Tracker of Pending Federal Healthcare Regulations, Legislation, and Submitted Comments
4/10/2018

Title/Agency Action/Regulation Link	Agency release date; due date for comments	Agency's Summary of Action	Notes:
PRIORITY HEALTH CARE REGULATIONS, POLICIES and BULLETINS			
Final 2019 HHS Notice of Benefits and Payment Parameters (CMS-9930-F) **AGENCY: CMS** **Final Rule** https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-07355.pdf	Published: 4/9/2018 Effective:	This final rule sets forth payment parameters and provisions related to the risk adjustment and risk adjustment data validation programs; cost-sharing parameters; and user fees for Federally-facilitated Exchanges and State Exchanges on the Federal platform. It finalizes changes that provide additional flexibility to States to apply the definition of essential health benefits (EHB) to their markets, enhance the role of States regarding the certification of qualified health plans (QHPs); and provide States with additional flexibility in the operation and establishment of Exchanges, including the Small Business Health Options Program (SHOP) Exchanges. It includes changes to standards related to Exchanges; the required functions of the SHOPs; actuarial value for stand-alone dental plans; the rate review program; the medical loss ratio program; eligibility and enrollment; exemptions; and other related topics. To allow insurers to offer more affordable health plans, CMS is providing states with additional flexibility in how they select their EHB-benchmark plan. The final rule provides states with substantially more options in what they can select as an EHB-benchmark plan. Instead of being limited to 10 options, states will now be able to choose from the 50 EHB-benchmark plans used for the 2017 plan year. The final rule returns important oversight authority to states regarding state review of network adequacy, and eases burden on issuers related to essential community providers. The rule also eliminates the meaningful difference requirement for QHPs to give insurers more flexibility in designing plans. Exchanges will be able to make a determination of lack of affordable coverage based on projected income using the lowest cost Exchange metal level plan offered through the Exchange when there is no bronze level plan available in the service area. he final rule improves program integrity by requiring Exchanges to implement stronger checks to verify applicants actually earn the income they claim to qualify for APTCs. The rule also requires Exchanges to	CMS Press Release 2019 Letter to Issuers in the FFM

		discontinue APTCs for enrollees who fail to file taxes and reconcile past APTCs, even if the Exchange does not first send notice directly to the tax filer.	
CMS Lowers the Cost of Prescription Drugs for Medicare Beneficiaries for Calendar Year (CY) 2019 2019 Medicare Advantage and Part D Rate Announcement and Call Letter https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf	Published: 4/2/2018	CMS finalized polices for Medicare health and drug plans for 2019 that will save Medicare beneficiaries money on prescription drugs while offering additional plan choices. The final policies announced today further the Trump Administration's commitment to lowering drug prices. CMS is finalizing a reduction in the maximum amount that low-income beneficiaries pay for certain innovative medicines known as "biosimilars." Other actions that CMS is finalizing to lower the cost of prescription drugs include: • Allowing for certain low-cost generic drugs to be substituted onto plan formularies at any point during the year, so beneficiaries immediately benefit and have lower cost sharing. • Increasing competition among plans by removing the requirement that certain Part D plans have to "meaningfully differ" from each other, making more plan options available. • Increasing competition among pharmacies by clarifying the "any willing provider" requirement, to increase the number of pharmacy options that beneficiaries have. These policies provide Medicare with additional tools to combat opioid overprescribing and abuse, and to protect families and communities across the nation. For example, CMS is finalizing a new authority that permits Part D sponsors to require beneficiaries at risk of addiction or overuse to use only selected prescribers or pharmacies for opioid prescriptions. As part of today's announcement and guidance, the agency is reinterpreting the standards for health-related supplemental benefits in the Medicare Advantage program to include additional services that increase health and improve quality of life, including coverage of non-skilled in-home supports and other assistive devices. CMS is expanding the definition of "primarily health related." Under the new definition, the agency will allow supplemental benefits if they compensate for physical impairments, diminish the impact of injuries or health conditions, and/or reduce avoidable emergency room utilization.	
CMS Finalizes Policy Changes and Updates	Published:	This final rule will revise the Medicare Advantage (MA) program (Part C)	Fact Sheet

for Medicare Advantage and the Prescription Drug Benefit Program for Contract Year 2019 (CMS-4182-F) **AGENCY: CMS** **Final Rule** https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-07179.pdf	4/2/2018 **Effective: 6/16/2018**	regulations and Prescription Drug Benefit program (Part D) regulations to implement certain provisions of the Comprehensive Addiction and Recovery Act (CARA) to further reduce the number of beneficiaries who may potentially misuse or overdose on opioids while still having access to important treatment options; implement certain provisions of the 21st Century Cures Act; support innovative approaches to improve program quality, accessibility, and affordability; offer beneficiaries more choices and better care; improve the CMS customer experience and maintain high beneficiary satisfaction; address program integrity policies related to payments based on prescriber, provider and supplier status in MA, Medicare cost plan, Medicare Part D and the PACE programs; provide an update to the official Medicare Part D electronic prescribing standards; and clarify program requirements and certain technical changes regarding treatment of Medicare Part A and Part B appeal rights related to premiums adjustments.	
60 Day Proposed Information Collection: Indian Health Service Purchased/Referred Care Proof of Residency **AGENCY: IHS** **Notice and request for comments** https://www.gpo.gov/fdsys/pkg/FR-2018-03-30/pdf/2018-06521.pdf	Published: 3/30/2018 **Due Date: 5/30/2018**	This is a new information request for a three-year approval of this new information collection, 0917– XXXX. Forms: Purchase/Referred Care Proof of Residency. Title of Proposal: Purchased/Referred Care Program. Need and Use of Information Collection: The IHS PRC Program needs this information to certify that health care services requested and authorized by the IHS have been provided to individuals who have provided documentation that meets the eligibility requirements to receive medical services from PRC provider(s); and to serve as a legal document for health and medical care authorized by the IHS and rendered by health care providers under contract with the IHS.	
Medicaid Program; Announcement of Medicaid Drug Rebate Program National Rebate Agreement **AGENCY: CMS** **Final notice** https://www.gpo.gov/fdsys/pkg/FR-2018-03-23/pdf/2018-05947.pdf	Published: 3/23/2018 **Effective: 3/23/2018**	This final notice announces changes to the Medicaid National Drug Rebate Agreement (NDRA, or Agreement) for use by the Secretary of the Department of Health and Human Services (HHS) and manufacturers under the Medicaid Drug Rebate Program (MDRP). We are updating the NDRA to incorporate legislative and regulatory changes that have occurred since the Agreement was published in the February 21, 1991 Federal Register (56 FR 7049). We are also updating the NDRA to make editorial and structural revisions, such as references to the updated Office of Management and Budget (OMB)-approved data collection forms and electronic data reporting.	
Medicaid Program; Methods for Assuring Access to Covered Medicaid Services – Exemptions for States with High Managed Care Penetration Rates and Rate Reduction Threshold **AGENCY: CMS**	Published: 3/23/2018 **Due Date: 5/22/2018**	This proposed rule would amend the process for states to document whether Medicaid payments in fee-for-service systems are sufficient to enlist providers to assure beneficiary access to covered care and services consistent with the statute. States have raised concerns over the administrative burden associated with the current requirements, particularly for states with high rates of Medicaid managed care enrollment. This proposed rule would provide burden relief and address those concerns.	CMS Press Release Provides state flexibility from certain regulatory access to care requirements within the Medicaid program. Exempts states

Proposed Rule https://www.gpo.gov/fdsys/pkg/FR-2018-03-23/pdf/2018-05898.pdf		Current regulations at 42 CFR 447.203(b) require states to develop and submit to CMS an access monitoring review plan (AMRP) for Medicaid services provided through a fee-for-service (FFS) delivery system. The AMRP must be updated at least every 3 years and address the following categories of Medicaid services: Primary care services (including those provided by a physician, federally qualified health center (FQHC), clinic or dental care); physician specialist services (for example, cardiology, radiology, urology); behavioral health services (including mental health and substance use disorder); pre- and post-natal obstetric services (including labor and delivery); and home health. Section 447.204 requires states to undertake a public process and submit specific information regarding access to care when proposing to reduce or restructure Medicaid provider payment rates. This proposed rule would provide an exemption to the regulatory requirements in §§ 447.203(b)(1) through (6) and 447.204(a) through (c) for states with comprehensive, risk-based Medicaid managed care enrollment rates above 85 percent of the total covered population under a state's Medicaid program, including managed care comprehensive risk contracts under a state's section 1115 Medicaid demonstration. The proposed rule would also provide an exemption to the regulatory requirements in §§ 447.203(b)(6) and 447.204(a) through (c) for states that submit state plan amendments (SPAs) to reduce rates or restructure payments where the overall reduction is 4 percent or less of overall spending within the affected state plan service category for a single state fiscal year (SFY) and 6 percent or less over 2 consecutive SFYs. Additionally, the proposed rule would modify the requirements in § 447.204(b)(2) so that, for SPAs that reduce or restructure Medicaid payment rates, states would be required to submit to CMS an assurance that data indicates current access is consistent with requirements of the Social Security Act (the Act) instead of an analysis anticipating the effects of a proposed change in payment rates or structure. Under the proposal, states would not have to analyze and monitor access to care if an overwhelming share of covered lives received care through managed care plans. The rule would also make it easier for all states to make minor cuts to fee-for-service payment rates.	from requirements to analyze certain data and monitor access when the vast majority receive services through managed care plans. Similar flexibility for states when they make nominal rate reductions to fee-for-service payment rates. • States with an overall Medicaid managed care penetration rate of 85% or greater (currently, 17 States) would be exempt from most access monitoring requirements. • Reductions to provider payments of less than 4% percent in overall service category spending during a State fiscal year (and 6% over two consecutive years) would not be subject to the specific access analysis.. • When states reduce Medicaid payment rates, they would rely on baseline information regarding access under current payment rates, rather than be required to predict the effects of rate reductions on access to care, which states have found very difficult to do.
CMS Finalizes Coverage of Next Generation	Published:	CMS finalized a National Coverage Determination that covers diagnostic	

Sequencing Tests, Ensuring Enhanced Access for Cancer Patients https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-03-16.html	3/16/2018	laboratory tests using Next Generation Sequencing (NGS) for patients with advanced cancer (i.e., recurrent, metastatic, relapsed, refractory, or stages III or IV cancer). CMS believes when these tests are used as a companion diagnostic to identify patients with certain genetic mutations that may benefit from U.S. Food and Drug Administration (FDA)-approved treatments, these tests can assist patients and their oncologists in making more informed treatment decisions. Additionally, when a known cancer mutation cannot be matched to a treatment then results from the diagnostic lab test using NGS can help determine a patient's candidacy for cancer clinical trials. CMS issued a proposed NCD for NGS cancer diagnostics. F1CDx™ is the first breakthrough-designated, NGS-based in vitro diagnostic test that is a companion diagnostic for 15 targeted therapies as well as can detect genetic mutations in 324 genes and two genomic signatures in any solid tumor.	
Short-Term Limited-Duration Insurance **AGENCY: CMS, HHS, IRS, Treasury, DOL** **Proposed Rule** https://www.gpo.gov/fdsys/pkg/FR-2018-02-21/pdf/2018-03208.pdf	Published: 2/21/2018 **Due Date: 4/23/2018**	HHS issued a proposed rule that expands the availability of short-term health insurance by allowing the purchase of plans providing coverage for up to 12 months, the latest in the Trump administration's plans to weaken the Affordable Care Act. The action builds off a request for information by HHS last June on ways to increase affordability of health insurance. The current maximum period for such plans is less than three months, a change made by the Obama administration in 2016. The proposed rule would mark a return to the pre-2016 era, but CMS noted that it is seeking comment on offering short-term plans for periods longer than 12 months. Consumers buying these short-terms plans could lose access to certain healthcare services and providers and experience an increase in out-of-pocket expenditures for some patients, according to the proposal. The short-term plans "would be unlikely to include all the elements of ACA-compliant plans, such as the preexisting condition exclusion prohibition, coverage of essential health benefits without annual or lifetime dollar limits, preventive care, maternity and prescription drug coverage, rating restrictions and guaranteed renewability," according to the proposed rule. The Trump administration argues that expanding access to short-term plans is increasingly important due to rising premiums in the individual markets. The American Hospital Association and Association for Community Affiliated Plans also slammed the short-term plans, saying they would increase the cost of comprehensive coverage. "Short-term, limited-duration health plans have a role for consumers who experience gaps in coverage. They are not unlike the small spare tire in a car: they get the job done for short periods of time, but they have severe limitations and you'll get in trouble if you drive	CMS Fact Sheet: Short-Term, Limited-Duration Insurance Proposed Rule HHS Press Release Healthcare Dive Brief Blue Cross of Idaho Offers New Choices in State-Based Health Insurance Plans CMS Letter to Idaho regarding Bulletin No. 18-01

		too fast on them," ACAP CEO Margaret Murray said in a statement. America's Health Insurance Plans has stated that they are concerned that the use of short-term policies could further fragment the individual market, which would lead to higher premiums for many consumers. HHS anticipates most individuals switching from individual market plans to short-term coverage plans would be relatively young or healthy and not eligible to receive ACA's premium tax credits.	
		IHS DEAR TRIBAL LEADER LETTERS	
IHS Efforts to Expand the Community Health Aide Program (CHAP); 1) formation of CHAP Tribal Advisory Group, and 2) develop formal policy and implementation plan https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/2018_Letters/DTLL_02272018.pdf	Published: 2/27/2018	Provides updates on the efforts to expand the Community Health Aide Program (CHAP) including: 1) formation of the CHAP Tribal Advisory Group (TAG), and 2) developing the formal policy and implementation plan. The CHAP TAG will focus on addressing the next steps, which will include providing subject matter expertise, program information, innovative solutions, and advice to the IHS to establish the national CHAP. The IHS Area Directors are soliciting nominations for one primary and one alternate to serve on the CHAP TAG. As with all advisory groups chartered by the IHS, this body will operate under the Intergovernmental Exemption of the Federal Advisory Committee Act as authorized by the Unfunded Mandates Reform Act (2 U.S.C. § 1534(b)). The CHAP TAG will be comprised of elected Tribal Leaders from all 12 IHS Areas. The IHS adopted the recommendation from the IHS Direct Service Tribes and Tribal Self-Governance Advisory Committees to utilize their Tribal Chairs on the CHAP TAG. The IHS will convene a two-day, in-person meeting of the CHAP TAG from March 21 - 22, 2018.	• IHS CHAP Workgroup Portland Area Representatives: Portland Primary Delegate: John Stephens, Swinomish Tribal Health Director Portland Alternate Delegate: NPAIHB Chairman Andy Joseph, the Confederated Tribes of Colville IHS_CHAP_Updates.pdf
IHS Launches National Accountability Dashboard https://www.ihs.gov/newsroom/ihs-blog/february2018/ihs-launches-national-accountability-dashboard-for-quality/ **Submit Comments:** https://www.ihs.gov/quality/contactus/	Published: 2/20/2018	In October, IHS announced a new tool to monitor and report information from across IHS. The National Accountability Dashboard for Quality will enable IHS to report on key performance data in a display to monitor and improve quality of care. The dashboard has been updated with data from the last three months of 2017. The dashboard will monitor and report information on compliance with IHS policy requirements, accreditation standards, or regulations at hospitals and ambulatory health centers. The tool also supports oversight and management and will allow IHS to	• Efforts in response to Government Accountability Office (GAO) including IHS and Indian programs in High Risk List in May 2017

		make fact-based decisions to ensure quality and safety of care. In the future, the dashboard will reflect the most important requirements for IHS facilities. The dashboard currently tracks issued related to quality of care, including safety reporting, emergency preparedness, opioid policy, patient-centered medical home programs, and other factors. The dashboard came about as part of the development of IHS's 2016-2017 Quality Framework, to support the agency's oversight and quality management functions. IHS is accepting feedback on the dashboard from tribal leaders, partner organizations, IHS staff and the public: https://www.ihs.gov/quality/contactus/	
Update on the Progress of the Indian Health Service (IHS) Strategic Planning Workgroup activities **AGENCY: IHS** https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/2017_Letters/DTLL_DUIOLL_StrategicPlanUpdate_12292017.pdf	Published: 12/29/2017	IHS is writing to update tribes on the progress of the IHS Strategic Planning Workgroup and timeline on the IHS draft Strategic Plan 2018-2022. The Workgroup has met several times to develop objectives, strategies and measures for each goal in the Strategic Plan. **The anticipated completion date for the Workgroup to produce a draft Strategic Plan will be the end of January 2018. IHS will then initiate a 30-day public comment period for tribes to comment on the draft Strategic plan. IHS will hold a National All Tribal and Urban Leader Call to share updates and provide a forum for comments on the draft Strategic plan. IHS expects the final IHS Strategic Plan to be completed and published in April 2018.** IHS has accepted the tribal recommendation and request from several Workgroup members for additional time for the Workgroup to consider IHS-operated, tribally-operated, and Urban health care environments. The additional time and meetings have been added to the Workgroup schedule.	• Anticipated completion date for the draft Strategic Plan 2018-2022 will be the end of January. **The final IHS Strategic Plan should be completed and published in April 2018.** • Progress and meeting minutes can be found on the IHS Strategic Planning web page: https://www.ihs.gov/dper/planning/strategicplanning. • IHS continues to accept comments throughout the Strategic Planning process.

			 NPAIHB IHS Strategic Plan 2018-2022 Comı
CSC Policy Update to the Indian Health Service (IHS) Health Manual, Part 6 – Services to Tribal Governments and Organizations, Chapter 3- Contract Support Costs (CSC) **AGENCY: IHS** https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/2017_Letters/59018-1_DTLL_12212017.pdf	Published: 12/21/2017 **Effective: 12/21/2017**	Effective immediately, the IHS has decided to temporarily rescind § 6-3.2E(3) – Alternative Methods for Calculating Indirect Costs Associated with Recurring Service Unit Shares of the CSC policy. The IHS will initiate Tribal Consultation in the near future regarding this provision prior to making a final decision on how to amend the CSC policy. The guiding principle states that it will be reassessed on a regular basis and changes will be implemented after tribal consultation. IHS will seek input from the CSC Workgroup no later than mid-January 2018. This section of the CSC policy, often referred to by Federal and Tribal ISDEAA negotiators as the "97/3 Split" or "97/3 Method," permits a Tribe or Tribal organization to exercise the option for "Service Unit level shares" that is similar to the option that previously applied only to "Area" and "Headquarters" level shares. In sum, this option in the policy provides an alternative method for use in determining the amount in a Tribe's or Tribal organization's indirect cost pool that is associated with transferred programs, functions, services, or activities already funded by the Secretarial amount, as defined by the ISDEAA. After a year of implementing the revised CSC policy, the IHS has found that in certain circumstances, this option yields a result that is inconsistent with statutory authority.	• ISDEAA statutory authority. • IHS will seek input from the CSC Workgroup no later than mid-January 2018. • , the tribal side originally proposed a duplication offset somewhere in the 1-1.5% range and IHS was somewhere in the 10% range. Once the tribal side brought up the substantial amount of third-party revenues that support many of these programs and the fact that IHS's assumptions seemed to ignore other funding sources, that is when IHS started moving downwards, eventually agreeing to 3%, which the agency said was the lowest number they could agree to based on their look at actual data.

			• Update will be provided during the next IHS All Tribal Leader and Urban Indian Organization Leader Call.
In the Spring of 2018 the Indian Health Service will initiate a Tribal Consultation on the Draft Sanitation Deficiency System-Guide for Report Sanitation Deficiencies for Indian Homes and Communities (SDS Guide) https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/2017_Letters/DTLL_SDSGuide_11222017.pdf	Published: 11/22/2017	Next Spring, in 2018, the Indian Health Service (IHS) will initiate a Tribal Consultation on our Working Draft Sanitation Deficiency System- Guide for Reporting Sanitation Deficiencies for Indian Homes and Communities (SDS Guide). The last formal update of this working draft document was May 2003. While the Agency has engaged Tribes on the SDS Guide in a variety of forums since the working draft was released, it is timely to conduct a formal review now as the update of the SDS Guide is finalized. As you are aware, the IHS uses the SDS Guide and data gathered from Tribes to submit an annual report to Congress in accordance with the Indian Health Care Improvement Act. The IHS Annual Report to the Congress of the United States on Sanitation Deficiency Levels for Indian Homes and Communities, catalogues sanitation deficiency levels for each sanitation facilities project of each Indian Tribe or community.	
Update on Indian Health Service Actions Relating to the Indian Health Care Improvement Fund https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/2017_Letters/58860-1_DTLL_11132017.pdf	Published: 11/13/2017	IHS update on Indian Health Service (IHS) actions relating to the Indian Health Care Improvement Fund (IHCIF), which is authorized by the Indian Health Care Improvement Act (25 U.S.C. § 1621). This includes our immediate plans to establish a new IHS/Tribal IHCIF workgroup to review the existing IHCIF formula and recommend changes for future use. The IHCIF formula was established to determine the overall level of need funded for health care facilities operated by the IHS, Tribes, or Tribal organizations. With the beginning of the fiscal year (FY) and action by Congress on the FY 2018 budget, a possibility of receiving a funding increase for the IHCIF in FY 2018 makes our actions particularly timely. After reauthorization of the Indian Health Care Improvement Act in 2010, the IHS initiated Tribal Consultation on the IHCIF and its formula on December 30, 2010. The IHS shared its decisions made after Tribal	IHCIF Meeting occurred January 30-31 in Washington D.C. Portland Area Representatives: - Vice Chair Gail Hatcher, Klamath Tribes -Tribal Council Member Steven Kutz, Cowlitz Tribe -Ann Arnett, IHS Executive Officer -Nichole Swanberg, IHS Acting Financial

		Consultation in a subsequent letter to Tribal Leaders dated November 25, 2011. The letters are available on the IHS website at: https://www.ihs.gov/newsroom/triballeaderletters/. A review of the IHCIF formula at this time acknowledges the considerable changes in the health care environment since the 2010 Tribal Consultation on IHCIF. The IHS is currently updating the data used in the existing IHCIF formula by collecting and analyzing the FY 2016 user population numbers, recurring base budgets at IHS and Tribal sites, geographic cost differentials, and health status data. IHS anticipates having this data update completed in January 2018, at which time they plan to share the findings in a report to the IHS/Tribal IHCIF workgroup to assist them in conducting their work. In the interim between now and January, IHS is looking to establish a new IHS/Tribal IHCIF workgroup. With regard to the IHCIF formula, the workgroup will assess a number of factors, which include, but are not limited to, the impact of past allocations in addressing funding inequities and the effects of the current health care environment on the formula. The IHS/Tribal IHCIF workgroup will also make recommendations regarding the IHCIF formula that will be sent out for Tribal Consultation prior to the IHS issuing a decision on any changes. Throughout this month, IHS Area Directors will reach out to Tribal Leaders to identify individuals interested in serving as a primary or alternate Tribal representative to the workgroup.	Management Officer.
		115th CONGRESS LEGISLATION	
S.2545 Native Behavioral Health Access Improvement Act of 2018 **Senate Committee on Indian Affairs**	Introduced: 3/14/2018	To amend the Public Health Service Act to authorize a special behavioral health program for Indians. The Director of IHS with the Assistant Secretary for Mental Health and Substance Use, shall award grants for providing services for the prevention and treatment of mental health and substance use disorders. Services must be provided through IHS, an Indian health program operated by a tribe or tribal organization, or an urban Indian health	

Sponsor: Sen. Tina Smith (D-MN) https://www.congress.gov/bill/115th-congress/senate-bill/2545?r=4		program. Establishes a technical assistance center to provide assistance to grantees and collect and evaluate information of the program. Appropriates $150,000,000 for each year of fiscal years 2018 through 2022.	
S.2515 the Practical Reforms and Other Goals to Reinforce the Effectiveness of Self-Governance and Self-Determination (PROGRESS) for Indian Tribes Act **Senate Committee on Indian Affairs** **Sponsor: Sen. John Hoeven (R-ND)** https://www.congress.gov/bill/115th-congress/senate-bill/2515?q=%7B%22search%22%3A%5B%22S.2515%22%5D%7D&r=1	Introduced: 3/7/2018	This bill amends the Indian Self-Determination and Education Assistance Act to provide further self-governance to Indian tribes by streamlining the Interior Department's self-governance process and providing tribes with greater flexibility to administer federal programs. -Sec.402 establishes a Tribal Self-Governance Program "This legislation builds on the foundation of successful tribal self-governance policy and makes key improvements to enhance efficient tribal administration of federal programs and services," said Chairman Hoeven.	3 cosponsors
H.R. 5140 Tribal Addiction and Recovery Act (TARA) Act of 2018 **House Energy and Commerce Committee** **Sponsor: Rep. Markwayne Mullin (R-OK-2)** https://www.congress.gov/bill/115th-congress/house-bill/5140?q=%7B%22search%22%3A%5B%22hr+5140%22%5D%7D&r=1	Introduced: 3/1/2018	To make improvements to the Account For the State Response to the Opioid Abuse Crisis to improve tribal health. Inserts tribal after state in Sec. 1003 of the 21st Century Cures Act. TARA would allow Tribes to receive opioid prevention funding directly from the federal government. The bill also clarifies that funds can be used to treat opioids and other addictive substances, such as alcohol or methamphetamine. This bill is very similar to S. 2270 introduced by Senator Steve Daines (R-MT) in December 2017. Grants awarded to a State, Indian tribe, or tribal organization under this subsection may be used to carry out activities to prevent and treat prescription drug abuse and the use of other addictive substances (such as alcohol, heroin, and methamphetamine), including by providing mental health services."	2 cosponsors
H.R. 5128 the Tribal Uranium Exposure Treatment Enhancement Act of 2018	Introduced: 2/27/2018	To authorize the Secretary of Agriculture to award grants to tribal health programs located on reservations impacted by uranium mining or milling, and for other purposes.	

House Agriculture Committee **Sponsor: Rep. Tom O'Halleran (D-AZ-1)** https://www.congress.gov/bill/115th-congress/house-bill/5128?q=%7B%22search%22%3A%5B%22H.R.+5128%22%5D%7D&r=1			
S.2456 CARA 2.0 Act of 2018 **Senate Health, Education, Labor, and Pensions Committee** **Sponsor: Sen. Rob Portman (R-OH)** https://www.congress.gov/bill/115th-congress/senate-bill/2456/text?q=%7B%22search%22%3A%5B%22CARA%22%5D%7D&r=1	Introduced: 2/27/2018	A bill to reauthorize and expand the Comprehensive Addiction and Recovery Act of 2016. -Allows states to put in place a 3 day limit on first time opioid prescriptions. -Allows tribes to apply to receive $300,000,000 for evidence-based prescription opioid and heroin treatment and intervention demonstrations for FY 2019-2023. -Allows states to raise patient caps under certain conditions for Medication-Assisted Treatment for recovery from addiction. -Requires the use of prescription drug monitoring programs. Increases civil and criminal penalties for opioid manufacturers. -$300,000,000 for FY 2019-2023 for evidence-based prescription opioid and heroin treatment and intervention demonstrations -Section 8 creates a national youth recovery initiative and authorizes SAMHSA and the Secretary of Education to award grants to be used for activities to develop, support, or maintain substance use recovery support services for youth or young adults. We recommend the inclusion of tribes and a portion of the initiative being dedicated to tribal youth. -$100,000,000 is proposed for improving treatment for pregnant and postpartum women.	RECOMMENDATIONS: -Allowing tribes access to the program outlined in section 6 (regional technical assistance centers) -Section 7 allows states to increase a 3-day limit on first time opiate prescriptions provided in section 3 of the bill if the state implements a law/statewide regulations. -Tribal law should have same authority in section 7. -Tribes should have access to section 10 for funding to states for treatment programs toward pregnant or post-partum women. -Adding language to section 13 to consult with tribes on implementation of their prescription monitoring program.
S.2437 Opioid Response Enhancement Act **Senate Health, Education, Labor, and Pensions Committee** **Sponsor: Sen. Tammy Baldwin (D-WI)**	Introduced: 2/15/2018	This legislation amends the 21st Century Cures Act to allow tribal entities to be eligible for State Targeted Opioid Response (STR) Grants and provides a 10 percent set aside for tribal entities. Further, S. 2437 would allow states and tribes to use STR Grant program funding to address other substance abuse issues. The bill also establishes an STR Enhancement Grant for $2 billion over five years for at least ten states and tribal entities with high needs.	15 cosponsors

https://www.congress.gov/bill/115th-congress/senate-bill/2437/text?q=%7B%22search%22%3A%5B%22S.2437%22%5D%7D&r=1		10% set-aside for tribes "This crisis is not going away, and this legislation takes an important step to extend and improve a critical program and to open up new resources to help states and tribal communities continue to have the tools they need to save lives," said Senator Baldwin.	
S.2270 Mitigating METH Act **Senate Health, Education, Labor, and Pensions Committee** **Sponsor: Sen. Steve Daines (R-MT)** https://www.congress.gov/bill/115th-congress/senate-bill/2270/text?q=%7B%22search%22%3A%5B%22s.2270%22%5D%7D&r=1	Introduced and referred to Senate HELP Committee: 12/21/2017	To make improvements to the account for the State response to the opioid abuse crisis to improve tribal health. **SEC. 2. ACCOUNT FOR THE STATE RESPONSE TO THE OPIOID ABUSE CRISIS.** Section 1003 of the 21st Century Cures Act (42 U.S.C. 290ee–3 note) is amended— (1) in subsection (b)— (A) in paragraph (1), by inserting "and Tribal" after "State"; (B) in paragraph (2)(A)(ii), by striking "$500,000,000" and inserting "$525,000,000"; and (C) in paragraph (3)(B), by inserting "and Tribal" after "State"; (i) in the paragraph heading, by striking "STATE RESPONSE TO THE OPIOID" and inserting "STATE AND TRIBAL RESPONSE TO THE OPIOID"; (ii) in the first sentence, by inserting "and Indian tribes and Tribal organizations (as the terms 'Indian tribes' and 'tribal organizations' are defined in the Indian Self-Determination and Education Assistance Act)" after "grants to States"; and (iii) in the second sentence, by inserting "and Tribes" after "States" each place that such term appears; "(3) OTHER SUBSTANCES.—A State or Indian tribe may use grants awarded under this section for prevention and treatment of the use of other substances such as methamphetamine, if the use of such other substances is determined by the State or tribe to have a substantial public health impact on the State or tribe."; and (3) in subsection (d), by inserting ", Tribe, or tribal organization" after "A State".	5 cosponsors including Sen. Jeff Merkley (D-OR)

H.R. 4242 VA Care in the Community Act **Committee** **Sponsor: Rep. David Roe (R-TN-1)** https://www.congress.gov/bill/115th-congress/house-bill/4242/text?q=%7B%22search%22%3A%5B%22HR+4242%22%5D%7D&r=1	Introduced: 11/3/2017 Referred to Subcommittee on Health: 11/3/2017 Ordered to be Amended by Years and Nays 14-9	Contains exemption for Tribal and federal providers on rates to negotiate higher rates rather than value-based or Medicare rates Allows IHS as an in-network provider and "Any health care provider not otherwise covered under any of subparagraphs (A) 5 through (F) that meets criteria established by the Secretary for purposes of such section."	28 cosponsors
S.2193 Caring for our Veterans Act **Senate Committee on Veterans Affairs** **Sponsor: Sen. Johnny Isakson (R-GA)** https://www.congress.gov/bill/115th-congress/senate-bill/2193/text?q=%7B%22search%22%3A%5B%22S.2193%22%5D%7D&r=1	Introduced: 12/5/2017 Placed on Legislative Calendar: 12/5/2017	Similar provisions to house on Tribal and federal "in network" providers Does not include exempt from value-based reimbursement, or Medicare rates Explicitly supports MOUs with Tribes and IHS Increases number of GME spots, allows IHS and Tribes to participate Includes a provision to establish or affiliate with graduate medical residency programs at facilities operated by Indian Tribes, Tribal organizations, and the IHS in rural areas. Section 101(d)(1): *The Secretary of Veterans Affairs shall continue all contracts, memorandums of understanding, memorandums of agreements, and other arrangements that were in effect on the day before the date of the enactment of this Act between the Department of Veterans Affairs and the American Indian and Alaska Native health care systems as established under the terms of the Department of Veterans Affairs and Indian Health Service Memorandum of Understanding, signed October 1, 2010, 5 the National Reimbursement Agreement, signed December 5, 2012, and agreements entered into under sections 102 and 103 of the Veterans Access, 8 Choice, and Accountability Act of 2014 (Public Law 9 113–146).* Trying to add language (or report language) emphasizing that PRC could be repaid through the MOU/MOA arrangements	GAO is conducting a study on impacts of IHS/Tribal/VA MOUs and is looking for more tribal participants Likely to pass, but cost is an issue. Related Bill: S.1449 Serving our Rural Veterans Act of 2017 - To authorize payment by the VA for the costs associated with training and supervision of medical residents and interns at certain facilities that are not Department facilities, to require the Secretary of VA to carry out a pilot program to establish or affiliate with residency programs at facilities operated by

			Indian tribes, tribal organizations, and the IHS, and for other purposes.
H.R. 4359 Tribal HUD-VASH Act of 2017 **House Committee on Financial Services** **Sponsor: Rep. Ben Ray Lujan (D-NM-3)** https://www.congress.gov/bill/115th-congress/house-bill/4359?r=7 **Related Bill-** **S.1333 Tribal HUD-VASH Act of 2017** -Placed on Senate legislative calendar on 12/20/2017	Introduced: 11/9/2017	To provide for rental assistance for homeless or at-risk Indian veterans. Rental assistance made available under the Program shall be administered in accordance with the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 et seq.), except that grantees shall— "(I) submit to the Secretary, in a manner prescribed by the Secretary, reports on the utilization of rental assistance provided under the Program; and "(II) provide to the Secretary information specified by the Secretary to assess the effectiveness of the Program in serving eligible Indian veterans. "(vii) CONSULTATION.— "(I) GRANT RECIPIENTS; TRIBAL ORGANIZATIONS.—The Secretary, in coordination with the Secretary of Veterans Affairs, shall consult with eligible recipients and any other appropriate tribal organization on the design of the Program to ensure the effective delivery of rental assistance and supportive services to eligible Indian veterans under the Program. "(II) INDIAN HEALTH SERVICE.—The Director of the Indian Health Service shall provide any assistance requested by the Secretary or the Secretary of Veterans Affairs in carrying out the Program. "(viii) WAIVER.— "(I) IN GENERAL.—Except as provided in subclause (II), the Secretary may waive or specify alternative requirements for any provision of law (including regulations) that the Secretary administers in connection with the use of rental assistance made	Related bill: S.1333 Tribal HUD-VASH Act of 2017 -Placed on Senate legislative calendar on 12/20/2017 1 cosponsor

		available under the Program if the Secretary finds that the waiver or alternative requirement is necessary for the effective delivery and administration of rental assistance under the Program to eligible Indian veterans. "(II) EXCEPTION.—The Secretary may not waive or specify alternative requirements under subclause (I) for any provision of law (including regulations) relating to labor standards or the environment. "(ix) REPORTING.—Every 5 years, the Secretary, in coordination with the Secretary of Veterans Affairs and the Director of the Indian Health Service, shall— "(I) conduct a review of the implementation of the Program, including any factors that may have limited its success; and "(II) submit a report describing the results of the review under subclause (I) to— "(aa) the Committee on Indian Affairs, the Committee on Banking, Housing, and Urban Affairs, the Committee on Veterans' Affairs, and the Committee on Appropriations of the Senate; and "(bb) the Subcommittee on Indian, Insular and Alaska Native Affairs of the Committee on Natural Resources, the Committee on Financial Services, the Committee on Veterans' Affairs, and the Committee on Appropriations of the House of Representatives.".	
H.R. 3706 Native Health and Wellness Act of 2017 **House Energy and Commerce Committee** **Sponsor: Rep. Raul Ruiz (D-CA-36)** https://www.congress.gov/bill/115th-congress/house-bill/3706/text?q=%7B%22search%22%3	Introduced: 9/7/2017 Referred to Subcommittee on Health: 9/08/2017	To amend the Public Health Service Act to improve the public health system in tribal communities and increase the number of American Indians and Alaska Natives pursuing health careers, and for other purposes. **"SEC. 317U. TRIBAL HEALTH BLOCK GRANT.** "(a) In General.—To the extent and in the amounts made available in advance by appropriations, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award a grant, in	1 cosponsor

A%5B%22American+Indian%22%5D%7D&r=38		an amount determined pursuant to the formula developed under subsection (e), to each eligible Indian tribe or tribal organization for the purposes of promoting health, preventing disease, and reducing health disparities among American Indians and Alaska Natives. "(b) Consultation.—The Secretary shall carry out this section, including the development of the formula required by subsection (e), in consultation with eligible Indian tribes and tribal organizations. "(c) Eligibility.—To be eligible for a grant under this section for a fiscal year, an Indian tribe or tribal organization shall submit to the Secretary a plan at such time, in such manner, and containing such information as the Secretary may require. "(d) Use Of Funds.—Each grantee under this section shall use the grant funds— "(1) to establish or support preventive health service programs that facilitate the achievement of health-status goals; "(2) to establish or support public health services that reduce the prevalence of chronic disease among American Indians and Alaska Natives; or "(3) to strengthen public health infrastructure to facilitate the surveillance and response to infectious disease and foodborne illness outbreaks. "(e) Formula.—The Secretary shall develop a formula to be used in allocating the total amount of funds made available to carry out this section for a fiscal year among the eligible Indian tribes and tribal organizations. "(f) Reports.—Each grantee under this section shall submit reports at such time, in such manner, and containing such information as the Secretary may require. **"SEC. 779. RECRUITMENT AND MENTORING OF AMERICAN INDIAN AND ALASKA NATIVE YOUTH**	

		AND YOUNG ADULTS. "(a) In General.—The Secretary shall make grants to Indian tribes and tribal organizations for the purpose of recruiting and mentoring American Indian and Alaska Native youth and young adults in health professions. "(b) Use Of Funds.—An Indian tribe or tribal organization receiving a grant under subsection (a) shall use the grant funds— "(1) to expose American Indian and Alaska Native adolescent youth or young adults to health professions; "(2) to promote science education; "(3) to establish mentoring relationships between— "(A) American Indian and Alaska Native youth or young adults; and "(B) health professionals; "(4) to provide hands-on learning experiences in a health care setting; "(5) to establish partnerships with institutions of higher education (including tribal colleges), local educational agencies, and other community-based entities to develop a larger and more competitive applicant pool for health professional careers; or "(6) to provide counseling, mentoring, and other services designed to assist American Indian and Alaska Native youth or young adults in the pursuit of higher education with respect to health professions.	
S.1870 SURVIVE Act **Senate Committee on Indian Affairs** **Sponsor: Sen. John Hoeven** https://www.congress.gov/bill/115th-congress/senate-bill/1870/text?q=%7B%22search%22%3A%5B%22indian%22%5D%7D&r=20	Introduced: 9/27/2017 Referred and reported without amendment: 12/6/2017	To amend the Victims of Crime Act of 1984 to secure urgent resources vital to Indian victims of crime, and for other purposes. "(9) SERVICES TO VICTIMS OF CRIME. "(A) has the meaning given the term in section 1404; and "(B) includes efforts that— "(i) respond to the emotional, psychological, or physical needs of a victim of crime; "(ii) assist a victim of crime in stabilizing his or her life after victimization; "(iii) assist a victim of crime in understanding and participating	10 cosponsors including Sen. Patty Murray (D-WA)

		in the criminal justice system; or "(iv) restore a measure of security and safety for a victim of crime. Grant Program.— "(1) IN GENERAL.—On an annual basis, the Director shall make grants to eligible Indian tribes for the purposes of funding— "(A) a program, administered by one or more Indian tribes, that provides services to victims of crime, which may be provided in traditional form or through electronic, digital, or other technological formats, including— "(i) services to victims of crime provided through subgrants to agencies or departments of tribal governments or nonprofit organizations; "(ii) domestic violence shelters, rape crisis centers, child abuse programs, child advocacy centers, and elder abuse programs providing services to victims of crime; "(iii) medical care, equipment, treatment, and related evaluations arising from the victimization, including— "(I) emergency medical care and evaluation, nonemergency medical care and evaluation, psychological and psychiatric care and evaluation, and other forms of medical assistance, treatment, or therapy, regardless of the setting in which the services are delivered; "(II) mental and behavioral health and crisis counseling, evaluation, and assistance, including outpatient therapy, counseling services, substance abuse treatment, and other forms of specialized treatment, including intervention and prevention services; "(III) prophylactic treatment to prevent an individual from contracting HIV/AIDS or any other sexually transmitted disease or infection; and	
H.R. 3704 Native Health Access Improvement Act of 2017 **House Energy and Commerce Committee** **House Natural Resources Committee** **House Ways and Means Committee** **Sponsor: Rep. Frank Pallone, Jr. (D-NJ-6)**	Introduced: 9/7/2017 Referred to Subcommittee on Indian, Insular and Alaska Native Affairs:	To amend the Public Health Service Act to improve behavioral health outcomes for American Indians and Alaskan Natives, and for other purposes. **SEC. 506B. SPECIAL BEHAVIORAL HEALTH PROGRAM FOR INDIANS.** "(a) In General.—The Director of the Indian Health Service, in coordination with the Assistant Secretary for Mental Health and Substance Use, shall award grants for	1 cosponsor

https://www.congress.gov/bill/115th-congress/house-bill/3704/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=33	9/13/2017	providing services in accordance with subsection (b) for the prevention and treatment of mental health and substance use disorders. "(b) Services Through Indian Health Facilities.—For purposes of subsection (a), services are provided in accordance with this subsection if the services are provided through any of the following entities: "(1) The Indian Health Service. "(2) An Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5301 et seq.). "(3) An urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.). "(c) Reports.—Each grantee under this section shall submit reports at such time, in such manner, and containing such information as the Director of the Indian Health Service may require. "(d) Technical Assistance Center.— "(1) ESTABLISHMENT.—The Director of the Indian Health Service, in coordination with the Assistant Secretary for Mental Health and Substance Use, shall establish a technical assistance center (directly or by contract or cooperative agreement)— "(A) to provide technical assistance to grantees under this section; and "(B) to collect and evaluate information on the program carried out under this section. "(2) CONSULTATION.—The technical assistance center shall consult with grantees under this section for purposes of developing evaluation measures and data submission requirements for purposes of the collection	

		and evaluation of information under paragraph (1)(B). "(3) DATA SUBMISSION.—As a condition on receipt of a grant under this section, an applicant shall agree to submit data consistent with the data submission requirements developed under paragraph (2). "(e) Funding.— "(1) IN GENERAL.—For the purpose of making grants under this section, there is authorized to be appropriated, and there is appropriated, out of any money in the Treasury not otherwise appropriated, $150,000,000 for each of fiscal years 2018 through 2022. "(2) TECHNICAL ASSISTANCE CENTER.—Of the amount made available to carry out this section for each of fiscal years 2018 through 2022, the Director of the Indian Health Service shall allocate a percentage of such amount, to be determined by the Director in consultation with Indian tribes, for the technical assistance center under subsection (d).	
H.R. 3473 **Native American Suicide Prevention Act of 2017** **House Energy and Commerce Committee** **Sponsor: Rep. Raul M. Grijalva (D-AZ-3)** https://www.congress.gov/bill/115th-congress/house-bill/3473/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=1	Introduced: 7/27/2017	To amend section 520E of the Public Health Service Act to require States and their designees receiving grants for development and implementation of statewide suicide early intervention and prevention strategies to collaborate with each Federally recognized Indian tribe, tribal organization, and urban Indian organization in the State.	21 cosponsors
S. 304 Tribal Veterans Health Care Enhancement Act **Senate Committee on Indian Affairs**	Introduced: 2/3/2017 Placed on	This bill amends the Indian Health Care Improvement Act to permit the Indian Health Service (IHS) to pay copayments owed to the Department of Veterans Affairs (VA) by Indian veterans for medical services authorized under the Purchased/Referred Care program and	1 cosponsor

Sponsor: Sen. John Thune (R-SD) https://www.congress.gov/bill/115th-congress/senate-bill/304/text?q=%7B%22search%22%3A%5B%22indian%22%5D%7D&r=71 Senate Committee on Indian Affairs Written Report	Senate Legislative Calendar No.149: 6/15/2017 Written report on 6/15/2017	administered at a VA facility. The IHS, the VA, and tribal health programs, in consultation with impacted tribes, must enter into a memorandum of understanding that authorizes the IHS or a tribal health program to pay such copayments unless it would decrease the quality of, or access to, health care for individuals receiving care from the IHS or the VA. The IHS and the VA must report on veterans who are eligible for IHS assistance and have received care from the VA.	
H.R. 2662 Restoring Accountability in the Indian Health Service Act of 2017 **House Natural Resources Committee** **House Energy and Commerce Committee** **House Ways and Means Committee** **House Oversight and Government Reform Committee** **Sponsor: Rep. Kristi Noem (R-SD-At Large)** https://www.congress.gov/bill/115th-congress/house-bill/2662/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=24	Introduced: 5/25/2017 Hearings Held: 6/21/2017	To amend the Indian Health Care Improvement Act to improve the recruitment and retention of employees in the Indian Health Service, restore accountability in the Indian Health Service, improve health services, and for other purposes. The Bill would provide incentives to health care professionals to serve in the IHS, including pay flexibility and relocation reimbursements when employees move to high-need areas, as well as a housing voucher program for rental assistance to employees. Require IHS to create standards to measure wait times and for IHS employees to attend cultural training annually Amend processes to make volunteering at IHS facilities easier by providing liability protections for medical professionals who want to volunteer at IHS hospitals or service units and centralizing the agency's medical credentialing system. Require IHS to engage in a negotiated rulemaking process to establish a new tribal consultation policy for IHS. à Many tribes in Great Plains area have said that IHS is not consulting with them on big issues, and need a better definition of what triggers consultation. Put additional requirements on IHS to ensure that reports and plans are provided to Congress in a timely manner The HHS Office of the Inspector General must put together reports every	8 cosponsors including Rep. Cathy McMorris-Rodgers (R-WA) Related bill: S.1250 Restoring Accountability in the Indian Health Service Act of 2017 6/21/2017 Hearing held in the House Natural Resources Subcommittee on Indian, Insular and Alaska Native Affairs

		two years on "patient harm events occurring in Service units and deferrals and denials of care of patients of the Service." Requires 3rd party revenue to be used on essential medical equipment, purchased/referred care, and staffing only for IHS operated facilities	
S. 1250 Restoring Accountability in the Indian Health Service Act of 2017 **Senate Committee on Indian Affairs** **Sponsor: Sen. John Barrasso (R-WY)** https://www.congress.gov/bill/115th-congress/senate-bill/1250/text?q=%7B%22search%22%3A%5B%22S+1250%22%5D%7D&r=1	Introduced: 5/25/2017 Hearings Held: 6/13/2017	To amend the Indian Health Care Improvement Act to improve the recruitment and retention of employees in the Indian Health Service, restore accountability in the Indian Health Service, improve health services, and for other purposes. • Pay flexibility and relocation reimbursements for employees • Mandated IHS employee cultural competency training • Reforms Hiring and Firing for IHS Employees • Additional incentives for hiring medical professionals • Measure appt. wait times • Requiring HHS to revisit and reform Tribal Consultation policy • Regular reports to Congress • HHS OIG reports every 2 years on patient harm and denial of care AMENDMENTS **Self Governance Exemption** Clarification on the fact that the provisions would not impact self-governance contracts/compacts. **Indian preference waived** for hiring of an employee **only** "at the request of an Indian tribe." It also changes language from "shall" to "may" **IHS Tribal Consultation policy** – Adds language that requires "meaningful consultation with representatives of affected Indian Tribes" in the development of the consultation policy. Took out specific language on the negotiated rulemaking process. **IHS Employment Provisions** Re-written to improve upon the introduced language that was originally borrowed from reform at the Veterans' Administration legislation. The new language will better address some constitutionality issues that the original language had.	Related bill: H.R. 2662 Restoring Accountability in the Indian Health Service Act of 2017 6/13/2017 Hearing held by the Senate Committee on Indian Affairs Business meeting re-scheduled for April 11.
H.R. 2545 **Special Diabetes Program for Indians Reauthorization Act of 2017**	Introduced: 5/18/2017	Referred to the Subcommittee on Health 5/19/2017 This Act may be cited as the "Special Diabetes Program for Indians Reauthorization Act of 2017 ".	21 cosponsors including Rep. Earl Blumenauer (D-OR-3); Rep. Denny Heck

House Energy and Commerce Committee **Sponsor: Rep. Norma J. Torres (D-CA-35)** https://www.congress.gov/bill/115th-congress/house-bill/2545/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=7	Referred to Subcommittee on Health: 5/19/2017	Since the first authorization, the Special Diabetes Programs for Indians have— (A) made it possible for Native communities to develop and sustain quality diabetes treatment and prevention programs, including— (i) a 40-percent increase in number of diabetes clinics; (ii) a 42-percent increase in access to registered nutritionists; and (iii) a 61-percent increase in availability of culturally tailored education programs; (B) resulted in concrete health outcomes, like a 48-percent decrease in end-stage renal disease among American Indian and Alaska Native populations; and (C) led to millions of dollars in healthcare cost savings by decreasing the prevalence of costly preventable diabetes complications. (6) Due to the continued positive impact of the Special Diabetes Programs for Indians on Native communities and the large return on investment for healthcare funding, Congress has shown its support for the programs by— (A) reauthorizing the Special Diabetes Programs for Indians no less than 8 times; and (B) sending letters of support for the Special Diabetes Programs to Congressional leadership signed by more than 350 Representatives and 75 Senators. Section 330C(c) of the Public Health Service Act (42 U.S.C. 254c–3(c)) is amended by striking paragraph (2) and inserting the following: APPROPRIATIONS.— "(i) $150,000,000 for fiscal year 2018; and "(ii) the amount specified in subparagraph (B) for each of fiscal years	(D-WA-10); Rep. Derek Kilmer (D-WA-6) Related Bills: S.747 Special Diabetes Program for Indians Reauthorization Act of 2017 (identical bill)

		2019 through 2024.	
S. 747 Special Diabetes Program for Indians Reauthorization Act of 2017 **Senate Health, Education, Labor and Pensions Committee** **Sponsor: Sen. Tom Udall (D-NM)** https://www.congress.gov/bill/115th-congress/senate-bill/747/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=8	Introduced: 3/28/2017	This Act may be cited as the "Special Diabetes Program for Indians Reauthorization Act of 2017 ". Section 330C(c) of the Public Health Service Act (42 U.S.C. 254c–3(c)) is amended by striking paragraph (2) and inserting the following: "(2) APPROPRIATIONS.— "(A) IN GENERAL.—For the purpose of making grants under this section, there is appropriated, out of any money in the Treasury not otherwise appropriated— "(i) $150,000,000 for fiscal year 2018 for each of fiscal years 2019 through 2024.	Related Bills: H.R. 2545 Special Diabetes Program for Indians Reauthorization Act of 2017
H.R. 1369 Indian Healthcare Improvement Act of 2017 **House Natural Resources Committee** **House Energy and Commerce Committee** **House Ways and Means Committee** **House Budget Committee** **Sponsor: Rep. Tom Cole (R-OK-4)**	Introduced: 3/6/2017 Referred to Subcommittee on Indian, Insular and Alaska Native Affairs: 3/20/2017	Sec. 101. Reauthorization. Sec. 102. Findings. Sec. 103. Declaration of national Indian health policy. Sec. 104. Definitions. Subtitle A—Indian Health Manpower Sec. 111. Community Health Aide Program. Sec. 112. Health professional chronic shortage demonstration programs. Sec. 113. Exemption from payment of certain fees. Subtitle B—Health Services Sec. 121. Indian Health Care Improvement Fund. Sec. 122. Catastrophic Health Emergency Fund. Sec. 123. Diabetes prevention, treatment, and control. Sec. 124. Other authority for provision of services; shared services for long-term care. Sec. 125. Reimbursement from certain third parties of costs of health services. Sec. 126. Crediting of reimbursements. Sec. 127. Behavioral health training and community education programs. Sec. 128. Cancer screenings.	

		Sec. 129. Patient travel costs. Sec. 130. Epidemiology centers. Sec. 131. Indian youth grant program. Sec. 132. American Indians Into Psychology Program. Sec. 133. Prevention, control, and elimination of communicable and infectious diseases. Sec. 134. Methods to increase clinician recruitment and retention issues. Sec. 135. Liability for payment. Sec. 136. Offices of Indian Men's Health and Indian Women's Health. Sec. 137. Contract health service administration and disbursement formula. Subtitle C—Health Facilities Sec. 141. Health care facility priority system. Sec. 142. Priority of certain projects protected. Sec. 143. Indian health care delivery demonstration projects. Sec. 144. Tribal management of federally owned quarters. Sec. 145. Other funding, equipment, and supplies for facilities. Sec. 146. Indian country modular component facilities demonstration program. Sec. 147. Mobile health stations demonstration program. Subtitle D—Access To Health Services Sec. 151. Treatment of payments under Social Security Act health benefits programs. Sec. 152. Purchasing health care coverage. 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. Sec. 154. Sharing arrangements with Federal agencies. Sec. 155. Eligible Indian veteran services. Sec. 156. Nondiscrimination under Federal health care programs in qualifications for reimbursement for services. Sec. 157. Access to Federal insurance. Sec. 158. General exceptions. Sec. 159. Navajo Nation Medicaid Agency feasibility study. Subtitle E—Health Services For Urban IndianS Sec. 161. Facilities renovation. Sec. 162. Treatment of certain demonstration projects. Sec. 163. Requirement to confer with urban Indian organizations. Sec. 164. Expanded program authority for urban Indian organizations. Sec. 165. Community health representatives. Sec. 166. Use of Federal Government facilities and sources of supply; health information technology. Subtitle F—Organizational Improvements	

		Sec. 171. Establishment of the Indian Health Service as an agency of the Public Health Service. Sec. 172. Office of Direct Service Tribes. Sec. 173. Nevada area office. Subtitle G—Behavioral Health Programs Sec. 181. Behavioral health programs. Subtitle H—Miscellaneous Sec. 191. Confidentiality of medical quality assurance records; qualified immunity for participants. Sec. 192. Limitation on use of funds appropraited to the Indian Health Service.	
S.465 Independent Outside Audit of the Indian Health Service Act of 2017 **Senate Committee on Indian Affairs** **Sponsor: Sen. Mike Rounds (R-SD)** https://www.congress.gov/bill/115th-congress/senate-bill/465/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=19	Introduced: 2/28/2017 Hearings held: 11/8/2017	On Wednesday, November 8, at 2:30 pm EST, the Senate Committee on Indian Affairs held a hearing on S. 465, the Independent Outside Audit of IHS Act of 2017. This legislation would require that the Department of Health and Human Services (HHS) initiate an independent audit of the Indian Health Service. The legislation recommends that HHS contract with a private entity to do that work. It requires that the assessment investigate several areas of service delivery including: • Demographics and health care needs of the patient population, • Health care capabilities and resources, • Staffing levels at medical facilities and the productivity of each health care provider, • Information technology strategies related to providing health care, • Business processes, • Competency of leadership regarding specified issues, • Tracking patients eligible for other federal health care programs, and • Number of procurement contracts and awards under the Buy Indian Act. To provide for an independent outside audit of the Indian Health Service.	2 cosponsors

		(d) Areas Of Study.—Each assessment conducted under subsection (b) shall address each of the following: (1) Current and projected demographics and unique health care needs of the patient population served by the Service. (2) Current and projected health care capabilities and resources of the Service, including hospital care, medical services, and other health care furnished by non-Service facilities under contract with the Service, to provide timely and accessible care to eligible patients. (3) The authorities and mechanisms under which the Secretary may furnish hospital care, medical services, and other health care at non-Service facilities, including whether it is recommended that the Secretary have the authority to furnish such care and services at such facilities through the completion of episodes of care. (4) The appropriate systemwide access standard applicable to hospital care, medical services, and other health care furnished by and through the Service, including an identification of appropriate access standards for each individual specialty and post-care rehabilitation. (5) The workflow process at each medical facility of the Service for scheduling appointments to receive hospital care, medical services, or other health care from the Service. (6) The organization, workflow processes, and tools used by the Service to support clinical staffing, access to care, effective length-of-stay management and care transitions, positive patient experience, accurate documentation, and subsequent coding of inpatient services. (7) The staffing level at each medical facility of the Service and the productivity of each health care provider at such medical facility, compared with health care industry performance metrics, which may include an assessment of any of the following: (A) The case load of, and number of patients treated by, each health care provider at such medical facility during an average week. (B) The time spent by such health care provider on matters other than the case load of such health care provider. (C) The amount of personnel used for administration compared with direct health care in the Service being comparable to the amount used for administration compared with direct health care in private	

		health care institutions. (D) The allocation of the budget of the Service used for administration compared with the allocation of the budget used for direct health care at Service-operated facilities. (E) Any vacancies in positions of full-time equivalent employees that the Service— (i) does not intend to fill; or (ii) has not filled during the 12-month period beginning on the date on which the position became vacant. (F) The disposition of amounts budgeted for full-time equivalent employees that is not used for those employees because the positions of the employees are vacant, including— (i) whether the amounts are redeployed; and (ii) if the amounts are redeployed, how the redeployment is determined. (G) With respect to the approximately 3,700 Medicaid-reimbursable full-time equivalent employees of the Service— (i) the number of those employees who are certified coders; and (ii) whether that number of employees is necessary. (8) The information technology strategies of the Service with respect to furnishing and managing health care, including an identification of any weaknesses and opportunities with respect to the technology used by the Service, especially those strategies with respect to clinical documentation of episodes of hospital care, medical services, and other health care, including any clinical images and associated textual reports, furnished by the Service in Service or non-Service facilities. (9) Business processes of the Service, including processes relating to furnishing non-Service health care, insurance identification, third-party revenue collection, and vendor reimbursement, including an identification of mechanisms as follows: (A) To avoid the payment of penalties to vendors. (B) To increase the collection of amounts owed to the Service for hospital care, medical services, or other health care provided by the Service for which reimbursement from a third party is authorized and to ensure that such amounts collected are accurate. (C) To increase the collection of any other amounts owed to the Service with respect to hospital care, medical services, and other	

		health care and to ensure that such amounts collected are accurate. (D) To increase the accuracy and timeliness of Service payments to vendors and providers. (10) The purchasing, distribution, and use of pharmaceuticals, medical and surgical supplies, medical devices, and health care related services by the Service, including the following: (A) The prices paid for, standardization of, and use by the Service of, the following: (i) Pharmaceuticals. (ii) Medical and surgical supplies. (iii) Medical devices. (B) The use by the Service of group purchasing arrangements to purchase pharmaceuticals, medical and surgical supplies, medical devices, and health care related services. (C) The strategy and systems used by the Service to distribute pharmaceuticals, medical and surgical supplies, medical devices, and health care related services to medical facilities of the Service. (11) The process of the Service for carrying out construction and maintenance projects at medical facilities of the Service and the medical facility leasing program of the Service, including— (A) whether the maintenance budget is updated or increased to reflect increases in maintenance costs with the addition of new facilities and whether any increase is sufficient to support the growth of the facilities; and (B) what the process is for facilities that reach the end of their proposed life cycle. (12) The competency of leadership with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management, including— (A) the reasons for a lack in transparency in the culture of the Service, leading tribal leadership to request increased transparency and more open communication between the Service and the people served by the Service; and (B) whether any checks and balances exist to assess potential fraud or misuse of amounts within the Service. (13) The lack of a funding formula to distribute base funding to the 12	

		Service areas, including the following: (A) The establishment of the current process of funding being distributed based on historical allocations and not on need such as population growth, number of facilities, etc. (B) How the implementation of self-governance policies has impacted health care delivery. (C) The communication to area office directors on distribution decisionmaking. (D) How the tribal and residual shares are determined for each Indian tribe and the amounts of those shares. (E) The auditing or evaluation process used by the Service to determine whether amounts are distributed and expended appropriately, including— (i) whether periodic or end-of-year records document the actual distributions; and (ii) whether any auditing or evaluation is conducted in accordance with generally accepted accounting principles or other appropriate practices. (14) Whether the Service tracks patients eligible for two or more of either the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), health care received through the Service, or any other Federal health care program (referred to in this section as "dual eligible patients"). If so, how dual eligible patients are managed. (15) The number of procurement contracts entered into and awards made by the Service under section 23 of the Act of June 25, 1910 (commonly known as the "Buy Indian Act") (25 U.S.C. 47), and a comparison of that number, with— (A) the total number of procurement contracts entered into and awards made by the Service during the 5 fiscal years prior to the date of enactment of this Act; and (B) the process used by the Service facilities to ensure compliance with section 23 of the Act of June 25, 1910 (commonly known as the "Buy Indian Act") (25 U.S.C. 47). (16) Any other items the reputable private entity determines should be addressed in the independent assessment of the Service.	

H.R. 235 Indian Health Service Advance Appropriations Act of 2017 **House Budget Committee** **House Natural Resources Committee** **House Energy and Commerce Committee** **Sponsor: Rep. Don Young (R-AK-At Large)** https://www.congress.gov/bill/115th-congress/house-bill/235/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=16	Introduced: 1/3/2017 Referred to Subcommittee on Indian, Insular and Alaska Native Affairs: 2/10/2017	To amend the Indian Health Care Improvement Act to authorize advance appropriations for the Indian Health Service by providing 2-fiscal-year budget authority, and for other purposes. **SEC. 2. ADVANCE APPROPRIATIONS FOR CERTAIN INDIAN HEALTH SERVICE ACCOUNTS.** (a) In General.—Section 825 of the Indian Health Care Improvement Act (25 U.S.C. 1680o) is amended— (1) by inserting "(a)" before "There are authorized"; and (2) by adding at the end the following: "(b) For each fiscal year, beginning with the first fiscal year that starts during the year after the year in which this subsection is enacted, discretionary new budget authority provided for the Indian Health Services and Indian Health Facilities accounts of the Indian Health Service shall include advance discretionary new budget authority that first becomes available for the first fiscal year after the budget year. "(c) The Secretary shall include in documents submitted to Congress in support of the President's budget submitted pursuant to section 1105 of title 31, United States Code, for each fiscal year to which subsection (b) applies detailed estimates of the funds necessary for the IndianHealth Services and Indian Health Facilities accounts of the Indian Health Service for the fiscal year following the fiscal year for which the budget is submitted.". (b) Submission Of Budget Request.—Section 1105(a) of title 31, United States Code, is amended by adding at the end the following new paragraph.	
		EXECUTIVE ORDERS, PRESIDENTIAL MEMORANDUMS, PRESIDENTIAL ACTIONS AND INITIATVES	

Trump Administration Announces MyHealthEData Initiative to Put Patients at the Center of the US Healthcare System **AGENCY: CMS** **CMS Press Release**	Published: 3/6/2018	CMS Administrator Seema Verma announced a new Trump Administration initiative – MyHealthEData – to empower patients by giving them control of their healthcare data, and allowing it to follow them through their healthcare journey. The government-wide MyHealthEData initiative is led by the White House Office of American Innovation with participation from the Department of Health and Human Services (HHS) – and its Centers for Medicare & Medicaid Services (CMS), Office of the National Coordinator for Health Information Technology (ONC), and National Institutes of Health (NIH) – as well as the Department of Veterans Affairs (VA). The initiative is designed to empower patients around a common aim - giving every American control of their medical data. MyHealthEData will help to break down the barriers that prevent patients from having electronic access and true control of their own health records from the device or application of their choice. Patients will be able to choose the provider that best meets their needs and then give that provider secure access to their data, leading to greater competition and reducing costs. The MyHealthEData initiative will work to make clear that patients deserve to not only electronically receive a copy of their entire health record, but also be able to share their data with whomever they want, making the patient the center of the healthcare system. Patients can use their information to actively seek out providers and services that meet their unique healthcare needs, have a better understanding of their overall health, prevent disease, and make more informed decisions about their care. Additionally, CMS intends to overhaul its Electronic Health Record (EHR) Incentive Programs to refocus the programs on interoperability and to reduce the time and cost required of providers to comply with the programs' requirements. CMS will continue to collaborate with ONC to improve the clinician experience with their EHRs. Administrator Verma said CMS has implemented laws regarding information blocking – a practice in which providers prevent patients from getting their data. Under some CMS programs, hospitals and clinicians must show they have not engaged in information blocking activities. The Administrator also highlighted other CMS plans to empower patients	MyHealthEData Initiative at HIMSS18 Fact Sheet

		with data: • CMS is requiring providers to update their systems to ensure data sharing. • CMS intends to require that a patient's data follow them after they are discharged from the hospital. • CMS is working to streamline documentation and billing requirements for providers to allow doctors to spend more time with their patients. • CMS is working to reduce the incidence of unnecessary and duplicative testing which occurs as a result of providers not sharing data.	
President Trump's FY 2019 Budget Request in Brief https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf	Published: 2/12/2018	President Trump released the fiscal year (FY) 2019 (begins October 1, 2018) Budget Request to Congress. This is the proposal that the Administration provides the Congress as they will develop the FY 2019 appropriation including funds for IHS and other health programs serving Indian Country. The details of the budget proposal have not been released yet, but a budget summary has been released. The IHS would receive an 8% increase over the current FY 2018 budget, but the proposal still cuts or eliminates several programs at IHS. Trump's budget request eliminates $3.6 trillion from domestic spending programs including for Medicare, Medicaid, public health and social safety net programs. Many of these programs are at HHS which, as a whole, would take a 21% cut in the President's budget. The budget would also make major cuts to Supplemental Nutrition Assistance Program (SNAP), 22% of the program and $213.5 billion over the next decade. The proposal also would redesign SNAP by using a portion of benefits to buy and deliver a package of commodities to SNAP households, noting that it would utilize the government's buying power to obtain common foods at lower costs.	
COMMENTS SUBMITTED			

Agency Information Collection: Standards Related to Reinsurance, Risk Corridors, Risk Adjustment, and Payment Appeals **AGENCY: CMS** **Notice** https://www.gpo.gov/fdsys/pkg/FR-2018-01-08/pdf/2018-00086.pdf	Published: 1/8/2018 **Submitted: 3/9/2018**	NPAIHB requested that CMS continue to require QHP issuers to submit individual, enrollee-level data on the usage of CSRs. The NPAIHB further asks that CMS make any future adjustments to the induced utilization factor based on enrollee-level data to capture the great variation in the degree to which some AI/ANs access the Indian-specific CSRs. In addition, the NPAIHB urges CMS to consider modifying the Federal risk adjustment model, either through the induced utilization factor or through some other mechanism, to account for the loss of CSR payments to issuers for the Indian-specific CSRs for AI/AN enrollees. NPAIHB commented on health insurance issuer reporting of enrollee-level data related to the permanent risk adjustment program, specifically data that CMS uses in determining the adjustment for the receipt of CSRs in the Federal risk adjustment model (referred to as the "induced utilization factor"). The NPAIHB believes that continued collection of individual, enrollee-level data on the usage of CSRs and overall health care service utilization—for the purposes of determining the induced utilization factor—is justified and essential to ensuring a precise accounting of utilization among AI/ANs and the accurate reimbursement to issuers for induced utilization resulting from the provision of comprehensive, Indian-specific CSRs for certain AI/AN enrollees. Without the data needed to calculate an accurate induced utilization factor, a situation that could result in underpayments to certain health plans, plans might have a disincentive to enrolling AI/ANs and/or applying fully the comprehensive, Indian-specific CSRs. Second, NPAIHB wishes to highlight the potential for the costs of the Indian-specific cost-sharing protections to be shifted to Marketplace enrollees—including eligible AI/ANs themselves—due to the elimination of direct Federal funding of the CSRs and proposes modifying the Federal risk adjustment model to help address this concern.	NPAIHB CMS-10401 Reinsurance Risk Corr
Senate Finance Committee Opioid Input Solicitation Letter	Published: 2/2/2018 **Submitted:**	NPAIHB highlighted the drastic need for more funding and resources to address the crisis in tribal communities. NPAIHB highlighted the role of Medicaid and Medicare for tribes.	NPAIHB Comments on Senate Finance Co

	2/16/2018	It is critical that the Committee consider the unique challenges and opportunities in the Indian health system as it looks to make reforms to Medicare and Medicaid as it relates to the opioid crisis. The Committee must also contemplate the differences for Medicaid beneficiaries who reside in Medicaid expansion states versus non-expansion states. NPAIHB and our member tribes are supportive of an evaluation of how health programs under the Committee's jurisdiction can include the pain management and substance use disorders needs of tribes. The Committee must utilize Northwest tribes as partners and a best practice model while creating legislative language. Tribal clinics in the Northwest serve both native and non-native patients in rural underserved areas in the Northwest. The Committee must take into consideration the unique status of AI/ANs as well as the unique health care system that serves AI/ANs. Legislation must assist in expanding access to integrated services and reach critically underserved AI/AN people. The Committee also must consider that Medicare and Medicaid payment incentives do not work in tribal clinics because of the unique health care system that services AI/ANs, chronic underfunding of the Indian health system, limited health care resources available to tribes, and lack of infrastructure, including outdated electronic health record systems. NPAIHB recommends that the Committee investigate tribal best practices to learn more about the success rates and needs of these programs, and encourages the Committee to communicate directly with the Northwest tribes and NPAIHB in order to improve broad awareness, support and secure future funding. A best practice policy recommendation to be considered for tribal clinics or rural clinics is financial assistance and incentives for an integrated continuum of care for OUD patients. Although, it is difficult to truly integrate our services. Federally funded health care programs should include reimbursement for non-pharmaceutical therapies and alternative methods to treat pain. There are limited types of non-pharmaceutical therapies that are reimbursable, therefore tribes must rely on the ability to use PRC program funds. Physical therapy, oral health services, and acupuncture are examples of additional therapies and services that OUD patients need. NPAIHB supports the expansion – and commensurate Medicaid and Medicare reimbursement – of the Community Health Aide Program (CHAP) to Tribes outside of Alaska. The Community Health Aide Program (CHAP) is an excellent example of reform that was developed in response to a need for providers in Alaska. CHAP	

		model, a Tribally created and driven system, was developed in response to unique Tribal communities' needs. A best practice for prevention and identification is the inclusion of culturally responsive and community relevant prevention, treatment, and aftercare practices for OUD patients (i.e. Methamphetamine and Suicide Prevention Initiative (MSPI) Healing patients in tribal communities must be done through traditional healing and cultural practices along with MAT. However, funding is very limited for the financial support of traditional services to Medicare and Medicaid beneficiaries. A significant problem that must be addressed is the limited availability of trainings for providers on proper prescribing, and limited provider education on substance use prevention and treatment protocols and procedures. There is a need to streamline data sharing and reporting. Tribes have limited support and training to do case management through their electronic health record (EHR) and Resource Patient Management System (RPMS). Tribal Epidemiology Centers (TECs) must be included as partners in data sharing and coordination.	
IHS Tribal Consultation and Urban Confer on the IHS Strategic Plan Draft Framework https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/2017_Letters/58653-1_IHS_StrategicPlan_09152017.pdf	Published: 9/15/2017 **Submitted: 10/31/2017** *IHS is still accepting comments*	The process to gather input from tribes is very expedited. NPAIHB requested that IHS extend the comment period for the draft framework and the strategic plan in order to receive adequate input from each IHS Area. **Mission: To raise the physical, mental, social, and spiritual health of AI/ANs to the highest level:** NPAIHB recommendations, included: · Tie the organization and its mission to the trust responsibility. · Provide a clear definition of what the highest level is and whom the highest level is compared to. · Consider language about inequities in the mission statement. · Include language that Indians strive to be the healthiest people. · Include language about the need for full funding.	NPAIHB IHS Strategic Plan 2018-

		Vision: A health system that promotes Tribal ownership and pride. NPAIHB recommendations included: ·Broaden the vision statement to reflect all IHS, Tribal, and urban Indian organization (I/T/Us) and AI/ANs. · Include more specific language for a health care system that promotes tribal sovereignty and tribal self-determination instead of ownership. · Mirror language to reflect tribal laws and resolutions to take ownership and emphasize self-determination. · Focus on the Native health system vision to provide high quality care in a culturally responsive manner. ***Goal 1: To ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.*** NPAIHB expressed support of Goal 1 but recommended: · "American Indian and Alaska Native" should be moved to beginning of the sentence because it gets lost in the goal. · Replacement of "culturally acceptable" with culturally responsive or "culturally informed" personal and public health services because culturally acceptable is an antiquated term. · Include sustainability and traditional medicine in the Goal 1 statement. ***Objective 1.1: Recruit, develop, and retain a dedicated, competent, caring workforce.*** NPAIHB recommended: ·Must include self-governance tribes in this objective since this objective appears to be focused on IHS direct service facilities.	

		Self-governance tribes have had significant issues with recruitment and retention. · Include innovative recruitment and retention strategies that make tribal communities a sought after job/placement for health care providers. For example, Portland Area Tribes have highlighted the lack of loan repayment as a barrier to retention because health care providers are usually waitlisted, especially in underserved communities. · Ensure culturally responsive training for all health care professionals be included in Objective 1. · Consider metrics to evaluate the recruitment and retention of workforce objective, i.e., aim for 80% - 90% of personnel by the end of the following fiscal year. · Improve access to physical, behavioral and oral health services in underserved and rural tribal communities by supporting the Community Health Aide Program (CHAP). CHAP provides training, recruitment, placement, and retention of behavioral health, dental health, and primary care providers to address workforce shortages, reduce disparities and ensure an equitable workforce distribution. There is strong early evidence that dental health aide therapists (or dental therapists), midwives, nurse practitioners, tribal community health providers available through the CHAP in Alaska, and other primary health and oral health providers will be necessary to strengthen the health care workforce and improve access to care. There is a significant challenge to access health care for underserved and rural populations. ***Objective 1.2: Build, strengthen, and sustain collaborative relationships.*** NPAIHB believes that IHS should strive to collaborate across federal agencies and stakeholders to ensure effective and coordinated implementation of issues such as mental health parity, especially as it pertains to substance use disorders and serious mental illness are key to improving health care outcomes in tribal communities.	

		Objective 1.3: Increase access to quality health care services. In order to focus the objectives on the goal of increasing access, IHS must include additional objectives that address increasing access threats. An access threat that NPAIHB recommended IHS address as an objective is when tribes must refer out to find specialty providers, which are unable to be acquired on occasion. Therefore, telecommunications and funding are crucial to allow tribes to access specialty services outside of the community. NPAIHB proposed that IHS include transportation as a strategy to increase access to care in rural tribal communities. Distance is a consistent barrier in relation to access to care for AI/ANs in rural and underserved communities. Further, IHS must clearly include preventative public health services within health care services to reduce or eliminate risk of illness or injury. We also recommend that an objective be added to Goal 1 that increases access and funding to support comprehensive health services. Additionally, we recommended a strategy to explore ways to more efficiently direct funds intended to serve Indian Country at the local level, such as interagency agreements with other Department of Health and Human Services (HHS) agencies. ***Goal 2: To promote excellence and quality through innovation of the Indian health system into an optimally performing organization.*** Innovation is at the center of Goal 2, but there are no objectives that talk about innovation in the Indian health care system. NPAIHB recommends that there be more language to support tribal innovation and make it clear that IHS will work with tribes to develop these opportunities. The intention for tribes, especially 638	

		compacted tribes is to be self-determined and innovative. Tribal innovation is fundamental for the culture of improvement for tribal hospitals and clinics. IHS must partner with tribes to promote innovation. Tribes must be involved in developing innovation initiative measures with IHS. NPAIHB recommended that IHS switch Goal 2 and 3 so that the goal to strengthen IHS program management and operations becomes Goal 2. Program management and operations are more significant issues for tribes. Further, we recommend that IHS add an objective surrounding research, design, and implement best practices for business processes. ***Objective 2.1: Create quality improvement capability at all levels of the organization.*** NPAIHB and our member tribes recommend that IHS include a customer satisfaction survey to measure quality improvement at all levels of the organization. ***Objective 2.2: Provide care to better meet the health care needs of Indian communities.*** In order to provide better care to meet the health care needs of tribal communities, we propose that IHS include environmental determinants of health (many tribes deal with superfund sites that have not been cleaned up, drinking water toxins), trauma informed care (tribes have been adversely impacted by the boarding school era with lasting impacts on health), and social determinants of health (housing, community gardens, adequate nutrition are all important). ***Goal 3: Strengthen IHS program management and operations*** NPAIHB support Goal 3, but it must strengthen program management and operations through the entire IHS	

		system to filter to the tribes, not just through direct service. Further, we request the addition of "Indian health system" after IHS in the goal. We recommend an additional objective focused on the priority of infrastructure and facilities, especially in regard to an overhaul of the health care facilities construction priority system. Northwest Tribes continue to support a moratorium on new facilities construction until an equitable funding methodology can be implemented by the IHS. ***Objective 3.2: Improve communication within the organization, with Tribes and other stakeholders, and with the general public.*** NPAIHB recommends that Objective 1 should solely include improvement of communication within the organization, Area offices and with tribes. Northwest Tribes have expressed disappointment with the IHS partnership with tribes because the rollout of the IHS draft Strategic Framework occurred at the National Indian Health Board (NIHB) conference. We recommended that IHS add another objective focused on increased coordination with other HHS agencies to address AI/AN health care issues early. ***Objective 3.2: Secure and effectively manage assets and resources.*** NPAIHB recommends more transparency on the IHS budget. We also recommend that IHS move away from discretionary funding to mandatory. Additionally, we recommend that IHS include a statement to streamline the operations and business processes within the organization. ***Objective 3.3: Modernize information technology and***	

		information systems to support data driven decision. To strengthen and modernize the information technology infrastructure, the objective must include enhanced partnership with tribal data. NPAIHB and our member tribes believe that tribes should have equitable access to the data IHS has. We recommended the inclusion of an objective focused on preparation and response to public health emergencies in Indian country. IHS should be involved as a partner with other agencies to address public health emergencies in Indian country. IHS ought to promote emergency preparedness and improve the response capacity in Indian Country through prioritization of resources and technical support to maximize preparedness for tribal communities. Further, we recommend IHS create an objective to ensure that the needs for disadvantaged and at-risk populations in Indian country are met in emergencies through effective collaboration with tribes to build the capacity of underserved, rural and tribal communities to respond to emergencies. ***Additional Comments*** NPAIHB requested that IHS include a preamble highlighting the trust responsibility that the federal government has with tribes. NPAIHB requested a fourth goal emphasizing health care facilities, equipment and information technology. Portland Area Tribes have numerous aging health care facilities and aging equipment that do not adequately support the health care needs of our tribal communities. We recommend that the measures created to evaluate the goals and objectives must be structured to reflect the treaty and trust obligations and must not be limited by funding. IHS must also find a way to incorporate	

		continuous quality assurance.	