 150%	3.0	4.0	3.02 (+0.7)	4.02 (+0.5)	3.05 (+1.0)	4.07 (+1.2)	3.06 (+0.3)	4.08 (+0.2)
150% to 200%	4.0	6.3	4.02 (+0.5)	6.34 (+0.6)	4.07 (+1.2)	6.41 (+1.1)	4.08 (+0.2)	6.43 (+0.3)
200% to 250%	6.3	8.05	6.34 (+0.6)	8.10 (+0.6)	6.41 (+1.1)	8.18 (+1.0)	6.43 (+0.3)	8.21 (+0.4)
250% to 300%	8.05	9.5	8.10 (+0.6)	9.56 (+0.6)	8.18 (+1.0)	9.66 (+1.0)	8.21 (+0.4)	9.69 (+0.3)
300% to 400%	9.5	9.5	9.56 (+0.6)	9.56 (+0.6)	9.66 (+1.0)	9.66 (+1.0)	9.69 (+0.3)	9.69 (+0.3)

Source: IRS, Rev. Proc. 2014-37, Rev. Proc. 2014-62, and Rev. Proc. 2016-24. Percentage change from previous year appears in parenthesis.

[1] This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Doneg McDonough, TSGAC Technical Advisor, at DonegMcD@Outlook.com.

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contribution percentages for 2014 and authorized IRS to adjust these percentages annually to reflect the excess of the rate of premium growth for the preceding calendar year[1] over the rate of income growth for the preceding calendar year.[2] The applicable percentage contribution amounts for each calendar year/coverage year are shown in Table 1 above.

Repayment of Overpayments

The Marketplace determines eligibility for PTC, and the amount of any PTC, based on the information that individuals applying for coverage provide about their expected household income and family size for the year. Individuals who receive advance PTC payments over the coverage year must reconcile these payments with the amount of PTC for which they qualify based on their actual income for the year reported on their federal tax return.[3] If individuals receive advance PTC payments that are less than the amount of PTC for which they qualify based on their actual income, they will receive the difference as a reduction in their tax bill or an increase in their refund. However, if individuals receive advance PTC payments that exceed the PTC for which they ultimately qualify based on their actual income, they will have to repay the excess amount, subject to certain limits (see Table 2 below).

Table 2: Premium Tax Credit Repayment Limits for 2014 Through 2016

Household Income	2014 (2013 tax year)		2015 (2014 tax year)		2016 (2015 tax year)	
	Single	Other	Single	Other	Single	Other
0%-200% FPL	$300	$600	$300	$600	$300	$600
201%-300% FPL	$750	$1,500	$750	$1,500	$750	$1,500
301%-400% FPL	$1,250	$2,500	$1,250	$2,500	$1,275	$2,550
401%+ FPL	No Limit	No Limit	No Limit	No Limit	No Limit	No Limit

Source: IRS, Instructions for Form 8962, 2014-2016.

Income-Based Exemption from Shared Responsibility Payment Penalty for No Coverage

A. Affordability Percentage (Required Contribution Percentage for Affordability Determinations)

Starting in 2014, § 5000A of the Code (as added by ACA), requires individuals of all ages to make a shared responsibility payment when filing their federal income tax return if they do not have qualifying health insurance (minimum essential coverage) for each month or do not qualify for an exemption. American Indians and Alaska Natives are able to file for an exemption from this payment on their federal income tax forms. Other individuals and families who cannot afford coverage because their premiums would exceed a certain percentage of household income, *i.e.* the affordability percentage, qualify for an income-based exemption. Section § 5000A of the Code set the affordability percentage at 8 percent for 2014 and authorized HHS to adjust this percentage annually to reflect the excess of the rate of premium growth between the preceding calendar year and 2013 (premium adjustment percentage) over the rate of income growth for that period.[4] The affordability percentages are shown, by calendar year (CY), in Table 3 below.

Table 3: Affordability Percentage for CY 2014 Through CY 2017

	2014	2015	2016	2017	2018
Affordability Percentage	8.0	8.05	8.13	8.16	8.05

Source: CMS, CMS-9949-F, CMS-9944-F, CMS-9937-F, and CMS-9934-P.

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B. Federal Income Tax Filing Threshold

In addition to the income-based exemption discussed above, individuals who do not have gross income that meets the minimum threshold for having to file a federal income tax return qualify for an exemption from the shared responsibility payment, provided that no one can claim these individuals as a dependent.[5] IRS determines the tax filing threshold annually.

Table 4: Federal Income Tax Filing Threshold for 2014 Through 2016 (Ages 0-64)

Tax Filing Status	2014 (2013 tax year)	2015 (2014 tax year)	2016 (2015 tax year)
Single	$10,000	$10,150	$10,300
Head of Household	$11,500	$13,050	$13,250
Married Filing Jointly	$20,000	$20,300	$20,600
Married Filing Separately	$3,900	$3,950	$4,000
Qualifying Widower with Child Dependent	$16,100	$16,350	$16,600

Source: IRS, Publication 501, 2013-2015.

Shared Responsibility Payment Penalty for No Coverage

Individuals who neither have qualifying health insurance (minimum essential coverage) for each month nor qualify for an exemption must make a "shared responsibility payment." In general, the amount of the annual payment equals *the greater of*: (1) a percentage of household income, with a cap at the national average premium for the bronze plan available through the Marketplace that provides coverage for the

Table 5: Individual Shared Responsibility Annual Payment Amounts for 2014 Through 2017

Household (HH) pays greater of:	Formula	2014	2015	2016	2017
Percentage Amount	Specified % of HH income above tax filing threshold	1%	2%	2.5%	2.5%
	With amount not exceeding:	$2,448 per person	$2,484 per person	$2,676 per person	Not yet released
		$12,240 per HH of 5+	$12,420 per HH of 5+	$13,380 per HH of 5+	
Flat Amount	Specified per person $ figure	$95 per adult $47.50 per child	$325 per adult $162.50 per child	$695 per adult $347.50 per child	$695 per adult $347.50 per child
	With amount not exceeding:	$285 per HH	$975 per HH	$2,085 per HH	$2,085 per HH

Sources: Healthcare.gov (https://www.healthcare.gov/fees/fee-for-not-being-covered/); IRS, "Individual Shared Responsibility Provision--Reporting and Calculating the Payment," Rev. Proc. 2015-15, Rev. Proc. 2016-43, and Rev. Proc. 2016-55. See Table 4 above for tax filing thresholds for determining the percentage amount. For the flat amount, IRS after 2016 will base the dollar figures on the 2016 figures plus a cost-of-living adjustment. Note: Actual payment amounts are 1/12th the amounts shown for each month individuals do not have minimum essential coverage or an exemption during the tax year.

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applicable family size involved, or (2) a flat dollar amount, with a maximum flat amount per family of three times the adult amount (see Table 5 above). Federal regulations set the percentages of household income used to determine the percentage amount at 1.0% in 2014, 2.0% in 2015, and 2.5% in 2016 and subsequent years. For 2014, 2015, and 2016, federal regulations set the flat amount per adult at $95, $325, and $695, respectively, and for 2017 and subsequent years $695 plus cost-of living adjustments. Federal regulations set the flat amount per child at half the amount per adult.

Annual Limitations on Cost-Sharing

ACA established maximum annual limitations on cost-sharing for individual (self-only) and family (non-self-only) health insurance coverage. In May 2013, IRS set these limitations at $6,350 and $12,700, respectively, for plan year (PY) 2014.[6] For plan years after 2014, 45 CFR 156.130(a)(2) granted HHS the authority to adjust the limitation on cost-sharing; cost sharing for self-only coverage cannot exceed the dollar limit for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage,[7] and for family coverage, the limit is twice the dollar limit for individual coverage.[8] HHS issued regulations updating the limitations on cost-sharing for PY 2015 in 2014,[9] for PY 2016 in 2015,[10] PY 2017 in 2016,[11] and PY 2018 in 2016[12] (see Table 6 below).

Table 6: Annual Limitations on Cost-Sharing for PY 2014 Through PY 2018

2014		2015		2016		2017		2018	
Ind.	Family	Ind.	Family	Ind.	Family	Ind.	Family	Ind.	Family
$6,350	$12,700	$6,600	$13,200	$6,850	$13,700	$7,150	$14,300	$7,350	$14,700

Source: IRS, Rev. Proc. 2013-25; CMS, CMS-9949-F, CMS-9944-F, and CMS-9937-F.

Required Contribution Percentage (for Calculating Affordability of Employer Offer of Coverage)

Under section 4980H of the Code, as added by ACA, applicable large employers (ALEs)--those with at least a certain number of employees (generally 50 full-time employees or a combination of full-time and part-time employees equivalent to 50 full-time employees)--might have to make a shared responsibility payment if they do not offer affordable health insurance to their full-time employees.[13] The required contribution percentage, *i.e.* the percentage of household income an employee must contribute for self-only coverage, is used to determine whether employer-sponsored insurance is considered affordable.[14] Section § 36B of the Code set the affordability percentage at 9.5 percent for 2014 and authorized IRS to adjust this percentage annually to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year. In 2014, IRS released guidance updating the required contribution percentages for CY 2015[15] and CY 2016[16] (see Table 7 below).

Table 7: Required Contribution Percentage for CY 2014 Through CY 2017

	2014	2015	2016	2017
Required Contribution %	9.5	9.56	9.66	9.69

Source: IRS, Rev. Proc. 2014-37, Rev. Proc. 2014-62, and Rev. Proc. 2016-24.

Employer Shared Responsibility Payments

ALEs subject to a shared responsibility payment will have to make one of two types of payment, but not both. The first type of payment applies if, for any month in 2016 and subsequent years, an ALE does not offer minimum essential coverage to at least 95 percent of its full-time employees (and their dependents)

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and if at least one full-time employee receives a premium tax credit for purchasing health insurance through the Marketplace. In this case, the ALE must make an annual payment of $2,160 (for 2016; calculated at 1/12th per applicable month) for each full-time employee (without regard to whether each employee received a premium tax credit), after excluding the first 30 full-time employees from the calculation. Since 2015, IRS has indexed this figure annually.[17] In 2014 and 2015, there were transition rules that lessened the requirements on employers.

Even if an ALE offers minimum essential coverage to a sufficient number of full-time employees (and their dependents) to avoid liability for the first type of shared responsibility payment, the ALE generally still will have to make the second type of payment for each full-time employee (if any) who receives a premium tax credit for purchasing health insurance through the Marketplace. In this case, the ALE must make an annual payment of $3,240 (for 2016; calculated at 1/12th per applicable month) for each full-time employee who received a premium tax credit or cost-sharing assistance. Since 2015, IRS has indexed this figure annually.[18]

Table 8: Applicable Payment Amount (Employer Shared Responsibility) for CY 2014 Through CY 2016

	2014	2015	2016	2017
Applicable Payment Amount (1st Type)	$2,000	2,080	$2,160	$2,270 (est.)
Applicable Payment Amount (2nd Type)	$3,000	3,120	$3,240	$3,400 (est.)

Source: IRS, Notice 2015-87.

[1] "Premium growth for the preceding calendar year" for this and the other measures refers to the quotient determined by dividing the projected per enrollee spending for employer-sponsored private health insurance for the preceding calendar year by the projected per enrollee spending for employer-sponsored private health insurance for the calendar year two years prior. The projections are the National Health Expenditure Projections published by the CMS Office of the Actuary.
[2] In years after 2018, an additional adjustment will be made, which is to reflect the excess (if any) of the rate of premium growth for the preceding calendar year over the rate of growth in the consumer price index for the preceding calendar years.
[3] For example, an individual might enroll in Marketplace coverage effective January 1, 2016. PTCs might be paid to the enrollee's health plan each month during the 2016 coverage year (advance payments), reducing the premium amount the enrollee pays to the health plan each month. The individual by April 15, 2017, files a federal income tax return that calculates the amount of PTCs "earned" for the 2016 coverage year.
[4] CMS substituted personal income (PI) for per capita gross domestic product (GDP) as the measure of income growth in CMS-9937-F, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017." See https://www.gpo.gov/fdsys/pkg/FR-2016-03-08/pdf/2016-04439.pdf.
[5] See CCIIO, "Shared Responsibility Guidance—Filing Threshold Hardship Exemption," at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Filing-Threshold-Exemption-Guidance-9-18-14.pdf and IRS, Notice 2014-76, at https://www.irs.gov/pub/irs-drop/n-14-76.pdf.
[6] See IRS, Rev. Proc. 2013-25, at https://www.irs.gov/pub/irs-drop/rp-13-25.pdf.
[7] "Premium adjustment percentage" for this and other measures refers to the percentage (if any) by which the average per capita premium for health insurance for the preceding calendar year exceeds the average per capita premium for health insurance for 2013. See 45 CFR 156.130(e).
[8] See 45 CFR 156.130(a)(2).
[9] See CMS-9949-F.
[10] See CMS-9944-F.
[11] See CMS-9937-F.
[12] See CMS-9934-P.
[13] A description of the employer requirements under the Affordable Care Act, and subsequent amendments, is available at https://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act#Making.

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[14] The determination of "affordability" of the employer offer of coverage applies to the full-time employee, as well as to any family member who also is offered coverage by the employer, whether or not the employer makes a contribution for the premiums of the employee's family member(s).
[15] See IRS, Rev. Proc. 2014-37.
[16] See IRS, Rev. Proc. 2014-62.
[17] As required by section 4980H of the Code, IRS will increase this figure by an amount equal to the product of the figure and the premium adjustment percentage for the calendar year.
[18] Ibid.

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Health Care Reform in Indian Country

Self-Governance Communication & Education

Self-Governance Tribes Striving Towards Excellence in Health Care

Indian Health Service Reimbursement Rates for 2017[1]

February 6, 2017

This brief seeks to provide guidance to Tribes on Indian Health Service (IHS) reimbursement rates—also known as "OMB rates" or "encounter rates"—for calendar year (CY) 2017.

On January 18, 2017, a notice was published in the Federal Register[2] announcing that the IHS Principal Deputy Director, under the authority of sections 321(a) and 322(b) of the Public Health Service Act, Public Law 83-568, and the Indian Health Care Improvement Act, has approved the following rates for inpatient and outpatient medical care provided by IHS facilities for CY 2017 for Medicare and Medicaid beneficiaries, beneficiaries of other federal programs, and for recoveries under the federal Medical Care Recovery Act. This notice does not include Medicare Part A inpatient rates, as they are paid based on the prospective payment system. Since the inpatient per diem rates set forth in this notice do not include all physician services and practitioner services, additional payment shall be available to the extent that those services are provided. The IHS reimbursement rates for CY 2017 appear below.

IHS Reimbursement Rates for CY 2017

Inpatient Hospital Per Diem Rate (Excludes Physician/Practitioner Services)

Lower 48 States $2,933

Alaska $3,235

Outpatient Per Visit Rate (Excluding Medicare)

Lower 48 States $391

Alaska $616

Outpatient Per Visit Rate (Medicare)

Lower 48 States $349

Alaska $577

Medicare Part B Inpatient Ancillary Per Diem Rate

Lower 48 States $679

Alaska $1,046

Outpatient Surgery Rate (Medicare): Established Medicare rates for freestanding Ambulatory Surgery Centers.

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[1] This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Doneg McDonough, TSGAC Technical Advisor, at DonegMcD@Outlook.com.

[2] IHS, "Reimbursement Rates for Calendar Year 2017"; see 82 FR 5585. https://www.gpo.gov/fdsys/pkg/FR-2017-01-18/pdf/2017-01075.pdf

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Effective Date for CY 2017 Rates: Consistent with previous annual rate revisions, the CY 2017 rates will take effect for services provided on/or after January 1, 2017, to the extent consistent with payment authorities including the applicable Medicaid State plan.

Table 1 below provides a comparison of IHS reimbursement rates for CY 2017 and CY 2016.

Table 1: Comparison of IHS Reimbursement Rates, CY 2017 and CY 2016

Service		CY 2017 Rate	CY 2016 Rate	$ Change	% Change
Inpatient Hospital Per Diem Rate (Excludes Physician/ Practitioner Services)	Lower 48 States	**$2,933**	**$2,655**	**$278**	**10.5%**
	Alaska	**$3,235**	**$3,335**	**-$100**	**-3.0%**
Outpatient Per Visit Rate (Excluding Medicare)	Lower 48 States	**$391**	**$368**	**$23**	**6.3%**
	Alaska	**$616**	**$603**	**$13**	**2.2%**
Outpatient Per Visit Rate (Medicare)	Lower 48 States	**$349**	**$324**	**$25**	**7.7%**
	Alaska	**$577**	**$582**	**-$5**	**-0.9%**
Medicare Part B Inpatient Ancillary Per Diem Rate	Lower 48 States	**$679**	**$637**	**$42**	**6.6%**
	Alaska	**$1,046**	**$1,082**	**-$36**	**-3.3%**
Outpatient Surgery Rate (Medicare)	Lower 48 States and Alaska	Established Medicare rates for freestanding ambulatory surgery centers	Established Medicare rates for freestanding ambulatory surgery centers	N/A	N/A

Sources: IHS, 81 FR 12513 and 82 FR 5585

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

Affordable Care Act in 2017; Trump and Ryan Health Insurance Approaches[1]

January 6, 2017

This brief provides an outline of the health care proposals of President-Elect Donald Trump and House Speaker Paul Ryan—potential starting points for efforts by Republicans to "repeal and replace" the Affordable Care Act (ACA)—and examines their potential impact on the number of uninsured individuals and key provisions of the ACA. In addition, this brief offers a possible timeline for executive and congressional actions on health insurance market legislation.

Take-Away

There is great uncertainty as to: (a) how the government-financed health insurance sector will change under a Trump Administration and the new Congress; and, (b) to what extent the current rules applicable to employer-sponsored insurance will be modified. The proposals presented by then-presidential candidate Donald Trump and Speaker Paul Ryan are outlined below and provide a starting point to potential legislative action by Republicans.

- It is probably best to describe the Trump proposal as an "approach" rather than a "plan," given the lack of detail, a fact not-too-dissimilar to the "approach" outlined by candidate Obama in 2008. In contrast, though, the Obama approach—which was subsequently fashioned into the Affordable Care Act (ACA)—had an explicit goal of making affordable health insurance coverage available to all Americans. No such commitment or goal appears in the Trump approach—the Trump approach would reduce dramatically the number of Americans with health insurance coverage.
- With the Ryan plan, despite six years of promising a "replacement" to the ACA, legislation has not been drafted, key details have not been identified, and an evaluation of the proposal has not been prepared by the Congressional Budget Office. Nonetheless, the Ryan proposal is a serious effort to provide an alternative approach.

For the short term, the following might serve as a guide:

- For persons securing coverage in the individual market, health insurance options for the 2017 calendar year are most likely to continue as is, with the exception that the requirement for individuals to secure insurance coverage could be waived. **As such, to the extent the Trump Administration does not proactively act to dismantle the ACA in 2017 prior to a replacement plan being in place, *the purchase of health insurance coverage for Tribal members through a Health Insurance Marketplace established under the ACA (referred to as Tribal Sponsorship)***

[1] This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Doneg McDonough, TSGAC Technical Advisor, at DonegMcD@Outlook.com.

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continues to offer opportunities for Tribes to secure substantial increases in health care resources for the Indian health system and for Tribal members.

- With regard to employer-sponsored insurance, ***we could see immediate executive actions that postpone or largely relieve employer requirements under the ACA***, such as the requirement to offer coverage to full-time employees or make payments to the federal government, as well as lessen or eliminate employer reporting requirements.
- **In 2017, the most immediate threat to funding of the Indian Health Service (IHS) is likely to be an interest in Congress to reducing the non-defense discretionary (appropriations) budget.** *Increases to IHS funding seen in recent years are likely to be halted, with a threat that appropriations could be reduced below fiscal year 2016 levels.*

As to the longer-term changes, the proposals presented by then-candidate Trump and Speaker Ryan serve as a starting point for one or more pieces of potential "replacement" legislation. But given the complexity of the health insurance market, the opposition of a sizable number of Republican members of Congress to any government intervention in the private health insurance market, and the potential ability of Senate Democrats to frustrate Republican attempts to legislate in this area, it is difficult to anticipate what the actual "replacement" to the ACA might be.

Timing of Executive and Congressional Actions

There are likely to be two tensions/goals of the Republicans as they attempt to move forward to "repeal and replace" the ACA.

1. Keep their campaign promise to "repeal the ACA."
2. Minimize disruptions to the availability and affordability of health insurance that can be blamed on Republicans as they transition to an alternative approach ("replace") to the ACA.

Even with control of both houses of Congress and the White House, a full repeal of ACA will remain difficult, as will enacting a replacement bill(s), as Republicans will hold fewer than the 60 seats in the Senate needed to stop a filibuster. Republicans could use the "budget reconciliation" process to make some major changes to ACA and enact replacement provisions (without being subject to a filibuster), but the breadth of the changes are constrained to items impacting federal spending, as the budget reconciliation process excludes changes to non-budgetary provisions.

In Attachment A below, a summary of the budget reconciliation legislation advanced (but vetoed by President Obama) in early 2016 is shown. The legislation demonstrates the breadth of the changes in the ACA that can be accomplished through the budget reconciliation process.

In order to transition to an alternative approach to the ACA, a replacement needs to be agreed upon and moved through the legislative process. This will require time and might ultimately require agreement with Democrats, as Senate Democrats are likely to filibuster alternatives that result in dramatically reduced affordability and lower levels of insurance coverage. Further, a sizable number of House and Senate Republicans might balk at signing on to any substantial alternative.

There will be numerous opportunities for a President Trump to undermine the ACA without needing congressional assistance. For instance, enforcement of the "individual mandate" and the "employer mandate" could be delayed. Cost-sharing protections could be de-funded. Risk adjustment payments to health plans could be canceled. Each of these items would show that a President Trump was acting on a promise to repeal the ACA. But each action would violate the second goal / tension if not done in conjunction with a set of "replacement" actions.

Trump and Ryan Approaches – Analysis and Impacts

President-elect Trump and Speaker Ryan each have proposed alternative approaches to the ACA. The Trump proposal is as close to non-existent as could be and still be called a proposal and, according to several analyses, would result in millions of Americans losing health insurance coverage. The Ryan approach is more substantial, but with significantly less financial support for low-income Americans than under current law, resulting in large increases in the number of uninsured Americans.

In September 2006, the Commonwealth Fund released a report that analyzed the impact of several aspects of the Trump approach, including their effect on the number of uninsured U.S. residents. The report examined the impact of the following policies: 1) repeal the ACA in its entirety; 2) repeal the ACA and allow individuals to deduct fully health insurance premiums from their tax returns; 3) repeal the ACA and provide states with Medicaid and CHIP block grants; 4) repeal the ACA and promote the sale of coverage across state lines; and 5) implement a combination of all of the policies. According to the report, each of the proposals would result in a significant increase in the number of uninsured, with a combined effect of 20.2 million, or 81%, more individuals lacking health insurance in 2018 than under current law (see Table 1 below).[2]

Table 1. Impact of Trump Health Care Policies on Number of Insured and Uninsured Individuals (in Millions), 2018

Insurance status (by coverage type)	ACA (current)	Trump Proposals					
		Repeal alone	Repeal and tax deduction	Repeal and Medicaid block grants	Repeal and sales across state lines	Combination	% Change Under Combination
All insured	251.6	231.9	236	226.5	234.1	**231.3**	**-8.07%**
Employer	156.3	158.6	156.6	158.6	157.5	**155.3**	**-0.64%**
Exchange/individual	22.6	9.6	15.3	9.6	12.9	**17.6**	**-22.12%**
Medicaid	60.3	51.5	51.8	46.1	51.5	**46.2**	**-23.38%**
Other	12.3	12.2	12.2	12.2	12.2	**12.2**	**-0.81%**
Uninsured	24.9	44.6	40.5	50	42.4	**45.1**	**81.12%**

Source: Commonwealth Fund, "Donald Trump's Health Care Reform Proposals: Anticipated Effects on Insurance Coverage, Out-of-Pocket Costs, and the Federal Deficit," September 2016.

The Committee for a Responsible Federal Budget in May 2016 also released an analysis of the Trump approach and reached a similar conclusion as the Commonwealth Fund, finding that it would cause about 21 million individuals to lose health insurance in 2018.[3] In addition, the Center for Health and

[2] See http://www.commonwealthfund.org/publications/issue-briefs/2016/sep/trump-presidential-health-care-proposal.

[3] See http://crfb.org/blogs/analysis-donald-trumps-health-care-plan.

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Economy in July 2016 projected that about 18 million individuals would lose health insurance in 2017 under the Trump approach.[4]

The Ryan approach, although providing more details than the Trump approach, lacks specifics in a number of areas, making it difficult to analyze its impact on the number of uninsured U.S. residents. Using certain assumptions, however, the Center for Health and Economy in August 2016 estimated that about 1 million individuals would lose health insurance in 2018 under these policies, with the number expected to jump to 4 million by 2026.[5]

Neither approach includes Indian-specific benefits and protections: (1) no federally-funded cost-sharing protections for American Indians and Alaska Natives (AI/ANs); and, (2) no guarantee for AI/ANs to purchase health insurance throughout the year without consideration of pre-existing conditions. In fact, there is no indication in the materials released by the Trump campaign or by Speaker Ryan of any recognition that the Indian Health Care Reauthorization and Extension Act was a component of the ACA, as enacted.

The most consequential elements of the Trump and Ryan approaches, as compared with the current ACA, are the following:

- ACA: Both approaches are predicated on full repeal of the ACA, although Speaker Ryan's budget retained the increases in tax revenues under the ACA while deleting the coverage provisions. Again, no mention is made of the Indian Health Care Improvement Act.
- Premium Tax Credits: The Trump approach would replace the ACA's income-based premium tax credits with a federal income tax deduction for the cost of health insurance coverage (tax-free spending on health insurance). This would reduce the total cost of insurance by 0% to 35% or so, depending on someone's marginal tax rate, *resulting in federal subsidies increasing as household income increases*. The Ryan approach creates a tax credit, although the size of the credit is based on age (older, more subsidy) and not on income, and the tax credit does not increase based on the cost of available insurance. Information is not available on the income level at which families would be excluded from the tax credits.
    - In contrast, the ACA provides income-based premium tax credits that limit premium payments to no more than a specified percentage of household income (2% at 100% FPL to 9.6% at 400% FPL). As such, the ACA's tax credits are larger for lower-income families, smaller for higher-income families, and absent for families with an income above 400% FPL.
- Cadillac Tax: Ryan's plan caps the amount of the exclusion from income for employer-sponsored coverage, as does the ACA.
- Medicaid: Both Republican approaches block-grant Medicaid to the States and then limit the annual funding increases, *after removing* the new funding under the ACA's Medicaid expansions.

[4] See http://healthandeconomy.org/healthcare-reform-to-make-america-great-again/.
[5] See http://healthandeconomy.org/a-better-way-to-fix-health-care/.

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- Medicare: Ryan's plan converts Medicare into a voucher (i.e., defined contribution), and not, as it is today, a guaranteed level of funding for a defined set of benefits. Trump's plan cancels the ACA's payment reforms, as well as eliminates the tax on higher income Americans that generates revenues to extend the solvency of the Medicare Part A Trust Fund.

Outline of Proposals

President-Elect Trump, as part of his presidential campaign, proposed to repeal the ACA, most recently proposing to call a special session of Congress to address the issue. And in June, Speaker Ryan issued a report outlining his health care reform elements, which included the full repeal of the ACA. With their wins in the November 8 election, Republicans likely will move forward with efforts to repeal or scale back the ACA.

The health care proposals offered by President-Elect Trump and Speaker Ryan are outlined below.

Trump Approach

Trump has proposed a seven-point approach that would repeal ACA in its entirety and implement several policies generally supported by Republicans. As published on the Trump campaign Web site, the following is the Trump approach:

1. Completely repeal Obamacare. Our elected representatives must eliminate the individual mandate. No person should be required to buy insurance unless he or she wants to.
2. Modify existing law that inhibits the sale of health insurance across state lines. As long as the plan purchased complies with state requirements, any vendor ought to be able to offer insurance in any state. By allowing full competition in this market, insurance costs will go down and consumer satisfaction will go up.
3. Allow individuals to fully deduct health insurance premium payments from their tax returns under the current tax system. Businesses are allowed to take these deductions so why wouldn't Congress allow individuals the same exemptions? As we allow the free market to provide insurance coverage opportunities to companies and individuals, we must also make sure that no one slips through the cracks simply because they cannot afford insurance. We must review basic options for Medicaid and work with states to ensure that those who want healthcare coverage can have it.
4. Allow individuals to use Health Savings Accounts (HSAs). Contributions into HSAs should be tax-free and should be allowed to accumulate. These accounts would become part of the estate of the individual and could be passed on to heirs without fear of any death penalty. These plans should be particularly attractive to young people who are healthy and can afford high-deductible insurance plans. These funds can be used by any member of a family without penalty. The flexibility and security provided by HSAs will be of great benefit to all who participate.
5. Require price transparency from all healthcare providers, especially doctors and healthcare organizations like clinics and hospitals. Individuals should be able to shop to find the best prices for procedures, exams or any other medical-related procedure.
6. Block-grant Medicaid to the states. Nearly every state already offers benefits beyond what is required in the current Medicaid structure. The state governments know their people best and can manage the administration of Medicaid far better without federal overhead. States will have the incentives to seek out and eliminate fraud, waste and abuse to preserve our precious resources.

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7. Remove barriers to entry into free markets for drug providers that offer safe, reliable and cheaper products. Congress will need the courage to step away from the special interests and do what is right for America. Though the pharmaceutical industry is in the private sector, drug companies provide a public service. Allowing consumers access to imported, safe and dependable drugs from overseas will bring more options to consumers.[6]

Ryan Approach

In a 37-page report released in June 2016 and titled "A Better Way: Our Vision for a Confident America," Speaker Ryan proposed a health care plan that would repeal ACA in its entirety and implement a number of policies generally supported by Republicans.[7] A brief summary of the recommendations in the report appears below.

1. *Consumer-Directed Health Care*

- Allow spouses to make "catch-up" contributions to the same HSA account;
- Allow qualified medical expenses incurred before HSA-qualified coverage begins to be reimbursed from an HSA account as long as the account is established within 60 days;
- Set the maximum contribution to an HSA at the maximum combined and allowed annual deductible and out-of-pocket expense limits;
- Expand accessibility for HSAs to certain groups, like those who get services through the Indian Health Service and TRICARE; and
- Encourage the use of direct or "defined contribution" methods, such as health reimbursement accounts (HRAs)

2. *Portable Financial Support*

- Provide every American with access to financial support for an insurance plan chosen by the individual, allowing them to take the payment with them job-to-job, home to start a small business or raise a family, and into retirement years;
- Make the portable payment available at the beginning of every month, adjusting it for age over time; and
- For those who do not have access to job-based coverage, Medicare, or Medicaid, provide a universal advanceable, refundable tax credit for individuals and families.

3. *Employer-Sponsored Health Insurance Tax Exclusion*

- Cap the amount of the tax exclusion employees can take for the value of employer-sponsored health insurance.

4. *Purchasing Coverage Across State Lines*

[6] See https://www.donaldjtrump.com/positions/healthcare-reform, as of November 9, 2016.
[7] See https://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf.

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- Allow consumers to purchase health insurance licensed in another state; and
- Make it easier for states to enter into interstate compacts for pooling.

5. *Small Business Health Plans*

- Allow small businesses to band together to offer small business health plans, also known as association health plans (AHPs).

6. *Employee Wellness Programs*

- To encourage healthy lifestyle behaviors and lower costs, companies that sponsor a weight loss or smoking-cessation program should have the ability to continue to offer participating employees health care coverage at a lower cost, provided that those programs do not exceed the limits under current law; and
- Stipulate that voluntary collection of medical information from employee family members as part of a wellness program cannot violate the Genetic Information Nondiscrimination Act of 2008 (GINA).

7. *Employer Flexibility for Self-Insurance*

- Prevent restrictions on employer choice of health insurance options, including self-insurance and stop-loss protections, by preserving the current definition of stop-loss insurance and maintaining its distinct difference from "group health insurance."

8. *Medical Liability Reform*

- Cap non-economic damage awards in medical malpractice lawsuits;
- Work with the states to pursue a wide variety of reform options, such as loser-pays, proportional liability, the collateral source rule, consideration of the statute of limitation, safe harbor provisions, health courts, and independent pre-discovery medical review panels; and
- Seek to strengthen federal health programs by pursuing laws that allow safe harbors and higher standards of evidence for medical professionals following clinical practice guidelines developed by national and state professional medical societies.

9. *Patient Protections*

- No American should ever be denied coverage or face a coverage exclusion on the basis of a pre-existing condition. [But insurers would be able to charge sicker patients higher rates.]
- We would allow dependents up to age 26 to stay on their parents' plan.
- Insurers should never be able to unfairly cancel coverage.

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10. Conscience Protections

- Permanently enact and expand the Weldon amendment, which bars distribution of federal funding to states that discriminate against health care providers exercising their conscience.
- Ensure the application of the Hyde amendment, which prohibits the use of federal funding for abortion or abortion services

11. Medicaid Reform

- Allow states to opt for a per capita federal Medicaid allotment: Under this proposal, in 2019, each state could draw down a total federal Medicaid allotment based on its federal matching rate. The amount of the allotment would equal the product of the per capita allotment of the state for the four major beneficiary categories—aged, blind and disabled, children, and adults—and the number of enrollees in each of those four categories, with the per capita allotment for each beneficiary category determined by the average medical assistance and non-benefit expenditures per full-year-equivalent enrollee during the base year (2016), adjusted for inflation; or
- Allow states to opt for a Medicaid block grant: Under this approach, states would receive federal Medicaid funding using a base year in a manner that would assume the transition of individuals currently enrolled in Medicaid under the optional ACA expansion into other sources of coverage. States would receive maximum flexibility for the management of eligibility and benefits for non-disabled, non-elderly adults and children, no longer having to obtain waivers from HHS for changes to their Medicaid programs. States would have to provide required services to elderly and disabled individuals described as mandatory Medicaid populations under current law.

12. Medicare Reform

- Repeal many of the Medicare provisions contained in ACA;
- Implement a number of structural reforms to Medicare; and
- Implement a premium support program, under which, beginning in 2024, Medicare beneficiaries would receive a premium support payment to cover or help offset the premium of the plan chosen by the beneficiary on a newly created Medicare Exchange, where private health plans would compete alongside traditional FFS Medicare.

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Attachment A

A summary of the provisions of HR 3762, a Republican-sponsored budget reconciliation bill vetoed by President Obama in early 2016, appears below. The legislation included a number of provisions designed to scale back the ACA. Additional information on the bill is available at https://www.congress.gov/bill/114th-congress/house-bill/3762. This legislation is significant for showing the breadth / extent to which provisions of the ACA can be overturned through the budget reconciliation process.

TITLE I--HEALTH, EDUCATION, LABOR, AND PENSIONS

(Sec. 101) This bill amends the Patient Protection and Affordable Care Act (PPACA) to terminate the Prevention and Public Health Fund, which provides for investment in prevention and public health programs to improve health and restrain the rate of growth in health care costs. Unobligated funds are rescinded.

(Sec. 102) Funding for community health centers is increased.

(Sec. 103) Certain funding for U.S. territories that establish health insurance exchanges is no longer available after 2017.

(Sec. 104) The Department of Health and Human Services (HHS) may not collect fees or make payments under the transitional reinsurance program.

(Sec. 105) This bill makes appropriations for FY2016 and FY2017 for HHS to award grants to states to address substance abuse or to respond to urgent mental health needs.

TITLE II--FINANCE

(Sec. 201) This bill amends the Internal Revenue Code to require individuals to pay back the full amount of advance payments in excess of their premium assistance tax credit. (Currently, there is a limit on the amount of excess an individual must pay back.)

(Sec. 202) Provisions relating to the premium assistance tax credit, reduced cost-sharing, and eligibility determinations for these subsidies are repealed on December 31, 2017. (These are the core ACA provisions making health insurance and health care services more affordable for low and moderate income Americans.)

(Sec. 203) The small employer health insurance tax credit does not apply after 2017. (This credit is for certain employers who make contributions toward employee health coverage purchased through a health insurance exchange.)

(Sec. 204) The penalty for individuals who do not maintain minimum essential health care coverage is eliminated.

(Sec. 205) Large employers are no longer required to make shared responsibility payments.

(Sec. 206) For one year, this bill restricts the availability of federal funding to a state for payments to an entity (e.g., Planned Parenthood Federation of America) that:

- Is a 501(c)(3) tax-exempt organization;
- Is an essential community provider primarily engaged in family planning services and reproductive health;
- Provides for abortions other than abortions in cases of rape or incest, or where a physical condition endangers a woman's life unless an abortion is performed; and
- Received a total of more than $350 million under Medicaid in FY2014, including payments to affiliates, subsidiaries, successors, or clinics.

(Sec. 207) This bill amends part A (General Provisions) of title XI of the Social Security Act (SSAct) to require the additional payments to U.S. territories for Medicaid under the Health Care and Education Reconciliation Act of 2010 to be made by the end of FY2017 instead of the end of FY2019. In addition:

- This bill amends title XIX (Medicaid) of the SSAct to end the expansion of Medicaid under PPACA on December 31, 2017.
- After 2017, hospitals may no longer elect to provide Medicaid services to individuals during a presumptive eligibility period.
- States must maintain Medicaid eligibility standards for individuals under 19 years old through FY2017 instead of through FY2019.
- The federal medical assistance percentage (FMAP, the federal matching rate for Medicaid expenditures) for U.S. territories is 50% after 2017 (currently, the FMAP is 55%).
- The increased FMAP for childless adults and home and community-based attendant services under PPACA ends December 31, 2017.
- After 2017, states may no longer elect to provide certain individuals with a presumptive eligibility period for Medicaid.
- Medicaid benchmark plans are no longer required to provide minimum essential health benefits after 2017.
- After 2017, states are no longer required to operate a website for Medicaid enrollment that is linked to the state's health benefit exchange and Children's Health Insurance program (CHIP).

(Sec. 208) Medicaid allotments for disproportionate share hospitals are increased.

(Sec. 209) The excise tax on high cost employer-sponsored health coverage (popularly known as the "Cadillac tax") does not apply after 2017.

(Sec. 210) Health savings accounts (HSAs), Archer medical savings accounts (MSAs), health flexible spending arrangements (HFSAs), and health reimbursement arrangements may be used to pay for over-the-counter medications.

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(Sec. 211) This bill lowers the tax on distributions from HSAs and Archer MSAs that are not used for medical expenses.

(Sec. 212) Salary reduction contributions to an HFSA under a cafeteria plan are no longer limited.

(Sec. 213) The annual fee on manufacturers and importers of brand name prescription drugs is eliminated.

(Sec. 214) The excise tax on medical devices is eliminated.

(Sec. 215) The annual fee on health insurers is eliminated.

(Sec. 216) Medical costs are allowed as a tax deduction regardless of whether the costs are taken into account when determining the amount of the subsidy for an employer-sponsored retiree prescription drug plan under Medicare part D (Voluntary Prescription Drug Benefit Program).

(Sec. 217) A tax deduction is allowed for medical expenses in excess of 7.5% (currently, 10%) of adjusted gross income.

(Sec. 218) The additional Medicare tax on income above a certain threshold is eliminated.

(Sec. 219) The indoor tanning services tax is eliminated.

(Sec. 220) The net investment income tax is eliminated.

(Sec. 221) A health insurer is allowed a tax deduction for the full amount of an employee's compensation. (Currently, there is a limit on the amount of an employee's compensation that a health insurer may deduct.)

(Sec. 222) Provisions relating to the economic substance doctrine are repealed. (The economic substance doctrine treats a transaction as having economic substance if it has a purpose other than reducing income taxes. Currently, there are penalties for claiming tax benefits for transactions without economic substance.)

(Sec. 223) Funds are transferred from the Department of the Treasury to the Federal Hospital Insurance Trust Fund. (This provision maintains the length of solvency of the Medicare Part A Trust Fund but reduces funds available for general government operations as the existing associated tax is repealed.)

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

Analysis of House Republican Health Plan in Comparison to Current Law / Affordable Care Act[1]

March 14, 2017

This brief examines key elements of the health plan under consideration by the House of Representatives (House Plan) in comparison to current law, inclusive of the Patient Protection and Affordable Care Act (Affordable Care Act, or ACA).

Analysis of Select Provisions of House Plan

In the attached matrix, a side-by-side comparison of the House Plan versus the Affordable Care Act is provided on a number of key elements.

Financial Impact of House Plan on American Indian/Alaska Native Families in Comparison to ACA

In the attached tables, examples are shown of the financial impact of the House Plan on American Indian / Alaska Native (AI/AN) families at various household income levels, as compared to current ACA law. All family members in the examples shown meet the definition of Indian under the Affordable Care Act as a member of an Indian tribe or shareholder in an Alaska Native regional or village corporation.

The examples shown are for:

- Household of two 40 year-olds and two 20 year-olds
  - At $35,000; $50,00; $75,000; $150,000
- Household of two 60 year-olds and two 20 year-olds
  - At $35,000; $50,00; $75,000; $150,000

In the first table, the financial analysis displays the average net financial impact on the households. In addition, a second table presents the net financial impact as a percentage of household income.

The examples shown are for residents of Big Horn County, Montana. The financial impact on a particular AI/AN family will vary by location, but the examples shown represent a typical impact under the House Plan versus the Affordable Care Act.

[1] This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Doneg McDonough, TSGAC Technical Advisor, at DonegMcD@Outlook.com.

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Congressional Budget Office Assessment

A comprehensive assessment of the House Plan was released by the Congressional Budget Office (CBO) on March 13, 2017. The CBO report can be accessed at: https://www.cbo.gov/publication/52486.

The impact projected by the CBO is a net increase in the number of uninsured individuals of 14 million in 2018 and an increase of 24 million uninsured by 2026. Federal Medicaid funding would decline by $880 billion between 2017 and 2026, mostly as a result of a 14 million reduction in Medicaid enrollees.

Under the House Plan, the total reduction in government assistance for purchasing health insurance (*e.g.*, premium tax credits) and accessing health care services (*e.g.*, cost-sharing protections) is sufficiently large for the federal deficit to be reduced by $335 billion over the next decade, despite a loss of $660 billion in revenues to the federal government as a result of tax repeals contained in the legislation. Stated another way, federal financial assistance is reduced under the House Plan by $1.2 trillion over the next decade, with $.9 trillion of the savings used to offset tax cuts contained in the legislation and $335 billion remaining to reduce the deficit of the federal government.

Key Findings from Analysis

Summarized below are key findings pertaining to coverage in the non-group market (*e.g.*, Marketplace) from the analysis of the House Plan in comparison to current law.

- The majority of the House Plan coverage provisions begin January 1, 2020, so many of the ACA provisions would continue in 2017, 2018 and 2019.
- The House Plan (as with current law) provides "advanceable" (over the course of a year) and refundable premium tax credits (PTCs), so that the amount of the PTCs can exceed someone's tax liability.
- The ability of AI/ANs to enroll throughout the year is retained for Marketplace coverage.
- For the general population, someone enrolling after a break in coverage of 63 days or more will be subject to a 30% increase in the premium charged for a twelve month period.
  - IHS eligible persons are exempt from paying the 30% penalty.
- The PTCs under the House Plan are less for families under 300% FPL (approx. $60,000 for family of three) and more for higher-income families.
- The House Plan eliminates the ACAs cost-sharing reductions (generally and for AI/ANs). This has a negative impact of more than $2,000 per AI/AN Marketplace enrollee.
- When considering the combined impact of PTCs and cost-sharing reductions, there is a substantial difference in the net health insurance costs under the House Plan versus ACA/current law. A financial analysis is provided in the attachment, with a summary of the findings here.
  - The first example set is for a family of four (two 40 years-olds; two 20 year-olds) at difference income levels. The net health insurance costs (after PTCs and cost-sharing protections) are $6,893 - $11,380 greater under the House Plan for families with

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household income just above Medicaid eligibility levels (140% FPL) to $75,000 (309% FPL).
    - Families above 400% FPL do somewhat better under the House Plan ($3,070 in lower costs) as the House Plan continues PTCs to $150,000 (and then phases out the PTCs); the ACA does not provide PTCs for households above 400% FPL ($97,000 for a family of four).
    - As a percentage of total household (HH) income (shown in the second table), the House Plan requires a contribution of 8% to 33% of HH income for the examples shown. In comparison, the ACA/current law requires between 0% and 10% of HH for AI/AN families.
  - The second example set is for a family of four (two 60 year-olds; two 20 year-olds) at different income levels. The net health insurance costs (after PTCs and cost-sharing protections) are $17,828 - $ $20,227 greater under the House Plan than under current law / ACA for low to middle-income households.
    - Families above 400% do better under the House Plan, with net health insurance costs $5,000 per year less under the House bill.
    - As a percentage of total household (HH) income for these examples, the House Plan requires between 13% and 58% of HH income. The ACA/current law requires between 0% and 17% of HH income for AI/AN families for the HH income levels shown.

Summarized below are key findings pertaining to Medicaid coverage from the analysis of the House Plan in comparison to current law.

- Medicaid is converted to a "per capita cap" funding formula. This means that—for most health care services—the federal government will reimburse a state no more than a defined amount for each Medicaid enrollee. The amount is calculated from the average costs for different eligibility groups in 2016, and then inflated forward using the medical component of the Consumer Price Index. In general, the CPI-adjuster is expected to increase more slowly than under the current projections for annual medical expenditures.
  - For example, the first year "per capita" figures (in 2020) are anticipated to be below projected per enrollee spending levels for 2020.
- There is continuation of the 100% federal contribution (FMAP) for services provided to AI/ANs by or through IHS and Tribal providers. This spending is not subject to federal per capita caps.
- For services to AI/ANs provided outside of the I/T system, there are complicated calculations required to determine the impact on federal funding of state expenditures.
- The Medicaid Expansion under the ACA is eliminated in 2020, meaning the 90% FMAP funding is eliminated / phased out. (A state could continue enrolling this population but at the regular federal contribution / FMAP rate.) Only for individuals enrolled under the Medicaid Expansion as of January 1, 2020 will the 90% funding continue, as long as the individuals do not have a break in Medicaid coverage.

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- The federal requirements for “essential health benefits” will be eliminated for benchmark plans under Medicaid.
- As a result of the financial pressures of the per capita caps, it is anticipated that states might resort to cutting back on eligibility levels, cutting back on covered services, and lowering payment rates.
    - Given (1) that AI/ANs are not a separate eligibility category under Medicaid, (2) that (nationally) only 20% of payments for health care services to AI/ANs on Medicaid are at I/T facilities, and (3) the benefit package for AI/ANs generally mirrors that of the general Medicaid population; as a result of the proposed changes to current law required under the House Plan, eligibility reductions, benefit cuts, and payment reductions could impact on AI/ANs in similar ways as the general population.

Attachments

- Side-by-side comparison of House Plan versus current law / ACA
- Tables presenting financial impact on AI/AN households from House Plan versus current law / ACA

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Proposal		Affordable Care Act (ACA)	American Health Care Act (REVISED analysis of bill as of 3/14/2017; 8:15 am ET)
Bill Number (if applicable)		(Current; enacted in 2010; Public Law 111–148)	N/A [Republican FAQs]
Date Introduced			3/6/2017 draft, as amended by committee on 3/9/2017
Main Sponsor(s)			Speaker Paul Ryan, House E&C/W&Ms Committees
Indian-Specific Provisions	Cost-Sharing Protections	--For members of an Indian tribe or shareholders in an Alaska Native regional or village corporation, eligibility for either a zero or limited cost-sharing Marketplace plan, depending on income level (under both plan variations, AI/AN enrollees have no cost-sharing when receiving health care services). -- Ability for AI/ANs to enroll in bronze plan and still receive cost-sharing protections. -- Ban on Marketplace plans reducing payments to Indian health care providers by the amount of any cost-sharing that AI/AN enrollees would have otherwise owed for health care services.	**-- No Indian-specific cost-sharing protections (as of 2020).** -- No cost-sharing protections for general population (as of 2020).
	M-SEPs	-- Monthly special enrollment periods (M-SEPs) for AI/ANs and their dependents.	CORRECTION: -- M-SEPs for AI/ANs are not repealed and continue to be effective for coverage secured through a Marketplace.
	Other Provisions	--AI/AN exemption from individual shared responsibility payments (individual mandate). --Expansion and permanent reauthorization of the Indian Health Care Improvement Act (IHCIA).	-- No individual mandate (retroactive to January 1, 2016) **-- IHCIA: No changes in this law.**
Insurance Market Provisions (Afford-ability)	Premium Tax Credits (PTCs)	-- Household income-based, advanceable, refundable PTCs for individuals and families with incomes of 100-400% FPL, with amounts adjusted for geographic differences in cost of health insurance premiums. -- Not eligible for PTCs if eligible for other public insurance programs, or employer-sponsored coverage that meets affordability, coverage, and AV standards. IHS eligibility not considered "coverage". (See attachment for comparison of impact of ACA and AHCA PTCs for households at various income levels.)	-- In 2019, ACA's PTCs adjusted to modify caps on the household income percentage contribution: 4.3% < 30 yrs; 5.9% < 40 yrs; 8.35% < 50 yrs; 10.5% < 59 yrs; 11.5% >59 yrs. (Increased for 50+; decreased for <50.) -- Not eligible for PTCs if eligible for other public insurance programs, or employer-sponsored coverage (no affordability or coverage standards for employer coverage). -- Repeal ACA's PTCs at end of 2019. -- Starting in 2020, new, advanceable, refundable, age-adjusted tax credits, with amounts initially set at following levels (2020): $2,000 for 0-29 year-olds; $2,500 for 30-39; $3,000 for 40-49; $3,500 for 50-59; $4,000 for 60+; $14,000 per family max tax credits. -- Except for phase-out period, PTCs not based on household income; PTCs not based on regional differences in the cost insurance premiums. -- PTCs begin phase out for single filers at $75,000 (to $95,000/$105,000 range) and joint filers at $150,000 (to $170,000/190,000 range). -- Can use PTCs on coverage purchased inside or outside Marketplace, including catastrophic plans (possibly beginning 2018).
	Cost-Sharing Protections	- 100% cost-sharing protections for members of an Indian tribe or shareholders in an Alaska Native regional or village corporation. -- Reduced out-of-pocket costs for individuals / families under 250% FPL in Marketplace coverage.	-- Retains out-of-pocket maximums per individual and family. -- Repeals Indian-specific and general cost-sharing protections completely.
	Repayment of Over-payments	-- Limits repayment of excess premium tax credits advanced, based on income of tax filer	-- Requires 100% repayment of any excess premium tax credits advanced (effective for 2018 and 2019)
	Health Savings Accounts (HSAs)	-- Permitted (HSA contribution of approx. $3,350 (self-only coverage) and $6,750 (family coverage).	-- Allowable HSA tax-deductible contribution increased to amount of deductible/out-of-pocket maximum (approx. $6,750 (single coverage); $13,500 (family coverage). -- Allows deposit of excess PTCs (in excess of premium costs) into HSA. -- Other provisions to promote the use of HSAs.

Proposal		Affordable Care Act (ACA)	American Health Care Act (REVISED analysis of bill as of 3/14/2017; 8:15 am ET)
Bill Number (if applicable)		(Current; enacted in 2010; Public Law 111–148)	N/A [Republican FAQs]
Date Introduced			3/6/2017 draft, as amended by committee on 3/9/2017
Main Sponsor(s)			Speaker Paul Ryan, House E&C/W&Ms Committees
Market Stability Mechanisms	3 R's	-- Three risk adjustment mechanisms: Risk corridors; Reinsurance; Risk adjustment [Subsequently, Republican Congress eliminated majority of funding for 2 of 3]	-- Establishes a "Patient and State Stability Fund", which includes a default federal reinsurance program ("Market Stabilization") for issuers. $100 billion in funding over 2018 - 2026. -- As part of Patient and State Stability Fund, allows funding for a range of purposes.
	Coverage Requirement	-- Requires individuals to secure health insurance coverage or make a payment to federal government (exemption from requirement for AI/ANs).	-- Individual coverage requirement technically retained (because of "reconciliation" restrictions) but penalties for not securing coverage repealed, retroactive to January 1, 2016. -- Health plan required "to increase monthly premium rate" by 30% for persons with a break in coverage of more than 63 days. IHS eligibility considered "creditable coverage" for purposes of not being subject to non-continuous coverage (30%) penalty.
State Insurance Market Operations		-- Health plan offerings standardized with actuarial values (AVs) set by metal level to facilitate plan comparisons. -- Maximum out-pocket amounts established. -- Requirement for each state to establish a Marketplace that allows individuals to: Learn about their health insurance options; compare health plans based on costs, standardized benefits (EHBs), and other important features; obtain information on insurance affordability programs designed to help individuals with low-to-moderate incomes pay for coverage; select a health plan and enroll in coverage. -- Permits 3:1 premium ratings, by age. -- Permits catastrophic plans (AV = 55%) for < 30 year olds (no PTCs).	-- Requirement for plans to be offered by specified actuarial value (metal level) repealed as of December 31, 2019. -- Maximum out-of-pocket limits retained. -- Requirement for a state-by-state Marketplace not repealed. -- EHB standards retained. -- Permits 5:1 premium rating, by age -- Permits catastrophic plans for all enrollees (with PTCs)
Funding Provisions	ESI Excise Tax/Tax Exclusion Cap	-- Beginning in 2020, 40% tax (Cadillac tax) imposed on cost of employer-sponsored insurance (ESI) exceeding the following amounts, with amounts adjusted annually for CPI: --For individuals, $10,200 times health cost adjustment percentage;[1] --For families, $27,500 times health cost adjustment percentage[1]	--Delay of the ACA Cadillac tax until 2025. ~~-- ESI exclusion cap set at the 90th percentile of premiums in 2019 (2020), with amounts adjusted annually for CPI plus 2 percentage points~~ (deleted)
	Employer Mandate	Employers required to offer insurance to full-time (FT) employees and pay a portion of premium if employee enrolls, or make an annual per FT employee payment (approx. $2,000) to federal government	-- Repeal of employer mandate penalties retroactive to January 1, 2016. (Coverage requirements technically staying in effect.) -- Employer reporting requirements remain in effect.
	Net Investment Income Tax	3.8% tax on individuals, estates, and trusts that have certain investment income exceeding certain thresholds.	Repeal of tax effective for years after 2017.
	Additional Medicare Tax	0.9% tax on wages and self-employment income that exceeds the following thresholds: --$250,000 for married taxpayers filing jointly; --$125,000 for married taxpayers filing separately; --$200,000 for all other taxpayers	Repeal of tax effective for years after 2017.
	Health Insurance Provider Fee	Fee on each covered entity engaged in the business of providing health insurance for U.S. health risks (moratorium instituted for 2017).	Repeal of fee effective for years after 2017.
	Medical Device Excise Tax	2.3% tax on manufacturers and importers for sales of certain medical devices (moratorium instituted for 2016 and 2017).	Repeal of tax effective for years after 2017.
	PCORI Fee	Fee on issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans to fund the Patient-Centered Outcomes Research Institute.	Repeal of fee effective for years after 2017.
	Excise Tax on Tanning Services	10% tax on indoor UV tanning services.	Repeal of tax effective for years after 2017.

Proposal		Affordable Care Act (ACA)	American Health Care Act (REVISED analysis of bill as of 3/14/2017; 8:15 am ET)
Bill Number (if applicable)		(Current; enacted in 2010; Public Law 111–148)	N/A [Republican FAQs]
Date Introduced			3/6/2017 draft, as amended by committee on 3/9/2017
Main Sponsor(s)			Speaker Paul Ryan, House E&C/W&Ms Committees
Insurance Market Regulations	Individual Market Rules/ Protections	--Ban on annual and lifetime coverage limits; --Ban on rescissions (withdrawal of coverage); --Required coverage of preventive services; --Dependent coverage through age 26; --Required Summary of Benefits and Coverage; --Required internal claims/appeals/external review; --Ban on pre-existing condition exclusions; --Ban on discriminatory premium rates; --Guaranteed availability/renewability of coverage; --Ban on discrimination based on health status; --Nondiscrimination in health care; --Ban on excessive waiting periods; --Required coverage of mental health services/parity	-- Retains ACA's: ban on pre-existing condition exclusions; health status underwriting; life-time and annual coverage limits; coverage for adult children to age 26; essential health benefit (EHB) requirements (although likely to be modified by regulation); and other ACA consumer protections. --Penalty equal to 30% of the premium required for 12 months for enrollees who do not maintain continuous coverage (individuals eligible for IHS services exempt from penalty). -- Repeals plan actuarial value and metal level requirements. --Essential health benefits (EHBs) determined / regulated by states. --Increases allowable age rating of premiums to 5:1 (from 3:1). --Verification requirement for enrollment during SEPs. --Option to continue offering ACA Marketplace plans outside of Marketplace.
	Coverage of Reproductive Services	--Ban on use of federal funding to pay for abortions (with certain exceptions). --Marketplace plans not required to cover abortions. --Marketplace plans covering abortions (if allowed by state law) must take steps to ensure no use of federal funding to pay for abortions.	-- Ban on use of federal funding to pay for abortions (with certain exceptions) -- Prohibits using premium tax credits on health plan that covers abortion services. -- Bars Medicaid funding for Planned Parenthood.
	Interstate Insurance Market	Permits states to enter into cross-state compacts.	-- No changes made (due to "reconciliation" restrictions).
Medicaid Program Changes	ACA's Medicaid Expansion (to 138% FPL)	--Optional Medicaid expansion under which states can extend eligibility to all non-elderly residents with incomes up to 138% FPL. --Availability of federal financial assistance covering 100% of Medicaid spending on health care services for the expansion population through 2016, with the rate gradually decreasing to a fixed level of 90% in 2020.	**-- Repeal of ACA Medicaid expansion for years after 2019.** -- Starting in 2020, 90% FMAP applies only to persons enrolled as of January 1, 2020, with no break in coverage greater than 30 days. -- States can continue existing eligibility expansion but at regular FMAP rates.
	Base Medicaid Program	-- Eligibility requirements. -- Health care benefit package requirements. -- Consumer protections, including under managed care plans. -- Numerous other provisions. -- Retroactive program eligibility of up to 3 months from date of application.	-- Per capita cap / allotment on federal financial assistance for Medicaid spending on health care services. -- AI/AN enrollees (and spending at non-I/T providers) included in applicable section 1903A category. --Repeal of Essential Health Benefits (EHBs) requirement for benchmark plans. --For non-expansion states, repeal of Medicaid DSH allotment reductions and provides increased federal assistance for safety net providers. --Repeal of 3-month retroactive eligibility (limit to month of enrollment) and other provisions to reduce Medicaid costs (update allowable home equity limits; require states to conduct income eligibility redeterminations at least every six months).
	AI/AN provisions	-- Cost-sharing prohibited for AI/AN. -- Mandatory managed care enrollment prohibited for AI/AN. -- 100% FMAP for services to AI/ANs by / through IHS and Tribal providers. -- Tribal consultation requirements.	-- Continuation of 100% FMAP for services to AI/ANs by / through IHS and Tribal providers. This spending is not subject to federal per capita caps. -- For services to AI/ANs provided outside of I/T system, complicated calculations and impact on state funding. During months an AI/AN receives a service from / through an I/T, AI/AN enrollee not included in count of Section 1903A enrollees. Depending on status of per capita cap application to a Section 1903A enrollee category, spending on AI/AN enrollees at non-I/T providers in months when enrollee also receives services by / through an I/T provider might not be reimbursed by CMS.

Proposal	Affordable Care Act (ACA)	American Health Care Act (REVISED analysis of bill as of 3/14/2017; 8:15 am ET)
Bill Number (if applicable)	(Current; enacted in 2010; Public Law 111–148)	N/A [Republican FAQs]
Date Introduced		3/6/2017 draft, as amended by committee on 3/9/2017
Main Sponsor(s)		Speaker Paul Ryan, House E&C/W&Ms Committees
Medicare Program Changes	--Phase-out of the Part D coverage gap. --Increased financial assistance for individuals in the Part D coverage gap. --Elimination of copays for certain preventive services. --Changes in payment rates. --Provisions designed to improve efficiency/quality/program integrity.	-- Retain phase-out of the Part D coverage gap. -- Repeal ACA taxes dedicated to funding Part A Trust Fund. [-- Other TBD.]
Notes and Recommended Articles:	[1] Health cost adjustment percentage equals 100% plus the excess (if any) of the percentage over 55% by which the per employee cost for providing coverage under the BC BS standard benefit option under FEHBP for plan year 2018 (determined by using the benefit package for such coverage in 2010) exceeds such cost for plan year 2010	--Tim Jost: http://healthaffairs.org/blog/2017/03/07/examining-the-house-republican-aca-repeal-and-replace-legislation/ -- https://www.nytimes.com/interactive/2017/03/06/us/politics/republican-obamacare-replacement.html?WT.nav=top-news&action=click&clickSource=story-heading&emc=edit_nn_20170307&hp=&module=a-lede-package-region&nl=morning-briefing&nlid=69595147&pgtype=Homepage&region=top-news&te=1 - http://www.msn.com/en-us/news/politics/house-republicans-unveil-plan-to-replace-health-law/ar-AAnV0qh?li=BBnb7Kz&ocid=wispr - http://www.modernhealthcare.com/article/20170306/NEWS/170309925?utm_source=modernhealthcare&utm_medium=email&utm_content=20170306-NEWS-170309925&utm_campaign=mh-alert - http://www.politico.com/story/2017/02/house-republicans-obamacare-repeal-package-235343 - http://www.politico.com/story/2017/03/house-obamacare-repeal-bill-what-does-it-say-235648

Example 1: Household of two 40 year-olds and two 20 year-olds

Comparison of Federal Financial Assistance for Health Insurance Costs (Individual Market): Affordable Care Act (ACA) vs. House Republican Plan[1]						
Example of 4-Person AI/AN Family in Big Horn County, MT; 2017						
Two 40-year-olds; two 20-year-olds; all meet ACA definition of Indian						
	Household Income	Total Plan Premium[2]	Average Out-of-Pocket (OOP) Costs[3]	Premium Tax Credit (PTC)[4, 5]	Net Premium Costs	Net Total Costs
ACA (Current)	$35,000 (144% FPL)	$14,450	$0	$14,450	$0	$0
House GOP Plan			$6,930	$10,000	$4,450	$11,380
DIFFERENCE: House GOP plan vs. ACA:					$4,450	$11,380
ACA (Current)	$50,000 (206% FPL)	$14,450	$0	$13,913	$537	$537
House GOP Plan			$6,930	$10,000	$4,450	$11,380
DIFFERENCE: House GOP plan vs. ACA:					$3,913	$10,843
ACA (Current)	$75,000 (309% FPL)	$14,450	$0	$9,963	$4,487	$4,487
House GOP Plan			$6,930	$10,000	$4,450	$11,380
DIFFERENCE: House GOP plan vs. ACA:					-$37	$6,893
ACA (Current)	$150,000 (617% FPL)	$14,450	$0	$0	$14,450	$14,450
House GOP Plan			$6,930	$10,000	$4,450	$11,380
DIFFERENCE: House GOP plan vs. ACA:					-$10,000	-$3,070

[1] House Republican plan is based on March 6, 2017 W&Ms and E&C Committee mark.

[2] Premium is for the selected bronze PPO (BC BS Basic 103, a MSP) on the Marketplace in 2017, with all four family members enrolling in the plan. The plan has an annual deductible of $6,100 per individual/$12,200 per family and an OOP maximum of $7,150 per individual/$14,300 per family.

[3] ACA eliminates cost-sharing for Marketplace enrollees who meet the definition of Indian. Average OOP costs for House Republican plan are based on average cost-sharing payments made to providers by the federal government on behalf of AI/AN Marketplace enrollees in Montana.

[4] The PTCs shown for ACA are generated by HealthCare.gov and capped at the amount of the total plan premium. Additional PTCs might be available under ACA for a higher-cost plan.

[5] The PTCs shown for House Republican plan are for 2020, with amounts in future years to include an adjustment for inflation. Under the House Republican plan, PTCs cannot exceed $14,000 per taxpayer per year in 2020 (with cap adjusted for inflation in future years). PTCs begin phase out for single filers at $75,000 and joint filers at $150,000.

Comparison of Net Household Contribution for Health Insurance-Related Costs (Individual Market): Affordable Care Act (ACA) vs. House Republican Plan[1]							
Example of 4-Person AI/AN Family in Big Horn County, MT; 2017							
	Two 40-year-olds; two 20-year-olds; all meet ACA definition of Indian; bronze plan enrollment						Household Contribution Difference (House Rep. vs. ACA)
	Household Income		Net Enrollee Premium Costs		Total Costs: Premiums and OOP		
	Household Income ($)	Federal Poverty Level (%)	Net Household Premium Contribution ($)	Net Household Premium Contribution (%)	Total Net Household Contribution ($)	Total Net Household Contribution (%)	
ACA (Current)	$35,000	144%	$0	0%	$0	0%	+33 perct. points
House Rep. Plan			$4,450	13%	$11,380	33%	
ACA (Current)	$50,000	206%	$537	1%	$537	1%	+22 perct. points
House Rep. Plan			$4,450	9%	$11,380	23%	
ACA (Current)	$75,000	309%	$4,487	6%	$4,487	9%	+6 perct. points
House Rep. Plan			$4,450	6%	$11,380	15%	
ACA (Current)	$150,000	617%	$14,450	10%	$14,450	10%	-2 perct. points
House Rep. Plan			$4,450	3%	$11,380	8%	

[1] House Republican plan is based on March 6, 2017 W&Ms and E&C Committee mark.

Example 2: Household of two 60 year-olds and two 20 year-olds

Comparison of Federal Financial Assistance for Health Insurance Costs (Individual Market): Affordable Care Act (ACA) vs. House Republican Plan[1]						
Example of 4-Person AI/AN Family in Big Horn County, MT; 2017						
Two 60-year-olds; two 20-year-olds; all meet ACA definition of Indian; bronze plan enrollment						
	Household Income	Total Plan Premium[2]	Average Out-of-Pocket (OOP) Costs[3]	Premium Tax Credit (PTC)[4, 5]	Net Premium Costs	Net Total Costs
ACA (Current)	$35,000 (144% FPL)	$25,297	$0	$25,297	$0	$0
House GOP Plan			$6,930	$12,000	$13,297	$20,227
DIFFERENCE: House GOP plan vs. ACA:					$13,297	$20,227
ACA (Current)	$50,000 (206% FPL)	$25,297	$0	$25,297	$0	$0
House GOP Plan			$6,930	$12,000	$13,297	$20,227
DIFFERENCE: House GOP plan vs. ACA:					$13,297	$20,227
ACA (Current)	$75,000 (309% FPL)	$25,297	$0	$22,898	$2,399	$2,399
House GOP Plan			$6,930	$12,000	$13,297	$20,227
DIFFERENCE: House GOP plan vs. ACA:					$10,898	$17,828
ACA (Current)	$150,000 (617% FPL)	$25,297	$0	$0	$25,297	$25,297
House GOP Plan			$6,930	$12,000	$13,297	$20,227
DIFFERENCE: House GOP plan vs. ACA:					-$12,000	-$5,070

[1] House Republican plan is based on March 6, 2017 W&Ms and E&C Committee mark.

[2] Premium is for the selected bronze PPO (BC BS Basic 103, a MSP) on the Marketplace in 2017, with all four family members enrolling in the plan. The plan has an annual deductible of $6,100 per individual/$12,200 per family and an OOP maximum of $7,150 per individual/$14,300 per family.

[3] ACA eliminates cost-sharing for Marketplace enrollees who meet the definition of Indian. Average OOP costs for House Republican plan are based on average cost-sharing payments made to providers by the federal government on behalf of AI/AN Marketplace enrollees in Montana.

[4] The PTCs shown for ACA are generated by HealthCare.gov and capped at the amount of the total plan premium. Additional PTCs might be available under ACA for a higher-cost plan.

[5] The PTCs shown for House Republican plan are for 2020, with amounts in future years to include an adjustment for inflation. Under the House Republican plan, PTCs cannot exceed $14,000 per taxpayer per year in 2020 (with cap adjusted for inflation in future years). PTCs begin to phase out for single filers at $75,000 and joint filers at $150,000.

Comparison of Net Household Contribution for Health Insurance-Related Costs (Individual Market): Affordable Care Act (ACA) vs. House Republican Plan[1]							
Example of 4-Person AI/AN Family in Big Horn County, MT; 2017							
	Two 60-year-olds; two 20-year-olds; all meet ACA definition of Indian; bronze plan enrollment						Household Contribution Difference (House Rep. vs. ACA)
	Household Income		Net Enrollee Premium Costs		Total Costs: Premiums and OOP		
	Household Income ($)	Federal Poverty Level (%)	Net Household Premium Contribution ($)	Net Household Premium Contribution (%)	Total Net Household Contribution ($)	Total Net Household Contribution (%)	
ACA (Current)	$35,000	144%	$0	0%	$0	0%	+58 perct. points
House Rep. Plan			$13,297	38%	$20,227	58%	
ACA (Current)	$50,000	206%	$0	0%	$0	0%	+40 perct. points
House Rep. Plan			$13,297	27%	$20,227	40%	
ACA (Current)	$75,000	309%	$2,399	3%	$2,399	5%	+22 perct. points
House Rep. Plan			$13,297	18%	$20,227	27%	
ACA (Current)	$150,000	617%	$25,297	17%	$25,297	17%	-4 perct. points
House Rep. Plan			$13,297	9%	$20,227	13%	

[1] House Republican plan is based on March 6, 2017 W&Ms and E&C Committee mark.

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

Despite Large Increases in Marketplace Premiums in 2017, Net Health Insurance Costs Fall for Low- to Moderate-Income Families in Many States[1]

January 11, 2017

This brief examines the impact of Marketplace premium increases on health insurance costs in 2017 for low- to moderate-income American Indian and Alaska Native (AI/AN) families.[2] Based on an analysis of Marketplace premiums in three states, despite the rise in Marketplace premiums, health insurance costs likely will decline for many AI/AN families enrolled in bronze plans because the federal government will cover a greater share of their costs through premium tax credits (PTCs).

Background

Individuals and families enrolled through a Marketplace with incomes between 100% and 400% of the federal poverty level (FPL) qualify for PTCs to help cover their health insurance costs. The amount of the PTC generally equals the premium for the second-lowest-cost silver plan, minus a specified percentage of household (HH) income (in 2017, 2.04% to 9.69%, depending on HH income level), with the amount of the PTC not to exceed the full cost of the premium for the Marketplace enrollees.

- The percentage of HH income contributed stays relatively constant from year-to-year (*e.g.*, maximum of 9.69% in 2017 and maximum of 9.66% in 2016). As such, even if premiums increase sharply, the PTC—not the HH contribution—increases to cover the increased costs.
- Second, if an AI/AN individual or family enrolls in a lower-cost bronze plan (to maximize cost-sharing protections), the individual or family realizes the savings as the total premium costs fall. And, in fact, the bigger the differential between the second-lowest-cost silver plan and the bronze plan premiums, the larger the savings for the individual / family enrolling in bronze coverage.

Analysis

The table below shows the premiums for the lowest-cost bronze preferred provider organization (PPO) plan (the Marketplace plan with the broadest access to providers) and the second-lowest-cost silver plan, the percentage change from 2016 to 2017, as well as the differential between these premiums, in three states for 2016 and 2017. From 2016 to 2017, the premium for the lowest-cost bronze PPO increased significantly in each state—by 21% in Alaska, by 30% in Connecticut, and by 73% in Oklahoma. However, because the HH contribution percentage remained roughly constant from 2016 to 2017, the

[1] This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Doneg McDonough, TSGAC Technical Advisor, at DonegMcD@Outlook.com.

[2] For 2017, in 18 states premium increases were less than 10% for the second lowest-cost silver plan; in 33 states, premium increases were 10% or greater. http://kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/

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PTC increased to fund the entire increase in premiums.[3] And because the differential between the premiums for the lowest-cost bronze PPO and the second-lowest-cost silver plan increased in 2017, for example, in Oklahoma, enrollees in the State who qualify for PTCs actually would have up to $976 lower per enrollee health insurance premium costs in 2017 than in 2016.

Differential Between Lowest-Cost Bronze and Second-Lowest-Cost Silver Plans: Individual Alaska, Connecticut, and Oklahoma Marketplace (2016 vs. 2017)							
Coverage Year	**Status**	**Annual Premium[1]**	**Difference: Reference Plan vs. Lowest Cost Bronze PPO**	**Annual Premium[2]**	**Difference: Reference Plan vs. Lowest Cost Bronze PPO**	**Annual Premium[3]**	**Difference: Reference Plan vs. Lowest Cost Bronze PPO**
		Alaska Marketplace		**Connecticut Marketplace (Access Health CT)**		**Oklahoma Marketplace**	
2016	Lowest cost bronze	$6,948	$1,260	$2,798	$1,329	$3,056	$1,117
	2nd lowest cost silver (Reference Plan)	$8,208		$4,126		$4,173	
2017	Lowest cost bronze	$8,436	$2,412	$3,624	$1,302	$5,280	$2,092
	2nd lowest cost silver (Reference Plan)	$10,848		$4,926		$7,372	
Change in Differential (silver vs. bronze)	Bronze	+21%	+$1,152	+30%	-$27	+73%	+$976
	Silver	+32%		+19%		+77%	

[1] Premiums are for a 40-year-old enrollee in the lowest-cost bronze PPO and second-lowest cost silver plan offered on the Marketplace in Anchorage, AK.
[2] Premiums are for a 40-year-old enrollee in the lowest-cost bronze PPO and second-lowest cost silver plan offered on the Marketplace in New London County, CT.
[3] Premiums are for a 40-year-old enrollee in the lowest-cost bronze PPO and second-lowest cost silver plan offered on the Marketplace in Kay County, OK.

The following table shows the sources and amounts of funding in 2016 and 2017 for an AI/AN family of three in Kay County, Oklahoma with HH income of $50,400. As discussed above, although the premium for the lowest-cost bronze PPO jumped by 73% from 2016 to 2017, the annual net health insurance costs for the family would decrease. In fact, the family's net premium costs fell from $1,320 to $0.

[3] In the linked document, net premium costs are shown for an individual enrolled in silver-level coverage, comparing 2016 to 2017, by state. http://kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/

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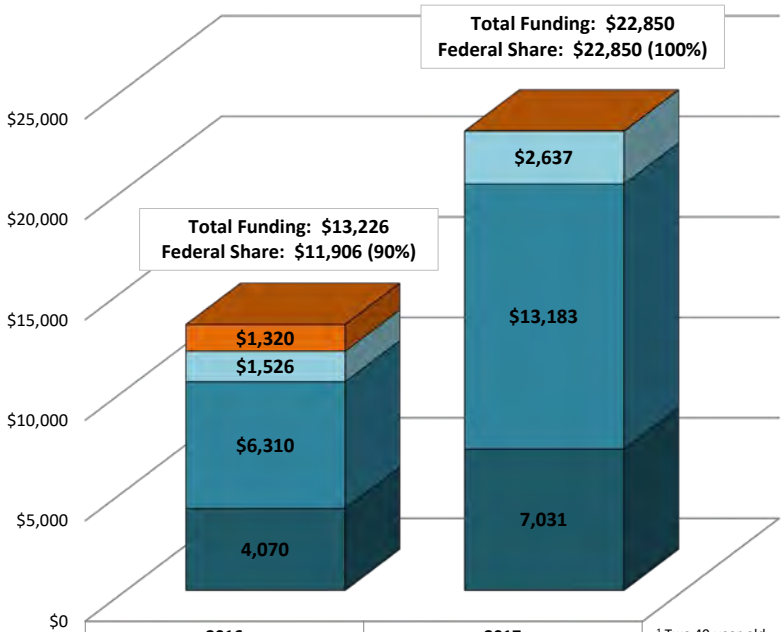
Source and Distribution of Funding for Marketplace Coverage, 2016 vs. 2017
- American Indian or Alaska Native Family -
Three-person household; annual income 250% FPL: $50,400
(3 enrollees;[1] Kay County, OK; bronze-level coverage)



	2016	2017
Enrollee - Premium Share	$1,320	$0
Enrollee - Cost-Sharing	$0	$0
Federal - IU Payment	$1,526	$2,637
Federal - Premium Share	$6,310	$13,183
Federal - Cost-Sharing	$4,070	$7,031

[1] Two 40-year-old adults and one minor child enroll in the Marketplace.

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Health Care Reform in Indian Country
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Tribal Sponsorship of Medicare Part B and Part D Premiums[1]

November 23, 2016

Medicare plays an important role for elderly American Indians and Alaska Natives (AI/ANs) in obtaining necessary health care services.[2] But because of premiums and out-of-pocket costs, many Medicare-eligible AI/ANs are not able to access critical services covered under the various components of the Medicare program. Although Medicare beneficiaries generally pay no premiums for Part A, which covers inpatient hospital care, enrollment in Part B, which covers physician and outpatient services, and Part D, which covers prescription drugs, does require payment of premiums (see Tables 1, 2 and 3 below), prompting some elderly AI/ANs to opt not to enroll.

Premiums for Medicare Part B and D cover approximately 25% of program costs, with the federal government contributing the remaining funding.[3] As a result, the value of the services paid for under Medicare Part B and D typically far exceeds the amount of the premium payment, whether an enrollee has average or higher-than-average health care expenditures.

Table 1. Summary of Medicare Benefits

Medicare Part	Covered Services	Premium	Cost-Sharing
Part A	Inpatient hospital care	No	Inpatient deductible ($1,316 in 2017).
Part B	Physician services, outpatient care and certain other services	Yes ($134.00 in 2017, with higher premiums for higher-income beneficiaries)	Annual deductible ($183 in 2017) and coinsurance (20% for most services).
Part C	Medicare Parts A and B through private health plans	Yes (Part B premium plus plan premium)	Deductible, copayments, or coinsurance (might apply for certain services)
Part D	Outpatient prescription drugs	Yes (Varies by plan)	Copayments or coinsurance

[1] This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Doneg McDonough, TSGAC Technical Advisor, at DonegMcD@Outlook.com.

[2] For example, Medicare Part B makes payment for services such as outpatient specialty services. And, Medicare Part D covers, among other things, high-cost specialty medications that can contribute to tremendous improvements in the quality of life for certain patients, treatments that otherwise might not be available through the Indian Health Service (IHS) or through PRC referral.

[3] For more information on Medicare Part B costs, see https://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html. For more information on Part D costs, see https://www.medicare.gov/part-d/costs/part-d-costs.html.

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enrollment period, the annual enrollment period for Part B runs from January 1 to March 31, with coverage beginning July 1. Some individuals might qualify for a special enrollment period (SEP) that allows enrollment at other times, but no SEP is available specifically for AI/ANs.[8]

Part B enrollment requires payment of a premium, although lower-income enrollees might be eligible for premium assistance through a Medicare Shared Savings Program. Eligibility for these programs is determined by income level and an asset test (see Table 2 below for income eligibility and asset requirements).[9] Individuals pay their Medicare Part B premium via a direct deduction from their monthly Social Security checks. As such, if a Tribe seeks to pay Medicare Part B premiums on behalf of eligible Tribal members, it would do so by reimbursing these individuals by the amount of their deductions. The Tribe, as part of such a Sponsorship program, could ask sponsored Tribal members to provide documentation that these deductions have occurred and then reimburse them on a monthly basis or through a single annual payment.

Table 2. Medicare Shared Savings Program Income Eligibility and Asset Requirements for 2016

Medicare Savings Program	Helps Pay for:	Annual Income Limits		Asset Limits	
		Individual	Couple	Individual	Couple
Qualified Medicare Beneficiary (QMB)	Part A premiums Part B premiums Part A and B out-of-pocket costs	$12,120	$16,260	$7,280	$10,930
Specified Low-Income Medicare Beneficiary (SLMB)	Part B premiums only	$14,496	$19,464	$7,280	$10,930
Qualifying Individual (QI)	Part B premiums only	$16,284	$21,876	$7,280	$10,930
Qualified Disabled Working Individual (QDWI)[1]	Part A premiums only	$48,540	$65,100	$4,000	$6,000

[1] Figures include certain earned income disregards.

Late Enrollment in Part B

In most cases, if individuals do not enroll in Medicare Part B when they first become eligible, they must pay a late enrollment penalty for as long as they participate in Part B.[10] The Part B

[8] A list of the circumstances that trigger special enrollment periods for Medicare Part B is available at https://www.medicare.gov/sign-up-change-plans/get-parts-a-and-b/special-conditions/special-conditions.html.
[9] The Qualified Medicare Beneficiary (QMB) Program, Specified Low-Income Medicare Beneficiary (SLMB) Program, and Qualifying Individual (QI) Program provide assistance in paying Medicare Part B premiums. See https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html.
[10] Generally, individuals who do not enroll in Medicare Part B during the 7-month period that (1) begins 3 months before the month they turn 65, (2) includes the month they turn 65, and (3) ends 3 months after the month they turn 65 are subject to this penalty (however, individuals who continue to work past age 65 for firms with more

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To help maximize enrollment of AI/ANs in Medicare Part B and Part D (and increase the resources available to Indian health programs), Tribes can initiate programs to pay premiums on behalf of Tribal members ("Sponsorship").[4]

- Under federal regulations, employers, lodges, unions, or other organizations, including Tribes, can pay **Medicare Part B** premiums on behalf of one or more enrollees, and some Tribes have implemented Part B Sponsorship programs.[5]
- **Medicare Part D** law and regulations do not specifically address Tribal Sponsorship of premiums. However, Tribes are permitted to sponsor Part D enrollees, and some Tribes have implemented Part D Sponsorship programs.[6,7]

Medicare Part B Sponsorship

Medicare Part B covers a range of health care services for enrollees, including:

- Physician services;
- Outpatient care;
- Preventive services, such as screenings for diabetes, cancer, and cardiovascular disease;
- Some home health services;
- Some diabetes supplies;
- Clinical laboratory and diagnostic tests;
- Durable medical equipment; and
- Ambulance services.

Most individuals will get automatically enrolled in Medicare Part B at the time they reach age 65 and become eligible for Medicare, but others (*e.g.*, individuals who have not begun to receive Social Security benefits because they remain employed) will not get automatically enrolled. For individuals not automatically enrolled, enrollment in Part B can begin during the 7-month period that (1) starts 3 months before the month they turn 65, (2) includes the month they turn 65, and (3) ends 3 months after the month they turn 65. Outside of this initial

[4] In addition to paying the premiums for Medicare Part B and Part D, the option is available to Tribes to sponsor Medicare beneficiaries for "Medicare Supplemental" coverage which covers the out-of-pocket costs (e.g., deductibles and co-payments) charged beneficiaries under Medicare Parts A and B.
[5] See KFF, "The Role of Medicare and the Indian Health Service for American Indians and Alaska Natives: Health, Access and Coverage," page 9, at http://files.kff.org/attachment/report-the-role-of-medicare-and-the-indian-health-service-for-american-indians-and-alaska-natives-health-access-and-coverage.
[6] See TTAG, "Indian Sponsorship Under Exchanges," Attachment 1, page 1, at http://www.nihb.org/tribalhealthreform/wp-content/uploads/2013/06012011/TTAG%20-%20Enabling%20an%20Indian%20Sponsorship%20Option%20DIST%202011-04-13.pdf.
[7] IHS also has the authority to pay Medicare Part B (but not Part D) premiums on behalf of eligible AI/ANs. As of December 2014, however, IHS had not used this authority. See GAO, "Medicare and Medicaid: CMS and State Efforts to Interact with the Indian Health Service and Indian Tribes," page 10, at http://www.gao.gov/new.items/d08724.pdf.

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premium typically increases by 10% for each full 12-month period that individuals could have enrolled, but did not enroll, in Part B.[11, 12]

Table 3. Medicare Part B Premiums and Late Enrollment Penalties, by Beneficiary Income and Tax Filing Status						
Beneficiary Annual Income and Tax Filing Status (2015)			Monthly Premium (2017)	Monthly Premium with Late Enrollment Penalty		
Filing Individually[1]	Married, Filing Joinly[2]	Married, Filing Separately		After 12 Months	After 24 Months	After 36 Months
$85,000 or less	$170,000 or less	$85,000 or less	$134.00	$147.40	$160.80	$174.20
$85,001-$107,000	$170,001-$214,000	--	$187.50	$206.25	$225.00	$243.75
$107,001-$160,000	$214,001-$320,000	--	$267.90	$294.69	$321.48	$348.27
$160,001-$214,000	$320,001-$428,000	$85,001-$129,000	$348.30	$383.13	$417.96	$452.79
$214,001 or more	$428,000 or more	$129,000 or more	$428.60	$471.46	$514.32	$557.18

[1] Individuals with annual income less than $16,284 might qualify for a Medicare Shared Savings Program that helps pay Part B premiums (in 2016).
[2] Couples with annual income less than $21,876 might qualify for a Medicare Shared Savings Program that helps pay Part B premiums (in 2016).

Medicare Part D

Medicare Part D covers outpatient prescription drugs through private prescription drug plans. In addition, prescription drug coverage is made available to Medicare beneficiaries through private Part C plans, referred to as Medicare Advantage, which combines Part D prescription drug coverage with the comprehensive medical services under Medicare Parts A and B. Part D enrollment requires payment of a premium, although lower-income enrollees might qualify for qualify for the Low-Income Subsidy (LIS) program (also called "Extra Help"), which provides assistance with paying for Part D premiums, deductibles, and coinsurance.[13] Eligibility for these programs is determined by income level and an asset test (See Table 4 below for income eligibility and asset requirements). For eligible Medicare beneficiaries, the LIS program covers between 0% and 100% of their Part B premium, with those with the lowest income and asset levels receiving the most generous subsidies. Medicare beneficiaries can apply for the LIS program with the Social Security Administration (SSA) or their state Medicaid agency.

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than 20 employees can delay enrolling in Part B until they leave their jobs, after which time they have an 8-month window for enrolling).

[11] Individuals who receive premium assistance through a Medicare Savings Program do not pay the late enrollment penalty. These programs include the QMB Program, SLMB Program, QI Program, and Qualified Disabled and Working Individuals (QDWI) Program.

[12] There is not an Indian-specific provision exempting AI/ANs from late enrollment fees.

[13] For more information on the LIS program, see https://www.medicare.gov/your-medicare-costs/help-paying-costs/save-on-drug-costs/save-on-drug-costs.html.

Table 4. LIS Program Income Eligibility and Asset Requirements for 2016			
Annual Income Limits		Asset Limits	
Individual	Couple	Individual	Couple
$17,820	$24,030	$13,640	$27,250

In general, individuals can begin to enroll in Medicare Part D during the 7-month period that (1) begins 3 months before the month they turn 65, (2) includes the month they turn 65, and (3) ends 3 months after the month they turn 65. Outside of this initial enrollment period, most individuals can enroll in Part D only during the annual open enrollment period that runs from October 15 through December 7, with coverage beginning January 1. Some individuals might qualify for an SEP that allows enrollment at other times.[14] For example, individuals eligible for Medicare and Medicaid (dual eligibles) can enroll in, switch, or drop Part D plans at any time. Individuals who qualify for the LIS program also can enroll in, switch, or drop Part D plans at any time. No special enrollment period is available specifically for AI/ANs.

Individuals pay their Medicare Part D premium via direct payment to Part D plans. If a Tribe seeks to pay Medicare Part D premiums on behalf of Tribal members, it could do so by working directly with Part D plans to expedite the process and minimize costs. Under such a Sponsorship program, the Tribe could provide information on the program to eligible Tribal members and have staff assist these individuals with the online enrollment process.[15] Tribal staff also could work with account managers at Part D plans to reach agreements under which the Tribe provides the plans with a list of sponsored Tribal members and the plans send consolidated bills to the Tribe on a monthly basis.

Late Enrollment in Part D

Individuals eligible for the Indian Health Service (IHS) do *not* have to pay a late enrollment penalty for Medicare Part D if enrolling after the initial enrollment period. For the general population, if individuals go without a Part D plan, a Part C plan that offers Part D coverage, or some other form of "creditable" Part D coverage for any continuous period of 63 days or more after their initial enrollment period ends, they might have a late enrollment penalty added to

[14] A list of the circumstances that trigger special enrollment periods for Medicare Part D is available at https://www.medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/special-circumstances/join-plan-special-circumstances.html.

[15] AI/ANs enrolling in Medicare Part D plans outside of the initial enrollment period might need to show the plan proof of creditable Part D coverage (IHS eligibility) to avoid the late enrollment penalty (*e.g.*, through a letter or telephone call from the Tribe or IHS).

their Part D premium. But because eligibility for IHS qualifies as creditable Part D coverage,[16] IHS-eligible individuals do not have pay the late enrollment penalty.

Table 5. Medicare Part D Premiums and Late Enrollment Penalties, by Beneficiary Status, Income, and Tax Filing Status

Beneficiary Annual Income and Tax Filing Status (2015)[2]				Monthly Premium (2017)[1,2]	Late Enrollment Penalty[3,4]		
Beneficiary Status	Filing Individually[1]	Married, Filing Joinly	Married, Filing Separately		After 12 Months	After 24 Months	After 36 Months
Individuals without Part D or creditable prescription drug coverage	$85,000 or less	$170,000 or less	$85,000 or less	$35.63	$4.30	$8.60	$12.80
	$85,001-$107,000	$170,001-$214,000	--	$48.93	$4.30	$8.60	$12.80
	$107,001-$160,000	$214,001-$320,000	--	$69.83	$4.30	$8.60	$12.80
	$160,001-$214,000	$320,001-$428,000	$85,001-$129,000	$90.83	$4.30	$8.60	$12.80
	$214,001 or more	$428,000 or more	$129,000 or more	$111.83	$4.30	$8.60	$12.80
IHS-eligible individuals	$85,000 or less	$170,000 or less	$85,000 or less	$35.63	No penalty	No penalty	No penalty
	$85,001-$107,000	$170,001-$214,000	--	$48.93	No penalty	No penalty	No penalty
	$107,001-$160,000	$214,001-$320,000	--	$69.83	No penalty	No penalty	No penalty
	$160,001-$214,000	$320,001-$428,000	$85,001-$129,000	$90.83	No penalty	No penalty	No penalty
	$214,001 or more	$428,000 or more	$129,000 or more	$111.83	No penalty	No penalty	No penalty

[1] "National base beneficiary premium" ($35.63 in 2017) is used as the basis for the premium amounts listed in the table; actual Part D premiums vary by prescription drug plan.

[2] Individuals with annual income less than $17,820 and couples with annual income less than $24,030 might qualify for the LIS program, which helps pay Part D premiums (in 2016).

[3] Late enrollement penalty equals 1% of the national base beneficiary premium times the number of full months without Part D (or creditable) coverage.

[4] Table assumes no increase in the national base beneficiary premium from year to year; the national base beneficiary premium might increase from year to year, and as such, the actual penalty might increase from year to year.

Coverage/Cost-Sharing under Part D Plans

Medicare Part D plans must offer either the defined standard benefit or an alternative equal in value ("actuarially equivalent") and also can provide enhanced benefits (see Table 6 below for information on the standard benefit).[17] However, Part D plans vary on their specific benefit design, cost-sharing amounts, utilization management tools (i.e., prior authorization, quantity limits, and step therapy), formularies (i.e., covered medications), and provider networks. *Prior to enrolling members in part D plan, the Tribe should (1) assess the ability of plan enrollees to*

[16] Other examples of "creditable" coverage include coverage from a former employer or union, TRICARE, the Department of Veterans Affairs, or the Federal Employees Health Benefits Program; no similar exemption exists for the late enrollment penalty for Medicare Part B. See CRS, "Medicare: Part B Premiums," page 6, at https://www.fas.org/sgp/crs/misc/R40082.pdf.

[17] For more information on Medicare Part D benefit parameters, see https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf.

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access Indian health care providers (IHCPs) as in-network providers and (2) assess the ability of IHCPs to receive payment from a Part C plan for services rendered.[18]

Part D plan formularies must include drug classes covering all disease states and a minimum of two chemically distinct medications in each class. In addition, Part D plans must cover all drugs in six "protected" classes: immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastics.

For 2017, the Part D standard benefit requires enrollees to pay a $400 deductible and 25% coinsurance until they reach a coverage limit of $3,700 in total drug costs, followed by a coverage gap. In the coverage gap, enrollees must pay for a larger share of their total drug costs than in the initial coverage period, until their total out-of-pocket spending reaches $4,950. After enrollees reach the catastrophic coverage threshold, they must pay either 5% of their total drug costs or $3.30/$8.25 for each generic/brand-name drug, respectively. Medicare indexes the standard benefit amounts annually based on the rate of Part D per capita spending growth.

Table 6. Medicare Part D Standard Benefit for 2017

Initial coverage period	Deductible	$400
	Percentage of cost covered by enrollee	25%
	Initial coverage period coverage limit	$3,700
	Out-of-pocket (OOP) spending threshold before coverage gap begins	$4,950
Coverage gap	Percentage of cost covered by enrollee	40% for brand-name drugs; 51% for generic drugs
	Estimated OOP spending threshold before catastrophic coverage begins	$8,071.16
Catastrophic coverage	Percentage of cost covered by enrollee	5%
	Minimum cost covered by enrollee	$3.30 for generic/preferred drugs; $8.25 for other drugs

Alternative Prescription Drug Coverage Under Part C Plans

As another option, Medicare beneficiaries can obtain prescription drug coverage and potentially lower out-of-pocket costs by enrolling in a Part C (Medicare Advantage) plan. Under Part C, Medicare beneficiaries enroll in private plans that provide both Part A and Part B

[18] Under section 206 of the Indian Health Care Improvement Act (IHCIA), an IHCP is provided a right of recovery from an insurance company and other third party entities, including Part D plans, for reasonable charges billed by an IHCP when providing services, or, if higher, the highest amount the third party would pay for services furnished by other providers. This right of recovery applies whether the IHCP is in a plan network or not.

coverage and, in many cases, Part D coverage. Not all Medicare Advantage plans offer Part D coverage. Medicare beneficiaries who enroll in Part C plans must pay the Part B premium and, in many cases, an additional plan premium ($31.40 per month, on average, in 2017).[19]

In addition to premiums, Medicare Part C plan enrollees often must pay deductibles and coinsurance (or copayments) when accessing services, with these amounts determined annually by the plan effective January 1 of the coverage year. As compared to traditional Medicare Part A and Part B coverage, the Medicare Advantage plan might offer reduced out-of-pocket costs, although patients are typically required to receive services from a more restricted list of health care providers than is available under fee-for-service Medicare. *If a Tribe seeks to pay Part C premiums on behalf of Tribal members, prior to enrolling members in the plan, the Tribe should (1) assess the ability of plan enrollees to access Indian health care providers (IHCPs) as in-network providers and (2) assess the ability of IHCPs to receive payment from a Part C plan for services rendered.*[20]

Out-of-pocket costs for Part C plan enrollees can vary widely, depending on the following factors:

- Whether the plan charges a monthly premium (in addition to the Part B premium);
- Whether the plan pays any of the monthly Part B premium;
- The amount of any annual (Part A or Part B) deductible or additional deductibles;
- The amount of any coinsurance or copayments the enrollee must pay for accessing services;
- The type and amount of services used;
- Whether the enrollee obtains services from in-network or out-of-network providers;
- Whether the enrollee requires extra benefits and whether the plan charges for those benefits;
- The amount of any out-of-pocket cost limit implemented by the plan; and
- Whether the enrollee qualifies for Medicaid or obtains financial assistance from their state.

Comparison of Part B and Part D Considerations

Table 7 below provides a comparison of considerations for Medicare Part B and Part D Sponsorship programs. In addition to the listed factors, for Part D plan Sponsorship, whether

[19] The amount of premiums charged by (and level of access to) Medicare Part C plans varies substantially in different regions of the United States.

[20] Under section 206 of the Indian Health Care Improvement Act (IHCIA), an IHCP is provided a right of recovery from an insurance company and other third party entities, including Medicare Advantage plans, for reasonable charges billed by an IHCP when providing services, or, if higher, the highest amount the third party would pay for services furnished by other providers. This right of recovery applies whether the IHCP is in a plan network or not.

IHCPs are included in the provider network of a Part D plan and what the payment rates are under the Part D plan are two additional considerations.

Table 7. Comparison of Medicare Part B and Part D Sponsorship Considerations

Sponsorship Program Type	Covered Services	Enrollment Process	Late Enrollment Penalty	Late Enrollment Penalty Amount	Late Enrollment Penalty Exemption for Creditable Coverage (*e.g.*,	Premium Payment Mechanism (w/o Sponsorship)	Premium Payment Mechanism (w/ Sponsorship)
Part B	Physician services, outpatient care and certain other services	Automatic at age 65 (for SS check recipients; optional for others)	Yes	10% increase in premium ($134.00 for standard premium in 2017) for each full 12-month period eligible for, but not enrolled in, Part B	No	Deduction from enrollee SS check paid to federal government	Tribe payment to enrollee for SS check deduction
Part D [1]	Outpatient prescription drugs	Optional at age 65	Maybe	No late fee for IHS-eligible individuals[2]	Yes	Enrollee payment to private plan	Tribe payment to private plan (consolidated)

[1] Likewise, a Medicare beneficiary can enroll in a Part C (Medicare Advantage) plan that offers Part D prescription drug coverage.
[2] For the general population, the late enrollment penalty is 1% of the "national base beneficiary premium" ($35.63 in 2017) times the number of full months without Part D (or creditable) coverage.

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TRADITIONAL SERVICES

Families have the choice to use their child's individual budget to access Medicaid services through two different pathways, the Traditional model and Family-Directed Services model. Families who want to access services through the Traditional model will continue to receive services from Medicaid developmental disability providers who are paid for providing defined Medicaid benefits.

State Plan – HCBS Services

All children with developmental disabilities will qualify for the following services:

Respite – provides supervision to a child on an intermittent or short-term basis because of the need for relief of the primary unpaid caregiver. Respite may be used on a regular basis to provide relief to the caregiver and is available during family emergency or crisis.

Habilitative Supports – provides assistance to children with disabilities by facilitating independence and integration into the community. This service provides children with an opportunity to explore their interests and improve their skills through community participation and integration. The service provides opportunities for children to practice the skills they have learned in other therapeutic and natural environments.

Family Education – assistance to families to help them better meet the needs of their child. Family Education offers education to the parent or legal guardian that is specific to the individual needs of the family. Education topics can include: orientation to developmental disabilities, generalized strategies for behavior modification and intervention techniques.

Waiver Services

Children who meet 'Institutional Level of Care' will qualify for the following services:

Habilitative Intervention – services are provided to improve a child's functional skills and minimize problem behaviors. Intervention services are outcome-based, therapeutic services delivered by a professional. Intervention is based upon well-known and widely regarded principals of evidence based treatment.

Family Training – 'one-on-one' instruction to families on intervention techniques. Family training is provided to the parent or guardian when the child is present.

Interdisciplinary Training – instruction and training from service professionals to other direct service providers. Interdisciplinary training focuses on maximizing the coordination of all the services the child receives and allows professionals to train each other on how to better meet the needs of the child.

Therapeutic Consultation – consultation provided to a child's Habilitative Interventionist and family. This services is utilized when it is determined that a more advanced level of training and assistance is required based on a child's complex needs.

Crisis Intervention – services provide direct consultation and clinical evaluation of children who are currently experiencing or may be expected to experience a psychological, behavioral or emotional crisis. Services include training and staff development related to the needs of the child. The service may also provide emergency back-up for the child in crisis.

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FAMILY- DIRECTED SERVICES

Families have the choice to use their child's individual budget to access Medicaid services through two different pathways, the "Traditional" model and "Family-Directed Services" model.

When it comes to choosing services, everyone has different needs and preferences. Additionally, every community offers a different amount and variety of services. The Family-Directed Services pathway is designed for families who want a more hands-on and flexible approach in determining the types of services and supports their children need.

The flexibility in this model allows parents to choose, design and direct services outside of the Traditional menu of services. The Family-Directed Services pathway allows for more creative ways to access services than the Traditional pathway while still maintaining accountability required by federal authorities.

Family-Directed Services May Be Right For Your Family If:

- You would like to gain more control over the resources that are available for your child and have more freedom to create and access untraditional services and supports.
- You want to manage your child's budget that is based on his or her assessed needs.
- You want to recruit, hire and train and (and dismiss, if necessary) your own service providers.
- You want to set wages for your service providers based on your child's budget and market rate.
- You want to maintain detailed records, monitor services and spending, set schedules, submit timesheets and hire/dismiss your providers.
- You are willing to follow program guidelines and accept the responsibilities that come with managing your child's program.

How It Works

1. A child is determined eligible for services and is assigned a budget based on their strengths and assessed needs.
2. Families have the choice between two pathways to services, the Traditional model and Family-Directed Services model. These two models offer different levels of control and responsibility over your child's services and supports.
3. If the family chooses Family-Directed Services, they will hire a Support Broker to assist them in developing and managing services. The Support Broker helps create the Support and Spending Plan, budget the money, and monitor services.
4. The plan is authorized by the Department of Health and Welfare. A Fiscal Employer Agent takes care of the financial considerations including paying for authorized services and goods, withholding applicable taxes and providing monthly expenditure reports.
5. Together you, your Support Broker and the Department will work together to assure that your child's health and safety needs are met.

*Choosing Family-Directed Services **allows you more control over your child's services** if you wish to take more responsibility for coordination and management.*

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Idaho Smiles Medicaid Program

February 15, 2017

Welcome!

Purpose:

1. Introduction to MCNA Dental Plan
2. Idaho Smiles Medicaid Program
3. Contact information

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Overview

- About MCNA
- Dental Benefit Programs
- Overview of MCNA
- Quality Assurance Focus
- Our Technology
- Our Purpose
- Idaho Provider Network
- Idaho Membership
- Provider Relations
- Claims
- Network Participation

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About MCNA

MCNA Dental (*MCNA Insurance Company and Managed Care of North America, Inc.*) is a leading dental benefits management company committed to providing high quality services to state agencies and managed care organizations. Additionally, we also offer dental plans for private employers, individuals, and families.

We have been devoted to improving the overall health of our members by making sure they get great dental care and service they can trust.

At MCNA, we care about smiles!

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Overview of MCNA

- For over 20 years, the MCNA organization has been a premier underwriter and administrator of dental benefits with a focus on providing exceptional service for **Medicaid**, **Children's Health Insurance Program** (CHIP), and **Medicare** members.
- MCNA serves over **3.5 million children and adults** nationwide, with operations in **Texas, Louisiana, Florida, Iowa, West Virginia, and Idaho.**
  - MCNA is contracted as the State of Idaho's sole dental benefit administrator for Medicaid and CHIP.
  - MCNA is also the sole dental benefit plan manager in Louisiana for Medicaid and CHIP.
  - MCNA administers dental benefits for half of the Medicaid and CHIP enrollees in Texas.
- Founded by Dr. Jeffrey P. Feingold, a Florida-licensed Periodontist and Diplomate of the American Board of Periodontology, we are a family-owned business headquartered in **Fort Lauderdale, Florida**, with regional offices in **San Antonio, Texas** and **New Orleans, Louisiana**.

Quality Assurance Focus

- In 2014, MCNA became the first dental plan in the nation to receive full **Dental Plan Accreditation** and **Claims Processing Accreditation** from **URAC**.
  - Our Chief Dental Officer, Dr. Ronald Ruth, currently serves on the URAC Advisory Board.
- We are certified by the **National Committee for Quality Assurance** (NCQA) in Credentialing and Recredentialing.
- MCNA is a member of the **Dental Quality Alliance (DQA)**, a national organization established by the **ADA** to advance performance measurement as a means to improve oral health, patient care, and safety through a consensus-building process.

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Our Technology

MCNA Dental provides a full range of dental benefits management services including:

- Primary and Specialty Care Dental Network
- Member Services
- Provider Relations
- Claims
- Enrollment
- Quality Assurance and Improvement
- Risk Management
- Credentialing
- Compliance

MCNA manages member enrollment, provider network, claims handling, and other operations through a database called **DentalTrac™**, which includes online benefit enrollment and eligibility determination.

MCNA has successfully completed an independent, third-party Service Organization Control (SOC) 2 audit of the processes and controls that ensure security and availability.

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Idaho Smiles

MCNA is proud to be a Dental Benefit Administrator for the state of Idaho to serve the 300,000 Members enrolled in the Idaho Smiles Program

Go Live date 02/01/2017

Eligibility will be determined by IDHW

Our **mission** is to deliver value to our Members and Providers by providing access, quality, and service excellence that improves the oral health outcomes of our members.

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Commitment to Idaho Members

At MCNA, Member Services is an essential part of our company and with high member satisfaction ratings. This demonstrates our ability to effectively communicate with our members about their benefits and how to access care.

Our commitment to our members is to provide awareness of their overall health through outreach and education. We encourage providers to submit Member Outreach forms for those members who have special needs or need education about keeping scheduled appointments.

MCNA educates members on:

- Keeping scheduled appointments
- Following treatment plans
- Provide further explanation on their benefits/ covered services
- Good oral health with best practices for a healthy smile
- Understand Member's Rights and Responsibilities

MCNA Member Services Hotline
1-855-233-6262
Mon-Fri, 6am-6pm MST

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Idaho Provider Network

Providing service excellence to the dentists that make up our provider network is important to us. MCNA is a provider-friendly dental benefits management company founded and run by dentists.

We build and maintain strong relationships with our network providers that allow us to ensure access to quality dental care and services for the unique population we serve.

Current Network analysis in Idaho:

- 471 Participating Providers

	Participating Specialty Count
DENTURIST	13
ENDODONTIST	2
GENERAL DENTIST	349
ORAL SURGEON	16
ORTHODONTIST	35
PEDODONTIST	48
PERIODONTIST	1
PROSTHODONTIST	1

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Network Participation

Please visit our website at www.mcnaid.net for the following options for Provider Enrollment:

- Enroll online by completing the registration process
- Download and complete the MCNA Credentialing Application or Complete Online Credentialing Application
- Download and complete with signature the MCNA Participating Provider Agreement (contract)

Please send all complete credentialing application and Provider Agreement on paper via:

- **Fax**: (877) 483-9778
- **Email**: network_development@mcna.net
  MCNA Dental
- **Mail**: c/o Idaho Network Development
  P.O. Box 29008
  San Antonio, TX 78229

Toll-free Provider Relations Dept.: 1-855-235-6262

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Provider Relations

MCNA's Provider Relations department offers our dental professionals timely and accurate responses to all inquiries and questions, and addresses any dissatisfaction expressed by a Provider.

Our purpose is to build strong, collaborative and lasting relationships with our network Providers through outreach and education.

Through effective communication and efficient training, we strive to ensure our Providers and their staff are getting the necessary resources, tools, and information on MCNA's program guidelines by utilizing our Provider Manual.

Provider Relations Representatives provide ongoing education, office visits, and assistance since launch on the following:

- Provider Orientation
- Online Portal training
- Education on Provider Manual
- Policies and Procedures
- Claim and Pre-Authorization submissions

MCNA Provider Services Hotline
1-855-235-6262
Mon-Fri, 6am-6pm MST

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Plan Processes

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Referrals to a Specialist

An approved referral is necessary for members to access in network **Oral Surgeons** and **Orthodontists**.

Emergency services do not require a referral. Please indicate any emergency services provided via a detailed narrative and/or rationale with your claim submission.

Oral Surgery Referrals from General Dentists or Pediatric Dentists, require the following information :

- Narrative or Office Remarks – Tooth IDs and all symptoms should be provided. Describe any symptoms such as acute pain or infection in narrative form. (The use of “cut and paste” narratives is unacceptable. They must be patient specific.)
- X-rays – Either a pano, periapical, or bitewings illustrating the issue.

All submissions will be evaluated for medical necessity and compliance with plan rules.

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Referrals to Specialist

Referral to an Orthodontist is required for a pre-orthodontic examination and submission of a pre-authorization request to submit a case. Only an Orthodontist and approved Orthodontic providers are able to be reimbursed for D8660.

Orthodontic referrals from General Dentists or Pediatric Dentists require the following information:

- Narrative or office remarks –All identified symptoms or conditions should be provided in narrative form. (The use of "cut and paste" narratives is unacceptable. They must be patient specific.)
- X-rays – A panoramic, periapical, or bitewing radiograph illustrating the issue when possible.

In order for orthodontic treatment to be initiated the child must have received a prophylaxis (D1110 or D1120) within six months prior to the placement of appliances. Additionally, all 1st and 2nd molars eligible for sealants must be placed prior to banding. This approach is designed to lessen the occurrence of tooth decay and promote the best possible outcome for the orthodontic treatment.

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Pre-Authorizations for Treatment

What is a Pre-Authorization?

- The process of determining medical necessity for specific services **before** they are **rendered** and is utilized to evaluate the medical necessity of dental care services.

MCNA Pre-authorization determination timeframes:

- Standard requests will be processed within 14 calendar days of receipt.
- Urgent/expedited requests will be processed within three business days of receipt.

Failure to submit a request for pre-authorization and supporting documentation will result in non-payment to the provider for services that require pre-authorization.

Emergency services do not require Pre-Authorization

Requests may be submitted electronically via MCNA's Provider Portal at: http://portal.mcna.net

Or mailed to our office at:

MCNA Utilization Dept.
200 Cypress Creek Road, Suite 500
Fort Lauderdale, FL 33309

For any questions related to Utilization Management call the Provider Hotline at: 1-855-235-6262

- **Faxed Pre-Authorizations are not accepted**

All requests are reviewed by a licensed dentist. Please ensure to include all documentation reflecting medical necessity (x-rays, colored photographs, narrative, etc)

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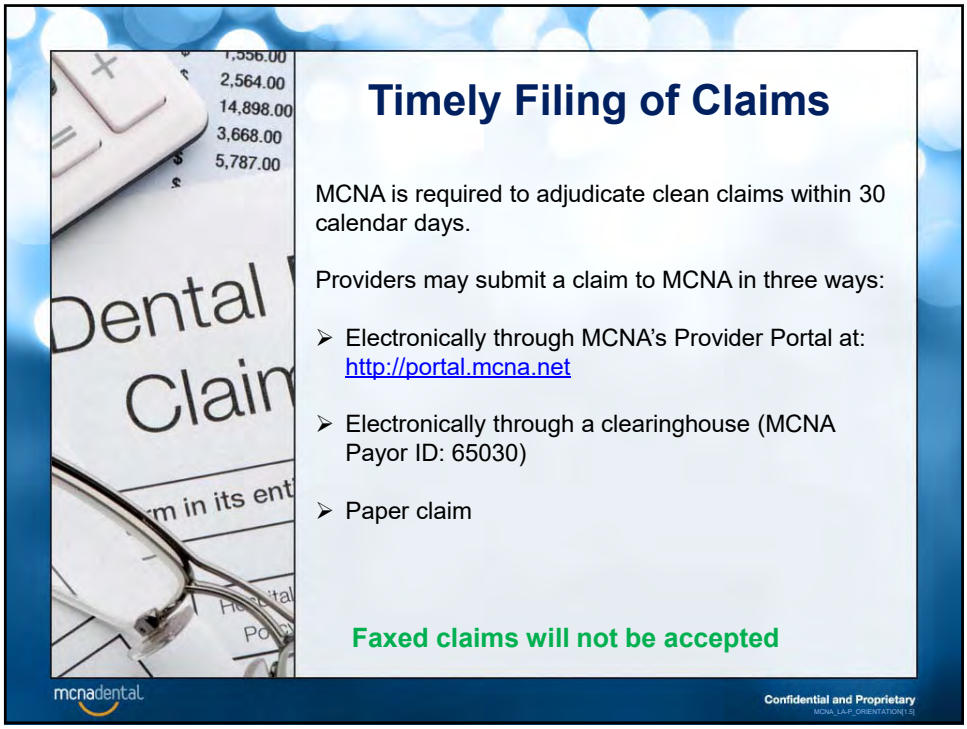
Timely Filing of Claims
MCNA is required to adjudicate clean claims within 30 calendar days.
Providers may submit a claim to MCNA in three ways:
Electronically through MCNA's Provider Portal at: http://portal.mcna.net
Electronically through a clearinghouse (MCNA Payor ID: 65030)
Paper claim
Faxed claims will not be accepted
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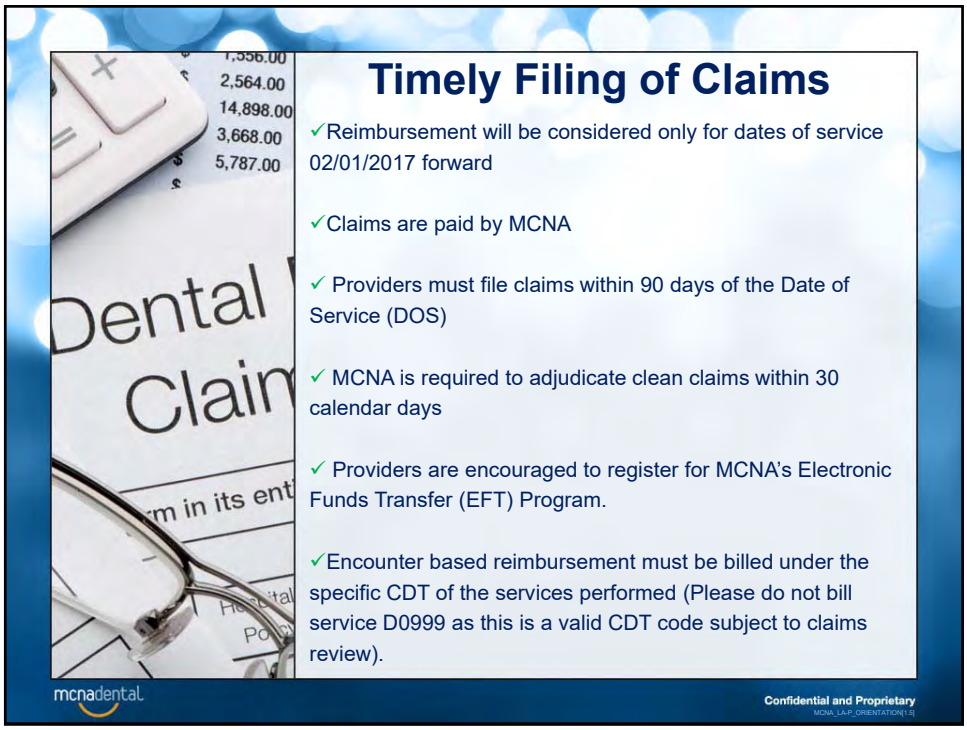
Timely Filing of Claims
✓Reimbursement will be considered only for dates of service 02/01/2017 forward
✓Claims are paid by MCNA
✓ Providers must file claims within 90 days of the Date of Service (DOS)
✓ MCNA is required to adjudicate clean claims within 30 calendar days
✓ Providers are encouraged to register for MCNA's Electronic Funds Transfer (EFT) Program.
✓Encounter based reimbursement must be billed under the specific CDT of the services performed (Please do not bill service D0999 as this is a valid CDT code subject to claims review).
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MCNA Provider Support

Member Outreach

- MCNA's member outreach activities help members better understand their dental benefits and how to appropriately access services within MCNA.
- MCNA's providers can request assistance from our Member Advocate Outreach Specialists to provide additional education to members who need further explanation.
- Providers can refer non-adherent members for additional education regarding their benefits and services by completing a member Outreach Form, which can be found on the Provider Portal.

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Member Outreach Form

The information in this box is required. Please complete all lines.

Member Name:		
ID #:		DOB:
Parent/Guardian Name:		
Phone #:		
MDH Name:		MCNA Provider ID#:
Date of Last Visit:		

An MCNA representative will contact the member to provide education, assist with scheduling appointments, and assist with transportation as needed.

Member is being referred for the following:

O Behind on annual dental visit
O Behind on 6-month follow-up
O Chronic no show for appointments or follow-up care: (please list dates of missed appointments and reason for the appointments) _____
O Member non-compliant with treatment plan
O Member is non-compliant with office policies and behavior is unacceptable
O Member Education Regarding Referral Use
O Referral for services and required follow-up from MCNA Outreach Representative: (please be specific) _____

Comments/Additional information:

MDH Contact Person: _____ MDH Phone #: _____

Date of Request: _____ Date Received (MCNA use): _____

Mail or fax to:

MCNA Dental: Member Advocate Outreach Specialist
PO Box 29008
San Antonio, Texas 78229

If you have questions concerning the use of this form, call the Provider Relations Hotline at 1-855-PRO-MCNA (1-855-776-6262).

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Your Idaho Network / Provider Relations Team

Rene Canales
Director of Network Development
1-800-494-6262 Ext: 591
rcanales@mcna.net

Shannon Hays
Manager of Network Development
and Provider Relations
1-800-494-6262 Ext: 543
shays@mcna.net

Caitlin Lacy
Provider Relations Rep
1-800-494-6262 Ext: 524
clacy@mcna.net

Heaven Thibodeaux
Provider Relations Support
1-800-494-6262
hthibodeaux@mcna.net

Rebecca Poff
Member Advocate & Outreach Manager
1-800-494-6262 Ext: 541
rpoff@mcna.net

Questions and Answers

Thank you!

www.mcnaid.net

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Division of Behavioral Health Update
Idaho Tribes/Idaho Medicaid Meeting
February 15, 2017

Access to Recovery

- We are now in the third and final year of ATR 4 and the program is beginning to wind down. Client referrals for veterans and child protection families will no longer be accepted as of March 1, 2017. Limited referrals for the homeless population may be accepted a little longer, depending on funding availability.

Recovery Coaching

- DBH is no longer in the business of providing Recovery Coach training. Those interested in receiving this training will need to contact Recovery Idaho.

Peer Support Connections Conference 2017

- Last year's peer support connections were so successful that we are doing them again! The planning process has begun. A statewide steering committee has been developed that will act in an advisory capacity to three local conference committees within the three hubs of the state. Each local committee is responsible for organizing its own Peer Support Connections Conference. These conferences will be held in the Fall of 2017. Currently Hub Committee Leads are looking to build their conference organizing committees. Interested individuals may contact the following people to join the conference committee:
    - Northern Hub - Alyia Rushing, 208-770-9746, alyia.rushing@sequelyouthservices.com
    - Southwest Hub - Heather Hieb, 208-703-8728, hhieb@asmh.org
    - Eastern Hub- Rebecca Perrenound, 208-478-9822, missbecca123@aol.com

Respite Care

- Respite Standards for eligibility are being updated to allow that services be provided to all Idaho families with children with SED, not only those who have an open case with DBH Children's Mental Health. Questions? Contact Treena Clark at clarkt@dhw.idaho.gov

Mental Health Awareness Month

- MH Awareness Month will be celebrated in May. DBH will be coordinating a statewide event again this year, honoring Idahoans with mental illness who have made a difference in communities across the state. We will be working with the Behavioral Health Boards in coordinating these activities and encourage the boards to start thinking about nominees – individuals with lived experience who you'd like to see recognized for their contributions. We will be asking for names of nominees by March 31, 2017. Crystal Campbell will be requesting a few minutes of agenda time from each of the boards during February or March to give more details (Rs, 3, 5, 6, 7 in Feb; Rs 1, 2, 4 in March.)

Suicide Prevention Program

- The Mental Health Reform Act recently passed includes the establishment of new adult suicide prevention and intervention program for individuals aged 25 years or old. Grant funding for the program is expected.
- Suicide Prevention Program team is traveling throughout Idaho communities to introduce themselves and discuss their plans for the Zero Suicide initiative. For more information, contact Kira Burgess-Elmer at Kira.Burgess-Elmer@dhw.idaho.gov or 208.334.4944.

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Idaho Department of Health and Welfare/Tribes in Idaho
Quarterly Meeting
Boise, ID
Wednesday, February 15-16, 2017

Division of Public Health - Updates and Opportunities

For more information, please contact:
JamieLou Delavan, Cultural Liaison/Health Equity Program Specialist and Minority Health Coordinator
Project Filter, Bureau of Community & Environmental Health, Division of Public Health
PO Box 83720, Boise, ID 83720-0036
Jamie.Delavan@dhw.idaho.gov Tel: 208-334-0643 or 208-850-0513 (cell)

PROGRAM UPDATES

Division of Public Health
The Division of Public Health site visit with the Public Health Accreditation Board (PHAB) has been scheduled! The site visit will be held on April 25-26th at the central office in Boise. The purpose of the site visit is to provide PHAB the opportunity to acquire a more comprehensive review of the health department through a combination of interviews, meetings with key stakeholders, and visual observations of the health department.

Comprehensive Cancer Control
The cancer section will begin reaching out to individuals/tribal clinics to find out what types of cancer screening activities are happening across Idaho. We will be scheduling either phone or in person meetings. If you have a specific cancer outreach coordinator/contact please let us know to ensure we're reaching out to the right people. Contact Charlene Cariou, Health Program Manager, Comprehensive Cancer Control 208.332.7344 Charlene.Cariou@dhw.idaho.gov

Idaho specific cancer materials are available for order at http://healthtools.dhw.idaho.gov/ (these materials are meant for PUBLIC distribution).

Updated Cancer in Idaho factsheets are available at (these are meant for PROFESSIONAL distribution):
http://healthandwelfare.idaho.gov/Health/DiseasesConditions/Cancer/ColonCancer/tabid/699/Default.aspx#tabs_dnn_ctr14885_JQueryTabs-2

Question: What type of health coverage do enrolled tribal members have access to related to cancer screenings? What type of information/education can Women's Health Check provide to help with increasing screening for those who don't have health coverage?

Funding Opportunities

Diabetes and Hypertension Improvement Project
The Bureau of Community and Environmental Health's Diabetes, Heart Disease and Stroke Programs (DPCP/HDSP) will have funding available to support the Tribal Health Systems in implementing activities related to hypertension and diabetes control for the upcoming fiscal year (July 1, 2017 – June 29, 2018). We will be soliciting workplans and budgets from the Tribal Health Systems to develop contracts to support the proposed work. Activities funded by this process

shall commence on or about July 1, 2017 and must be completed by June 29, 2018. We anticipate having approximately **$10,000 available per Tribal Health** organization to support activities to achieve the goals stated below.

Tribes are asked to select at least one or more of the following strategies:

- Increase access to Diabetes Self-Management Education (DSME) in the primary care setting by becoming American Diabetes Association (ADA) Recognized or American Association of Diabetes Educators (AADE)-Accredited Program.
- Increase community awareness of prediabetes among people at high risk for type 2 diabetes and increase the number of primary care staff who receive prediabetes training specific to their position.
- Increase access to the Diabetes Prevention Program (DPP) in the primary care setting by developing and implementing a standardized referral process for patients with prediabetes or patients at high risk to develop diabetes.
- Increase the effective use of electronic health records (EHR) and health information technology (HIT) to ensure that all hypertensive, diabetic and prediabetic patients are identified.
- Increase use of team-based care for hypertension and diabetes control (including the use of evidence-based community resources for hypertension and/or diabetes control such as: DSME, CDC-recognized DPP, Weight Watchers and TOPS).
- Increase use of quality improvement activities (i.e. PDSA cycles or other quality improvement process) for hypertension and diabetes control;
- Increase use of self-measured blood pressure monitoring tied with clinical support;
- Promote participation and increase proportion of people with diabetes who have at least one encounter at a DSME program.
- Increase access to DSME programs in community settings.
- Increase access to the National DPP for the primary prevention of type 2 diabetes.

Please request a copy of last year's proposal packet for examples of workplans by strategy. For more information, please contact Nicole Stickney, Health Program Specialist at 208.334.5610 or nicole.stickney@dhw.idaho.gov

Offers of Technical Assistance

Radon
For assistance/training in radon testing and mitigation contact Jim Faust, Indoor Environment Program Manager (208) 334-5717

Public Health Business Office
Is everything going perfectly or are there a few things you would like to improve? If you feel some targets are not being met or some processes could be better, we would like to help. The Division of Public Health is offering technical assistance to tribes on **performance management and quality improvement**. Dan Ward, Performance Improvement Manager, has an extensive PM/QI background with years of experience in helping organizations become more efficient and effective in their work. If you need more information or would like technical assistance, please contact:

Dan Ward, MPA
Performance Improvement Manager - Division of Public Health
Daniel.Ward@dhw.idaho.gov (208) 334-6563

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Other Opportunities

Trainings and Conferences

Annual Clinical STD Update
August 9, 2017 -Spring Hill Suites on Park Center, Boise

This is a one-day; in-person training and CEUs are available. Anyone with an interest in the clinical "updates" around STDs is welcome to attend. Our program can offer stipends to help cover the $150 registration fee. If interested, contact Diana Gardner, STD Prevention Program Specialist, directly regarding registration and stipend information.
208.334.5785 or diana.gardner@dhw.idaho.gov

Basic information on the STD Update training:
University of Washington's Prevention Training Center - 1 Day Clinical STD Update For Healthcare Staff in Idaho
This 1-day didactic STD Update course provides participants with training in the most recent advancements in the epidemiology, diagnosis, and management of viral & bacterial STDs. An optional 2-day clinical practicum is available to participants who complete this Update.

Topics include (subject to change):
· Update on 2015 CDC STD Treatment Guidelines | Christine Johnston, MD, MPH
· Update on Gonorrhea and Chlamydia | Laura Quilter, MD
· Update on Human Papillomavirus | Sue Szabo, PA-C
· Syphilis: Clinical Refresher and Update in Epidemiologic Trends and Diagnosis | Sue Szabo, PA-C
· HIV-1 Pre-Exposure Prophylaxis | Brian Wood, MD

Course participants will learn how to:
√ Describe the latest clinical and lab diagnostic and testing procedures for the infections covered.
√ List the current recommended treatments, follow-up, and prevention messages for the sexually transmitted infections covered.

Six credit hours available**.**

Shot Smarts Immunization Conference – The conference will provide updates and education to healthcare providers, nurses, and office staff about immunization best practices. www.immunizeidaho.com for more information.

- Monday, April 24, 2017 – Pocatello (ISU)
- Wednesday, April 26, 2017 – Boise (BSU)
- Friday, April 28, 2017 – Coeur d'Alene (NIC)

Booster Shots Workshops:

- September 12, 2017 – Twin Falls
- September 13, 2017 – Idaho Falls
- September 26, 2017 – Lewiston
- September 27, 2017 – Ponderay
- October 11, 2017 – Caldwell
- October 12, 2017 - McCall

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Collaborating for Health Conference:
October 24-25, 2017, Riverside Hotel, Boise. Pre-conference coalition meetings on October 24.
Topics include: Policy, Systems and Environmental Change; Population Health; Adverse Childhood Experiences; Health Equity; Healthcare Transformation and Evaluation

Comprehensive Cancer Alliance of Idaho:

- Sign up for newsletters at http://eepurl.com/ctuGJb
- Annual Update Webinar – March 2, 2-3pm (MT), sign up for listserv to stay in the loop!

Colorectal Cancer Roundtable:

- Newsletter sign up at http://eepurl.com/cm8CKb
- Webinar - *"What is 80% by 2018"* February 22, 2-3pm (MT) Webinar registration: HERE

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

MATT WIMMER - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

January 20, 2017

Dear Tribal Representative:

The purpose of this letter is to give notice that Idaho Medicaid intends to submit a State Plan Amendment (SPA). Idaho's Alternative Benefit Plans (ABPs) are indexed to a Base Benchmark Plan selected by Idaho Medicaid, the Preferred Blue PPO Small Group Plan, offered by Blue Cross of Idaho Health Service, Inc. (BCI). Although this SPA is intended to align the ABPs with minor changes made in 2014 to the Base Benchmark Plan, the amendment is not expected to result in any significant and material changes to member benefits under the State Plan.

We intend to submit the SPA no later than March 31, 2017. The effective date of these changes is January 1, 2017.

The bulk of the changes are to align Idaho's Alternative Benefit Plans (ABPs) with revisions by BCI to the Lifetime Limits, Amount Limits, Authorization Requirements, and/or Scope Limits for certain benefits being offered under this plan. Other changes to the ABPs are being made to clarify benefits or policies, to reflect amendments to federal regulations or state administrative rules, or to correct typographical or technical errors in the current versions on file.

Idaho Medicaid's development of the proposed SPA will be reviewed as part of the Policy Update at the next quarterly Tribal meeting, tentatively scheduled for February 16, 2017. Idaho Medicaid is interested in receiving your comments, questions, or suggestions relating to this change. Should you have questions about this letter or the upcoming SPA submission, please contact Clay Lord at (208) 364-1979 or by e-mail at Clay.Lord@dhw.idaho.gov prior to February 28, 2017.

Sincerely,

Matt Wimmer

MATT WIMMER
Administrator

MW/cl

LEGAL NOTICE

Pursuant to 42 CFR §440.386 and 42 CFR §440.345, and in compliance with the provisions of section 5006(e) of the ARRA of 2009, the Department of Health and Welfare is giving public notice of an impending change in the Idaho Medicaid State Plan.

Idaho Medicaid intends to submit State Plan Amendments in order to update three Alternative Benefit Plans (ABPs): the Basic ABP, the Enhanced ABP, and the Medicare-Medicaid Coordinated Plan ABP. These Alternative Benefit Plans must be updated to reflect changes to Idaho's Base Benchmark Plan, the Preferred Blue PPO Small Group Plan, effective date March 1, 2014, offered by Blue Cross of Idaho Health Service, Inc. (BCI). The bulk of the changes are to align the ABPs with revisions by BCI to the Lifetime Limits, Amount Limits, Authorization Requirements, and/or Scope Limits for certain benefits being offered under this plan. Other changes to the ABPs are being made to clarify benefits or policies, to reflect amendments to federal regulations or state administrative rules, or to correct typographical or technical errors in the current versions on file.

The effective date of these changes is January 1, 2017.

No public hearings have been scheduled at this time.

For technical questions or to review the changes, call Clay Lord at (208) 364-1979, or email the request to Clay.Lord@dhw.idaho.gov.

Written comments may also be sent to and reviewed by the public at the following address:

Bureau of Medical Care
Division of Medicaid
Department of Health and Welfare
3232 Elder Street
Boise, Idaho 83705
Phone (208) 364-1979; Fax (208) 334-2465

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February 13, 2017

Dear Tribal Representative:

The purpose of this letter is to give notice that Idaho Medicaid intends to submit a State Plan Amendment (SPA) related to the reimbursement of Medicaid providers that deliver drugs and pharmacy services to Medicaid participants. These revisions are necessary in order to comply with changes to federal regulations at 42 CFR 447 that became law with the 2016 passage of the Covered Outpatient Drug final rule.

While this SPA will impact reimbursements to pharmacies, health facilities dispensing physician-administered drugs, and certain Medicaid providers operating as 340B covered entities, the amendment is not expected to result in any significant and material changes to member benefits under the State Plan.

Most of the changes to the State Plan are intended to clarify the Department of Health and Welfare's use of the appropriate pricing methodologies to provide reimbursement to Medicaid providers, including pharmacies, health clinics, and 340B covered entities. The remainder of the changes will help to align State Plan language and definitions with recent modifications to federal regulations.

We intend to submit the SPA no later than June 30, 2017. The effective date of these changes is April 1, 2017.

Idaho Medicaid's development of the proposed SPA will be reviewed as part of the Policy Update at the next quarterly Tribal meeting, tentatively scheduled for February 15, 2017. Idaho Medicaid is interested in receiving your comments, questions, or suggestions relating to this change. Should you have questions about this letter or the upcoming SPA submission, please contact Clay Lord at (208) 364-1979 or by e-mail at Clay.Lord@dhw.idaho.gov prior to March 31, 2017.

Sincerely,

Matt Wimmer

MATT WIMMER
Administrator

MW/cl

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Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

March 9, 2017

Dear Tribal Representative:

In accordance with section 1902(a)(73)(A) of the Social Security Act regarding the solitation of advice prior to the submission of any Medicaid State Plan Amendment (SPA) or waiver likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations, the Idaho Department of Health and Welfare (Idaho Medicaid) provides notice on the following matter.

Purpose
Idaho Medicaid intends to submit applications to the Centers for Medicare and Medicaid Services (CMS) prior to June 30, 2017 to renew the Aged and Disabled (A&D) and Adult Developmental Disabilities (DD) Home and Community-Based Services (HCBS) waivers.

Idaho Medicaid's currently approved waivers will expire on September 30, 2017. The proposed changes to the existing waivers are expected to include:

- Revisions to the reimbursement methodology for Residential Habilitation – Supportive Living services (prior notice and opportunity to comment regarding this change for the A&D HCBS waiver was given on August 19, 2016 and for the DD HCBS waiver was given on August 12, 2016);
- Updated cost projections and expected utilization of waiver services, based on historical trends; and
- Other minor revisions to clarify grammar and language.

Anticipated Impact on Indians/Indian Health Program/Urban Indian Organizations
Indians receiving waiver services may be impacted by these changes. There is no anticipated impact on Indian Health Programs, or Urban Indian Organizations.

Availability for Review
Idaho Medicaid is in the process of drafting the waiver renewal applications, and will notify Tribal Representatives when these drafts become available for review.

Comments and Questions
Idaho Medicaid will make drafts of the proposed waiver renewal text available for tribal review and comment. This tribal comment period is expected to begin in early April 2017, and will continue for a period of at least 30 days. Idaho Medicaid will notify Tribal Representatives of the specific dates prior to the start of the comment period.

If you have any questions prior to the start of the official comment period, you may email Idaho Medicaid at HCBSWaivers@dhw.idaho.gov or call Ali Fernández at (208) 287-1156 for questions pertaining to the A&D HCBS waiver renewal and Karen Westbrook at (208) 364-1960 for questions pertaining to the DD HCBS waiver renewal.

Idaho Medicaid's renewal of the HCBS waivers will be reviewed as part of the Policy Update at the next quarterly Tribal meeting.

Sincerely,

MATT WIMMER
Administrator

MW/kw

MCNA QUICK REFERENCE GUIDE AND CONTACT INFORMATION - IDAHO SMILES PROGRAM 2017

MCNA DENTAL CONTACT INFORMATION

MCNA Member Hotline	(855) 233-6262
MCNA Provider Hotline	(855) 235-6262
Hearing Impaired (TTY)	(800) 377-3529
MCNA Fraud Hotline	(855) 392-6262

MCNA ADDRESS

Billing Address	4400 NW Loop 410, Ste 250, San Antonio, TX 78229
Mailing Address	PO Box 29008, San Antonio, TX 78229

Please indicate the department when mailing.

CLAIMS SUBMISSION

MCNA's Provider Portal	https://portal.mcna.net/
Clearinghouse Submission	Payor ID: 65030
ADA Claim Form (2012 or newer)	**MCNA Dental** **Attn: Claims Department** 200 West Cypress Creek Road Suite 500 Fort Lauderdale, FL 33309

IMPORTANT LINKS

MCNA ID Website	http://www.mcnaid.net
Provider Manual	http://manuals.mcna.net/idaho
Provider Portal	https://portal.mcna.net
Online Credentialing	https://credentialing.mcna.net
Credentialing Email	mcnacredentialing@mcna.net
Utilization Management Email	um_id_group@mcna.net

PROVIDER PORTAL INFORMATION

Visit MCNA's Portal at **https://portal.mcna.net/** and register using the following:

Facility ID / Office ID	Five digit number provided by MCNA on Welcome Letter
Work Phone	Office Phone Number
Federal ID	Office Tax ID Number
5 Digit Zip Code	Office Zip Code
First Name	User's First Name
Last Name	User's Last Name
Email Address	User's email address (will be user name)

For more information on portal registration, verification of eligibility, claims/pre-authorizations/referral submission and more, watch our Provider Portal tutorial videos at: http://youtube.com/MCNADental

MCNA QUICK REFERENCE GUIDE AND CONTACT INFORMATION - IDAHO SMILES PROGRAM 2017

IMPORTANT TIME FRAMES

Claims Submission	90 days from date of service
Claims Turnaround	30 days from date of receipt
Referral Turnaround	14 calendar days from date of receipt
Pre-Authorization/ Referral Expiration	180 days from approval
Pre-Authorization Turnaround	Standard Requests: 14 calendar days from date of receipt Urgent Requests: 3 business days from date of receipt

ACCESS & AVAILABILITY STANDARDS

Emergency Care	Immediate
Urgent Care	Within 24 hours of request
Non-Urgent Care	Within 7 calendar days of request
Preventive Care	Within 45 calendar days of request

MCNA PROVIDER ISSUE ESCALATION AND RESOLUTION

Tier 1 Escalation: Provider Hotline	1-855-235-6262 provider_hotline_leadership@mcna.net
Tier 2 Escalation: Provider Relations Representative	**Caitlin Lacy** clacy@mcna.net idahopr@mcna.net
Tier 3 Escalation: Provider Relations Management	**Shannon Hays** shays@mcna.net

MCNA MEMBER ISSUE ESCALATION AND RESOLUTION

Tier 1 Escalation: Member Services	1-855-233-6262
Tier 2 Escalation: Member Advocate Outreach Specialist	**Lisa Guzman** lguzman@mcna.net
Tier 3 Escalation: Member Advocate Outreach Specialist Management	**Rebecca Poff-Galloway** rpoff@mcna.net

We sincerely appreciate your partnership in the Idaho Smiles Medicaid Program.
Please contact us at idahopr@mcna.net with any additional questions, concerns or feedback.

Lisa Griggs

From: Laura Platero
Sent: Friday, February 24, 2017 1:22 PM
To: Lisa Griggs
Subject: New Oregon ACA website & Governor/State responses to Congressional inquiries

Lisa, Please send to Oregon delegates, THDs and Clinic Directors.

The State launched a new website on the benefits of the ACA in Oregon which is now available at: http://www.95percentoregon.com. We learned last week that Congressional representatives sent inquiries to all of the Governors and insurance commissioners on health care reform late last year and early this year. Governor Brown and/or other state leadership responded to these letters and they are available at this link: http://www.95percentoregon.com/news-and-updates.html.

Please contact Laura Platero if you have any questions at lplatero@npaihb.org.

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