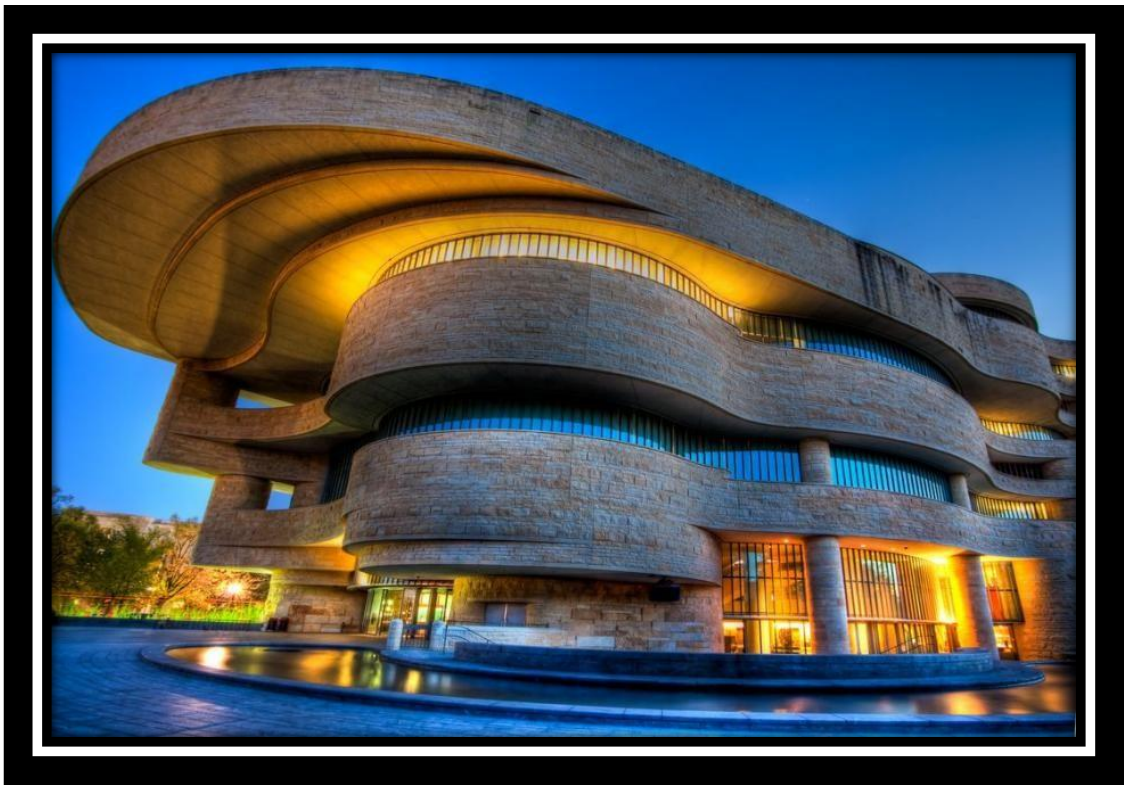
IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE (TSGAC)

QUARTERLY MEETING

January 27-28, 2016



Embassy Suites DC Convention Center

900 10th Street Northwest, Washington, DC 20001

Phone: (202) 739-2001

IHS Tribal Self-Governance Advisory Committee and Technical Workgroup Quarterly Meeting

Wednesday, January 27, 2016
Thursday, January 28, 2016

Embassy Suites Washington DC - DC Convention Center
900-10th Street NW
Washington, DC 20001
Phone: (202) 739-2001

Table of Contents

2015-2016 National Calendar

Date	Meeting	Location
January 26-27	DOI SGAC Quarterly Meeting	Embassy Suites-DC Convention Center
January 27-28	IHS TSGAC Quarterly Meeting	
February 22-25	NCAI Executive Council Winter Session	Washington, DC
March 13-17	National Indian Gaming Association Annual Conference	Phoenix, Az
March 21-24	TIBC	Washington, DC
March 21-24	RES	Las Vegas, NV
March 29-30	DOI SGAC Quarterly Meeting	Embassy Suites-DC Convention Center
March 30-31	IHS TSGAC Quarterly Meeting	Choctaw, MS
April 3-6	National Indian Child Welfare Association Annual Conference	St. Paul, MN
April 6	Self-Governance/ Indian Health Services Training	Anchorage, AK
April 18-19	NAFOA Annual Conference	Phoenix, AZ
April 24-28	2016 Annual Consultation Conference	Buena Vista Palace-Orlando, FL
May 10-12	TIBC	Washington, DC
June 7-8	Self-Governance/ Indian Health Services Training	TBD- Portland Area
June 27-30	2016 NCAI Mid-Year Conference & Marketplace	Spokane, WA
July 19-20	DOI SGAC Quarterly Meeting	Embassy Suites-DC Convention Center
July 20-21	IHS TSGAC Quarterly Meeting	
September 7-8	2016 Tribal Self-Governance Annual Strategy Session	TBD
September 19-23	NIHB Annual Consumer Conference	Tucson Area
October 5-8	NIEA National Convention	Reno, NV
October 9-14	73rd Annual NCA Convention & Marketplace	Phoenix, AZ
October 25-26	DOI SGAC Quarterly Meeting	Embassy Suites-DC Convention Center
October 26-27	IHS TSGAC Quarterly Meeting	
November 7-9	TBIC	Washington, DC
November 14-17	RES	Santa Fe, NM
November 16-17	Strategy Session	TBD

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education
P.O. Box 1734, McAlester, OK 74501
Telephone (918) 302-0252 ~ Facsimile (918) 423-7639 ~ Website: www.tribalselfgov.org

MEMBERSHIP LIST

(January 5, 2015)

AREA	MEMBER (name/title/organization)	STATUS	CONTACT INFORMATION
Alaska	**Jaylene Peterson-Nyren** Executive Director, Kenaitze Indian Tribe	**Primary**	150 N Willow St. Kenai, AK 99611 P: (907) 335-7200 Email: Jaylene@kenaitze.org
	Gerald "Jerry" Moses Senior Director, Intergovernmental Affairs, Alaska Native Tribal Health Consortium	Alternate	4000 Ambassador Drive, LIGA Department Anchorage, AK 99508 P: (907) 729-1900 Email: gmoses@anthc.org
Albuquerque	**Luis Romero, Governor** Pueblo of Taos	**Primary**	PO Box 1846 Taos, NM 87571 P: 575-758-9593 ~ F: 575-758-4604
	Raymond Loretto, DVM, Governor Pueblo of Jemez	Alternate	PO BOX 100 Jemez Pueblo, NM 87024 P: 575-834-7359 ~ F: 575-834-7331 Email: Raymond.loretto.dvm@jemezpueblo.org
Bemidji	**Greg Matson, Vice Chairman** Oneida Tribe of Wisconsin	**Primary**	PO Box 365 Oneida, WI 54155 P: (920) 869-4403 Email: gmatson@oneidanation.org
	Jessica Burger, Tribal Councilor, 9-County Representative Little River Band of Ottawa Indians	Alternate	2608 Government Center Drive Manistee, MI 49660 P: (231) 398-6867 Email: jlburger@lrboi-nsn.gov
Billings	**Beau Mitchell, Council Member** Chippewa Cree Tribe	**Primary**	PO Box 544 Box Elder, MT 59521 Email: beau@cct.rockyboy.org
	Shelly Fyant, Tribal Council Member The Confederated Salish and Kootenai Tribes of the Flathead Nation	Alternate	PO BOX 278 Pablo, MT 59855 P: (406) 275-2700 ~ F: (406) 275-2806 Email:
California	**Ryan Jackson, Council Member** Hoopa Valley Tribe	**Primary**	PO Box 1348 Hoopa, CA 95546 Email: cbfdistrict@gmail.com
	Robert Smith, Chairman Pala Band of Mission Indians	Alternate	35961 Pala-Temecula Rd. Pala, CA 92059 P: 760-891-3519 ~ F: 760-891-3584 Email: rsmith@palatribe.com
Nashville	**Marilynn (Lynn) Malerba, Chief** Mohegan Tribe of Connecticut **TSGAC Chairwoman**	**Primary**	5 Crow Hill Road Uncasville, CT 06382 P: 860-862-6192 ~ F: Email: lmalerba@moheganmail.com
	Casey Cooper, Chief Executive Officer Eastern Band of Cherokee Indians Hospital	Alternate	43 John Crowe Hill Rd. PO Box 666 Cherokee, NC 28719 Email: Casey.Cooper@cherokeehospital.org

TSGAC & Technical Work Group Membership List
July 27, 2015

Navajo	**Jonathan Nez, Vice President** Navajo Nation	**Primary**	PO BOX 7440 Window Rock, AZ 86515 P: (928) 871-7000 Email: jonmnez@yahoo.com
	Nathaniel Brown, Delegate of the 23rd Navajo Nation Council Navajo Nation	Alternate	PO BOX 3390 Window Rock, AZ 86515 P: (928) 871-6380 Email: nbrown@navajo-nsn.gov
Oklahoma	**John Barrett, Jr., Chairman** **Rhonda Butcher, Director** Citizen Potawatomi Nation	**Primary** **Proxy**	1601 S. Gordon Cooper Dr. Shawnee, OK 74801 P: 405-275-3121 x 1157 F:405-275-4658 Email: rbutcher@potawatomi.org
	VACANT	Alternate	
Oklahoma	**Jefferson Keel, Lt. Governor** Chickasaw Nation	**Primary**	PO Box 1548 Ada, OK 74821 P: 580-436-7232 ~ F: 580-436-7209 Email: lt.gov@chickasaw.net
	Gary Batton, Chief **Mickey Peercy, Executive Director** Choctaw Nation of Oklahoma	Alternate **Proxy**	PO Box 1210 Durant, OK 74702 P: 580-924-8280 ~ F: 580-920-3138 Email: mpeercy@choctawnation.com
Phoenix	**Lindsey Manning, Chairman** Shoshone-Paiute Tribes of the Duck Valley Indian Reservation	**Primary**	PO BOX 219 Owyhee, Nevada 89832 P: 208-759-3100 ~ F: 208-759-3102 Email: manning.lindseyw@shopai.org
	VACANT	Alternate	
Portland	**W. Ron Allen, Tribal Chairman/CEO** Jamestown S'Klallam Tribe **TSGAC Vice-Chairman**	**Primary**	1033 Old Blyn Highway Sequim, WA 98382 P: 360-681-4621 ~ F: 360-681-4643 Email: rallen@jamestowntribe.org
	Tyson Johnston, Vice President Quinault Indian Nation	Alternate	P.O. Box 189 (1214 Aalis Drive) Taholah, WA 98587 P: 360-276-8211 ~ F: 360-276-4191 Email: tjohnston@quinault.org

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education
P.O. Box 1734, McAlester, OK 74501
Telephone (918) 302-0252 ~ Facsimile (918) 423-7639 ~ Website: www.tribalselfgov.org

TSGAC TECHNICAL WORKGROUP

AREA	MEMBER (name/title/organization)	STATUS	CONTACT INFORMATION
Alaska	Dave Mather, Ph.D Mather & Associates	Tech Rep	1569 Northfield Rd Fairbanks, AK 99709 P: 907-455-6942 ~ F: 907-455-7391 Email: mather.david@gmail.com
	Brandon Biddle Alaska Native Tribal Health Consortium	Tech Rep	4000 Ambassador Drive Anchorage, Alaska 99508 P: 907-729-4687 Email: bbiddle@anthc.org
	Alberta Unok Deputy Director Alaska Native Health Board	Tech Rep	4000 Ambassador Drive Anchorage, Alaska 99508 P: 907-562-6006 Email: aunok@anhb.org
Albuquerque	Shawn Duran	Tech Rep	P.O. Box 1846 Taos, N.M. 87571 Office: 575.758.8626 ext. 115 Fax: 575.758.8831 Mobile: 575.741.0208 Email: SDuran@taospueblo.com
Bemidji	John Mojica Mille Lacs Band of Ojibwe	Tech Rep	43408 Oodena Drive Onamia, MN 56359 P: 320-532-7479 ~ F: 320-532-7505 Email: john.mojica@millelacsband.com
Billings	Ed Parisian Chippewa Cree Tribe	Tech Rep	PO Box 544 Box Elder, MT 59521 Email: eparisian@rbclinic.org
California		Tech Rep	
D.C. (National)	C. Juliet Pittman SENSE Incorporated	Tech Rep	Upshaw Place 1130 -20th Street, NW; Suite 220 Washington, DC 20036 P: 202-628-1151 ~ F: 202-638-4502 Email: pitt@senseinc.com
	Cyndi Ferguson SENSE Incorporated	Tech Rep	Upshaw Place 1130 -20th Street, NW; Suite 220 Washington, DC 20036 P: (202) 628-1151 ~ F: (603) 754-7625 C: (202) 638-4502 Email: cyndif@senseinc.com
	Laura Bird	Tech Rep (Health Reform)	PO BOX 67185 Albuquerque, NM 87193 Email: lauraobird@icloud.com
	Doneg McDonough	Tech Rep (Health Reform)	Phone: 202-486-3343 (cell) Fax: 202-499-1384 Email: d.mcdonough@yahoo.com
Nashville	Dee Sabattus United South and Eastern Tribes	Tech Rep	711 Stewarts Pike Ferry, Suite 100 Nashville, TN 37214 Email: dsabattus@usetinc.org

TSGAC & Technical Work Group Membership List
July 27, 2015

	Hillary Andrews United South and Eastern Tribes	Tech Rep	400 North Capitol Street, NW Suite 585 Washington, DC 20001 Email: HAndrews@USETINC.ORG
Navajo	Carolyn Drouin Navajo Nation Washington Office		750 First Street NE, Suite 1010 Washington, D.C. 20002 P: 202.682.7390 ~ F: 202.682.7391 E-mail: cdrouin@nnwo.org
Oklahoma	Mickey Peercy Choctaw Nation	Tech Rep	PO Box 1210 Durant, OK 74702 P: 580-924-8280 ~ F: 580-920-3138 Email: mpeercy@choctawnation.com
	Rhonda Farrimond Choctaw Nation	Tech Rep	PO Box 1210 Durant, OK 74702 P: 580-924-8280 ~ F: 580-920-3138 Email: rfarrimond@choctawnation.com
	Melanie Fourkiller Choctaw Nation **Tribal Technical Co-Chair**	Tech Rep	PO Box 1210 Durant, OK 74702 P: 580-924-8280 ~ F: 580-920-3138 C: 918-453-7338 Email: mfourkiller@choctawnation.com
	Theodore Scribner Chickasaw Nation	Tech Rep	PO Box 1548 Ada, OK 74821-1548 P: 580-436-7214 ~ F: 580-310-6461 Email:theodore.scribner@chickasaw.net
	Karen Ketcher Cherokee Nation	Tech Rep	PO Box 948 Tahlequah, OK 74465 P: 918-772-4130 Email: karen-ketcher@cherokee.org
	Kasie Nichols Citizen Potawatomi Nation	Tech Rep	1601 S. Gordon Cooper Dr. Shawnee, OK 74801 P: 405.275.3121 ~ F: 405.275.0198 C: 405-474-9126 kasie.nichols@potawatomi.org
	Clint Hastings Cherokee Nation	Tech Rep	PO Box 948 Tahlequah, OK 74465 P: 918-456-0671 ~ F: 918-458-6157 Email: clint-hastings@cherokee.org
Portland	Jennifer McLaughlin Jamestown S'Klallam Tribe	Tech Rep	1033 Old Blyn Highway Sequim, WA 98382 P: (360) 681-4612 ~ F: (360) 681-4648 Email: jmclaughlin@jamestowntribe.org
	Eugena R Hobucket Quinault Indian Nation	Tech Rep	PO BOX 189 Taholah WA 98587 P: (360) 276-8211 ~ F: (360) 276-8201 Email: ehobucket@quinault.org

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education
P.O. Box 1734, McAlester, OK 74501
Telephone (918) 302-0252 ~ Facsimile (918) 423-7639 ~ Website: www.tribalselfgov.org

FEDERAL TECHS

AREA	MEMBER (name/title)	STATUS	CONTACT INFORMATION
HQ	Jennifer Cooper Deputy Director, OTSG **(Federal Tech Co-Chair)**	OTSG Rep	801 Thompson Ave, Suite 240 Rockville, MD 20852 P: 301-443-7821 ~F: 310-443-1050 Jennifer.Cooper@ihs.gov
	Jeremy Marshall, Policy Analyst, OTSG	OTSG Rep	801 Thompson Ave, Suite 240 Rockville, MD 20852 P: 301-443-7821 ~F: 310-443-1050 Jeremy.Marshall@ihs.gov
Aberdeen	Sandy Nelson (POC) Director, Office of Tribal Programs	Area Rep	115 4th Avenue, SE, Suite 309 Aberdeen, SD 57401 P: 605-226-7276 ~F: 605-226-7541 Sandy.Nelson@ihs.gov
Alaska	Evangelyn Dotomain (POC) Director, Office of Tribal Programs	Area Rep	141 Ambassador Drive Anchorage, AK 99508-5928 P: 907-729-3677 ~F: 907-729-3678 Evangelyn.Dotomain@ihs.gov
California	Travis Coleman IHS Agency Lead Negotiator	Area Rep	650 Capitol Mall, Ste 7-100 Sacramento, CA 95814 P: 916-930-3927 ~F: 916-930-3952 Travis.Coleman@ihs.gov
Nashville	Lindsay King IHS Agency Lead Negotiator	Area Rep	711 Stewarts Ferry Pike Nashville, TN 37214-2634 P: 615- 467-1521 ~F: 615-467-1625 Lindsay.King@ihs.gov
Navajo	Floyd Thompson Executive Officer/ IHS Agency Lead Negotiator	Area Rep	Hwy 264 (St. Michael, AZ) Window Rock, AZ 86515-9020 P: 928-871-1444 ~F: 928-871-5819 Floyd.Thompson@ihs.gov
	Alva Tom (POC) Director, Indian Self-Determination	Area Rep	Hwy 264 (St. Michael, AZ) Window Rock, AZ 86515-9020 P: 928-871-1444 ~F: 928-871-5819 Alva.Tom@ihs.gov
Oklahoma	Max Tahsuda Director, Tribal Self-Determination IHS Agency Lead Negotiator (Acting) IHS Agency Lead Negotiator (Alaska)	Area Rep	701 Market Drive Oklahoma City, OK 73114 P: 405-951-3761 ~F: 405-951-3868 Max.Tahsuda@ihs.gov
Portland	Denise Imholt IHS Agency Lead Negotiator	Area Rep	1414 NW Northrup Street, Suite 800 Portland, OR 97209 P: 503-414-7792 ~F:503-414-7791 Denise.Imholt@ihs.gov
Tucson	Robert L. Price (POC) Public Health Advisor Office of Tribal Affairs	Area Rep	7900 South J Stock Road Tucson, AZ 85746 P: 520-295-2403 ~F:520-295-2540 Robert.Price@ihs.gov

OTHER RESOURCES		
MEMBER (name/title)	**ORGANIZATION**	**CONTACT INFORMATION**
Caitrin Shuy Director of Congressional Relations	National Indian Health Board	P: 202-507-4085 Email: cshuy@nihb.org

TSGAC Mailing Address:
c/o Self-Governance Communication and Education
P.O. Box 1734, McAlester, OK 74501
Telephone (918) 302-0252 ~ Facsimile (918) 423-7639 ~ Website: www.tribalselfgov.org

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education
P.O. Box 1734, McAlester, OK 74501
Telephone (918) 302-0252 ~ Facsimile (918) 423-7639 ~ Website: www.Tribalselfgov.org

INDIAN HEALTH SERVICE TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE
AND TECHNICAL WORKGROUP QUARTERLY MEETING
Tuesday, October 6, 2015 (8:00 am to 5:00 pm)
Wednesday, October 7, 2015 (8:30 am to 1:30 pm)

Embassy Suites Washington DC - DC Convention Center
900-10th Street NW
Washington, DC 20001
Phone: (202) 739-2001

MEETING SUMMARY

Tuesday, October 6, 2015 (8:00 am to 5:00 pm)

Meeting of Indian Health Service Tribal Self-Governance Advisory Committee (TSGAC) and Technical Workgroup with IHS Deputy Director Robert G. McSwain

Jessica Burger, Councilor of Little River Band of Ottawa Indians, provided the opening invocation.

TSGAC Opening Remarks

Chief Marilynn (Lynn) Malerba, Mohegan Tribe of Indians of Connecticut and Chairwoman, IHS TSGAC
Thank you for participating and representing Tribal nations

Roll Call:

Alaska:	Alberta Unok, Deputy Director, Alaska Native Health Board, Proxy for Jaylene Peterson-Nyren
Albuquerque:	Louis Romero, Governor, Pueblo of Taos
	Raymond Loretto, DVM, Governor, Pueblo of Jemez
California:	Maybeline Peterson, Financial Analyst, Hoopa Valley Tribe
	Danny Jordan, Self-Governance Coordinator, Hoopa Valley Tribe
Bemidji:	Jessica Burger, Councilor, Little River Band of Ottawa Indians
Nashville:	Marilynn (Lynn) Malerba, Chief, Mohegan Tribe of Indians of Connecticut
Navajo:	Jonathon Nez, Vice President, Navajo Nation
Oklahoma 1:	Rhonda Butcher, Director, Citizen Potawatomi Nation
Oklahoma 2:	Mickey Peercy, Executive Director, Choctaw Nation of Oklahoma
	Melissa Gower, Senior Policy Analyst, Chickasaw Nation
Phoenix:	Lindsey Manning, Chairman, Shoshone-Paiute Tribes of the Duck Valley Indian Reservation
	Delia Carlyle, Vice Chair, Ak-Chin Indian Community
Portland:	W. Ron Allen, Chairman/CEO, Jamestown S'Klallam Tribe
	Tyson Johnston, Vice President, Quinault Indian Nation

TSGAC Committee Business

MOTION
Citizen Potawatomi Nation made a motion to approve the July 2015 TSGAC Meeting Summary.
Pueblo of Taos seconded the motion.
Motion was approved without objection.

MOTION
Quinault Indian Nation made a motion to approve Jessica Burger, Councilor, Little River Band of Ottawa Indians as the Bemidji Area Alternate Representative.
Shoshone-Paiute Tribes of the Duck Valley Indian Reservation seconded the motion.
Motion was approved without objection.

MOTION
Jessica Burger was appointed as the Self-Governance Representative to the IHS Information Systems Advisory Committee by unanimous consent.

IHS Opening Remarks and Update

Robert G. McSwain, Principal Deputy Director, Indian Health Service (IHS)

- Mary Smith starts today as the Deputy Director for IHS. She and HHS Secretary Burwell have agreed to a set of priorities that will Mary fill in on and take on additional responsibilities.
- IHS is encouraging Centers for Medicare & Medicaid Services (CMS) to conduct Tribal Consultation to ensure that there is a continuation of services.
- The four priorities set by the previous Director are still being used, but revisions are also being made to reflect the new Urban Indian Health Care facilities confer policy.
- IHS Area Listening Sessions
    - The IHS Principal Deputy Director is calling on the areas to report to the Tribes including budget, revenue, services, etc.
    - They have finished all of the listening session
        - They've asked the Area Directors to address concerns with grant programs and access issues
        - IHS will put together a complete list of actions that were taken as a result of the listening session.
- IHS has found that the Affordable Care Act is allowing Tribes to get down to the priority four, elective services.
- Information Technology for MU 1 and 2, with 3 looming working through third party use issues
- IHS is working to address personnel shortages and long-term openings by allowing job announcements to remain open until filled.
- IHS has found that 60% of obligated providers through the loan repayment programs are staying on beyond two years.
- Generation-Indigenous Initiative
    - Every area has talked about suicides during the listening sessions.
    - IHS believes hiring young people through the pathways program is one of many new options for young people.
    - IHS is looking for other solutions that are concrete and create safe zones.
    - LGBTQ Youth have particular needs and IHS is seeking solutions for those needs.
- FY 2017 Budget
    - The IHS Budget requests have been presented to HHS and the Office of Management and Budget (OMB).
    - IHS has reported the Tribal budget formulation ideas to HHS.
    - Secretary forwarded those proposals to OMB and was very supportive of the Tribal priorities.
- FY 2018 Budget
    - Formulation will start at the region in late October.
    - New national and regional instructions were improved from last year.
- Contract Support Costs

  - IHS is still making good progress on $721 million in the CSC claims settlement process.
  - 1,273 offers have been made on the 1,412 claims.
  - The CSC Workgroup is moving forward toward policy development as well.
- IHS Methamphetamine and Suicide Prevention Intiative (MSPI) and Domestic Violence Prevention Initiative (DVPI) grants have been completed.
  - $13 million were granted to 117 MSPI programs.
  - $21 million grants were provided to 136 Tribes and Tribal Organizations serving 274 Tribes to promote domestic violence prevention.
- Special Diabetes Program for Indians (SDPI)
  - Has a new distribution methodology based on shared resources for Healthy Heart and SDPI funding.
  - Tribal Response:
    - Thank you for finding a solution to last quarter funding for tribes not on a fiscal year.
    - There are still concerns that the budget doesn't actually meet the need. There are disparities and we need to determine the level of need funding.
- Water Contamination on the Navajo Nation Reservation
  - We need better and cleaner drinking water where the Gold King Mine spill occurred.
  - Clean up is needed for mining sites and IHS has requested collaboration with the Environmental Protection Agency (EPA).
  - There is a request to build additional water wells.
  - IHS is working to fix some flooding issues in the Santa Fe facility.
- Identifying unmet need in the IHS budget.
  - IHS has learned that Mr. Cliff Wiggins is leaving.
  - This is an example of how IHS needs to find solutions to transition successors to highly technical information.
  - Tribes requested that IHS share information regarding the unmet need calculations currently utilized by IHS so that Tribes can participate in continued analysis.
- Tribal Discussion:
  - Tribes are continuing to seek an exemption from sequestration for IHS funding.
  - The Continuing Resolution process causes Tribal issues when they are looking for retention, recruitment, and long-term decisions.
  - The IHS is still approaching funding shortfalls and health care solutions with siloed solutions. The agency should consider more comprehensive solutions to meet the needs of American Indians and Alaska Natives.

Office of Tribal Self-Governance Update

P. Benjamin Smith, Director, Office of Tribal Self-Governance, IHS

- Osage Nation joined the Self-Governance Program on October 1, 2015. Bringing the Self-Governance numbers to:
  - 351 Tribes
  - 88 Compacts
  - 113 Funding Agreements
- OTSG Cooperative Agreements
  - 5 planning agreements
  - 2 negotiation agreements
- OTSG Staff
  - Program analyst interviews are moving forward this week.
- Self-Governance funding disbursements.

  - IHS will follow what has been included Funding Agreements.
  - Should expect 19.67% of the enacted level after a .2108% reduction.
- OTSG has coordinated Tribal delegation meetings that have provided great feedback beyond area listening sessions. Additionally, input from TSGAC is extremely important to the agency.
- Affordable Care Act National Indian Health Outreach & Education funding through Jamestown S'Klallam Tribe will continue in FY 2016. The group is planning several webinar and electronic training sessions.
- The Self-Governance Database has been updated and is now the OTSG Financial Management System.
  - Should be able to generate additional reports.
  - Kevin Quinn can assist in using the database if there are questions.

Contract Support Costs (CSC) Workgroup Update and Discussion

Chief Marilynn (Lynn) Malerba, Mohegan Tribe of Indians of Connecticut
Chairman W. Ron Allen, Jamestown S'Klallam Tribe
Mickey Peercy and Rhonda Butcher, IHS Contract Support Costs Workgroup Members
Roselyn Tso, IHS CSC Team Lead

- Tribal Discussion
  - Negotiated rates with Interior Business Center (IBC).
    - The policy discussion process has been frustrating because the Department of the Interior (DOI) is not taking this position.
    - Tribes believe the decision is being driven by the settlement and claims issues.
    - IHS needs to accept the procedures Tribes and IHS has already agreed too.
    - Categorical duplication of costs is also an issue that must be addressed.
  - The policy needs to provide for a range of options to Tribes.
  - Tribes request that IHS try to interpret the law to benefit Tribes as much as possible.
  - There is no way to make money on the Indirect Cost (IDC) rate.
  - The position of Tribes has been that the detailed changes proposed by the Agency are a direct result of the claims process.
- Workgroup will meet tomorrow to discuss incurred costs.
- Tribes believe the IHS Agency Lead Negotiators (ALNs) are not consistently negotiating across all Areas.
  - IHS has agreed that they are working to train ALNs to create more consistency.
- IHS has provided CSC training in 2014 and 2015 (9 of the areas have received training) on the Annual Cost Calculator (ACC) tool.
- IHS believes they are honoring the IBC rate
  - The agency is looking at the statute and the interpretation of the statute is different.
  - The Tribe's rate is not the only document that includes CSC.
  - IHS is trying to get out of the claims process, so they are trying to develop a streamlined approach to be able to appropriately calculate the exact costs of CSC.
  - IHS is trying to get better at calculating the actual rates and treating all Tribes fairly
- What other documents are used to calculate CSC
  - Is only calculated on dollars are paid to the Tribe
  - Look at the IBC rates and the duplication of costs

Budget Update

Elizabeth Fowler, Deputy Director for Management Operations, IHS
Melanie Fourkiller, Policy Analyst, Choctaw Nation and TSGAC Tribal Co-Chair
Caitrin Shuy, Director, Congressional Relations, NIHB

- Preparing for FY 2017 Budget Formulation
    - There will be different instructions this year to try and include a greater number of area-specific recommendations.
    - We do need to keep strengthening how we engage stakeholders together.
    - Information from tribes justifying increases has been very helpful.
    - However IHS has not done a great job of aligning dollars with program improvements.
    - This year the formulation team will try to answer "What improvements will you make with this amount of money?"
        - Performance measures and can we point to the changes that will occur as a result of increases.
        - Could Tribes track unfunded services instead of disease programs?
            - Purchased/Referred Care (PRC) and Catastrophic Health Emergency Fund (CHEF) is the only places we track that are unmet needs
- We've always heard that HHS uses a different inflationary rate than IHS uses for health care services. Is that true?
    - We need to have more in-depth discussions regarding inflation rates.
- Tribes reiterated that their preference is not to put increases into grants or short-term funding.

Patient Protection and Affordable Care Act (ACA) Implementation and Update

Mim Dixon, Consultant, Tribal Self-Governance Advisory Committee
Cyndi Ferguson, Self-Governance Specialist/Policy Analyst, SENSE Incorporated
Doneg McDonough, Consultant, Tribal Self-Governance Advisory Committee

- IHS will continue to fund ACA Outreach and Education for TSGAC
- Tribal sponsorship through Marketplace
    - Making sure any Tribe can do sponsorship.
    - Initial data is very favorable.
    - Tribes are currently adding language to the contracts and Funding Agreements (FAs) to allow for this.
    - There will be case studies to follow up on the effectiveness of the sponsorship programs.
- Introduction of Laura Bird as the new technical representative to TSGAC.
- There is a survey to collect feedback about the types of trainings that will be hosted under the ACA work plan.
- The final ACA outreach magazine and success stories were distributed at the National Congress for American Indians (NCAI) annual meeting.

Tribes as Employers under the ACA

Doneg McDonough, Consultant, Tribal Self-Governance Advisory Committee
Elliott Milhollin, Partner, Hobbs Strauss Dean & Walker
Laura Bird, Legislative Associate, National Congress of American Indians

- Cadillac Health Care Plan "Tax"
    - Tribal Discussion
        - The notion and calculation of what is considered a Cadillac plan, invoking the tax penalty, is incorrect
        - Tribes should be exempted as governments
        - What can be done administratively in terms of IRS' interpretation
        - Is this a tax on Tribal Government?
            - Yes, effectively because you are purchasing the insurance plan
- Employer Mandate Exemption
    - Our request is to delay implementation while we try to work out another issue

Centers for Medicare & Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG) Updates

Chairman W. Ron Allen, Jamestown S'Klallam Tribe
Terri Schmidt, Acting Director, Office of Management Services, IHS
Kitty Marx, Director, Division of Tribal Affairs, CMS

- Pending rule for grandfathered Federally Qualified Health Centers (FQHC)
  - It is very burdensome administratively.
  - Tribes will get about a third of the payment IHS is currently getting.
  - The grandfathered plan was put in place to address the unique position of the Tribal systems.
- 100% Federal Medical Assistance Percentage (FMAP) Proposals
  - Alaska expanded Medicaid.
  - South Dakota submitted a proposal for FMAP.
  - Working with Tribes and Tribal organization to expand FMAP under consultation.
  - Using contractual arrangements between Tribes and IHS to allow billing back up through the program, clinic, and hospital.

IHS Updates on ACA and IHCIA

Terri Schmidt, Acting Director, Office of Management Services, IHS
Francis Frazier, Acting Director, Office of Public Health Support, IHS

- IHS Medicare-Like Rates Regulation – status and measurement of outcomes
  - HHS is Proposing to call the rule PRC rates
  - They are in the third re-write and fourth round of interviews.
  - Estimated timeline?
    - It may go through the department this time?
    - Maybe January 1, 2016
    - It will probably take a long time to get through OMB
- Aligning Quality Data Requirements for Medicare, Medicaid and Government Performance and Results Act (GPRA)
  - They are working to get on the technical level to determine what can be integrated
  - Additional variable that to be considered is other integrated methods and ability to run reports through the National Data Warehouse.
  - Interface between proprietary and non-proprietary systems.
  - We need to know how best to pull data that communicates real changes and improvements.
  - The essential part of this is to create consistency in reporting data.
  - IHS is trying to figure out how and where to make the measurements the same while respecting the budget process.
    - It is tiresome to go through the HHS process to move GPRA measures around.
- Updating the Resource and Patient Management System (RPMS) system to accept third party data systems
  - Tribes want one database system that can extrapolate many measures and share information from across the board.

Joint TSGAC and IHS Deputy Director Discussion

- Facilities
  - The IHS Facilities Appropriation Advisory Board (FAAB) will prepare statement for March with top five priority clinics.

  - $185 million budget and defense will be easier
- When is the next FAAB meeting?
  - November 18-19 in Phoenix, AZ
- Joint Venture Construction Program apps will be approved for the remaining four of the top seven.
- MLR Regulation
  - HHS has had the rule four times, OMB has not reviewed it yet
  - Per the regulatory agenda IHS is 109 days late
  - Nothing has been signed to change the name of the rule
- Update on IHS/VA PRC inclusion
  - Mr. McSwain is pursuing this discussion now with the Secretary of VA.
  - VA Secretary McDonald was amenable to open discussions. IHS Chief Medical Officer Dr. Susan Karol will lead the negotiations from this point.
  - Tribal Discussion:
    - How well are IHS-VA MOUs represented?
      - All 128 service units are reporting on the IHS side.
    - Can the VA provide a report on the agreements?
      - IHS will work to create something.

Wednesday, October 7, 2015 (8:30 am – 1:30 pm)

Meeting of IHS Tribal Self-Governance Advisory Committee (TSGAC) and Technical Workgroup with IHS Deputy Director Robert G. McSwain

Chairman Lindsey Manning provided the invocation.

Roll Call:

Alaska:	Alberta Unok, Deputy Director, Alaska Native Health Board, Proxy for Jaylene Peterson-Nyren
Albuquerque:	Louis Romero, Governor, Pueblo of Taos
	Raymond Loretto, DVM, Governor, Pueblo of Jemez
California:	Maybeline Peterson, Financial Analyst, Hoopa Valley Tribe
	Danny Jordan, Self-Governance Coordinator, Hoopa Valley Tribe
Bemidji:	Jessica Burger, Councilor, Little River Band of Ottawa Indians
Nashville:	Marilynn (Lynn) Malerba, Chief, Mohegan Tribe of Indians of Connecticut
Navajo:	Jonathon Nez, Vice President, Navajo Nation
Oklahoma 1:	Rhonda Butcher, Director, Citizen Potawatomi Nation
Oklahoma 2:	Mickey Peercy, Executive Director, Choctaw Nation of Oklahoma
	Melissa Gower, Senior Policy Analyst, Chickasaw Nation
Phoenix:	Lindsey Manning, Chairman, Shoshone-Paiute Tribes of the Duck Valley Indian Reservation
	Delia Carlyle, Vice Chair, Ak-Chin Indian Community
Portland:	W. Ron Allen, Chairman/CEO, Jamestown S'Klallam Tribe
	Tyson Johnston, Vice President, Quinault Indian Nation

Introductions – All Participants & Invited Guests

Opening Remarks

Chief Marilynn (Lynn) Malerba, Mohegan Tribe of Indians of Connecticut and Chairwoman, IHS TSGAC
Robert G. McSwain, Deputy Director, Indian Health Service

Joint TSGAC and IHS Deputy Director Discussion

- IHS Deputy Director Mr. McSwain provided the following opening remarks and updates to the TSGAC
  - Pharmacy and Medically Underserved Areas Enhancement Act
    - TSGAC requested support for the Pharmacy Enhancement Act to open a medical billing stream as health providers. Because Pharmacists provide health service this would allow I/T/Us to increase third party revenue.
    - IHS Response:
      - Agrees that IHS relies on pharmacists to provide consultation and health services to users.
      - IHS will look to support this and determine if there are additional benefits to I/T/Us
      - Legislative affairs and others will track this issue.
      - Is there a place where we are billing as providers?
        - Geoff will ask Carl Harper to determine if there is a place where IHS is billing for pharmacists as providers.
        - There was a time in IHS was doing it Arizona, but this legislation would be different.
  - OTSG Report to Congress
    - TSGAC provided comments to the Annual Report Congress and leaders would like to know what the next step in the process.
    - IHS Response:
      - The law requires that the comments be included in the report to Congress
      - There were some strong recommendations from TSGAC and four others and they are looking to incorporate the changes in the report.
  - Class Action Employee Unions Settlement
    - TSGAC requested an update regarding the settlement. There was also a request about the guidance IHS is providing to ensure the opportunity for future lawsuits are minimized.
    - IHS Response:
      - Status of the case is the on August 14, 2015 $80 million dollars was transferred to Unions
      - IHS is matching the claims to clinics, hospitals, and areas. IHS is also having additional conversations with the arbiter because they are seeing claims in areas that were not originally discussed.
      - IHS will provide the following information:
        - Number of employees per service unit
        - Amount of resources per service unit
        - Why they were holding back resources?
      - Mr. McSwain has seen the initial information from the Areas and requested additional detail before sharing with Tribes.
      - IHS is missing a satisfactory response from Areas about why they are holding funds back from previous years.
      - Suits are being filed against other Operating Divisions with regard to overtime and FLSA
        - Mandatory training for all supervisors throughout the system

        - IHS went back through all of the position descriptions to make sure they are properly coded
        - Biggest disadvantage is that IHS has clinical providers who are managers balancing patient care and administrative functions.
        - HHS is watching the agency so that they can replicate processes if necessary.
    - TSGAC wants to make sure that we have processes and policies in place to ensure this doesn't happen again.
    - Are the FLSA standards changing?
        - IHS Response:
            - OPM left interpretation of each positions status as exempt or non-exempt.
            - IHS has reviewed all their positions descriptions to determine which are exempt and non-exempt.
- o RPMS
    - Self-Governance Tribes in many areas are having trouble access the technical assistance needed to stay in the RPMS system. Tribes are finding that many of the experts are retiring.
    - IHS Response:
        - There has been a lot of distraction because of other federal requirements related to Meaningful Use I and II and ICD-10.
        - There are difficulties implementing help desk and every level unit, area, and headquarters.
        - IHS recognizes that there are additional needs because of changes to meet federal requirements.
        - There have also been difficulties because of the data center moving from Albuquerque. The transition has been suspended, so that people can continue to oversee the center and servers.
        - This is the only federal EHR system that is certified.
        - OIT did conduct a survey last year with 66% response rate and TSGAC requested an aggregated report of the findings from the survey.
        - IHS also still needs to close the loop on the MPA letter sent to Tribes.
- o Staffing within the Bureau of Indian Affairs and IHS

  TSGAC Discussion
    - The average age at the two agencies is much older and about 60% are due for retirement in the near future.
    - We should discuss this at future conference or meeting.
    - Perhaps as the agency loses its workforce, we need to discuss how those positions will be filled with Tribal positions and sustaining the agencies at a level that makes sure the trust responsibility is fulfilled.
    - The reverse IPA is a model to consider.
- o Title VI Expansion and/or Crosscutting
    - There's a real inconsistency between the Department's adversity to Title VI and the President's willingness to promote the crosscutting budget.
    - Tribes are not seeing more flexibility or contracts, but the $21 billion actually represents primarily competitive grants. Grants require Tribes to use staff to seek out funding.
    - Tribes have interest in leveraging funding from other agencies with IHS to provide professional housing and ancillary programs to enhance health systems.

        - Failing to promote more consistent funding and flexibility is resulting in a perpetuation of more sophisticated Tribes being successful, while smaller Tribes with less capacity to plan, apply, and receive grants to support their community needs.
        - Some agencies are actually designing grants so that Tribes are not eligible or cannot qualify because the qualifications are too great for Tribes.
    - Youth Suicide as a Crosscutting Issue
        - This is another crosscutting issue where there are barriers because of the funding mechanisms across numerous agencies.
        - Central Council of Tlingit and Haida volunteered to assist in breaking down the barriers and creating a more seamless system.
        - This may be an example of a crosscutting issue on which Tribes could make significant progress.
        - IHS Response:
            - Mr. McSwain agrees with the Tribal comments on crosscutting budget.
            - He also restated the Tribal position to be that the government-to-government relationship is with the Federal government, not only the IHS.
    - Navajo Feasibility Study
        - The report indicates that it is feasible for Navajo to operate its own Medicaid program.
        - It takes statutory and legislative authority for CMS to fund directly.

ACA Employer Mandate Exemption and Cadillac Tax Discussion

Chief Marilynn (Lynn) Malerba, Mohegan Tribe of Indians of Connecticut and Chairwoman, IHS TSGAC
Dr. Elaine Buckberg, Deputy Assistant Secretary for Policy, Office of Economic Policy, Department of Treasury

- Employer Mandate
    - We are asking the Internal Revenue Service (IRS) to either make a determination to exempt Tribes or delay implementation in those communities while we work out issues.
    - IRS has determined the issue must be legislatively fixed.
        - Tribes did not comment on this issue during the proposed rules
        - 4988-H does apply to Tribal governments
    - It would be valuable to share comments both orally and in written form.
- Cadillac Tax
    - Deadline for comments on Excise tax were due on October 1, 2015
    - The Tribal request is that Tribes be exempted because we believe the law already excludes us.

TSGAC Adjourned at 1:30 PM

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education
P.O. Box 1734, McAlester, OK 74501
Telephone (918) 302-0252 ~ Facsimile (918) 423-7639 ~ Website: www.tribalselfgov.org

Technical Workgroup
Assignment Matrix – October 2015 Quarterly Meeting
Updated: January 15, 2016

Technical Workgroup Co-Chairs:
Melanie Fourkiller, Tribal Co-Chair
Jennifer Cooper, Federal Co-Chair

	Assignment	Person(s) Responsible	Date Task Originated	Status
1.	All correspondence with Secretary: discuss impact, relationships, and teamwork (refer to TSGAC summary 7/30/14). If the TSGAC specifically desires a response from the Sec'y, the letter should state so.	All	July 31, 2014	INFORMATIONAL ONLY. Consider when drafting correspondence to HHS Secretary.
2.	Continue to gather data from all Areas about impact of CR/shutdown. Specific programmatic impact, such as layoffs, closed programs, PRC, bad patient outcomes, etc. Reach out to the Health Directors in each Area.	Terra Branson	July 31, 2014	Ongoing – SGCE requested additional data and stories at the Strategy Session hosted recently
3.	Develop and include in IHS Self-Governance Policy protocols for self-governance negotiations, including but not limited to expectations for information and document sharing and protocol for proper communication with Tribal leadership. Review with TSGAC. (see April 10, 1997 letter to TSGAC from previous IHS Director). 1997 IHS Director Letter [SG Negotiations issue – whether IHS ALNs should accept provisions (at Tribal option) that have been previously negotiated in other Compacts/FAs, to the extent applicable to that Tribe.]	Ben Smith OTSG Mickey Peercy Rhonda Farrimond Melanie Fourkiller Cyndi Ferguson Jennifer LaMere	July 10, 2013	See recommendations under workgroup report tab
4.	Set up meeting with OMB (Julian Harris) through Reina Thiele, White House, re: Tribal 3rd party data being requested and effects of CRs (alternatives to Advanced Appropriations).	W. Ron Allen Jennifer McLaughlin	July 31, 2014	Hold and monitor for any future action needed. White paper developed.
5.	Appropriations "Think Tank" -- Develop ideas/options for: (1) Potential solutions to CRs (alternatives to Advanced Appropriations, such as an entire year CR with a "true up", etc; and (2) Long	Carolyn Crowder (Lead) Brandon Biddle Caitrin Shuy Liz Malerba Lloyd Miller	July 31, 2014	Ongoing – Submitted Long-Term CSC recommendations on August 28, 2014; Requested an "anomaly" from OMB for CSC

	term 'fix' for Contract Support Cost appropriations (alternatives to Mandatory Appropriations).			funding on September 5, 2014; held Budget Summit on Oct 13-14, 2014.
6.	Follow up regarding employer mandate in the ACA.	Mim Dixon	January 28, 2015	IRS is still considering options. Employer reporting deadline has been extended.
7.	Letter to IHS Director regarding transparency in funding tables for Facilities Acct, timeliness of fund distribution, application of formulas to OEHE funds, and funding for Small Ambulatory Grants and Dental Health Stations		March 25, 2015	
8.	Develop metrics to evaluate effectiveness of MLR after implementation.	Mickey Peercy (PRC Workgroup) Doneg McDonough	April 13, 2015	
9.	Write a letter to Deputy Director on OEHE issues regarding transparency and consultation on funding distribution methodologies for projects	Melanie Fourkiller Melissa Gower	July 22, 2015	
10.	Generate some examples of anti kickback statutes are or could potentially inhibit Tribes regarding health care reform.	Mim Dixon Melissa Gower Melanie Fourkiller Dave Mather Myra Munson SGCE to coordinate	July 22, 2015	
11.	Letter to Dr. Buckberg thanking her for attending TSGAC and addressing the requested extension on the employer mandate deadline, while other administrative remedies are being explored (make specific recommendations).	Mim, Doneg, Laura	October 7, 2015	Completed.
12.	Letter to Dr. Buckberg regarding Excise Tax; specifically requesting that any regulation or guidance issued clarify that Tribal governments are not included in the definition of Governmental plans.	Laura	October 7, 2015	Completed.
13.	Memo to TSGAC once the ECP List is published, conduct broadcast via SGCE and OTSG to SG Tribe and provide as an FYI to Office of Contracting and Direct Service Tribes	Doneg, Raho, and SGCE	October 7, 2015	Completed
14.	TSGAC Letter to the CMS Administrator regarding the proposed Grandfathered FQHCs	Melissa & Melanie	October 7, 2015	Completed
15.	Letter to IHS Principal Deputy requesting an accounting be made to all tribes, of funds paid for settling the civil service overtime claims, by SU.	Melanie	October 7, 2015	Completed.
16.	Letter from SGCE to Congress in	SGCE/Sense	October 7, 2015	

	support of the Pharmacy Enhancement Act.			
17.	Letter from SGCE regarding exemption from Sequestration and consideration of the Senate CSC language in the final FY 2016 Appropriations.	SGCE/Sonosky/ Hobbs	October 7, 2015	Completed.
18.	Letter to the Principal Deputy requesting follow up on the Tribal comments to the Multi-Purpose Agreement draft.		October 7, 2015	
19.	Letter appointing Councilwoman Burger to the ISAC	SGCE	October 7, 2015	Completed.
20.	Letter to OMB requesting a meeting with OMB between the Co-Chairs to discuss the OMB Tribal Advisory Committee	Jennifer McLaughlin	October 7, 2015	
21.	Letter to Burwell and McSwain regarding speedy resolution of MLR rule. Also include on the STAC Agenda. Also share request with OIRA at OMB.	Terra, Melanie	October 7, 2015	Completed
22.	National solution to AI/AN Medicaid – reconvene the workgroup and determine what implementation will require.	Workgroup	October 7, 2015	
23.	Develop a concept paper to suggest new ways to measure need that include pieces beyond LNF.	Doneg, Mim, Laura, Rhond B	October 7, 2015	
24.	Letter to IHS Principal Deputy Director regarding CSC duplication of costs.	Melanie, Rhonda B, Vickie, Hobbs, Sonosky	October 7, 2015	Completed

Summary of IHS Tribal Self-Governance Advisory Committee (TSGAC) Correspondence
Year: 2015-2016

Updated: January 13, 2016

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
1.	1/15/16	Center for Consumer Information and Insurance Oversight, CMS, HHS	Comments on Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces	TSGAC Comments on Draft Letter	
2.	1/13/16	Mr. Thomas West Tax Legislative Counsel Office of Economic Policy Department of Treasury	Invited to Jan 27-28, 2016 TSGAC Meeting	Continue discussion on Permanent Administrative Relief from Affordable Care Act's Employer Mandate on Tribes for Tribal Member Employees	Response Received January 14, 2016. Mr. West and others are unavailable, but continue to work on this issue as it is related to Tribes.
3.	1/5/16	Jerry Menikoff, M.D., J.D. Office for Human Research Protections Department of Health and Human Services 1101 Wootton Parkway Suite 200 Rockville, MD 20852	HHS-OPHS-2015-0008 – Proposed Revisions to the Federal Policy for the Protection of Human Subjects	TSGAC Official Comments on Proposed Rule	
4.	12/21/15	Centers for Medicare & Medicaid Services	CMS-9937-P, Notice of Benefit and Payment Parameters for 2017	TSGAC Official Comments on Proposed Regulation	
5.	11/17/15	Kitty Marx CMS	TSGAC comments	Support for 100 Percent FMAP Proposal	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
6.	11/10/15	Mr. Robert McSwain Principal Deputy Director, IHS	Payment of Settlements to Civil Service Employees	TSGAC requests that IHS provide an accounting to all Tribes of all payments made by IHS into the employee settlement fund by IHS Service Unit location, as well as the number of employees participating in settlement payments at each location.	
7.	11/9/15	U.S. Department of Health and Human Services Office for Civil Rights	Nondiscrimination in Health Programs and Activities (RIN 0945-AA02). 80 Fed. Reg. 54172 (Sep. 8, 2015).	TSGAC comments in response to its proposed rule on Nondiscrimination in Health Programs and Activities (RIN 0945-AA02). 80 Fed. Reg. 54172 (Sep. 8, 2015).	
8.	11/3/15	Mr. Robert McSwain Ms. Mary Smith IHS	Interpretation of Duplication Provision in 25 U.S.C. § 450j-1(a)(3)	TSGAC respectfully urges IHS to restore its prior position that funding for contract support costs will only be considered duplicative to the extent amounts for those items have been transferred in the Secretarial amount.	Response received from Mr. McSwain on 12/4/15. Due to pending litigation, the IHS letter provides a general response to the issues outlined in the TSGAC original correspondence of 11/3/15.
9.	11/3/15	Honorable Sylvia M. Burwell, Secretary Department of Health and Human Services	Final Rule related to expand the Medicare-Like Rate	TSGAC requests that HHS expedite the review and publication of the Final Rule related to expand the Medicare-Like Rate, entitled *"Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Programs and Medical Charges Associated With Non-Hospital-Based Care,"* 79 Fed. Reg. 72160, originally published on December 5, 2014.	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
10.	10/27/15	Honorable Robert A. McDonald Secretary of Veterans Affairs	Comments on Veterans Access, Choice and Accountability Act of 2014 (Choice Act)	Comments on the Secretary of Veterans Affairs' (VA) pending report to Congress concerning the consolidation of "all non-Department provider programs" pursuant to the Veterans Access, Choice and Accountability Act of 2014 (Choice Act).	
11.	10/26/15	Dr. Elaine Buckberg Deputy Assistant Secretary for Policy Office of Economic Policy Department of Treasury	Request for Permanent Administrative Relief from Affordable Care Act's Employer Mandate on Tribes for Tribal Member Employees	TSGAC provided a set of preferred options for addressing Tribal concerns pertaining to the imposition of the ACA's employer coverage and reporting requirements as they pertain to Tribal member employees.	
12.	10/23/15	Dr. Elaine Buckberg Deputy Assistant Secretary for Policy Office of Economic Policy Department of Treasury	Request for Extension of Transition Relief from the Employer Mandate	TSGAC requested an extension of transition relief in implementation of the employer mandate from January 1, 2015 until at least January 1, 2016 and preferably to January 1, 2017.	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
13.	10/21/15	Dr. Elaine Buckberg Deputy Assistant Secretary for Policy Office of Economic Policy Department of Treasury	Excise Tax on Certain Employer-Sponsored Health Benefits	Tribal leaders interpret Section 4980I as not applying to Tribal government thereby interpreting this to mean that the excise tax does not apply to Tribal government plans. The legal analysis for this position is provided in TSGAC's comments to the IRS on Notice 2015-16, submitted on May 15, 2015 (attached) to letter and again in further comments submitted on October 14, 2015 (also attached to letter).	
14.	10/16/15	Mr. Robert G. McSwain Mr. Ben Smith Mr. Carl Harper	Transmittal of FINAL Self-Governance National ACA Education and Outreach Report	No action needed. Transmittal of final report for the time period October 1, 2014 through September 30, 2015.	
15.	10/14/15	Internal Revenue Service P.O. Box 7604 Ben Franklin Station, Room 5203 Washington, DC 20044	Notice 2015-52 on Section 4980I — Excise Tax on High Cost Employer Sponsored Health Coverage	TSGAC comments and recommendations.	
16.	10/13/15	CDR Mark Rives Chief Information Officer and Director Office of Information Technology Indian Health Service The Reyes Building 801 Thompson Avenue Rockville MD, 20852	TSGAC Representative to ISAC	Appointment of Jessica Burger.	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
17.	9/30/15	Mr. Jeff Wu Deputy Director Center for Consumer Information and Insurance Oversight Centers for Medicare and Medicaid Services	Response to Request for Tribal Consultation on Referrals for Limited Cost-Sharing Variation Plans	TSGAC comments and recommendations.	
18.	8/28/15	Mr. Robert G. McSwain, Principal Deputy Director Indian Health Service	Fiscal Year 2014 Report to Congress on the Administration of the Tribal Self-Governance Program	TSGAC input on report in response to IHS request for comments.	
19.	8/4/15	Dr. Elaine Buckberg Deputy Assistant Secretary for Policy Office of Economic Policy Department of Treasury	Exemption of Tribes from the ACA Employer Mandate	Invitation to October 2015 TSGAC Quarterly meeting to discuss topic.	Confirmed attendance for Oct 7, 2015 at 10:30 am. Pre-briefing scheduled for Oct 2.
20.	8/4/15	Mr. Robert G. McSwain, Principal Deputy Director Indian Health Service	Quality Reporting Measures	Request that IHS conduct an analysis and comparison of the GPRA and Clinical Quality Management approaches.	Response received from Mr. McSwain on October 5, 2015. Mr. McSwain notified the TSGAC regarding implementation of a major change beginning in FY2016 on GPRA clinical performance measures. The IHS is prepared to implement the Integrated Data Collection System Date Mart (IDCS DM), a new reporting mechanism within the National Data Warehouse.
21.	8/4/15	Centers for Medicare and Medicaid Services Department of Health and Human Services Attn: CMS-10561	Comments on CMS-10561, ECP Data Collection to Support Qualified Health Plan (QHP) Certification for PY 2017	TSGAC Official Comments	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
22.	7/28/15	Geoffrey M. Standing Bear Principal Chief Osage Nation	Welcome to Self-Governance		
23.	7/27/15	Mr. Robert G. McSwain, Principal Deputy Director Indian Health Service	Multi-Purpose Agreement (MPA) and Joinder Agreement & ISAC Presentation	Address Tribal comments on MPA; and follow up with OIT to host Webinar regarding ISAC.	
24.	7/27/15	Centers for Medicare and Medicaid Services	Comments on CMS-2390-P, "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability: Proposed Rules	TSGAC provided a series of substantive comments (26 pages); along with accompanying attachments. The TSGAC comments mirror the model template developed by a team of health care experts from the MMPC/NIHB.	
25.	7/10/15	Carolina Manzano Chief Executive Officer Southern Indian Health Council, Inc.	Welcome to Self-Governance		
26.	7/10/15	Vincent Armenta Tribal Chairman Santa Ynez Band of Chumash Indians	Welcome to Self-Governance		

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
27.	7/10/15	Dan Courtney Chairman Cow Creek Band of Umpqua Tribe of Indians	Welcome to Self-Governance		
28.	6/29/15	Mr. Robert G. McSwain, Acting Director Indian Health Service	Determination of Contract Support Cost Requirements	TSGAC comments in response to IHS's position that the amount of contract support costs (CSC) owed under its contracts and compacts with Tribes and Tribal organizations under the Indian Self-Determination Act (ISDA) is determined based on "incurred costs."	
29.	6/12/15	Mr. P. Benjamin Smith, Director, Office of Tribal Self-Governance, Indian Health Service	Tribal Leadership Priorities for "Self-Governance National Indian Health Outreach and Education"	The TSGAC reaffirms the commitment to empower Tribal communities with the knowledge and tools needed to successfully manage and implement the Patient Protection and Affordable Care Act/Indian Health Care Improvement Act (ACA/IHCIA) provisions concerning health care insurance coverage options to improve the quality and access to care for Tribal citizens and Indian communities. TSGAC urges OTSG to amend the Agreement to renew and fund the "Self-Governance National Indian Health Outreach and Education" contract for FY2016	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
30.	6/9/15	Mr. Robert G. McSwain, Acting Director Indian Health Service	Payment of IHS Employee Settlements.	TSGAC provided comments to the May 22, 2015 IHS *Dear Tribal Leader Letter* (DTLL) on the Payment of Employee Settlements. For the current settlement described in the DTLL, and for any future settlements, the TSGAC strongly urges the IHS to reject the flawed plan to cut health care services and consider one or both alternatives proposed.	IHS Deputy Director provided a response back to Tribal Leaders on July 29, 2015. The letter addresses three questions about the settlement that have been raised frequently in various forums since then.
31.	5/15/15	Internal Revenue Service	Notice 2015-16 on Section 4980I — Excise Tax on High Cost Employer-Sponsored Health Coverage	TSGAC Comments in Request to Notice from IRS.	
32.	4/27/15	Mr. Robert G. McSwain, Acting Director Indian Health Service	Healing our Spirits Worldwide Gathering	Request of IHS support in this effort and the participation of P. Ben Smith, Director, Office of Tribal Self-Governance (OTSG).	IHS Responded on August 29, 2015 to the TSGAC and stated that Mr. Smith is confirmed to attend and participate in the HOSW gathering.
33.	4/23/15	Mr. Robert G. McSwain, Acting Director Indian Health Service	Detail of OTSG Deputy Director	TSGAC request to Director to re-evaluate the detail and assign other staff to OUIHP as soon as practicable.	IHS Responded on August 29, 2015 to the TSGAC and stated that OTSG Deputy Director has officially returned to her position as of 7/27/15.
34.	4/21/15	Mr. Robert G. McSwain, Acting Director Indian Health Service	Special Diabetes Program for Indians (SDPI)	TSGAC comments in response to the DTLL request for comments/consultation on the SDPI programs.	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
35.	4/20/15	Mr. Robert G. McSwain Mr. Ben Smith Mr. Carl Harper	Transmittal of Self-Governance National ACA Education and Outreach Report	No action needed. Transmittal of 6-month report for the time period October 1, 2014 through March 31, 2015.	
36.	4/8/15	Mr. Robert G. McSwain, Acting Director Indian Health Service	Payment of Contract Support Costs for MSPI and DVPI funding	Request that the agency review this issue and that, as committed during 3/24/15 TSGAC meeting, provide a final decision to Tribes on the eligibility of MSPI/DVPI for additional CSC funds within 30 days.	A Dear Tribal Leader was sent out from IHS Acting Director McSwain on 6/22/15 with an update on how the IHS will move forward with MSPI and DVPI over the next five years. Response received from IHS Acting Director McSwain on 5/18/15. Letter stated the IHS is not required to provide additional funds beyond what is included in the project budgets.
37.	4/8/15	Mr. Robert G. McSwain, Acting Director Indian Health Service	Thank you on Rates of CSC Settlement and Claim Resolutions	Continue timely resolution of outstanding claims and consistent full funding of CSC.	
38.	4/3/15	Mr. Gregory E. Demske, Chief Counsel to the Inspector General Ms. Melinda Golub, Senior Counsel Mr. Amitava "Jay" Mazumdar, Senior Counsel Office of Counsel to the Inspector General	Thank you for participating in the Tribal Self-Governance Advisory Committee Quarterly Meeting, March 24, 2015	Further dialogue to occur during the Thursday, April 30th Breakout Session A7, ***Pursuing and Reinvesting Third Party Revenue,*** at the upcoming 2015 Annual Tribal Self-Governance Consultation Conference in Reno, NV	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
39.	2/26/15	The Honorable Derek Kilmer	Self-Governance Tribes 2015 Appropriations Requests for the Bureau of Indian Affairs	Joint letter from TSGAC/SGAC	
40.	2/10/15	The Honorable Derek Kilmer	Self-Governance Tribes 2015 Appropriations Requests for Indian Health Service	Joint letter from TSGAC/SGAC	
41.	2/9/15	Chief Marilynn Malerba, Chairwoman TSGAC	Agency response to information requested QHPs to IHCPs in specific regions	CMS staff are available to address specific QHP problems and provide further assistance in the process	Response from Marilyn Tavenner, CMMS 2/2/15 to letter dated 12/19/14
42.	1/31/15	Chief Marilynn Malerba, Chairwoman TSGAC	Agency response to the ongoing and unprecedented international Ebola crisis		Response from Dr. Y.Roubideaux, IHS Director, 1/31/15 to letter dated 10-17-14
43.	2/5/15	IHS Director,Dr. Y. Roubideaux	Mandatory Appropriations for Contract Support Coasts	Appreciated partnership and looking forward to working to advance long-term solutions for funding CSC	
44.	2/4/15	Betty Gould, Regulations Officer, IHS and Carl Harper, Director ORAP,IHS Submit via regulations.gov	Comments on IHS Proposed Rule entitles "Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Programs and Medical Charges Associated with	Being able to engage in Tribal Consultation on the proposal	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
			Non-Hospital-Base Care		
45.	1/20/15	Chief Marilynn Malerba, Chairwoman TSGAC	Concerns regarding procedural consistency and information sharing during CSC negotiations on Disputed claims		Response from Dr. Y. Roubideaux, IHS Director, 1/20/15 to letter dated 12-2-14
46.	1/14/15	Ms Tracy Parker Warren Office of Public and Intergovernmental Affairs OTGR(075F)-VA	Comments Submitted Response to Notice of TC: Sec 102 © of the Veterans Access, Choice and Accountability Act of 2014	Urge the Reports enter into agreements for reimbursement also current agreements be used and expanded where possible to speed up implementation to eligible veterans	
47.	1/12/15	CCIIO-CMS-DHHS	Comments on Draft 2016 Letter to Issuers in the Federally-Facilitated Marketplace	We are available to discuss any of the recommendations contained in the correspondence and attachment on CMS-9944-P	
48.	1/8/15	IHS Director, Dr. Y. Roubideaux	2015 TGSAC Quarterly Meetings and Tribal Self-Governance Annual Conference Information	Adjustment to your schedule due to changes for the January Qrtly meetings	Response from Dr. Y.Roubideaux, IHS Director, 1/15/15 re: She will be in attendance Jan 28 also attendance at March Mtg on the 24th

2015 Tribal Self-Governance
Strategy Session Summary

Catoosa, OK
September 9-10, 2015
Updated January 15, 2016

The summary below does not include every idea discussed or proposed during the 2015 Tribal Self-Governance Strategy Session in Catoosa, OK on September 9th and 10th. It does make an effort to capture the broadest themes of the discussion and includes a list of action items requested during the two-day meeting. Updates were made for the January 2016 Advisory Committee Meetings based on recent changes.

Budget Discussion

Meet with Congressional members to share top Self-Governance Priorities.
Participants identified their top three budget priorities as (1) exemption from sequestration for Tribal programs; (2) adoption of advance appropriations for IHS; (3) shifting Tribal contract support costs to mandatory funding. A letter was drafted and shared with Self-Governance Tribes to send to their Congressional member ahead of the appropriations discussions.

One-time and short-term funding for Self-Governance Tribes.
Tribes are concerned that Contract Support Costs may be a reason the agencies are more support of one-time or short-term funding mechanism for Tribes. However there was also discussion that Tribal leaders, in an effort to bring in any resources, are supporting these short-term fixes. Participants recommended that the Advisory Committees continue to push back on these funding mechanisms and supported an analysis to determine the loss of capacity and resources when applying, receiving, and administering short-term funding.

Tell "Your" Self-Governance success stories to garner greater support.
Tribes noted regularly that Self-Governance success stories must be shared more often and to a broader audience. Self-Governance Tribes should make efforts to meet with their Congressional members while they are on break in their home state. Tribes also noted there is no formal mechanism to report Self-Governance success to Congressional members regularly. They asked that Tribes support one place and one method to share the best Self-Governance data.

Legislative Discussion

Passage of Title IV Amendments is the top legislative priority.
After hearing from technical experts, Tribal leaders believe this is the time to push the Title IV Amendments to successful passage. Many proposals were put forward to get more Self-Governance Tribes and Tribal Leadership engaged to increase advocacy for the amendments including, organizing Congressional meetings, updating leave behinds, and sharing new letters to send to members.

Continue to support a Carceri Fix.
Self-Governance Tribes were supportive of a Carceri Fix and requested that new draft letters be shared. Tribes also discussed how to evaluate the services and document direct activities that have positive outcomes in the community as a result of economic development.

Coordinate with the Tribal Transportation Unity Caucus (TTUC) to advocate for the enhancement of Tribal transportation provisions and the inclusion of Self-Governance in reauthorized legislation..
TTUC included Self-Governance expansion into the Department of Transportation (DOT) in their request to Congress. However there are several provisions which would increase support for Tribal transportation programs and increase funding to Tribes which Self-Governance Tribes should support.

Additionally, during quarterly meetings, SGAC and TSGAC should look to increase administrative support by sharing the importance of adequate transportation systems and funding for Tribes to develop those systems. Advisory Committee leadership should also consider how best to educate the Department of Transportation leadership about the tenants and vision of Self-Governance ahead of changes at DOT.
The Fast Act included expansion of Self-Governance into the Department of Transportation. SGCE hosted a webinar regarding the expansion on January 11, 2016. The recorded webinar and supporting materials are available on www.tribalselfgov.org.

Increase communication and updates regarding priorities.
Several ideas were discussed to make sure Self-Governance priorities receive greater advocacy when Self-Governance Tribal leadership meet with the Administration and Congress. Suggestions included, but not limited to a clearinghouse of upcoming hearings, regular communication regarding priorities and updated education materials, and more time for Tribes to act on legislative alerts.

Build a voting block for American Indian and Alaska Native Issues.
Self-Governance Tribes can play a critical role in educating citizens about local and statewide elections. Self-Governance Tribes should consider hosting voter registration drives, assisting citizens and employees to understand the voting process by sharing and educating them on filling out a sample ballot, and sharing strategies with local Tribes to increase voter participation by our constituency. In addition, Tribes should consider how best to build a voting block with Indian and non-Indian organizations to align and support Tribal issues. These organizations may be vested in legislative priorities because they are vendors for Tribes, local organizations that depend on Tribal economic development, or carry similar concerns about access to services. Some examples included national health provider organization and the US Chamber of Commerce.

Policy/Administrative Priorities

Develop a successful negotiation strategy for transitioning Agency Lead Negotiators and Tribal network to share questions and ideas.
Several Indian Health Service areas have experienced Agency Lead Negotiator turnover, resulting in the need to create a transition plan and training for the new employees fulfilling this role. Many areas reported differing decisions on previously acceptable changes during negotiations. A successful transition plan may ensure streamlined determinations on similar issues between areas. In addition, Tribes asked that there be a national network for Tribal peers to share information, concerns, and questions.
This recommendation was echoed by the workgroup that reviewed OTSG Policy and Procedures. Please see the summary under workgroup reports of the IHS TSGAC Meeting document.

Advocate for an exemption from the CHOICE Act
Tribes learned that the Veterans Administration (VA) must submit a report to Congress regarding how the Veterans Access, Choice and Accountability Act of 2014,(CHOICE Act) will affect other providers, including Tribes. During the discussion, Tribes were informed that the CHOICE Act creates a more restrictive environment than current negotiated MOUs. Self-Governance Tribes are encouraged to submit comments that would exempt Tribes from the CHOICE Act.

Encourage negotiated improvement to VA-Tribal Memoranda of Understanding.
There are still areas where VA-Tribal MOUs could be improved, including coordination of specialty care and providing services to non-Indian veterans. TSGAC should include Tribes who have successfully negotiated provisions related to these two areas in their best practices track at the Annual Consultation

Conference. TSGAC and/or SGCE should assist Tribes in identifying the best ways to advertise new opportunities to local veterans and in maximizing their reimbursement amounts.

Contract Support Costs

Streamline both DOI and IHS Policies.
The workgroups are currently working on very different policy changes. Self-Governance Tribes should continue to advocate for the simplest policy possible, sharing ideas with other agency workgroups, and creating more consistency throughout negotiations.

Improve distribution of DOI funding.
Presenters and participants noted one of the largest issues in estimating CSC costs at DOI was the lag in funding distribution. This issue, paired with the inability for BIA to pay CSC based on reprogramming requests, is causing a delay in CSC funding to be distributed and makes it difficult to estimate actual CSC need.

Agree to a final deadline for CSC changes.
Tribes should come to an agreement about when final CSC changes should be submitted following the end of a fiscal year.

Garner support for the Tribal position on incurred cost methodology and categorical duplication of costs.
Self-Governance Tribes participating in the IHS CSC workgroup are concerned that IHS is misinterpreting and adversely implementing policy decisions that are set forth in the policy, despite continued advocacy on the part of Tribes. Participants encouraged TSGAC to continue to monitor the IHS Workgroup plans and submit comments on behalf of Self-Governance Tribes which allow for simple implementation and consistency across areas.

Build a transition plan over the next twelve months.
Now is the time to start building the Self-Governance transition plan and prepare for the next Administration. Participants identified several priorities that should wait until the next Administration for increased advocacy. Those priorities include, (1) create a Director of American Indian and Alaska Native affairs at the Office of Management and Budget (OMB); (2) establish a Tribal Advisory Committee for OMB; and, (3) increase transparency at OMB during the budget development period.

DOI Advisory Committee Follow Up:

- Distribution of Self-Governance funds from BIA to Tribes
    - Timeliness
    - Long term funding versus short term and one time funding
- Continued transparency regarding funding and policy decisions that affect Self-Governance Tribes
- Evaluate how the Tribal Data Exchange can support funding initiatives for Self-Governance Tribes
- Encourage DOI/BIA to keep their websites up-to-date regarding workgroup meetings, etc.
- Monitor CSC workgroup developments and advocate for resolution.

IHS Advisory Committee Follow Up:

- Continue to guide the IHS Director nomination process and look to the future to push Congressional delegation to hold confirmation hearings to prevent a long lapse in leadership.
- Exemption from the CHOICE Act

    - Tribes need to submit comments to exempt the entire I/T/U system from the CHOICE Act because the environment is far more restrictive than current Tribal agreements with the VA.
- Renegotiated Tribal-VA MOUs may consider including non-Indian Veterans if an exemption is successful.
    - Grand Ronde is currently in negotiations to include non-Indian Veterans. Follow-up and best practices may be useful to share with Self-Governance Tribes.
- Reimbursements for under Tribal-VA MOUs seems low, perhaps there are systemic issues that need to be addressed.
- Ask IHS to maintain an updated calendar of events that, includes all workgroup meetings with a contact person.
- Monitor IHS CSC workgroup developments and continue to push leadership on their position regarding incurred costs and categorical duplication of costs.

ACTION ITEMS		
Item	**Responsible**	**Update**
Ahead of Impact Days: • Provide budget priority talking points and letter for those who cannot attend in person	SGCE	A broadcast was sent out to Self-Governance Tribes on September 16, 2015 with talking points, white papers, and sample letters.
Self-Governance History and Education for the Following Agencies/Offices: • Department of Transportation • Office of General Counsel at IHS and HHS • Congressional Offices from States without Federally-recognized Tribes	Tribal leaders SGCE	
Identify Tribal leaders in states that neighbor states without Tribes to educate Congressional members on ongoing budget, policy and legislative issues. • Share staff contact information with Tribal leadership	SGCE	
Develop an analysis to support parity for Tribal programs within DOI. The analysis should include the costs Tribes expend collecting additional resources to make up for underfunding.	SGAC SGCE	
Letters to Congressional Members that support sequestration exemption from Tribal Programs in all appropriations subcommittees	Tribes and Leadership	A sample letter is available for Tribal use on the SGCE Website
Share IHS Budget Health Summit Recommendation one pager with Tribal leadership ahead of area formulation meetings.	SGCE	The summary one pager is available on the SGCE website and was shared in the 9/16 broadcast.
Encourage more Tribal leadership to attend and participate in quarterly meetings.	SGCE	SGCE sent an announcement through e-mail regarding registration and reserving hotel rooms.
Send a letter to the House of Representatives to include the Senate CSC language in the final appropriations.	Technical workgroup	Completed.
Develop a network to distribute and collect information from new regional organizations such as Alaska Federation of Nations (AFN) and Pueblo Governors Group.	SGCE	
Commission a study to evaluate the health economics of prevention vs. treatment for diseases that are prevalent in Tribal communities	National Indian Health Board and TSGAC	
Create a clearinghouse for Legislative hearings and contact information so Tribes can reach out when necessary to provide testimony, etc.	SGCE	In progress.
Update the Title IV letter to share with targeted House members	Title IV Task Force	SENSE developed a letter and organized legislative meetings for Tribal leadership. Completed.
Send a letter to Congress and the supporting the authority of the Secretary to take land into trust	Technical Workgroup	

ACTION ITEMS		
Item	**Responsible**	**Update**
Collaborate to create a national campaign for a Congressional Tribal orientation	SGCE with other Nat'l Orgs	
Develop a peer review of the Trust Review process.	Salt River Creek Nation	
Coordinate an effort to develop amendments to IHCIA and build consensus among Tribes	Nat'l Orgs SGCE	
Develop and share national priorities with SG Tribes ahead of the White House Tribal Nations Conference	Technical Workgroup SGCE	Completed.
Send a letter to IHS regarding the categorical duplication of costs.	TSGAC Technical Workgroup	Completed.
Share Geoff Strommer's presentation regarding Self-Governance history and development	SGCE	A link to the American Indian Law Review (AILR) Article is posted on the homepage of the SGCE website.
Share Alaska's sample language to include specialty care coordination in Tribal-VA MOUs	SGCE Myra Munson	
Develop draft comments to exempt I/T/U facilities from the CHOICE Act requirements.	TSGAC	Completed.

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education
P.O. Box 1734, McAlester, Oklahoma 74501
Telephone (918) 302-0252 – Facsimile (918) 423-7639 – Website: www.tribalselfgov.org

WORKGROUP REPORTING FORM

NAME OF WORKGROUP *(please check which Committee this report will be for)*			
☐ Technical Workgroup		☐ Information Systems Advisory Committee (ISAC)	
☐ HHS Secretary's Tribal Advisory Committee (STAC)		☐ Contract Support Costs (CSC) Workgroup	
☐ Budget Formulation Workgroup		☐ Health Promotion/Disease Prevention Policy Group	
☐ Facilities Appropriation Advisory Board (FAAB)		☐ CDC Tribal Consultation Advisory Committee (TCAC)	
☐ Tribal Leaders Diabetes Committee (TLDC)		x Tribal Technical Advisory Group (CMS-TTAG)	
☐ AI/AN Health Research Advisory Group		☐ HHS Self-Governance Tribal Federal Workgroup (SGTFW)	
DATE OF MEETINGS	TTAG: Nov 18, 2015; Jan 13, 2016 MMPC: Nov 17, 2015; Jan 6, 2016	**LOCATION OF MEETINGS**	November meetings were in DC; January meetings were conference calls
COMMITTEE CHAIRMAN	W. Ron Allen		
COMMITTEE RECORDER	Laura Bird		
ATTENDANCE *(please list all present during the meeting)*			
W. Ron Allen, Melanie Fourkiller	Mim Dixon (not Jan mtgs), Doneg McDonough, and Laura Bird, Technical Advisors		

AGENDA ITEM	**SUMMARY/HIGHLIGHTS** *(Committee action should be noted in this section)*
Expanding 100% FMAP	On October 27, 2015, CMS issued a Request for Comment to update its policy as to the circumstances in which 100% FMAP would be available for services furnished to Medicaid-eligible AI/ANs through IHS or Tribal clinics. The request included policy options being considered and sought feedback from states, Tribes, and other stakeholders. Comments were due by November 17, 2015. TTAG and TSGAC submitted comments.
Issues related to Limited Cost Sharing Plans for AI/AN through the Marketplace	CMS has held several teleconferences and a listening session on Sept. 21, 2015, related to changing requirements for referral forms from the I/T/U for AI/AN enrolled in limited cost sharing plan variations through the Marketplace. The issue arose from a plan in Alaska that wants to impose additional requirements. Tribes have supported keeping the existing guidance, and the option for "blanket" or comprehensive referrals. Also, TTAG sent a letter to CCIIO requesting confirmation that eligibility determinations are being made correctly for the "03"/limited cost-sharing protections for AI/ANs enrolled in Marketplace coverage. CCIIO has responded by confirming that the "03/L-CSV" applies to AI/AN under 100% FPL and CCIIO is in the process of confirming that eligibility determinations are being made through the FFM accordingly. At the November meeting, Lisa Wilson at CCIIO reported that a referral policy is being developed.
Summary of Benefits and Coverage	The TTAG requested that all QHPs provide an SBC template on the zero and limited cost sharing plans. On December 2, 2015, there was a meeting with CCIIO Director Kevin Counihan on the need for an SBC template, but a template has not yet been issued. The template could be used by QHPs for to ensure consistency between QHPs. TSGAC representatives offered suggestions to CCIIO on the design of the template.
Exemption to Tribal Employer insurance mandate	The Employer Mandate under the ACA requires all employers with 50 or more full time equivalent employees to offer health insurance or pay a fixed amount to the federal government. Some Tribes feel that this is creating an economic hardship and is not consistent with the federal trust responsibility. One Tribe filed a lawsuit against the mandate, and has appealed a negative ruling on their lawsuit. Along with other national Indian organizations, NIHB/TSGAC/NCAI/DSTAC leadership attended a White House meeting on this issue on Sept. 10, 2015 . Dr. Elaine Buckberg from Treasury attended TSGAC's quarterly meeting and stated that Treasury determined that the mandate applies to Tribes. Since then, several Tribal strategy meetings have occurred. Mary Smith at IHS

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education
P.O. Box 1734, McAlester, Oklahoma 74501
Telephone (918) 302-0252 – Facsimile (918) 423-7639 – Website: www.tribalselfgov.org

WORKGROUP REPORTING FORM

	took the lead on coordinating meetings among the White House, IRS and HHS. A small workgroup came up with a Draft Tribal Member Employee Guidance that was shared with Ms. Smith. NIHB is also working with Congress on a legislative fix.
Tribal Exemption to "Cadillac Tax" provision in ACA	A provision in ACA would create a tax on insurance issuers that would likely be passed along to employers if the cost of health insurance exceeds a fixed amount. Depending on how the cost of insurance is calculated this could be costly for Tribes. Two Notices have been issued by the IRS on the Cadillac Tax. NIHB, TSGAC and other organizations/Tribes submitted comments asserting that Tribes are exempt from this provision in the ACA. The Cadillac Tax was scheduled to go into effect in 2018 but was delayed until 2020 under the Omnibus.
AI/AN Exemptions to the Individual Mandate for insurance under ACA	CMS announced at the November meeting that they will be delegating full authority to the IRS for issuing the exemptions to the Individual Mandate for AI/AN enrolled Tribal members and shareholders in ANSCA corporations, and IHS beneficiaries. In the past, the Marketplace also issued certificates of exemption, but this activity would be discontinued if authority to issue exemptions were fully transferred to the IRS by HHS.
Managed Care Regulations	The Managed Care regulations are being revised by Medicaid for the first time since 2003. The Notice of Proposed Rule Making (NPRM) was released on May 26, 2015 and comments were submitted July 27, 2015. The regulations were submitted to OMB In December 2015, and will be issued by February 2016, as an interim final rule. IHS is organizing a workgroup to implement the rule.
CMS Tribal Consultation Policy	The CMS AI/AN Strategic Plan Addendum calls for the CMS Tribal Consultation Policy to be revised by November 2014. CMS held an All Tribes call on this on September 15, and comments were due by October 1, 2014. CMS provided further edits to the Tribal draft that was submitted in December 2014. The revised policy was circulated by CMS in November, 2015 and approved by the TTAG. The Treasury Department issued its final Tribal Consultation policy on September 23rd.
Payer of Last Resort	On the January call, Nancy Dieter, Technical Director for Coordination of Benefits and Third Party Liability presented to the TTAG on a payer of last resort issue. Some Tribes and Tribal third party administrators, as employers, have been refusing to pay claims if a person is a Medicaid beneficiary. IHS and CMS are planning on issuing joint policy guidelines that Tribal employer coverage is the primary payer (and Medicaid the payer of last resort). TTAG raised concerns about the policy and requested further discussion. CMS will place this item on the agenda for the February face-to-face meeting.
AI/AN Enrollment in Medicaid, CHIP and Marketplace plans	TTAG Data Subcommittee continues to request timely reports on Marketplace enrollment of AI/ANs. From the data provided for enrollment in 2015, concerns were raised as to whether AI/ANs are being properly enrolled in limited cost sharing plans.For all the FFM, 125,882 AI/AN individuals applied; 66 percent (83,654) were determined eligible for QHPs (less than one percent (799) were eligible for Medicaid.) Among Tribal members determined eligible for QHPs, only 20 percent (26,256) ultimately selected a health plan.
CCIIO Tribal Workgroup	At the TTAG meeting on November 19, 2014, CCIIO Director Kevin Counihan offered to establish a joint CCIIO/Tribal Workgroup. Two meetings have been held to date. The last one was on December 2, 2015. Chaired by Chairman Allen, the meetings offer the potential for greater involvement of Director Counihan in resolving outstanding issues.

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education
P.O. Box 1734, McAlester, Oklahoma 74501
Telephone (918) 302-0252 – Facsimile (918) 423-7639 – Website: www.tribalselfgov.org

WORKGROUP REPORTING FORM

I/T/U Participation in QHP provider networks	The CMS 2015 letter to issuers requires all QHPs in the FFM to make a good faith effort to offer contracts with the contents of the Indian Addendum to all I/T/Us. CMS has reported that all QHPs have provided contracts with the Indian Addendum to all I/T/Us. In response to concerns from THOs that the QHP issuers were not fully complying with these requirements, TSGAC prepared a report on this issue. The report determined compliance was not uniform, and many QHPs had zero I/T/Us in their plan networks. TSGAC/TTAG recommended: 1) the requirements on QHP be put into regulations; and, 2) the requirements under the FFM be extended to state-operated Marketplaces. CCIIO is using the report to engage specific QHP issuers on compliance issues. On December 23, 2015, CMS issued its 2017 letter to issuers in the FFM with comments due by January 17, 2016. In addition, CCIIO issued the Essential Community Provider Petition for the 2017 Benefit Year which requests ECPs to respond by January 15, 2016 (extended from January 8, 2016) to be included on the 2017 ECP List. TSGAC and IHS held webinars to review the process for an IHCP to remain on the HHS ECP List.
Definition of Indian in Exchanges	TTAG, NCAI, NIHB, and TSGAC leadership and technical advisors are continuing to look for a vehicle for a legislative fix for the definition of Indian in ACA. Recent budget bills by both the House and the Senate have included language directing HHS, IHS and Treasury to better synchronize the various definitions of Indian.
Payment for Services provided by Tribes	Recent analysis has shown that cost sharing reductions are not being applied properly for people who have insurance through the FFM and receive services at a Tribal facility (and also at non-ICHPs). This may be a result of the improper assignment of people to limited cost sharing plans. TSGAC technical advisors have worked with NIHB to write a letter about this problem, and it has been on the CCIIO Work Group agenda, but no meeting has been held.
Medicare Provider-based rules	CMS has held Tribal Consultation on grandfathering the use of the Encounter Rate for Medicare for hospital-based provider services. Recent interpretation that hospitals and clinics are required to have same operating Board is a threat to Tribal sovereignty and the self-determination/self-governance process.
Medicare Payment Reforms	Value based purchasing and other payment reforms may reduce Medicare payments for IHS and Tribal hospitals that do not score high enough on quality measures. MMPC has formed a workgroup to consider these issues. The workgroup is reviewing CMS's Request for Information on the Certification Frequency and Requirements for the Reporting of Quality Measures Under CMS Programs. Comments are due on February 1, 2016. The workgroup also prepared questions related to the Merit Based-Incentive Payment System and Alternative Payment Model Provisions presentation on the January call. TTAG expressed concerns about the requirements. The NPRM will be issued in the spring and the final rule in the fall.
Medicaid Estate Recovery	While this applies primarily to people over 55 who may not otherwise qualify for long term care or community-based services, fear of estate recovery deters others from enrolling in Medicaid. STAC has requested the HHS Secretary to use her authority to waive estate recovery for AI/AN. CMS is working with the TTAG Outreach and Education Subcommittee to develop consumer education materials on Medicaid estate recovery.

RECOMMENDED TSGAC ACTIONS
1. Legislative advocacy: a. Make the definition of Indian in ACA the same as in Medicaid. b. Statutory requirement for Medicare-like rates for ambulatory services provided through CHS/PRC. c. Exempt Tribes from the employer mandate under ACA, and reaffirm that Tribes are exempt from

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education
P.O. Box 1734, McAlester, Oklahoma 74501
Telephone (918) 302-0252 – Facsimile (918) 423-7639 – Website: www.tribalselfgov.org

WORKGROUP REPORTING FORM

	"Cadillac Tax."
2.	Advocate with HHS Secretary to: a. Use authority for an administrative fix for definition of Indian in ACA. b. Use existing authority to waive Medicaid estate recovery for AI/AN.
3.	Continue to monitor developments in the implementation of ACA, participate in Tribal Consultations and policy subcommittees, and make formal comments. Current focus is: a. Proper assignment of people to limited cost sharing plans and proper application of cost sharing reductions in payment of invoices for services provided by I/T/U. b. Data for better monitoring of enrollment. c. Network adequacy and assuring the IHCPs receive contracts with the Indian Addendum.
4.	Advocate for implementation of the CMS AI/AN Strategic Plan, 2015-2018, as revised Feb 20, 2014.

IHS Tribal Self-Governance Program Information Review Workgroup
Discussion Items for TSGAC
December 2015

The IHS Tribal Self-Governance Program Information Review Workgroup (Workgroup) met on December 3, 2015 to review policy letters, memos, and recommendations regarding the Indian Health Service (IHS) Tribal Self-Governance Program. The following notes, discussion items and recommendations are a result of the meeting.

Items for TSGAC Discussion and Action

- **IHS Office of Tribal Self-Governance Office Reorganization.**
  During the Demonstration Project and just after permanent authorization of the Tribal Self-Governance Program, the TSGAC made many recommendations regarding the roles and responsibilities of the Office of Tribal Self-Governance (OTSG). The following are items the Workgroup believes are critical for discussion.

  Questions for TSGAC:
  - Should OTSG have a greater role throughout the negotiation process?
  - Should the OTSG Director exercise its full authority budget authority to execute the payment process?

- **Formalizing the role, responsibility and expectation for Agency Lead Negotiators.**
  The Workgroup discussed many of the cross cutting issues Tribes experience during negotiations. The Workgroup believes that many of the inconsistencies may be eased by formalizing the role of the Agency Lead Negotiators (ALN).

  Questions for TSGAC:
  - Should the ALN position be a formal position, including a formal job description, performance measurements, and direct reporting structure?
  - Is there a recommendation to IHS regarding how ALNs should be hired, trained, and where they should be positioned within the IHS?
  - Should the ALN's be part of the OTSG staff to ensure consistency across the Areas and to allow for better direction and oversight?

  Workgroup Recommendations:
  - Clarify role and expectations for the ALN and formulate new roles.
    - ALNs should be able to articulate any IHS retained services included in a Funding Agreement.
    - Include recommendation regarding timely responses as a performance measurement for the position.
    - Provision of documents at minimum amount of time in advance of negotiations
      - Share documents 120 days prior to a new funding year for Multi-year Funding Agreement or an updated/expired Funding Agreement

        - Suggested timeline for new Tribes entering Self-Governance, specifically document sharing directly after Tribal inquiry.
    - Finalize a teaching curriculum for ALNs.

- **Include Office of Environmental Health and Engineering funding in the recurring budget.** Tribes initially recommended that recurring OEHE funding should be eligible for Tribes' base budgets, however, to date IHS has not acted on this recommendation.
    - Does TSGAC want to continue to recommend OEHE be part of the recurring base?
    - Ask IHS: Why hasn't Title V implementation of base budget occurred for OEHE? {25 USC 458aaa-4(g)} {42 CFR Section 137.120-124}

- **Develop and codify definitions that are used, but not specified in regulation or statute.** There a few terms that are used regularly in Self-Governance negotiations, funding agreements, and discussions. However, some of these terms do not have standard definitions and may lead to confusion in negotiations.
    - Retained Tribal shares
    - Buy-back
    - Residual

- **Formalize TSGAC as an IHS Advisory Committee.**
  The TSGAC is formally recognized in the Title V regulations. However, the Workgroup recognizes there is concern about changing the current operating nature of the Committee. As Administrations change and Self-Governance history grows, a brief, published Charter in the Indian Health Manual may be useful to ensure its continued success and on-going advisory role across changing Administrations.
    - Would TSGAC like to submit a charter for inclusion in the Indian Health Manual?
    - Should the charter reference existing protocols?

<u>Recommended Actions</u>

- **Ask IHS to share documents to share regularly and publicly to the extent possible.**
    - Headquarters Tables 1-3 should be routinely provided in a timely and efficient manner.
    - Annually update information regarding Headquarters and Area residuals and PSFAs manuals.
    - Headquarters PSFA Manual and Area PSFA Manual should be available publicly.
    - Make the Joint Allocation Methodologies document public.
    - Determination of Tribal Share Distribution Formula.
    - What is the process for Tribes to question or appeal the formulas and process for determining Tribal Shares and Residual?

- **Ask IHS Areas without a PSFA Manual to develop and publish manuals online.**

- **Update IHS Functions and Authorities to reflect changes in law.**
    - OTSG

        - Payment process authority.
        - Self-Governance negotiations.
        - Include responsibility over area in addition to Headquarters shares.
    - Update Office of Tribal Programs or Human Resources to reflect IHCIA provisions.

Tribal Self-Governance Advisory Committee – Charter

Draft for Review

December 29, 2015

1. **BACKGROUND.** The IHS Tribal Self-Governance Program (TSGP) is a tribally driven, congressional legislative option that authorizes federally recognized Tribes and Tribal Organizations to negotiate with the IHS and assume full funding and control over programs, services, functions or activities (PSFAs), or portions thereof, that the IHS would otherwise provide.

2. **PURPOSE.** The Tribal Self-Governance Advisory Committee (TSGAC) provides information, education, advocacy and policy guidance for implementation of Self-Governance within the Indian Health Service.

3. **ROLE.** The TSGAC represents Self-Governance Tribes by acting on their behalf to clarify issues that affect all compacting tribes specific to issues affecting the delivery of health care of American Indian and Alaska Natives.

4. **RESPONSIBILITIES.** The TSGAC is responsible to:
    a. Provide advice to the IHS Director and OTSG Director, on policy, legislative, budget and program issues prior to final decisions that impact Self-Governance Tribes;
    b. Supplement the government-to-government consultation by coordinating with the Self-Governance Tribes in their respective regions, to include gathering input from on priority issues addressed at the TSGAC Quarterly Meetings;
    c. Maintain communication with Self-Governance Tribes in their respective region to collect and advance priority issues to the TSGAC to include on the Quarterly Meeting Agenda;
    d. Review, evaluate and recommend refinements for directives that define the relationship between Self-Governance Tribes and the U.S. Government;
    e. Review Self-Governance issues and make recommendations as appropriate and participate in evaluating progress in meeting the goals of Self-Governance; and
    f. Appoint subcommittees and/or workgroups as necessary to meet the goals of the TSGAC.

5. **MEMBERSHIP.**
    a. Composition.
        i. The composition of the TSGAC will change as new Tribal leadership is appointed/selected.
        ii. The TSGAC will be comprised of elected/appointed Tribal officials or their designee.
    b. Technical Workgroup. The Technical Workgroup provides technical assistance and development of recommendations to the TSGAC for their consideration.
        i. Technical advisors who are designated by members of the TSGAC and representatives of the IHS shall attend the TSGAC Quarterly Meetings and provide input as subject matter experts on issues addressed by the TSGAC. These advisors will not be official members of the TSGAC, but will be available to provide guidance and technical assistance.

6. **PROTOCOLS.** The TSGAC will maintain a set of protocols that guide committee membership, member responsibilities, and meeting requirements. TSGAC will assess amendments to the protocols every two years. Amendments will be made according to the effective protocols.

7. **EFFECTIVE DATE.** This circular becomes effective on the date of signature.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Indian Health Service
Rockville MD 20852

JAN 7 2016

Dear Tribal Leader:

I am writing to initiate a consultation on the Indian Health Service (IHS) Contract Support Costs (CSC) policy. Our goal is to update and implement a new policy in 2016. The policy has been developed and revised several times since 1992 through coordination and consultation with American Indian and Alaska Native (AI/AN) Tribes and Tribal Organizations, with the purpose of providing uniform and equitable guidance on the preparation and negotiation of requests for CSC funds for new and existing awards authorized by the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 450 et seq.

The current policy is located in the Indian Health Manual at Part 6, Chapter 3 (2007). You may access the policy online at: https://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p6c3. The IHS last initiated consultation on this policy in October 2011 and identified the need to establish a workgroup of Tribal leaders to work with the IHS to review, evaluate, and make recommendations to the policy (IHS CSC Workgroup).

Shortly after, in June 2012, the Supreme Court rendered a decision on CSC claims against the Department of the Interior in the case of *Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181 (2012) (*Ramah)*. The impact of this decision generated additional review for IHS, which was not a party to the *Ramah* case, and its CSC policy. After the decision, Congress requested that the IHS consult with AI/AN Tribes and Tribal Organizations on long-term solutions for CSC. The IHS utilized the expertise of the IHS CSC Workgroup to review and develop recommendations to improve CSC business processes, including the negotiation of CSC.

On November 23, 2015, I received a proposed draft IHS CSC Policy from the IHS Tribal Self-Governance Advisory Committee and I have since received input and recommendations from the IHS CSC Workgroup to refocus attention on updating this policy in light of the experience gained since the 2012 *Ramah* decision. To accomplish our goal to update the policy in 2016, the IHS CSC Workgroup will meet several times over the next two months to draft a revised policy that will be available for your review and comment in the first quarter of 2016.

Please watch for updates on the IHS website at http://www.ihs.gov/. In addition, the IHS will provide updates at national meetings such as the National Congress of American Indians or National Indian Health Board, as well as, during IHS Direct Service Tribes Advisory Committee and Tribal Self-Governance Advisory Committee quarterly meetings.

As we update the policy, I invite you to provide input or feedback in writing to me at the address below or electronically to the e-mail address consultation@ihs.gov.

Please send written comments to:

Robert G. McSwain
Principal Deputy Director
Indian Health Service
5600 Fishers Lane
Mail stop: 08E86
Rockville, MD 20857

Sincerely,

/Robert G. McSwain/

Robert G. McSwain
Principal Deputy Director

Indian Health Service Contract Support Costs Workgroup – Virtual Meeting

January 5, 2016
2:00 – 3:00 p.m. (Eastern)

Dial-in: 888-994-8798; Passcode: 5615380;
AdobeConnect: http://ihs.adobeconnect.com/ihscscwg/

Moderator: RADM Sandra Pattea, Deputy Director for Intergovernmental Affairs, IHS

AGENDA

Roll call

Opening Remarks

- Mr. Robert G. McSwain, Principal Deputy Director, IHS
- Ms. Mary Smith, Deputy Director, IHS
- Mr. Andrew C. Joseph, Tribal Co-Chair, IHS CSC Workgroup, and Tribal Councilman, Confederated Tribes of the Colville Indian Reservation

IHS Contract Support Costs Policy Proposals

- Ms. Mary Smith, Deputy Director, IHS
- Ms. Roselyn Tso, CSC Team Lead, IHS

Workgroup Discussion

- Identification of Follow-up for January 14-15 Meeting (Washington, D.C.)

Review of Meeting and Closing Comments

- Ms. Mary Smith, Deputy Director, IHS

FY 2016 Consolidated Appropriations Act Text Released
December 16, 2015

The House and Senate Appropriations committees filed a $1.15 trillion FY2016 omnibus spending bill early Wednesday morning. The bill (HR 2029, Consolidated Appropriations Act, 2016) rolls all twelve of the regular spending bills into one, providing updated funding and guidance to federal agencies through Sept. 30, 2016. The Interior-Environment bill funds the Bureau of Indian Affairs (BIA) and Indian Health Service (IHS), among other tribal programs. The Labor-Health and Human Services bill funds SAMHSA, Administration for Children and Families, and Department of Education. The links to explanatory statements for relevant divisions of the bill are below. At this late date, the massive federal spending bill appears likely to become law, and a federal government shutdown would be avoided.

DIVISION G—Department of the Interior, Environment, and Related Agencies Appropriations Act, 2016
DIVISION H—Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2016
DIVISION A—Agriculture, Rural Development, and Related Agencies Appropriations Act, 2016
DIVISION B—Commerce, Justice, Science, and Related Agencies Appropriations Act, 2016
DIVISION D—Energy and Water Development and Related Agencies Appropriations Act, 2016
DIVISION E—Financial Services and General Government Appropriations Act, 2016
DIVISION F—Department of Homeland Security Appropriations Act, 2016
DIVISION L—Transportation, HUD, and Related Agencies Appropriations Act, 2016

Key Points for Indian Country

- The rider prohibiting the use of funds to implement the proposed rule on "Federal Acknowledgement of American Indian Tribes" was not included.
- The Tribal Labor Sovereignty Act was not included.
- BIA's overall budget would increase by 7.5% over FY 2015 enacted, with a $194 million increase for a total of $2.796 billion.
- The Indian Health Service budget would increase by 3.6% above FY 2015 enacted amounts, for a total of $4.8 billion.
- Tribal Behavioral Health Grants would be funded at $30 million ($15 million in the Mental Health appropriation and $15 million in the Substance Abuse Prevention appropriation).

Interior-Environment Appropriations

Bureau of Indian Affairs

The bill would provide $2.796 billion for BIA and BIE, an increase of $194.6 million over the FY 2015 enacted amount, representing a 7.5% increase. Funding would increase for education programs, public safety programs, Tiwahe, some natural resources programs, and social services. (The Tiwahe initiative is a comprehensive and integrated approach to address the interrelated problems of poverty, violence, and substance abuse in American Indian communities.)

Education: Significant increases include a $63.7 for education construction which should complete the 2004 replacement school construction list and provide $8 million for planning and design of schools on the next list and a $41.8 million increase to education programs. The education increases include: $10.8 million to fully fund Tribal Grant Support Costs; $16.5 million for forward funded elementary and secondary programs; $5.1 million increase for forward funded postsecondary programs; fully fund Tribal Education Departments; $2 million for information technology.

Social Services: The omnibus would provide a $4 million increase for social services to implement the Tiwahe initiative.

Public Safety: Program increases include $3 million for criminal investigations and police services; $3 million for law enforcement special initiatives, $5 million for tribal courts for Tiwahe; $11 million for the Office of Tribal Justice Support to help implement VAWA (to work with tribes to pilot tribal court systems, including those tribes subject to full or partial state jurisdiction under PL 83-280).

Indian Energy Service Center: The bill includes $4.5 million for the Indian Energy Service Center.

Contract Support Costs: The omnibus includes new language establishing an indefinite appropriation for contract support costs estimated to be $277,000,000. Under the new budget structure, the full CSC that tribes are entitled to will be paid and other programs will not be reduced if payments are underestimated in the President's budget.

BIA	FY 2015 Enacted	FY 2016 Budget	Final Bill	Final Bill vs FY 2015	Bill vs. Request
Tribal Government:					
Aid to tribal government	24,614	24,833	24,833	219	---
Consolidated tribal government program	76,348	77,088	77,088	740	---
Self-governance compacts	158,767	162,321	162,321	3,554	---
Contract support	246,000	272,000	---	-246,000	-272,000
Indian self-determination fund	5,000	5,000	---	-5,000	-5,000
New tribes	463	464	464	1	
Small and needy tribes	1,845	3,095	1,845	---	-1,250
Road maintenance	26,461	26,693	26,693	232	
Tribal government program oversight	8,181	12,273	8,273	92	-4,000
subtotal	**547,679**	**583,767**	**301,517**	**-246,162**	**-282,250**
Human Services:					
Social services	40,871	47,179	45,179	4,308	-2,000
Welfare assistance	74,809	74,791	74,791	-18	---
Indian child welfare act	15,433	15,641	15,641	208	---
Housing improvement program	8,009	8,021	8,021	12	---
Human services tribal design	407	246	246	-161	---
Human services program oversight	3,105	3,126	3,126	21	---
subtotal	**142,634**	**149,004**	**147,004**	**4,370**	**-2,000**
Trust -Natural Resources Management:					
Naturel resources, general	5,089	8,168	5,168	79	-3,000
Irrigation operations and maintenance	11,359	12,898	11,398	39	-1,500
Rights protection implementation	35,420	40,138	37,638	2,218	-2,500
Tribal management/development program	9,244	14,263	9,263	19	-5,000
Endangered species	2,675	3,684	2,684	9	-1,000
Cooperative landscape conservation	9,948	30,355	9,955	7	-20,400
Integrated resource information program	2,996	3,996	2,996	---	-1,000
Agriculture and range	30,494	30,751	30,751	257	---
Forestry	47,735	51,914	51,914	4,179	---
Water resources	10,297	14,917	10,367	70	-4,550
Fish, wildlife and parks	13,577	15,646	13,646	69	-2,000

Resource management program oversight	6,018	6,066	6,066	48	
subtotal	184,852	232,796	191,846	---	-40,950
Trust Real Estate Services	127,002	143,686	127,486	484	-16200
subtotal	**184,852**	**232,796**	**191,846**	**6994**	**-40950**
Elementary and secondary pgms (fw funded)	536,897	565,517	553,458	16,561	-12,059
(Tribal grant support costs)	(62,395)	(75,335)	(73,276)	(+10,881)	(-2,059)
Post-secondary programs (forward funded)	69,793	69,793	74,893	5,100	5100
Subtotal, forward funded education	606,690	635,310	628,351		-6959
Elementary and secondary programs	119,195	142,361	134,263	15,068	-8,098
Post-secondary programs	64,182	69,412	64,602	420	-4,810
Education management	20,464	57,381	25,151	4,687	-32,230
Subtotal, Education	**810,531**	**904,464**	**852,367**	**41,836**	**-52,097**
Public Safety and Justice					
Law enforcement	328,296	334,976	347,976	19,680	13,000
tribal courts	23,280	28,173	28,173	4,893	---
fire protection	1,274	1,274	1,274	---	---
subtotal	**352,850**	**364,423**	**377,423**	**24,573**	**13,000**
Community and economic development	35,996	40,619	40,619	4,623	---
Executive direction/administrative services	227,692	241,832	229,662	1,970	-12170
(No-year funds in bill language)	(48,553)	(46,663)	(43,813)	(-4,740)	
Total Operation of Indian Programs	**2429236**	**2,660,591**	**2,267,924**	**-161,312**	**-392,667**
Contract Support Cost			**272,000**	**272,000**	**272,000**
Indian self-determination fund			**5,000**	**5,000**	**5,000**
Construction					
Education	74,501	133,245	138,245	63,744	5,000
Public Safety and Justice	11,306	11306	11,306	---	---
Resources management	34,427	34,488	34,488	61	---
General Administration	8,642	9,934	9,934	1,292	---
Subtotal	**128,876**	**188,973**	**193,973**	**65,097**	**5,000**
Indian Guaranteed Loan	7,731	7,748	7,748	17	---
Total BIA and BIE	**2,601,498**	**2,924,968**	**2,796,120**	**194,622**	**-128,848**
Percent Difference				**7.5%**	**-4.4%**

Indian Health Service

The bill would provide a total of $4.807 billion for IHS, a 3.6% increase over the FY 2015 enacted amount. Increases include: $10 million for the alcohol and substance abuse program to focus on tribal youth, $1.4 million for Dental Health, and $2 million for operating shortfalls at community health clinics.

An increase of $12.9 million is for staffing of newly opened health facilities.

The omnibus also includes $2 million in "new, flexible funding so that the Director may take actions necessary to ensure that CMS accreditation status is reinstated and retained, and, once accreditation has been reinstated, to restore third-party insurance reimbursement shortfalls."

Contract Support costs: The omnibus provides an indefinite appropriation for contract support costs estimated to be $717,970,000.

IHS	FY 2015 Enacted	FY 2016 President's Budget	Final Bill	Bill vs FY 2015	Bill vs. Request
Hospital and health clinics	1,836,789	1,936,323	1,857,225	20,436	-79,098
Dental Health	173,982	181,459	178,286	4,304	-3173
Mental Health	81145	84,485	82100	955	-2,385
Alcohol and substance abuse	190,981	227,062	205,305	14,324	-21,757
Purchased/Referred Care	914,139	984,475	914,139	---	-70,336
Subtotal	**3,197,036**	**3,413,804**	**3,237,055**	**40,019**	**-176,749**
Public Health Nursing	75,640	79,576	76,623	983	-2,953
Health Education	18,026	19136	18,255	229	-881
Community Health Representatives	58,469	62,363	58,906	437	-3,457
Immunization AK	1826	1950	1950	124	---
Subtotal	**153,961**	**163,025**	**155,734**	**1,773**	**-7,291**
Urban Health	43,604	43,604	44,741	1137	1137
Indian Health Professions	48,342	48,342	48,342		
Tribal Management Grants	2,442	2,442	2,442		
Direct Operations	68,065	68,338	72,338	4,273	4,000
Self-Governance	5,727	5,735	5,735	8	
Contract Support Costs	662,970	717,970	---	-662,970	-717,970
Subtotal	**831,150**	**886,431**	**173,598**	**-657,552**	**-712833**
Total Indian Health Service	**4,182,147**	**4,463,260**	**3,566,387**	**-615,760**	**-896,873**
Contract Support			**717,970**	**717,970**	**717,970**
Facilities					
Maintenance & Improvement	53,614	89,097	73,614	20,000	-15,483
Sanitation Facilities Construction	79,423	115138	99,423	20,000	-15,715
Health Care Facilities Construction	85,048	185,048	105,048	20,000	-80,000
Facilities & Envir Health Support	219,612	226,870	222,610	2,998	-4,260
Equipment	22,537	23,572	22,537	---	-1,035
subtotal	**460,234**	**639,725**	**523,232**	**62,998**	**-116,493**
Total IHS	**4,642,381**	**5,102,985**	**4,807,589**	**165,208**	**-295,396**
% Difference				**3.6%**	**-5.8%**

Labor-HHS-Education

Substance Abuse and Mental Health Administration (SAMHSA): Tribal Behavioral Health Grants would be funded at $30 million ($15 million in the Mental Health appropriation and $15 million in the Substance Abuse Prevention appropriation). The American Indian and Alaskan Native Suicide Prevention program would receive $2.9 million.

SAMHSA (Dollars in millions)	FY2015 Enacted	FY2016 Request	FY 2016 Omnibus	Change from 2015
Mental Health Appropriation				
AI/AN Suicide Prevention Initiative	2.9	2.9	2.9	0
Tribal Behavioral Health Grants	4.9	15	15	10
Substance Abuse Prevention Appropriation				
Tribal Behavioral Health Grants	--	15	15	15

Administration for Children and Families (ACF)

Within HHS, ACF provides the largest amount of funding to American Indians/Alaska Natives outside of the funds provided by the Indian Health Service. Out of a budget of $50 billion, ACF awards on the average $647 million to Native Americans from the following programs: Head Start, Child Care, TANF, LIHEAP, Child Support and the Administration for Native Americans, to name a few.

(Dollars in millions)	**FY2015**	**FY2016 Request**	**FY 2016 Omnibus**	**'16-'15**
Head Start, Total Resources	8,098.0	9,467.7	9,166.1	+570
Child Care & Development Block Grant, Formula Grants	2,435.0	2,805.1	2,761	+326
Child Welfare Services, Formula Grants	268.7	268.7	268.7	0
Community Services Block Grant, Formula Grants	674.0	674.0	715.0	+41
Family Violence Prevention & Services, Formula Grants	135.0	150.0	150.0	+15.0
LIHEAP, Formula Grants	3,390	3,190	3,390	-
Administration for Native Americans	46.5	50.0	50.0	+3.5

Domestic Violence Hotline.-The agreement includes an increase of$3.75 million for the Hotline, with some funds used to develop a tribal hotline.

Native American Programs.-The agreement includes $3 million for the Generation Indigenous initiative focused on improving Native American language instruction across the education continuum.

Department of Education

Department of Education Indian programs would see some moderate increases.

Department Education (Dollars in millions)	**FY 2015**	**FY 2016 Request**	**FY 2016 Omnibus**	**Change**
Impact Aid	1288.6	1288.6	1305.6	+17
Indian Student Education (Title VII)	123.9	173.9	143.9	+20.0
Grants to Local Education Agencies	*100.4*	*100.4*	*100.4*	-
Special Programs for Indian Children	*17.9*	*67.9*	*37.9*	*+20.0*
National Activities	*5.6*	*5.6*	*5.6*	-
Native Hawaiian Student Education	32.4	33.4	33.4	+1
Alaska Native Education Equity Assistance Program	31.4	32.4	32.4	+1
Strengthening AN/NH-Serving Inst (discretionary)	12.8	12.8	13.802	+.96
Strengthening TCUs (discretionary)	25.6	25.6	27.589	+1.9
Tribally Controlled Posts and Technical Institutions	7.7	7.7	8.286	+.58
Strengthening NA-Serving Nontribal Inst (Disc.)	3.1	3.1	3.3	+1.9

Native Youth Community Projects: Within Special Programs for Indian Children, the omnibus includes $22.89 million for Native Youth Community Projects, which makes competitive awards to support culturally-relevant coordinated strategies to improve the college- and career-readiness of Native American youth.

Commerce-Justice-Science
Department of Justice

- The Victims of Crime Act (VOCA) cap was set at over $3 billion, but still includes nothing for tribes.
- The omnibus includes $2.5 million for Special Domestic Violence Criminal Jurisdiction implementation, which is the first time that has been funded.
- The bill did not adopt the 7% across the board set-aside at the Office of Justice Programs. The omnibus would appropriate $30 million for "tribal assistance" instead.
- VAWA appropriations overall would increase, which will mean more in the core tribal VAWA programs.
- The bill includes $10 million for the Tribal Youth Program.
- $30 million for the COPS tribal hiring program.

Transportation and Housing
Housing and Urban Development:

- NAHASDA funding would be $650 million.
    - Language is included for reducing the formula allocation to tribes who have unspent funds that are three times the amount of funding.
- Technical Assistance and Training would receive $3.5 million.
- Section 184 would receive $7.8 million.
- Indian Community Development Block Grant would receive $60 million.

Department of Transportation:

- Tribal Transportation Program $465 million
- Tribal Transit Grant Program (Section 5311 Section (c)) $30 million

For more information, contact Amber Ebarb, NCAI Budget and Policy Analyst (aebarb@ncai.org).

HOBBS STRAUS DEAN & WALKER

2120 L Street, NW, Suite 700
Washington, DC 20037

T 202.822.8282
F 202.296.8834

HOBBSSTRAUS.COM

January 12, 2016

GENERAL MEMORANDUM 16-005

Indian Health Service Fiscal Year 2016 Appropriations;
Includes FY 2016 Indefinite Appropriation for Contract Support Costs

On December 18, 2015, President Obama signed the Consolidated Appropriations Act, 2016 as PL 114-113. The Act contains funding for all federal agencies, combining what under regular procedures would be 12 separate bills. In this Memorandum we report on FY 2016 funding for the Indian Health Service (IHS) which is in Division G (Interior, Environment and Related Agencies) of the Act. *In addition to the Explanatory Statement accompanying the Act, House and Senate Interior Appropriations report language (H. Rept. 114-170; S. Rept. 114-70) is to be complied with unless specifically contradicted by the bill language or the Explanatory Statement.* (See our General Memorandum 15-049 of July 7, 2015 comparing the House and Senate Committees' and the Administration's recommendations regarding the FY 2016 IHS budget.)

While the ink is barely dry on the Consolidated Appropriations Act, 2016, we are ready to begin a new appropriations season with President Obama submitting his FY 2017 proposed budget to Congress on February 9, 2016.

FUNDING OVERVIEW

The Act provides $4.8 billion for the IHS, a 3.6 percent increase over FY 2015, but $295 million below the Administration's request. As with FY 2015, no funding is provided for medical inflation or population growth although the Administration had requested $71 million and the House had proposed $53 million for medical inflation. The Act does include $19.4 million for a 1.3 percent pay cost increase.

Also included are the higher Senate recommendations for the Facilities account, Immunization, and $2 million in new funding for health clinic operating costs. The Act includes the higher House recommendation for Self-Governance and splits the difference between the Committees' recommendations for Hospitals and Clinics, Mental Health, Dental Health, Health Education, Community Heath Representatives, and Facilities and Environmental Health Support. However, the following accounts ended up with higher funding than had originally been recommended by the House and Senate Committees: Alcohol and Substance Abuse, Public Health Nursing and Urban Indian Health. Funding for Purchased and Referred Care remained flat.

Contract Support Costs. Most notable is the moving of Contract Support Costs (CSC) into its own account and the instructions in the Act that it is to be funded at "such sums as may

be necessary." The Explanatory Statement assumes a need of $717.9 million ($55 million over FY 2015). Should the need for CSC exceed the amount listed in the budget chart, additional CSC funds would be made available and the agencies' program funding will not be reduced. This provision is applicable to only the FY 2016 Appropriations Act and so discussion will continue on the issue of providing permanent mandatory funding for CSC. See the CSC section elsewhere in this Memorandum for additional information.

New Funding. New funding of $2 million is provided for operating shortfalls at community health clinics, and $2 million for use in ensuring the accreditation status of IHS-operated facilities.

Staffing of New Facilities. The Act provides $14.1 million in the Services and Facilities account combined for the staffing of new facilities at the Southern California Youth Treatment Center ($2.8 million Services, $311,000 Facilities) and the Choctaw (MS) Alternative Rural Health Care Center ($10 million Services, $930,000 Facilities). The Explanatory Statement notes: "Funds are limited to facilities funded through the Health Care Facilities Construction Priority System or the Joint Venture Construction Program that have opened in fiscal year 2015 or will open in fiscal year 2016. None of these funds may be allocated to a facility until such facility has achieved beneficial occupancy status."

CONTINUING BILL LANGUAGE

The Act continues bill language from previous bills, including the following:

Contract Support Costs. See CSC section below.

IDEA Data Collection Language. The Act continues to authorize the BIA to collect data from the IHS and tribes regarding disabled children in order to assist with the implementation of the Individuals with Disabilities Education Act (IDEA):

> *Provided further,* That the Bureau of Indian Affairs may collect from the Indian Health Service and tribes and tribal organizations operating health facilities pursuant to Public Law 93-638 such individually identifiable health information relating to disabled children as may be necessary for the purpose of carrying out its functions under the Individuals with Disabilities Education Act. (20 U.S.C. 1400, et. seq.)

Prohibition on Implementing Eligibility Regulations. The Act continues the prohibition on the implementation of the eligibility regulations, published September 16, 1987.

Services for Non-Indians. The Act continues the provision that allows the IHS and tribal facilities to extend health care services to non-Indians, subject to charges. The provision states:

> *Provided,* That in accordance with the provisions of the Indian Health Care Improvement Act, non-Indian patients may be extended health care at all tribally administered or Indian Health Service facilities, subject to charges, and the proceeds along with funds recovered under the Federal Medical Care Recovery Act (42 U.S.C. 2651-2653) shall be credited to the account of the facility providing the service and shall be available without fiscal year limitation.

Assessments by DHHS. The Act continues the provision that has been in Interior appropriations acts for a number of years which provides that no IHS funds may be used for any assessments or charges by the Department of Health and Human Services "unless identified in the budget justification and provided in this Act, or approved by the House and Senate Committees on Appropriations through the reprogramming process."

Limitation on No-Bid Contracts. The Act continues the provision regarding the use of no-bid contracts. The provision specifically exempts Indian Self-Determination agreements:

> Sec. 411. None of the funds appropriated or otherwise made available by this Act to executive branch agencies may be used to enter into any Federal contract unless such contract is entered into in accordance with the requirements of Chapter 33 of title 41 United States Code or chapter 137 of title 10, United States Code, and the Federal Acquisition Regulations, unless:
>
> (1) Federal law specifically authorizes a contract to be entered into without regard for these requirements, including formula grants for States, or federally recognized Indian tribes; or
>
> (2) such contract is authorized by the Indian Self-Determination and Education and Assistance Act (Public Law 93-638, 25 U.S.C. 450 et seq.) or by any other Federal laws that specifically authorize a contract within an Indian tribe as defined in section 4(e) of that Act (25 U.S.C. 450b(e)); or
>
> (3) Such contract was awarded prior to the date of enactment of this Act.

CONTRACT SUPPORT COSTS

FY 2015 Enacted	$662,970,000
FY 2016 Admin. Request	$717,970,000
FY 2016 Enacted	*Such sums as may be necessary*

The conferees adopted the Senate Committee-recommended approach to Contract Support Costs funding, creating a separate account for it and making it an indefinite appropriation at "such sums as may be necessary." These provisions are specific to FY 2016.

The Act states:

> For payments to tribes and tribal organizations for contract support costs associated with Indian Self-Determination and Education Assistance Act agreements with the Indian Health Service for fiscal year 2016, such sums as may be necessary: *Provided*, That amounts obligated but not expended by a tribe or tribal organization for contract support costs for such agreements for the current fiscal year shall be applied to contract support costs otherwise due for such agreements for subsequent fiscal years: *Provided further*, That, notwithstanding any other provision of law, no amounts made available under this hearing shall be available for transfer to another budget account.

The Explanatory Statement notes:

> CONTRACT SUPPPORT COSTS. The agreement provides an indefinite appropriation for contract support costs estimated to be $717,970,000, which is an increase of $55,000,000 above the fiscal year 2015 enacted level. The budget request proposed to fund this program within the "Indian Health Services" account. Under this heading the Committees have provided the full amount of the request for contract support costs. By virtue of the indefinite appropriation, additional funds may be provided by the agency if its budget estimate proves to be lower than necessary to meet the legal obligation to pay the full amount due to tribes. This account is solely for the purpose of paying contract support costs and no transfers from this account are permitted for other purposes.

Fiscal Year 2016 Limitation. Section 406 of Division G of the Act provides that no FY 2016 funds may be used by the IHS or the BIA to pay prior year CSC or to repay for Judgement Fund for payment of judgments or settlements related to past year CSC claims.

The Act states:

> SEC. 406. Amounts provided by this Act for fiscal year 2016 under the headings "Department of Health and Human Services, Indian Health Service, Contract Support Costs" and "Department of the Interior, Bureau of Indian Affairs and Bureau of Indian Education, Contract Support Costs" are the only amounts available for contract support costs arising out of self-determination or self-governance contracts, grants, compacts, or annual funding agreements for fiscal year 2016 with the Bureau of Indian Affairs or the Indian Health Service: *Provided*, That such amounts provided by this Act are not available for payments of claims for contract support costs for prior years, or for repayments of payments for settlements or judgements awarding contract support costs for prior years.

Prior Year Fiscal Limitations. Section 405 of Division G of the Act continues by reference to Sections 405 and 406 of Division F of Public Law 113-235 (Consolidated and Further Continuing Appropriations Act, 2015) the comparable limitation as noted for FY 2016 above.

FUNDING FOR INDIAN HEALTH SERVICES

FY 2015 Enacted	$3,519,177,000
FY 2016 Admin. Request	$4,463,260,000
FY 2016 Enacted	$3,566,387,000

Definition of Indian. The House Committee repeats language from FY 2015 which notes the problems caused by various definitions of "Indian" referenced in various federal health programs and urges the Department of Health and Human Services, the IHS, and the Treasury Department to work together to establish a consistent definition of "Indian" with regard to health care.

> The Committee recognizes the Federal government's trust responsibility for providing healthcare for American Indians and Alaska Natives. The Committee is aware that the definition of who is an "Indian" is inconsistent across various Federal health programs,

> which has led to confusion, increased paperwork and even differing determinations of health benefits within Indian families themselves. The Committee therefore directs the Department of Health and Human Services, the Indian Health Service, and the Department of the Treasury to work together to establish a consistent definition of an "Indian" for purposes of providing health benefits. (H. Rept. 114-170, p. 76)

HOSPITALS AND CLINICS

FY 2015 Enacted	$1,836,789,000
FY 2016 Admin. Request	$1,936,323,000
FY 2016 Enacted	$1,861,225,000

The Act includes $12.8 million for a pay cost increase, $7.6 million for staffing of new facilities, $2 million for operational shortfalls of tribal clinics, and $2 million to address accreditation emergencies.

Initiatives Funding Distribution. The Act includes language proposed by the Administration providing that the funds for methamphetamine and suicide prevention and treatment, the domestic violence prevention initiative, and efforts to improve collections from public and private insurance at IHS and tribally-operated facilities are to be allocated at the discretion of the Director. The conferees also added funds used for accreditation emergencies to this category. (The Administration has announced that it will not allocate contract support costs for the meth/suicide and domestic violence prevention initiatives, and in the budget request allocated $10 million for use in improving third party collections.)

Health Clinics. As mentioned above, the Act includes a $2 million increase for operational funds for health clinics:

> *Provided further*, That, of the funds provided, $2,000,000 shall be used to supplement funds available for operational costs at tribal clinics operated under an Indian Self-Determination and Education Assistance compact or contract where health care is delivered in space acquired through a full service lease, which is not eligible for maintenance and improvement and equipment funds from the Indian Health Service

Accreditation. The Explanatory Statement includes the following regarding accreditation issues at some IHS-operated facilities:

> The Committees are concerned about loss and potential loss of CMS accreditation status at multiple IHS-operated facilities. These facilities are all located within the same Service Area, suggesting that the problems are systemic. Whatever the causes, the Committees consider the loss of accreditation to be an emergency. The agreement therefore includes $2,000,000 in new, flexible funding so that the Director may take actions necessary to ensure that CMS accreditation status is reinstated and retained, and, once accreditation has been reinstated, to restore third-party insurance reimbursement shortfalls.

Health Care Provider Shortage. The House Report repeats language from FY 2015, encouraging IHS "to work with Tribes and health care organizations to find creative ways to address the Service's health care provider shortage, including improvements to the credentialing process." (H. Rept. 114-170, p. 77)

DENTAL SERVICES

FY 2015 Enacted	$173,982,000
FY 2016 Admin. Request	$181,459,000
FY 2016 Enacted	$178,286,000

The Act includes a $1.4 million program increase, $1.4 million for a pay cost increase, and $1.5 million for staffing of new facilities. As it did in FY 2015, the House Report encourages the IHS to work with the BIE to establish a pilot program integrating preventive dental care at schools within the Bureau system. (H. Rept. 114-170, p. 76)

MENTAL HEALTH

FY 2015 Enacted	$81,145,000
FY 2016 Admin. Request	$84,485,000
FY 2016 Enacted	$82,100,000

The Act includes $616,000 for a pay cost increase and $339,000 for staffing of new facilities.

ALCOHOL AND SUBSTANCE ABUSE

FY 2015 Enacted	$190,981,000
FY 2016 Admin. Request	$227,062,000
FY 2016 Enacted	$205,305,000

Included is a $10 million increase for programs focusing on tribal youth. The Administration's proposal requested an expansion of the methamphetamine/youth suicide prevention initiative by $25 million. Also provided is $1.3 million for a pay cost increase and $3 million for staffing of new facilities.

PURCHASED/REFERRED CARE

FY 2015 Enacted	$914,139,000
FY 2016 Admin. Request	$984,475,000
FY 2016 Enacted	$914,139,000

The Act includes within the total $51.5 million for the Catastrophic Health Emergency Fund, the same as in FY 2015.

Medicare-Like Rates Legislation Encouraged. While the Act does not include legislative language addressing the Medicare-Like Rates issue, the House and Senate Committees commented on it. In addition, the Administration included in its budget recommendation a proposal supporting enactment of legislation to provide Medicare-like rates for non-hospital services, thus stretching the funding for Purchased/Referred Care. The House Committee agreed, stating:

> The Committee urges the Service to work expeditiously with the relevant Congressional authorizing committees to enact authorization for the Service to cap payment rates for non-hospital services, as recommended by the Government Accountability Office (GAO 13-272). Failure to do so costs the program an estimated $30 million annually that could be used to purchase more services. (H. Rept. 114-170, p. 76)

The House Committee also referenced a GAO report (GAO 12-446) critical of the program:

> The Committee urges the Service, Tribes, and the congressional authorizing committees to make reasonable and expeditious progress to address the concerns and recommendations made by the Government Accountability Office (GAO), most notably with regard to unfair allocations, third-party overbilling and under-enrollment in other qualifying Federal programs. (H. Rept. 114-170, p. 76)

The Senate Committee, on the other hand, addressed a Purchased/Referred Care issue specific to Indian people in Oregon:

> The Committee is aware that certain Indian people in Oregon have not been counted for purposes of purchased and referred care under current Service policies and that the Service is currently considering options to address the situation, including the potential expansion of service delivery areas. The Committee believes that it is important that this issue be resolved without impacting existing purchased and referred care allocations to California and Oregon. Within 60 days of enactment of this act, the Service is directed to provide a report to the Committee detailing its proposed management actions to address the situation. (S. Rept. 114-70, p. 70)

PUBLIC HEALTH NURSING

FY 2015 Enacted	$75,640,000
FY 2016 Admin. Request	$79,576,000
FY 2016 Enacted	$76,623,000

The Act includes $605,000 for a pay cost increase and $378,000 for staffing of new facilities.

HEALTH EDUCATION

FY 2015 Enacted	$18,026,000
FY 2016 Admin. Request	$19,136,000
FY 2016 Enacted	$18,255,000

The Act includes $133,000 for a pay cost increase and $96,000 for staffing of new facilities.

COMMUNITY HEALTH REPRESENTATIVES

FY 2015 Enacted	$58,469,000
FY 2016 Admin. Request	$62,363,000
FY2016 Enacted	$58,906,000

The Act includes $437,000 for a pay cost increase.

HEPATITIS B and HAEMOPHILUS IMMUNIZATION (Hib) PROGRAMS IN ALASKA

FY 2015 Enacted	$1,826,000
FY 2016 Admin. Request	$1,950,000
FY 2016 Enacted	$1,950,000

The Act includes a $109,000 program increase and $15,000 for a pay cost increase.

URBAN INDIAN HEALTH

FY 2015 Enacted	$43,604,000
FY 2016 Admin. Request	$43,604,000
FY 2016 Enacted	$44,741,000

The Act includes a $1,137,000 program increase for Urban Indian Health which is higher than the amount initially recommended by the House or Senate. The Act includes new bill language instructing IHS to "develop a strategic plan for the Urban Indian Health program in consultation with urban Indians and the National Academy of Public Administration…"

The Explanatory Statement directs:

> The agency is directed to include current services estimates for Urban Indian Health in future budget requests. The Committees note the agency's failure to report the results of the needs assessment directed by House Report 111-180. Therefore, the recommendation

includes bill language requiring a program strategic plan developed in consultation with urban Indians and the National Academy of Public Administration.

INDIAN HEALTH PROFESSIONS

FY 2015 Enacted	$48,342,000
FY 2016 Admin. Request	$48,342,000
FY 2016 Enacted	$48,342,000

Programs funded under Indian Health Professions are: Health Professions Preparatory and Pre-Graduate Scholarships; Health Professions Scholarships; Extern Program; Loan Repayment Program; Quentin N. Burdick American Indians Into Nursing Program; Indians Into Medicine Program; and American Indians into Psychology. Consistent with the Administration's request, bill language provides $36 million for the loan repayment program.

Use of Defaulted Funds. The Act continues the provision that allows funds collected on defaults from the Loan Repayment and Health Professions Scholarship programs to be used to recruit health professionals for Indian communities:

> *Provided further*, That the amounts collected by the Federal Government as authorized by sections 104 and 108 of the Indian Health Care Improvement Act (25 U.S.C. 1613a and 1616a) during the preceding fiscal year for breach of contracts shall be deposited to the Fund authorized by section 108A of the Act (25 U.S.C. 1616a-1) and shall remain available until expended and, notwithstanding section 108A(c) of the Act (25 U.S.C. 1616a-1(c)), funds shall be available to make new awards under the loan repayment and scholarship programs under sections 104 and 108 of the Act (25 U.S.C. 1613a and 1616a).

TRIBAL MANAGEMENT

FY 2015 Enacted	$2,442,000
FY 2016 Admin. Request	$2,442,000
FY 2016 Enacted	$2,442,000

Funding is for new and continuation grants for the purpose of evaluating the feasibility of contracting IHS programs, developing tribal management capabilities, and evaluating health services. Funding priorities are, in order: 1) tribes that have received federal recognition or restoration within the past five years; 2) tribes/tribal organizations that are addressing audit material weaknesses; and 3) all other tribes/tribal organizations.

DIRECT OPERATIONS

FY 2015 Enacted	$68,065,000
FY 2016 Admin. Request	$68,338,000
FY 2016 Enacted	$68,338,000

The Act includes $273,000 for a pay cost increase. The IHS noted in its budget submission that 58.7 percent of the Direct Operations budget would go to Headquarters and 41.3 percent to the 12 Area Offices. Tribal Shares funding for Title I contracts and Title V compacts are also included.

SELF-GOVERNANCE

FY 2015 Enacted	$5,727,000
FY 2016 Admin. Request	$5,735,000
FY 2016 Enacted	$5,735,000

The Act includes $8,000 for a pay cost increase. The Self-Governance budget supports implementation of the IHS Tribal Self-Governance Program including funding required for Tribal Shares; oversight of the IHS Director's Agency Lead Negotiators; technical assistance on tribal consultation activities; analysis of Indian Health Care Improvement Act new authorities; and funding to support the activities of the IHS Director's Tribal Self-Governance Advisory Committee.

The IHS estimated in its budget justification that in FY 2015, $1.8 billion will be transferred to tribes to support 89 ISDEAA Title V compacts and 114 funding agreements.

SPECIAL DIABETES PROGRAM FOR INDIANS

While the entitlement funding for the Special Diabetes Program for Indians (SDPI) is not part of the IHS appropriations process, those funds are administered through the IHS. SDPI is currently funded through FY 2017 at $150 million (see our General Memorandum 15-032 of April 17, 2015).

FUNDING FOR INDIAN HEALTH FACILITIES

FY 2015 Enacted	$460,234,000
FY 2016 Admin. Request	$639,725,000
FY 2016 Enacted	$523,232,000

MAINTENANCE AND IMPROVEMENT

FY 2015 Enacted	$53,614,000
FY 2016 Admin. Request	$89,097,000
FY 2016 Enacted	$73,614,000

The Act includes a $20 million program increase. Maintenance and Improvement (M&I) funds are provided to Area Offices for distribution to projects in their regions. Funding is for the following purposes: 1) routine maintenance; 2) M&I Projects to reduce the backlog of

maintenance; 3) environmental compliance; and 4) demolition of vacant or obsolete health care facilities. The Act provides that up to $500,000 may be deposited in a Demolition Fund to be used for the demolition of vacant and obsolete federal buildings.

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

FY 2015 Enacted	$219,612,000
FY 2016 Admin. Request	$226,870,000
FY 2016 Enacted	$222,610,000

The Act includes $1.7 million for a pay cost increase and $1.2 million for staffing of new facilities.

MEDICAL EQUIPMENT

FY 2015 Enacted	$22,537,000
FY 2016 Admin. Request	$23,572,000
FY 2016 Enacted	$22,537,000

The Act continues language to provide up to $500,000 to purchase TRANSAM equipment from the Department of Defense and up to $2.7 million for the purchase of ambulances. The Administration's request was to distribute the FY 2016 requested funds as follows: $18 million for new and routine replacement medical equipment at over 1,500 federally- and tribally-operated health care facilities; $5 million for new medical equipment in tribally-constructed health care facilities; and $500,000 each for the TRANSAM and ambulance programs.

CONSTRUCTION

Construction of Sanitation Facilities

FY 2015 Enacted	$ 79,423,000
FY 2016 Admin. Request	$115,138,000
FY 2016 Enacted	$ 99,423,000

The Act includes a $20 million program increase. Four types of sanitation facilities projects are funded by the IHS: 1) projects to serve new or like-new housing; 2) projects to serve existing homes; 3) special projects such as studies, training, or other needs related to sanitation facilities construction; and 4) emergency projects. The IHS sanitation facilities construction funds cannot be used to provide sanitation facilities for HUD-built homes.

Most of the Administration's requested increase was for $30 million to service new and like-new homes, some of which could be used for sanitation facilities for individual homes of

disabled or ill persons with a physician referral, with priority for BIA Housing Improvement Projects.

Construction of Health Care Facilities

FY 2015 Enacted	$ 85,048,000
FY 2016 Admin. Request	$185,048,000
FY 2016 Enacted	$105,048,000

While the Act includes a $20 million increase over FY 2015, this is $80 million less than the Administration's request. We do not have a breakdown on the distribution of the funds, but the Administration's request of $185 million would have provided funds for the Gila River Southeast Health Center (Chandler, AZ); Salt River Northeast Health Center (Scottsdale, AZ); Rapid City Health Center; and New Dilkon (AZ) Alternative Rural Health Center.

If we may provide additional information or assistance regarding FY 2016 Indian Health Service appropriations, please contact us at the information below.

# # #

Inquiries may be directed to:
Karen Funk (kfunk@hobbsstraus.com)

Unfunded Provisions of ICHIA as Reported in April 2014

SECTION	SUMMARY	PROGRESS UPDATE
Sec. 123. Diabetes Prevention, Treatment and Control { 25 U.S.C. § 1621c }	Clarifies authorities/requirements for diabetes programs. Expands authority for dialysis to the extent funding is available. Maintains existing model diabetes projects and Area Office diabetes control officers.	• 19 Model Diabetes Projects existing on the date of enactment are preserved. • IHS clinical practice guidelines specify diabetes risk screening standards and prevention protocols. General informed consent is obtained during patient registration. • Dialysis programs are authorized, but sufficient funds have not been appropriated. A dialysis program option was added to annual budget formulation for prioritization. • Tribes or tribal organizations, that contract or compact with the IHS, may locally establish dialysis programs within available resources. • Diabetes control officer duties are carried out in each IHS Area. Tribal consultation is coordinated through the Tribal Leaders Diabetes Committee.
Sec. 124. Other authority for provision of services { 25 U.S.C. § 1621d }	Provides authority for new programs in Indian communities including authorization for hospice care, assisted living, long-term care and home-and community-based care, sharing of facilities.	• Long term care programs and assisted living services are authorized, but sufficient funds have not been appropriated. A long term care program option was added to annual budget formulation for prioritization. • Tribes or tribal organizations, that contract or compact with the IHS, may locally establish long term care and assisted living services within available resources. • A Dear Tribal Leader Letter on 1-6-2012 initiated consultation on recommendations developed at the national Indian Country Long Term Care conference. • IHS, CMS, and AOA continue to coordinate technical assistance for the provision of these services under an MOU signed on 9/23/2011.

Sec. 127. Behavioral Health Training and Community Education Programs { 25 U.S.C. § 1621h(d) }	Clarifies current law on training and community education programs. Requires that IHS and DOI, with tribal consultation, identify a scope of positions for such training, and a plan to increase such staff by 500 positions.	• A new hiring plan was completed in June 2010, including plans for consultation. It was described in the 7/22/2010 Dear Tribal Leader Letter and updated in a 5/5/2011 Dear Tribal Leader Letter. • The IHS, BIA, and BIE have identified the scope of positions whose qualifications should include behavioral health skills, qualifications and training criteria. • Sufficient funds have not been appropriated to implement the hiring plan and comprehensive behavioral health training programs. An option for expanded behavioral health training was added to annual budget formulation for prioritization.
Sec. 132. American Indians Into Psychology Program { 25 U.S.C. § 1621p }	Increases the number of college and universities that will be awarded grants to administer the American Indians Into Psychology program and increases the grant amount to colleges to make the program accessible to more Indian students who wish to enter the behavioral health field.	• Authorization of new IHS grants to colleges and universities to promote psychology careers for Indians were explained in a Dear Tribal Leader Letter (12/07/2010). • The three current American Indians in Psychology Program grants will conclude in August 2014. Information about the FY 2014 grant cycle, including available funding and number of grants to be awarded, will be released through a Federal Register Notice in May 2014. • Additional grants are authorized, but sufficient funding has not been appropriated. An option for additional grants was added to annual budget formulation for prioritization.
Sec. 133. Prevention, Control, and Elimination of Communicable and Infectious Diseases { 25 U.S.C. § 1621q }	Expands current authority by (1) expanding the communicable diseases from tuberculosis to other communicable and infectious diseases; (2) encouraging coordination with the Centers for Disease Control and state and local health agencies; and (3) a biennial report on the progress made towards the prevention, control, and elimination of communicable/infectious diseases made among Indians and urban Indians.	• A Dear Tribal Leader Letter (12/07/2010) explained provisions for grants and demonstration projects. • IHS works with CDC in engaging Tribes in CDC's grant programs for communicable and infectious disease prevention. • New grants and demonstration projects are authorized, but sufficient funds have not been appropriated. An option for new demonstration projects was added to annual budget formulation for prioritization.

Sec. 134. Methods to increase clinician recruitment and retention { 25 U.S.C. § 1621t }	Stipulates health care professionals employed by tribally operated health programs will be eligible for state licensure exemptions that are similar to exemptions available to Federal employees. Expands authority to provide allowances for professional development or establish programs to Indians to join or continue in an Indian health program and to provide services in rural /remote areas.	• State licensing exemptions for health care professionals employed by tribally operated programs for services provided as defined in statute are operative. • These provisions were explained in a 12/7/2010 Dear Tribal Leader Letter. • New education allowances and stipends for professional development are authorized, but sufficient funds have not been appropriated. An option for new allowances and stipends was added to annual budget formulation for prioritization.
Sec. 143. Indian Health Care Delivery Demonstration Projects { 25 U.S.C. § 1637 }	Authorizes the Secretary to carry out or enter into contracts or compacts with Tribes and Tribal Organizations pursuant to ISDEAA to test new models/means of health care delivery. Permits the use of other Federal funds, third party collections, and non-Federal funds to support these programs.	• Demonstration projects for Tribes and tribal organizations to test alternative health care models/means are authorized, but sufficient funds have not been appropriated. An option for new demonstration projects was added to annual budget formulation for prioritization. • Tribes or tribal organizations, that contract or compact with the IHS, may locally implement alternative health care models within available resources.
Sec. 147. Mobile Health Stations Demonstration Program { 25 U.S.C. § 1638g }	Authorizes a demonstration program to fund new ways to provide health care to Indian communities.	• Demonstration projects to purchase mobile health stations for certain specialty health care services are authorized, but sufficient funds have not been appropriated. An option for a demonstration program was added to annual budget formulation for prioritization. • Tribes or tribal organizations, that contract or compact with the IHS, may purchase mobile health stations within available resources.
Sec. 153. Grants to and Contracts with the Service, tribes, etc. to Facilitate Outreach, Enrollment, and Coverage of Indians under SSA and other Benefits Programs { 25 U.S.C. § 1644 }	New authority to issue grants or contracts to tribes, tribal organizations and urban Indian organizations to conduct outreach to enroll eligible Indians in Social Security Act health benefit programs.	• Grants or contracts for additional outreach and enrollment programs are authorized, but sufficient funds have not been appropriated. An option for new programs was added to annual budget formulation for prioritization. • Tribal organizations and urban Indian organizations may conduct outreach and enrollment within available resources.

Sec. 161. Facilities Renovation { 25 U.S.C. § 1659 }	Title V, urban Indian organizations are authorized to receive funding from IHS for minor renovations and to construct or expand urban Indian health facilities.	This provision was explained in the 8/26/2010 Dear urban Indian program director letter. • Construction or expansion of urban facilities is authorized, but sufficient funds have not been appropriated. An option for expanded urban facilities was added to annual budget formulation for prioritization.
Sec. 164. Expand Program Authority for Sec. Urban Indian Organizations { 25 U.S.C. § 1660e }	Expands authorities to urban organizations to receive grants for additional health related activities.	• The 8/26/2010 dear urban Indian program director letter describes this provision. • New grants to urban Indian organizations are authorized, but sufficient funds have not been appropriated. An option for expanded programs was added to annual budget formulation for prioritization.
Sec. 166. Use of Federal Government Facilities and Sources of Supply; Health Information Technology. { 25 U.S.C. § 1660g }	Authorizes access to real and personal property under the jurisdiction of the Secretary of HHS to meet the needs of urban Indian organizations.	• The 8/26/2010 Dear urban Indian program director letter describes these provisions. • Protocols to transfer facility and real property were developed. However, "transfer" costs such as site survey and appraisals require additional funding. • The IHS currently provides limited funding for information technology improvements thru urban Indian health 4-in-1 grants. • New grants to develop, adopt, and implement health information technology in urban Indian health programs are authorized, but sufficient funds have not been appropriated. An option for new grants was added to annual budget formulation for prioritization.
Sec. 192. Arizona, North Dakota and South Dakota as Contract Health Service Delivery Areas; eligibility of California Indians { 25 U.S.C. §§ 1678, 1678a, 1679 }	Establishes a single contract health services delivery area consisting of the states of North Dakota and South Dakota for the purposes of providing contract health care services to members of Indian tribes located in those states	• Implementation requires consultation. This provision would expand CHS eligibility in certain states if services to existing CHS patients are not diminished. • Establishment of new contract health service delivery areas is authorized, but sufficient funds have not been appropriated. An option was added to annual budget formulation for prioritization. • The CHS Workgroup reviewed Section 192 but decided not to make any recommendation at this time.

Sec. 702. Behavioral Health Prevention and Treatment Services Overview { 25 U.S.C. § 1665a }	Authorizes a comprehensive continuum of behavioral health care to include community-based care, detoxification, hospitalization, intensive out-patient treatment, residential treatment, transitional living, emergency shelter, case management, and diagnostic services. The Secretary, acting through the Service, shall coordinate behavioral health planning, to the extent feasible with other Federal agencies and with State agencies to encourage comprehensive behavioral health services for Indians regardless of their place of residence.	• These provisions were explained in a 5/5/2011 Dear Tribal Leader Letter. • The required inpatient mental health needs assessment was completed on March 17, 2011. • Existing behavioral health programs will continue. Providing an expanded continuum of behavioral health services is authorized, but sufficient funds have not been appropriated. An option for expanded programs was added to annual budget formulation for prioritization. • Tribes or tribal organizations, that contract or compact with the IHS, may implement the expanded services within available resources.
Sec. 704. Comprehensive Behavioral Health Prevention and Treatment Program { 25 U.S.C. § 1665c }	Clarifies and extends authority for a program of comprehensive behavioral health, prevention, treatment, and aftercare for members of Indian tribes including prevention through education, acute detox, psychiatric hospitalization, residential and intensive outpatient treatment, community based rehabilitation, community education and training, specialized residential treatment, diagnostic services	• This provision was explained in 3/8/2011 and 5/5/2011 Dear Tribal Leader Letters. Existing behavioral health programs continue. • Expanded behavioral health prevention and treatment programs are authorized, but sufficient funds have not been appropriated. An option for expanded programs was added to annual budget formulation for prioritization. • Tribes or tribal organizations, that contract or compact with the IHS, may expand services within available resources. • The Tribal Law and Order Act Minimum Program Standards Workgroup continue to develop guidelines.
Sec. 705. Mental Health Technician Program: { 25 U.S.C. § 1665d }	Authorizing the establishment of a mental health technician program within IHS to train Indians as mental health technicians to provide community-based mental health care to include identification, prevention, education, referral, and treatment services. The Secretary shall provide high-standard paraprofessional training in mental health care and shall ensure that the program involves the use/promotion of traditional health care practices of Indian tribes to be served.	• Comprehensive program within IHS to train mental health paraprofessionals is authorized, but sufficient funds have not been appropriated. An option for training mental health paraprofessionals was added to annual budget formulation for prioritization.

Sec. 707. Indian Women Treatment Programs { 25 U.S.C. § 1665f }	Authorizing IHS grants to Indian health programs to develop and implement comprehensive behavioral health programs that specifically address the cultural, historical, and social and child care needs of Indian women.	• IHS grants to Indian health programs to develop additional behavioral health programs for Indian women are authorized, but sufficient funds have not been appropriated. An option for new grants was added to annual budget formulation for prioritization.
Sec. 708. Indian Youth Program { 25 U.S.C. § 1665g }	Clarifies and expands authorities/requirements for the Youth Regional Treatment Centers (YRTCs).	• Expanded detoxification including behavioral care and family involvement is authorized, but sufficient funds have not been appropriated. An option for detoxification programs was added to annual budget formulation for prioritization. • 10 Youth Regional Treatment Centers (YRTC) currently provide residential substance abuse and other behavioral health interventions to Indian youth. • IHS acquired property for both the Northern and Southern California YRTC facilities. The Southern California YRTC is fully funded for construction to be completed in 2015. Construction funding is requested in the FY 2015 President's Budget for the Northern California YRTC. Staff funds will also need to be appropriated through the budget formulation process.
Sec. 710: Training and Community Education { 25 U.S.C. § 1665i }	Directs the Secretary to work with the Interior Secretary to develop and implement or assist Indian tribes and organizations in establishing a community education program to educate political leaders, tribal judges, law enforcement personnel, members of tribal health and education boards, health providers, including traditional practitioners, and other critical members of each tribal community about behavioral health issues.	• Implementation in progress. • In 2011, IHS, BIA, BIE, and SAMHSA provided behavioral health training at two action summits. In 2012, IHS hosted a national behavioral health conference for Indian country. • Collaboration is ongoing among IHS, BIA, BIE, and SAMHSA on community education, e.g., multi-agency online newsletter on alcohol and drug abuse information and prevention tools. • Comprehensive assistance from IHS to Tribes and tribal organizations to establish cross-cutting programs is authorized, but sufficient funds have not been appropriated. An option for comprehensive assistance was added to annual budget formulation for prioritization. • IHS provides ongoing training opportunities through its Tele-Behavioral Health Center of Excellence and the Tribal Forensic Healthcare Training project. Training is provided at no cost and offers continuing education credits for health care providers. Training topics include child maltreatment, alcohol and substance abuse, behavioral health topics, family relations, crisis intervention, and youth topics.

Sec. 711. Behavioral Health Program { 25 U.S.C. § 1665j }	Amends current law to expand a grant program for Indian health programs to establish innovative community-based behavioral health services to Indians. The grant program will be competitive.	• A new competitive grant program for innovative community-based behavioral health programs is authorized, but sufficient funds have not been appropriated. An option for a new grant program was added to annual budget formulation for prioritization.
Sec. 712. Fetal Alcohol Spectrum Disorders Programs { 25 U.S.C. § 1665k }	Expands authority in current law for a serious health problem in Indian communities.	• IHS clinical protocols specify risk identification and treatment of pregnant women for fetal alcohol spectrum disorders. One GPRA performance measure for IHS screens all women of child bearing age (15-44) for alcohol use. • A new comprehensive training program for FASD is authorized, but sufficient funds have not been appropriated. An option for a new training programs was added to annual budget formulation for prioritization. • Currently, the IHS Tele-behavioral Health Center for Excellence offers FASD training for providers.
Sec. 713. Child Sexual Abuse and Prevention Treatment Programs { 25 U.S.C. § 1665l }	Provides new authority for nation-wide prevention and treatment programs for victims of child sexual abuse, and their families.	• The Tribal Law and Order Act, Section 13, addresses multidisciplinary teams including health services for prevention and treatment of violence. • Child maltreatment policy and training protocols have been drafted and are under Agency review. • New regional demonstration projects and new treatment programs in every service area are authorized, but sufficient funds have not been appropriated. An option for new regional demonstration projects was added to annual budget formulation for prioritization.
Sec. 715. Behavioral Health Research { 25 U.S.C. § 1665n }	Authorizes IHS to make grants to Indian and non-Indian entities to perform research on Indian behavioral health issues, including the causes of Indian youth suicide.	• New grants to perform Indian behavioral health research are authorized, but sufficient funds have not been appropriated. An option for new grants was added to annual budget formulation for prioritization.
Sec. 723. Indian Youth Tele-mental Health Demonstration Project { 25 U.S.C. § 1667b }	Adds new authority for a grant program for technologically innovative approaches to assess/prevent/treat youth suicide.	• New demonstration projects to develop innovative tele-mental health approaches to youth suicide and other problems are authorized, but sufficient funds have not been appropriated. An option for demonstration projects was added to annual budget formulation for prioritization. • The IHS Tele-Behavioral Health Center of Excellence provides technical assistance to IHS and tribal Youth Regional Treatment Centers to reach at risk youth. The TBHCE website is scheduled to launch through www.ihs.gov in the spring of 2014.

Sec. 726. Indian Youth Life Skills Development Demonstration Program { 25 U.S.C. § 1667e }	Authorizes a demonstration grant program through the Substance Abuse and Mental Health Services Administration to provide grants to tribes and tribal organizations to provide culturally compatible, school-based suicide prevention curriculum to strengthen AI/AN teen “life skills”.	• A new demonstration grant program is under review by SAMHSA, but funds have not been appropriated.

Health Care Reform in Indian Country

Self-Governance Communication & Education

Self-Governance Tribes Striving Towards Excellence in Health Care

Self-Governance Health Reform Work Plan 2015-2016

December 2015

Table of Contents

1. Introduction

The Indian Health Service (IHS) amended the Funding Agreement with the Jamestown S'Klallam Tribe (JST) for the performance period September 1, 2015 –September 30, 2016 to provide outreach, education, technical, research and analytical support nationally to Self-Governance Tribes on P.L. 111-148 as amended by P.L. 111-152, collectively known as the Patient Protection and Affordable Care Act (ACA) and the Indian Health Care Improvement Act (IHCIA).

The Agreement indicates that *"the overall objective of this Project is to improve Indian health care by conducting training and technical assistance across Self-Governance communities to ensure that the Indian health care system and all American Indians/Alaska Natives (AI/ANs) are prepared to take advantage of the health insurance coverage options that will improve the quality of and access to health care services, and increase resources for AI/AN health care. This work is a part of a national campaign, comprised of national Indian organizations, IHS, and Tribal partners (Partners) that work together to conduct ACA/IHCIA training and technical assistance throughout Indian Country."* This objective will guide priority setting and activities conducted under this Agreement over the performance period as JTS works to address the sub-goals and deliverables articulated in the Agreement.

The scope of work (SOW) identifies project goals that are 3-fold: (1) Materials; (2) Training; and, (3) Technical assistance. To achieve these goals, 23 deliverables are listed in the Agreement that relate to outreach and education, policy analysis, information sharing and technical assistance, and training. The SOW requires JST to:

- Coordinate and develop a multiple strategy education and outreach training approach for I/T that reaches the widest audience possible in a timely fashion, appropriately tailored to the needs of Self-Governance communities (A1 in SOW); and,

- Continue to provide technical assistance to Tribes and Tribal health organizations with implementation of the ACA and IHCIA, and broadly disseminate to other Tribes and Tribal health organizations the experiences learned from the technical assistance (C1 in SOW).

This Work Plan has been developed to meet the above specific objectives. Other deliverables in the SOW are noted through this Plan.

2. Process for Development of Work Plan

This 2015-2016 Work Plan builds on JST's successful program of training and technical assistance from the previous two Project periods (2013-2014) and (2014-2015), as documented in the final reports for those respective years. Consistent with the deliverables identified, this Work Plan is organized into the following sections:

- Outreach and Education
- Policy Analysis
- Technical Assistance and Information Sharing
- Training/Webinars

Needs Assessment for Information Sharing, Training, and Technical Assistance

The deliverable C9 in the SOW calls for JST to "meet with stakeholders to identify their needs from a community level and access to education and outreach materials."

In the prior 2 years, the TSGAC conducted an on-line survey in October 2013 and again in October 2014 to learn about Tribal preferences for ACA/IHCIA training and technical assistance. In addition, on-line evaluations that followed each of the Webinars conducted have been used to identify additional topics for training.

Prior to developing this 2015-2016 Work Plan, Self-Governance Tribes were again surveyed to see how their needs and preferences have changed. Technical consultants also invited discussion on this and other aspects of the Work Plan at the TSGAC Quarterly Meeting held in Washington, DC on October 6-7, 2015.

A total of 68 surveys were completed and consolidated. (See Appendix A). Of those who responded, 87% participated in previous ACA/IHCIA Webinars and Trainings hosted by the TSGAC during 2014-2015; and all but 5 of those respondents shared information with others in their Tribe/Tribal Organization. Further, on a scale of 1 to 5 with 1 = Not Helpful to 5 = Very Helpful, 68% of those respondents rated the Trainings/Webinars as either a 4 or 5. (*These findings are nearly identical and consistent with those from last year's October 2014 survey.*)

There is strong support for Webinars as a way of delivering information. Further, respondents noted that the written materials included on the Health Care Reform section of the Self-Governance Communication and Education (SGCE) website were extremely helpful and requested reminders about the information, including when new information is added. Many responded that they would also like to see both National (e.g. Annual Tribal Self-Governance Conference, NCAI, NIHB) as well as regional training in their respective Areas. Finally, several respondents indicated that one-on-one training/technical assistance would also be preferred.

In 2015-2016, TSGAC will continue to explore ways to best coordinate with our IHS and Tribal Partners and Area Health Boards on national and regional training as well continue to share links within the SGCE website to assist in outreach efforts.

Flexibility

Every year there are new issues that emerge and new needs for policy analysis, technical assistance, training and other types of information sharing. With a fixed

budget, JST recognizes that some planned ideas may be changed to accommodate more urgent needs that may arise. This is in keeping with item C4 in the SOW deliverables:

> C4. The Tribe shall plan communication around key moments or events through the grant period to increase educational efforts.

In addition, flexibility has been built into the Work Plan by scheduling quarterly regulatory update Webinars, as explained further in the Training/Webinar Plan section of this Work Plan.

3. Outreach and Education

Update and Share Information on the Self-Governance Communication and Education Website. In both the 2013-2014 and 2014-2015 project periods, JST worked closely with the Self-Governance Communication and Education office (SGCE) to develop a Health Care Reform specific section on their website. In 2015, the entire SGCE website, including the health care reform sub-section, went through a comprehensive overhaul and update. The Health Care Reform section was updated and information was re-organized in a more "user-friendly" format. Currently, the main categories on the Health Care Reform section include:

A. Training (All recorded Webinars and Related Materials)
B. Best Practices (ACA Success Stories)
C. Events (Upcoming Webinars and Trainings)
D. Question and Answer ("Ask Us" section that allows people to submit questions which are answered by a technical expert). Based on receipt of questions received to date, Q&A have been organized and posted for others to access.
E. Resources and Documents (TSGAC memos, issue briefs, graphics, letters and other general notices and updates)

In 2015-2016, TSGAC technical representatives will continue to utilize the SGCE website to ensure that training and educational materials are widely distributed for Tribal leadership and frontline enrollment personnel. (C3 in SOW). Further efforts and actions to be continued in 2015-2015, include:

- Maintain an open question and answer forum regarding the ACA on the Self-Governance Communication and Education (SGCE) website. (Item A4 in SOW)

- Broadcast notices and emails and post them on the SGCE website. (Item A4 in SOW)

Work with TSGAC Tribal Leadership/Staff, IHS and Tribal Partners. Other outreach and education efforts which will be continued in 2015-2016 including:

- Provide measurable outcomes and performance improvement activities for ACA/IHCIA outreach and education actions. (Item A2 in SOW)

- Share information, innovative ideas, challenges and solutions, and provide progress reports. (Item A3 in SOW)

- Advise TSGAC and draft correspondence on key ACA/IHCIA issues. (Item A5 in SOW)

- Develop PowerPoint presentations, graphics, and issue briefs to be used as resource materials. (Item A7 in SOW)

Publication and Distribution of Success Stories Magazine (C5 in SOW) In 2014-2015, four Tribes and Tribal organization from four different states agreed to partner with TSGAC for the Success Stories project. (See 2014-2015 Final Report submitted to the IHS/OTSG for a detailed summary of the project and completed deliverables.) By the end of the 2014-2015 project year, all composite and photos were formatted into a 20-page magazine entitled, ***The Medicine Bundle: Healing, Strength and Protection***. 2000 copies of the magazine were printed and recently distributed during the Annual 2015 National Congress of American Indians (NCAI) Conference held in mid-October 2015 (*funding for printing was provided by NCAI*).

In 2015-2016, the TSGAC will work with OTSG to develop a plan for further publication and distribution. Options may include seeking additional funding from other sources for a wider distribution.

4. Policy Analysis Plan

Policy analysis. In coordination with the TSGAC, technical consultants will continue to review and coordinate ACA/IHCIA policy recommendations and strategies by Self Governance Tribes (B2 in SOW).

Performance metrics. Deliverables B1 and B5 in SOW requires the Tribe to "monitor and review ACA enrollment metrics" and "collect and disseminate data that tracks American Indian/Alaska Native enrollments through the Marketplaces into Qualified Health Plans and Medicaid, and analysis of barriers and opportunities." JST will develop and communicate recommended metrics to IHS and the Centers for Medicare and Medicaid Services (CMS) and work with partner organizations to secure the data from CMS.

In addition, JST technical consultants will review and analyze relevant data and reports that are produced by the Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE) and offices within CMS. Further, as was done in prior Project periods, JST will work to share that information broadly with partner organizations and Tribal leadership.

On behalf of the TSGAC, technical consultants will continue to advocate for better data from CMS to assess enrollment and participation in networks and assist in the definition of parameters to be reported. This policy work will be conducted both directly with CMS and in cooperation with the Data Subcommittee of the Tribal Technical Advisory Group (TTAG) for CMS. Specifically, efforts continue to provide more frequent reports on Marketplace enrollment of AI/ANs and to broaden the scope of the reporting.

In addition, TSGAC technical consultants will continue to engage with the Department of Health and Human Services Office of Assistant Secretary for Planning and Evaluation (HHS ASPE) on potential studies that include measuring the degree to which I/T/Us are under contract with Qualified Health Plans (QHPs) offered through the Marketplace. This work builds off the detailed study prepared and circulated by TSGAC in 2015 on QHP contracting with I/T/Us in five regions of the country.

Information sharing. JST will assure that all information is up-to-date at the time it is presented, as required in deliverable B3 in SOW:

> B3. The Tribe shall ensure the training curriculum content addresses all new regulations and operations for implementing the ACA/IHCIA requirements.

To further address this, the Training Plan detailed below will include quarterly updates on selected regulations issued by CMS and Internal Revenue Service (IRS) to implement the ACA.

5. Technical Assistance and Information Sharing

A range of avenues will be used to provide technical assistance and share information with Self-Governance Tribes, including:

TSGAC meetings. Technical consultants will continue to participate in TSGAC quarterly meetings, the Annual Tribal Self Governance Conference, and the yearly Self Governance Strategy Planning Session. These meetings provide an opportunity to assure that the TSGAC and Self-Governance Tribes are informed about current ACA/IHCIA issues and have an opportunity for interactive dialogue.

One-on-One Training/Technical Assistance from TSGAC Health Care Advisors. A number of venues are available and have been used to provide technical assistance, including one-on-one trainings to Self-Governance Tribes. For instance, the Q&A section on the SGCE Website provides a direct avenue for Tribes to request information on specific issues and submit specific questions that they have. The response is provided directly to the Tribe/Tribal Organizations as well as posted on the SGCE Website. Second, Tribes and Tribal Organizations will continue to schedule in-person meetings with TSGAC technical advisors in conjunction with national meetings. These meetings have proven to be an efficient and effective mechanism to assist Tribes. Prior

topics at these meeting have included how to structural "referrals for cost-sharing protections" and options for sponsoring Tribal members.

In the 2015–2016 period, regional IHS and Area Health Board meetings are likely to serve as a more frequent venue for technical assistance and training by TSGAC health care advisors. A number of Tribes have agreed to participate in in-depth reviews of sponsorship approaches available to the Tribes. These analyses are being prepared to assist the individual Tribes in their decision-making. Further, and possibly more importantly, the information gathered from the one-on-one interactions will be made available to all Tribes to assist in guiding decisions on effective approaches to Marketplace sponsorship and enrollment of Tribal members.

Other. In addition, the SOW requests that JST serve as a "resource broker and identify subject matter experts to conduct training and technical assistance for implementation of the ACA enrollments" (C8 in SOW). To meet this goal, TSGAC will assist Self Governance Tribes to identify qualified people that they might hire to do training and technical assistance at the Tribal level. JST will also utilize subject matter experts on related topics in the TSGAC Webinars and for the in-person Trainings.

In addition to maintaining professional relationships with policy experts in the private sector, TSGAC will also maintain relationships with key people who work inside agencies such as CMS, IRS, and IHS, and call upon them as needed to answer questions that arise.

6. Training/Webinar Plan

Webinars. The approach of using Webinars proved to be an effective way to reach a lot of people across the country on a timely basis. Participation has remained consistently high, numerous questions and comments are discussed and feedback has been positive, as demonstrated by the evaluation results included in the final reports for both the 2013-2014 and 2014-2015 project years.

In this 2015-2016 Work Plan, TSGAC will continue to build on this experience and maintain this approach for Webinars, including the advertisements, evaluations, certificates of completion, and posting recordings and materials on the SGCE website. In addition, technical consultants will foster distribution of the Webinars by sharing Web links to the recorded Webinars with partner organizations.

Two types of Webinars will be provided in 2015-2016: (1) Webinars on specific topics; and, (2) quarterly updates on select regulations and operational changes related to ACA implementation. We anticipate holding approximately 6 Webinars (scheduled every other month) during 2015-2016.

Tentative topics for upcoming Webinars include:

- Understanding New Regulations, Operations and Forms from IRS and CMS; explanation of new developments that could affect Tribes/Tribal Organization and their citizens (as identified in B3 in SOW)
- Updating entries on the HHS Essential Community Provider (ECP) List
- Children Dental Stand Alone Plans
- Tribal Sponsorship and Employer Options Analysis
- Assisting People to Apply for Exemptions from the Tax Penalty
- Understanding Medicare, Medicaid Payment Reforms

2016 Annual Tribal Self Governance Conference. Training will be provided through workshops at the 2016 Self-Governance Annual Conference to be held in Orlando, FL, April 24-28, 2016, either using the topics identified in this Training Plan or other topics that may be more relevant to Self-Governance Tribes at the time.

Other training opportunities. The TSGAC and technical consultants will participate in workshops at the NIHB Annual Consumer Conference in September 2016 and in conjunction with at least one other SGCE training that is provided in 2016. They may also participate in other training activities, depending on the need and availability of funding.

7. Project Team

TSGAC and JST Tribal leadership will coordinate with the Project Team and technical consultants as needed on the performance of these deliverables.

8. Evaluation Plan

Evaluation of Training Webinars and Training Sessions. An Evaluation Form will be used to collect information and obtain immediate feedback from all participants who participate in the Webinars and Trainings. The purpose of the evaluation will be to: (1) assess the value of the Training; (2) determine if the Training learning objectives have been achieved; and, (3) gather input which can be used to improve the content and presentation/delivery of the training materials for use in future sessions.

Information collected on the Evaluation Form will include:

- ➔ If the goals and objectives were clearly defined and met
- ➔ Relevancy of topics
- ➔ Content delivery
- ➔ Training materials
- ➔ Opportunity for interactive discussion
- ➔ Responsive to questions
- ➔ Topics requested for additional training

All participants who register and complete a Webinar or Training will be provided an Evaluation Form. All information collected on the Evaluation Forms will be summarized and shared with the TSGAC, OTSG and the Instructors/Trainers in order to assess if any changes need to be made to improve the Training Modules and/or Training Sessions.

Additional Evaluation. A tracking list of all deliverables in the SOW will be maintained for the items in this Work Plan and updated quarterly to assure that all the objectives are accomplished. A 6 month report and a final report will be submitted to the IHS OTSG, IHS Office of Resource Access and Partnerships and IHS Senior Advisor to the Director.

Health Care Reform in Indian Country

Self-Governance Communication & Education

Self-Governance Tribes Striving Towards Excellence in Health Care

Steps to Update (or Add) Entry on the HHS Essential Community Provider List (DUE DATE EXTENDED)[1]

--Revised January 14, 2016 with latest facility list--

This brief seeks to provide guidance to Indian health care providers (IHCPs) on the steps they need to take to update information or obtain placement on the list of essential community providers (ECPs) maintained by the federal Department of Health and Human Services (HHS ECP List) for benefit year 2017. IHCPs and other providers that seek to obtain placement on the HHS ECP List, or to update information in a current entry, must submit a petition, following the steps outlined in the table below.[2] HHS earlier this month announced a one-week extension of the deadline for providers that qualify as an ECP to submit updates/petitions, changing the due date from January 8, 2016, to **January 15, 2016**. *To confirm that HHS has a record of a non-Indian Health Service IHCP facility recently updating or adding an entry on the HHS ECP List for 2017, see the list at the end of this memorandum.*

Steps for Submitting the Essential Community Provider Petition for the 2017 Benefit Year

1.	Access the electronic petition at https://data.healthcare.gov/cciio/ecp_petition.
	Begin answering the questions, filling in all required data fields and scrolling over the "i" buttons for additional instructions (when available).
2.	Answer questions about you (the submitter) in the "About You" section.
3.	Indicate under "Requested Action" whether your facility wishes to obtain placement on, change its data on, or remove itself from the HHS ECP List in the "Requested Action" section.
4.	Find your facility (if your facility currently appears on the HHS ECP List) by clicking on the "Check to see if you are on the list" button in the "Requested Action" section (a searchable database will open) and note your row number (you will need this later to complete the petition / question 17).
5.	Complete the "Eligibility," "Site Information, Organization Information," and "Point of Contact" sections.
6.	After completing the petition, click the "Preview your Petition before Submitting" button.
7.	Fix validation errors (if any) found in the petition (indicated in red).
8.	Submit your finalized petition.

Link to FAQs: https://data.healthcare.gov/dataset/ECP-Petition-FAQs-12-07-15/igr2-dm75

[1] This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Doneg McDonough, TSGAC Technical Advisor, at DonegMcD@Outlook.com.

[2] For background, see "TSGAC Memo – Action Needed to Retain Status on HHS ECP List – 2015-12-18-(3)" found at http://tribalselfgov.org/health-reform/webinars/new-process-to-retain-status-as-essential-community-provider-ecp/

Contact for Assistance with Submitting Petition: EssentialCommunityProviders@cms.hhs.gov

Link to ECP Provider Petition Instructions: The instructions are embedded in the ECP Petition website (by clicking on Information icons). In addition, a copy of the ECP Provider Petition Instructions may be accessed on the TribalSelfGov.org website at http://tribalselfgov.org/wp/wp-content/uploads/2015/12/ECP-Provider-Petition-Instructions-12-09-15.pdf.

Facilities with Updated (or New) Entries on HHS ECP List:

According to HHS, as of January 14, 2016, the following non-IHS IHCPs had updated their information (or added a new entry) on the HHS ECP List for benefit year 2017 (see the list below, with spelling as indicated on HHS ECP List). **Because of the addition of several new data fields for the HHS ECP List for 2017, every provider that currently appears on the list, including IHCPs, will need to provide this missing data through the petition process**.

Site Name	Site City
Acoma-Canoncito-Laguna Hospital	Acoma
Akhiok Village Clinic	Akhiok
Alaska Native Medical Center - Fast Track	ANCHORAGE
Alaska Native Medical Center - Inpatient Pediatrics	ANCHORAGE
ALLAKAKET HEALTH CLINIC	Allakaket
Altona Brown Health Clinic	Ruby
American Indian Health & Family Services, S.E. Michigan (Detroit, MI)Amei	Detroit
American Indian Health & Services Corporation (Santa Barbara, CA)	Santa Barbara
AMERICAN INDIAN HEALTH & SERVICES, INC	SANTA BARBARA
American Indian Health Service-Chicago	Chicago
A-MO Salina Health Center	Salina
Anadarko Health Center	Anadarko
Anchorage Native Primary Care Center	Anchorage
Anchorage Native Primary Care Center Behavioral Health Clinic	Anchorage
Anza Indian Health - Outreach Office	Anza
Arapahoe Health Center	Arapahoe
ARCTIC VILLAGE HEALTH CLINIC	Arctic Village
ARCTIC VILLAGE HEALTH CLINIC	Arctic Village
Ardmore Health Clinic	Ardmore
Arlee Health Station	Arlee
BBAHC Aleknagik North Clinic	North Aleknagik
BBAHC Aleknagik South Side Clinic	South Aleknagik
BBAHC Chignik Bay Clinic	Chignik Bay

BBAHC Chignik Lake Clinic	Chignik Lake
BBAHC Clarks Point Clinic	Clarks Point
BBAHC Egegik Clinic	Egegik
BBAHC Ekwok Clinic	Ekwok
BBAHC Goodnews Bay Clinic	Goodnews Bay
BBAHC King Salmon Clinic	King Salmon
BBAHC Koliganek Clinic	Koliganek
BBAHC Levelock Clinic	Levelock
BBAHC Manokotak Clinic	Manokotak
BBAHC Naknek Clinic	Naknek
BBAHC New Stuyahok Clinic	New Stuyahok
BBAHC Perryville Clinic	Perryville
BBAHC Pilot Point Clinic	Pilot Point
BBAHC Port Heiden Clinic	Port Heiden
BBAHC South Naknek Clinic	South Naknek
BBAHC Togiak Clinic	Togiak
BBAHC Twin Hills Clinic	Twin Hills
BEAVER HEALTH CLINIC	Beaver
BEAVER HEALTH CLINIC	Beaver
Behavioral Health Fireweed	Anchorage
Behavioral Health Services	Scottsdale
BIRCH CREEK VILLAGE CLINIC	Fort Yukon
Black Hawk Health Center	Stroud
BLACKFEET COMMUNITY HOSPITAL	BROWNING
BO ZT OW ZHO Eagle Health Clinic	Eagle
Bogue Chitto Community Satellite Clinic	Philadelphia
Buford L Rolin Health Clinic	Atmore
Burney Clinic	Burney
Cameron Dental	Cameron
Carl T Curtis Health Education Center	Macy
Carnegie Health Center	Carnegie
Cass Lake Hospital	Cass Lake
Cass Lake Hospital	Cass Lake
Catawba Health Service	Rock Hill
Cattaraugus Indian Reservation Health Center	Irving
Cedar Community Health Center	Cedar City
Central Valley Indian Health, Clovis Clinic	Clovis
Central Valley Indian Health, Clovis Clinic	Clovis
Central Valley Indian Health, Prather Clinic	Prather
C'eyiits' Hwnax Life House Community Health Center	Sutton
Chemehuevi Health Station	Havasu Lake
Cherokee Indian Hospital	Cherokee
Cherokee Nation A-MO Health Center (Salina Community Clinic	Salina

Cherokee Nation Ga Du Gi Clinic	Tahlequah
Cherokee Nation Sam Hider Community Clinic	Jay
Cherokee Nation W.W. Hastings Hospital	Tahlequah
Cherry Creek Clinic	Eagle Butte
Cheyenne River Sioux Tribe Field Health	Eagle Butte
Chickasaw Nation - Purcell Indian Health Clinic	Purcell
Chickasaw Nation Medical Center (Carl Albert Indian Hospital	Ada
Chickasaw Nation Medical Center (Carl Albert Indian Hospital	Ada
Chickasaw Nation Medical Center (Carl Albert Indian Hospital)	Ada
Chief Andrew Issac Health Center	Fairbanks
Chignik Lagoon Clinic	Chignik Lagoon
Chinle Comprehensive Healthcare Facility	Chinle
Chinle Comprehensive Healthcare Facility	Chinle
Chippewa-Cree Tribe - (Rocky Boy's)	Box Elder
Chitimacha Health Center	Charenton
Choctaw Hospital (Philadelphia)	Choctaw
Choctaw Nation Health Clinic and Hospital Talihina	Talihina
Choctaw Nation Health Clinic Atoka	Atoka
Choctaw Nation Health Clinic Atoka	Atoka
Choctaw Nation Health Clinic Atoka	Atoka
Choctaw Nation Health Clinic Broken Bow	Broken Bow
Choctaw Nation Health Clinic Durant	Durant
Choctaw Nation Health Clinic Hugo	Hugo
Choctaw Nation Health Clinic Idabel	Idabel
Choctaw Nation Health Clinic McAlester	McAlester
Choctaw Nation Health Clinic Poteau	Poteau
Choctaw Nation Health Clinic Poteau	Poteau
Choctaw Nation Health Clinic Stigler	Stigler
Choctaw Nation Health Clinic Stigler	Stigler
Chugachmiut Anesia Anahonak Moonin Clinic (Port Graham)	Port Graham
Chugachmiut Chenega Bay Clinic	Chenega Bay
Chugachmiut Nanwalek Clinic	Nanwalek
Chugachmiut North Star Health Clinic	Seward
Chugachmiut Tatitlek Clinic	Tatitlek
Cibecue Health Center	Cibecue
Claremore Indian Hospital	Claremore
Clarence Wesley Health Center	Bylas
Clinton Health Center	Clinton
Coleville Clinic	Coleville
Colorado River Service Unit - Parker Hospital/ Peach Springs Health Center/Supai Clinic/Chemehuevi Clinic/Moapa Clinic	Parker
Conehatta Community Satellite Clinic	Conehatta
Consolidated Tribal Health Project, Inc.	Redwood

	Valley
Cooweescoowee Health Center	Ochelata
Copper River Native Association	Copper Center
Crow/Northern Cheyenne Hospital (Crow Agency Indian Hospital)	Crow Agency
Crownpoint Hospital	Crownpoint
Dena A Coy Residential	Anchorage
Dennehotso Health Clinic (Kayenta Service Unit)	Kayenta
Denver Indian Health and Family Services	Denver
DESERT VISIONS YOUTH WELLNESS CENTER	SACATON
DHHS IHS PHOENIX AREA DESERT VISIONS YOUTH WELLNESS CENTER	SACATON
DHHS IHS PHOENIX AREA NEVADA SKIES YOUTH WELLNESS CENTER	WADSWORTH
Dickenson Co Health Dept	Clintwood
Dot Lake Clinic	Dot Lake
Dzilth-Na-O-Dith-Hle Health Center	Bloomfield
Dzilth-Na-O-Dith-Hle Health Center	Bloomfield
Eastern Shoshone Recovery Program	Ft Washakie
Eastern Shoshone Recovery Program	Ft Washakie
Eastern Shoshone Recovery Program	Ft Washakie
Eastern Shoshone Tribal Health	Fort Washakie
Edgar Nollner Health Center	Galena
El Reno Health Center	El Reno
Elmo Health Station	Elmo
Fallon Tribal Health Center	Fallon
Feather River Tribal Health	Oroville
Feather River Tribal Health	Yuba City
First Nations Community HealthSource	Albuquerque
Flathead Tribal Health Service Unit	St. Ignatius
Fond Du Lac Band of Lake Superior Chippewa	Cloquet
Forest County Potawatomi(FCP)/FCP Health and Wellness Center/Chemical Dependency Outpatient Program	Crandon
Fort Belknap Indian Community (Harlem Indian Hospital)	Harlem
Fort Washakie Health Center (Wind River Service Unit)	Fort Washakie
Fort Yuma Health Center	Winterhaven
Four Corners Regional Health Center (part of Shiprock Service Unit)	Teec Nos Pos
FRANK TOBUK SR. HEALTH CENTER	Bettles
Fred LeRoy Health & Wellness Center	Omaha
Fred LeRoy Health & Wellness Center	Omaha
Fresno American Indian Health Project	Fresno
Gallup Indian Medical Center	Gallup
Gerald L. Ignace Indian Health Center, Inc. (Milwaukee, WI)	Milwaukee
HAINES HEALTH CENTER	Haines
Hannahville Health Center	Wilson
Hannahville Health Center	Wilson
Hannahville Health Center	Wilson

Haskell Indian Health Center	Lawrence
Helena Indian Alliance	Helena
Helena Indian Alliance	Helena
Helena Indian Alliance	Helena
Ho-Chunk Nation of Wisconsin/Ho-Chunk Nation Health Station (Whittenberg)/Ho-Chunk Nation Health Station (Tomah)/Ho-Chunk House of Wellness Hlth. Ctr.(Baraboo)/Ho-Chunk Behavioral Health/Black River Falls Health Center	Black River Falls
Hopi Health Care Center (Keams Canyon Service Unit)	Polacca
Houlton Band of Maliseet Indians	Houlton
Ilanka Community Health Center	Cordova
INCHELIUM COMMUNITY HLTH CENTER	Inchelium
Indian Family Health Clinic (Great Falls, MT	Great Falls
INDIAN HEALTH BOARD OF MINNEAPOLIS INC	Minneapolis
Inscription House Health Center	Shonto
Irene Benn Medical Center (Moapa Clinic)	Moapa
Jackson Rancheria Health Center - M.A.C.T. Health Board, Inc.	Jackson
Kalispel Tribe of Indians/ Camas Center for Community Wellness/Behavioral Health	Cusick
Kaltag Health Clinic	Kaltag
KANA (Alutiiq Enwia Clinic-Kodiak)	Kodiak
KANA (Mill Bay Health Clinic)	Kodiak
Kanakanak Hospital	Dillingham
Kanakanak Hospital	Dillingham
Kanosh Community Health Center	Kanosh
Karluk Health Clinic	Karluk
Kayenta Health Center	Kayenta
Ketchikan Indian Community	Ketchikan
Kewa Pueblo Health Center (Santo Domingo)	Santo Domingo
Koosharem Community Health Center	Richfield
Kootenai Tribal Health Clinic	Bonners Ferry
Koyukuk Health Clinic	Koyukuk
Kyle Health Center	Kyle
Lake County Tribal Health Program	Lakeport
Lame Deer Health Center (Northern Cheyenne Tribe)	Lame Deer
Larsen Bay Health Clinic	Larsen Bay
Lawton Indian Hospital	Lawton
LeChee Health Facility	LeChee
Lionel R John Health Center	Salamanca
Lockport Service Unit	Lockport
Lower Brule Indian Health Service	Lower Brule
Lummi Behavioral Health	Bellingham
Lummi Counseling Services	Bellingham
Lummi Tribal Health Center	Bellingham
Manistique Tribal Health Center	Manistique

Mantachie Rural Health Dental Clinic	Mantachie
Marilyn E. Koyukuk Evans Health Center	Hughes
Mariposa Indian Health Center - M.A.C.T. Health Board, Inc.	Mariposa
Mary C. Demientieff Health Clinic (Nenana)	Nenana
Mashantucket Pequot Health Center	Ledyard
Mashpee Service Unit-Indian Health Service	Mashpee
Maternal Child Health	San Carlos
McGrath Sub-Regional Health Center	McGrath
Mescalero Service Unit	Mescalero
Meskwaki Tribal Health Center	Tama
Micmac Service Unit	Presque Isle
Mille Lacs Band of Ojibwe Indians	Onamia
Morning Star Care Center	Fort Washakie
Morongo Indian Health Clinic	Banning
Mt. Edgecumbe Hospital (Sitka) - SEARHC	Sitka
Muckleshoot Health & Wellness Center	Auburn
Munising Tribal Health Center	Munising
MYRA ROBERTS CLINIC	Venetie
NACA Family Health Center	Flagstaff
Native American Health Center	Oakland
Native Americans for Community Action (Flagstaff, AZ)	Flagstaff
Native Health Central	Phoenix
NATIVE Project	Spokane
NHW Community Health Center	Phoenix
NILAVENA SUBREGIONAL CLINIC	Iliamna
Ninilchik Village Tribal Council (Ninilchik Community Clinic	Ninilchik
Nooksack Indian Tribe/Nooksack Indian Health Department /Dental/Behavioral Health	Everson
North Fork Indian & Community Health Center	North Fork
Northern Navajo Medical Center (Part of Shiprock Service Unit)	Shiprock
Northway Health Clinic	Northway
Nulato Health Clinic	Nulato
Oklahoma City Indian Clinic	Oklahoma City
Old Harbor Health Clinic	Old Harbor
Ouzinkie Health Clinic	Ouzinkie
Owyhee Community Health Facility	Owyhee
PARKER MEDICAL CENTER	Parker
Pascua Yaqui Tribe/Health Center	Tucson
Pawnee Indian Health Center	Pawnee
Peach Springs Health Center	Peach Springs
Peach Springs Health Center	Peach Springs
Pechanga Indian Health Center	Temecula
Penobscot Nation Health Department	Indian Island
Peter Christensen Health Center	Lac du Flambeau

Phoenix Indian Medical Center	Phoenix
Pine Hill Health Center	Pinehill
Pine Ridge	Pine Ridge
Pine Ridge	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hospital	Pine Ridge
Pine Ridge Hosptal	Pine Ridge
Pine Ridge Hosptial	Pine Ridge
Pinon Health Center	Pinon
Platinum Clinic	Platinum
Pleasant Point Health Center	Perry
Pokagon Health Services	Dowagiac
Polson Health Center	Polson
Ponca Hills Health & Wellness	Norfolk
Port Gamble S'Klallam Tribe(PGST)/ PGST See-yeels-out Wellness Center/PGST mental health/PGST Recovery Ctr./PGST Tribal Clinic	Kingston

Port Lions Health Clinic	Port Lions
Pueblo Pintado Health Center (Crownpoint Service Unit)	Cuba
Quentin N. Burdick Hospital/Belcourt Indian Hospital	Belcourt
Quinault Indian Nation	Taholah
Quyana Club House	ANCHORAGE
Quyana Club House Medical	Anchorage
Red Lake PHS Indian Hospital	Red Lake
Red Scaffold Clinic	Eagle Butte
Red Water Community Satellite Clinic	Carthage
Redbird Smith Health Center	Sallisaw
Reno-Sparks Tribal Health Center	Reno
Ronan Health Station	Ronan
Rose Ambrose Health Clinic	Huslia
Rosebud Hospital	Rosebud
Sacramento Native American Health Center	Sacramento
Sacred Peaks Health Center	Flagstaff
SAINT PAUL HEALTH CENTER Behavioral Health	Saint Paul
Saint Regis Mohawk Health Services	HOGANSBURG
Salt River Health Center	Scottsdale
Sam Hider Health Center	Jay
San Andreas Community Clinic - M.A.C.T. Health Board, Inc.	San Andreas
San Carlos Apache Healthcare Corporation	Peridot
San Diego American Indian Health Center (San Diego, CA)	San Diego
San Diego American Indian Health Center (San Diego, CA)	San Diego
San Diego American Indian Health Center (San Diego, CA)San Diego	San Diego
San Manual Health Clinic	Grand Terrace
SAN POIL VALLEY COMMUNITY HEALTH	Keller
Sanostee Health Station	Sanostee
Sault Tribal Health Center	Sault Sainte Marie
SEARHC Alicia Roberts Medical Center	Klawock
SEARHC Alma Cook Health Center	Hydaburg
SEARHC Ethal Lund Medical Center	Juneau
SEARHC Hoonah Health Center	Hoonah
SEARHC Jessie Norma Jim Health Center	Angoon
SEARHC Kake Health Center	Kake
SEARHC Kasaan Health Center	Kasaan
SEARHC Klukwan Health Center	Klukwan
SEARHC Pelican Health Clinic	Pelican
SEARHC Pelican Health Clinic	Pelican
SEARHC Petersburg Clinic	Petersburg
Seattle Indian Health Board	Seattle
Sherman Indian School Clinic	Riverside
Shinnecock Indian Health Service	Southhampto

	n
Shivwits Community Health Center	Ivins
Shoalwater Bay Tribe/Shoalwater Bay Wellness Center	Tokeland
Siletz Community Health Clinic	Siletz
Sisseton Wahpeton Oyate	Sisseton
Sisseton/W.W. Keeble Memorial Health Care Center	Sisseton
Sonoma County Indian Health	Santa Rosa
Sonora Indian Health Center - M.A.C.T. Health Board, Inc.	Sonora
Southern Indian Health Council - Campo Clinic	Campo
Southern Indian Health Council, Inc - Alpine Clinic	Alpine
Spokane Tribe of Indians	Wellpinit
ST PAUL HEALTH CENTER	Saint Paul
St. Ignace Tribal Health Center	Saint Ignace
St. Ignatius Health Center	Saint Ignatius
SUPAI HEALTH CLINIC	Supai
Supai Health Clinic	Supai
Suquamish Tribe/Suquamish Tribe Wellness Program	Suquamish
Swiftbird Clinic	Eagle Butte
Swinomish Indian Health Center	La Conner
Swinomish Indian Health Clinic	La Conner
Tachi Medical Center	Lemoore
Tanacross Health Clinic	Tanacross
Taos Picuris Health Center	Taos
Tetlin Health Clinic	Tok
The Pathway Home	Anchorage
Thoreau Health Station	Thoreau
Thorne Bay Health Clinic	Thorne Bay
Three Rivers Health Center	Muskogee
Tishomingo Health Clinic	Tishomingo
Toadlena Health Station	Shiprock
Tohatchi Health Center	Tohatchi
Torres-Martinez Health Clinic	Thermal
TRIBAL HEALTH PROGRAM OPERATED UNDER PL 93-638	SKOKOMISH NATION
Tsaile Health Center (Chinle Service Unit)	Tsaile
tuba city regional health care corporation	Tuba City
Tuba City Regional Health Care Corporation	Tuba City
Tuba City Regional Health Care Corporation	Tuba City
Tule River Indian Health Clinic	Porterville
Tuolumne MeWuk Health and Wellness Center	Sonora
Tuolumne MeWuk Indian Health Center	Tuolumne
Uintah & Ouray Res.-Fort Duchesne Health Center	Fort Duchesne
Upper Tanana Health Center	Tok
Urban Indian Health	Sioux Falls

Urban Indian Health	Pierre
Valley Native Primary Care Center	Wasilla
Verne E. Gibbs Health Center-Poplar	Poplar
Vinita Health Center	Vinita
Wagner Healthcare Facility	Wagner
Wagner Indian Health Service	Wagner
Wagner Indian Health Service	Wagner
WAH ZHA ZHI HEALTH CENTER	Pawhuska
WAH ZHA ZHI HEALTH CENTER	Pawhuska
Washoe Tribe Health Center	Gardnerville
Wassaja Memorial Health Center	Ft McDowell
Watonga Health Center	Watonga
Wewoka Health Center Wewoka	Wewoka
White Cloud Health Station	White Cloud
White Eagle Health Center	Ponca City
White Earth Health Center	Ogema
White Horse Clinic	Eagle Butte
White Sky Hope Center - Rocky Boy	Box Elder
Whiteriver Indian Hospital	Whiteriver
Will Rogers Health Center	Nowata
Wilma P. Mankiller Health Center	Stilwell
Wind River Dialysis Center	Fort Washakie
Winnebago Hospital	Winnebago
Wolf Point (Chief Redstone) Indian Health Center	Wolf Point
XL Clinic	Alturas
Yellowhawk Tribal Health Center	Pendleton
YKHC Yukon Kuskokwim Elder's Home	Bethel
YUKON FLATS HEALTH CENTER	Fort Yukon
Yukon Kuskokwim Delta Regional Hospital	Bethel
Yukon Kuskokwim Delta Regional Hospital	Bethel
Yukon-Kuskokwim Health Corporation Akiachak Clinic	Akiachak
Yukon-Kuskokwim Health Corporation Akiak Clinic	Akiak
Yukon-Kuskokwim Health Corporation Alakanuk Clinic	Alakanuk
YUKON-KUSKOKWIM HEALTH CORPORATION ANVIK CLINIC	Anvik
Yukon-Kuskokwim Health Corporation Atmautluak Clinic	Atmautluak
Yukon-Kuskokwim Health Corporation Behavioral Health	Bethel
YUKON-KUSKOKWIM HEALTH CORPORATION CHEFORNAK CLINIC	Chefornak
YUKON-KUSKOKWIM HEALTH CORPORATION CHEVAK CLINIC	Chevak
YUKON-KUSKOKWIM HEALTH CORPORATION CHUATHBALUK CLINIC	Chuathbaluk
YUKON-KUSKOKWIM HEALTH CORPORATION CROOKED CREEK CLINIC	Crooked Creek
Yukon-Kuskokwim Health Corporation Dental	Bethel
Yukon-Kuskokwim Health Corporation Dental	Bethel
Yukon-Kuskokwim Health Corporation Developmental Disabilities	Bethel

Yukon-Kuskokwim Health Corporation Eek Clinic	Eek
Yukon-Kuskokwim Health Corporation Family Infant Toddler	Bethel
YUKON-KUSKOKWIM HEALTH CORPORATION GRAYLING CLINIC	Grayling
YUKON-KUSKOKWIM HEALTH CORPORATION HOLY CROSS CLINIC	Holy Cross
Yukon-Kuskokwim Health Corporation Home Care	Bethel
Yukon-Kuskokwim Health Corporation Kasigluk Clinic	Kasigluk
Yukon-Kuskokwim Health Corporation Kipnuk Clinic	Kipnuk
Yukon-Kuskokwim Health Corporation Kongiganak Clinic	Kongiganak
YUKON-KUSKOKWIM HEALTH CORPORATION KOTLIK CLINIC	Kotlik
Yukon-Kuskokwim Health Corporation Kwethluk Clinic	Kwethluk
Yukon-Kuskokwim Health Corporation Kwigillingok Clinic	Kwigillingok
YUKON-KUSKOKWIM HEALTH CORPORATION LIME VILLIAGE CLINIC	Lime Village
YUKON-KUSKOKWIM HEALTH CORPORATION LOWER KALSKAG CLINIC	Lower Kalskag
YUKON-KUSKOKWIM HEALTH CORPORATION MARSHAL CLINIC	Marshall
Yukon-Kuskokwim Health Corporation McCann Treatment Center	Bethel
Yukon-Kuskokwim Health Corporation McCann Treatment Center	Bethel
YUKON-KUSKOKWIM HEALTH CORPORATION MEKORYUK CLINIC	Mekoryuk
YUKON-KUSKOKWIM HEALTH CORPORATION MOUNTAIN VILLAGE CLINIC	Mountain Village
Yukon-Kuskokwim Health Corporation Napakiak Clinic	Napakiak
Yukon-Kuskokwim Health Corporation Napaskiak Clinic	Napaskiak
YUKON-KUSKOKWIM HEALTH CORPORATION Newtok Clinic	Newtok
YUKON-KUSKOKWIM HEALTH CORPORATION NIGHTMUTE CLINIC	Nightmute
YUKON-KUSKOKWIM HEALTH CORPORATION NUNAM IQUA CLINIC	Nunam Iqua
Yukon-Kuskokwim Health Corporation Nunapitchuk Clinic	Nunapitchuk
Yukon-Kuskokwim Health Corporation Optometry	Bethel
Yukon-Kuskokwim Health Corporation Oscarville Clinic	Oscarville
Yukon-Kuskokwim Health Corporation Pharmacy	Bethel
YUKON-KUSKOKWIM HEALTH CORPORATION PILOT STATION CLINIC	Pilot Station
YUKON-KUSKOKWIM HEALTH CORPORATION PITKA'S POINT CLINIC	Pitka's Point
Yukon-Kuskokwim Health Corporation Quinhagak Clinic	Quinhagak
YUKON-KUSKOKWIM HEALTH CORPORATION Russian Mission Clinic	Russian Mission
YUKON-KUSKOKWIM HEALTH CORPORATION SCAMMON BAY CLINIC	Scammon Bay
YUKON-KUSKOKWIM HEALTH CORPORATION SHAGELUK CLINIC	Shageluk
YUKON-KUSKOKWIM HEALTH CORPORATION SLEETMUTE CLINIC	Sleetmute
YUKON-KUSKOKWIM HEALTH CORPORATION STONY RIVER CLINIC	Stony River
Yukon-Kuskokwim Health Corporation Tuluksak Clinic	Tuluksak
Yukon-Kuskokwim Health Corporation Tuntutuliak Clinic	Tuntutuliak
YUKON-KUSKOKWIM HEALTH CORPORATION Tununak Clinic	Tununak
YUKON-KUSKOKWIM HEALTH CORPORATION UPPER KALSKAG CLINIC	Upper Kalskag
Yukon-Kuskokwim Health Corporation Womens Care and Support Center	Bethel
Zuni Indian Hosptial	Zuni

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Indian Health Service
Rockville MD 20852

JUL 29 2015

Dear Tribal Leader:

I am writing to provide an update on my May 22 letter to you regarding a settlement that Indian Health Service (IHS) reached with employee unions. Specifically, I want to address three questions about the settlement that have been raised frequently in various forums since then.

The first question that is often asked is why the settlement payment is not being paid through the Judgment Fund? Because the settlement was reached through an administrative settlement of a Union grievance in arbitration, the Judgment Fund is not available to pay the costs of settlement. The authorizing statute for the Judgment Fund makes clear that it is only available for the payment of claims brought through a judicial (as opposed to Union grievance/arbitral) proceeding, or which are settled under the authority of specifically identified statutes (e.g., the Federal Tort Claims Act). The Fair Labor Standards Act is not one of the statutes identified in the Judgment Fund's authorizing legislation.

The second question I hear a lot is, if IHS must pay the settlement, why are service unit third party collections funds being used for the payment? The answer to this question is tied to the type of costs associated with the settlement. The $80 million settlement is comprised of two categories of costs: 1) $60 million for back pay and back pay-related costs (e.g., payroll taxes); and 2) $20 million for administrative costs and attorney's fees.

The claimants in this settlement are largely service unit employees, consistent with IHS's organizational structure in which approximately 90 percent of its workforce is at the service unit level. Therefore, the settlement payment is borne largely by the service units. In addition, the settlement covers Fiscal Years (FY) 2005 through 2014. Under requirements of Federal appropriations laws, the agency must charge back pay owed to an employee to the fiscal year in which the pay was earned. Past year appropriated funds for FY 2005-2009 that could have been used to pay the overtime are no longer available (as past year unspent appropriations are cancelled after five fiscal years). Consequently, the only funds which could be used to pay the overtime for those years, and which are available now, are third party collections. The agency has identified roughly $10 million in expired appropriated (but not yet cancelled) funds that may be used for the back pay from the FY 2010-2014. These funds will decrease the amount of third party collections needed to meet the settlement obligations. Therefore, the settlement will be paid from third party collections ($50 million) and expired appropriations ($10 million). Third party collections are only collected and spent at the service unit level so these funds must come from the service units. IHS has made an initial estimate of the amounts that would be owed by each service unit, for purposes of making the payment of the $60 million to the union. The union will provide quarterly reports to IHS of actual payments to claimants, which will then be used to adjust the initial estimated amounts contributed by each service unit to ensure each IHS service unit, Area Office, and Headquarters is charged as appropriate. From a legal perspective, these are not new obligations. Rather these are obligations that should have been recorded and paid in the appropriate Fiscal Year. Also, IHS is paying the $20 million in administrative costs and attorney's fees from current FY 2015 appropriations.

The third most asked question about the settlement is why Tribes were not consulted about the payment ahead of time? The settlement arose from a group grievance filed by the union. Information about employee grievances is generally an internal agency matter, and the agency does not disclose such information without consent of the aggrieved party. IHS communicated with Tribes and offered an opportunity to comment and ask questions as soon as it was practicable to do so.

Finally, I understand you are keenly interested in knowing how your service unit funding is impacted by this settlement. I have asked the Area Directors to ensure this information is available by August 14, 2015, when IHS must make the payment to the union. However, as described above, the initial amounts paid by each service unit will be reconciled as the union makes payments to individual employees. Area Directors will provide updated information once a final reconciliation has been completed.

I trust this update is helpful. Please do not hesitate to contact me with any additional questions.

Sincerely,

/Robert G. McSwain/

Robert G. McSwain
Deputy Director

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JAN 1 4 2016

Dear Tribal Leader:

I write to invite you to the *18th U.S. Department of Health and Human Services (HHS) Annual Tribal Budget Consultation (ATBC),* which will take place March 2-3, 2016, in the Great Hall of the Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC, as well as to our *2016 Annual Regional Tribal Consultations* held across the country.

The Department understands the importance of hearing from tribes on national cross-cutting issues, regional perspectives, as well as tribal-specific concerns and will continue to work with you to improve the consultation process. Below you will find a brief description of the ATBC and details for the Annual Regional Tribal Consultation sessions. HHS will begin hosting planning calls for the ATBC on Wednesday, January 27, 2016, at 3:00 p.m. EST.

Additional details are included in the enclosures.

18th HHS Annual Tribal Budget Consultation

The consultation session will provide a forum for tribes to collectively share their views and priorities with HHS officials on national health and human services funding priorities and recommendations for the Department's fiscal year 2018 budget request. We hope the consultation will provide a venue for a two-way conversation between tribal leaders and HHS officials on program issues and concerns that will lead to recommended actions. The schedule for this year's consultation is as follows:

One-on-one meetings with HHS Divisions: Wednesday, March 2, 2016

We will once again be providing tribes time for one-on-one meetings to share their specific health and human service issues with HHS officials. These meetings will occur from 9:00 a.m. to 5:00 p.m. on Wednesday, March 2. Officials from various HHS agencies will be available to listen and contribute to the conversation. For this specific portion of the consultation, we ask that you pre-register so that all tribes have an opportunity to meet with HHS representatives. Please note that the amount of time you are allotted to meet with individual HHS officials will be determined by the volume of requests we receive. To register for one-on-one meeting times, please email your request to consultation@hhs.gov and include the agency/agencies you would like to meet with. All requests for one-on-one meetings must be received by Friday, February 19.

Annual Budget Consultation: Thursday, March 3, 2016

We will begin the consultation session at 9:00 a.m. on Thursday, March 3. HHS will identify specific issues that we would like to consult with tribes about. We will discuss these issues on the planning calls so you can prepare your thoughts, ideas, and recommendations.

2016 Annual Regional Tribal Consultations

In addition to the ATBC, the Department will also again host the Annual Regional Tribal Consultations with sessions to address how the Department can continue to improve our outreach and coordination with tribes and to discuss programmatic issues and overall tribal concerns. Regional sessions will also include one-on-one time with the Regional Directors. More information on dates and locations of each of the regional sessions can be found in the enclosures.

Thank you for your continued support of the consultation process. We look forward to your participation and on-going partnership. Please contact Stacey Ecoffey, Principal Advisor for Tribal Affairs, at (202) 690-6060 or consultation@hhs.gov with any questions.

Sincerely,

Sylvia M. Burwell

Enclosures

U.S. Department of Health & Human Services
2016 HHS Regional Tribal Consultation
INFORMATION

Region 1:
Date: **TBD**
Location: **Boston, MA**
IHS Area: **Nashville Area**
Regional Contact Info:
Paul Jacobsen
Email: Paul.Jacobsen@hhs.gov

Region 2:
Date: **April 5, 2016**
Location: **Syracuse, NY**
IHS Area: **Nashville Area**
Regional Contact Info:
Sean Hightower
Email: Sean.Hightower@hhs.gov

Region 4:
Date: **May 18, 2016**
Location: **Atmore, AL**
IHS Area: **Nashville Area**
Regional Contact Info:
Deric Gilliard
Email: Deric.Gilliard@hhs.gov

Region 5:
Date: **April 7-8, 2016**
Location: **Green Bay, WI**
IHS Area: **Bemidji Area**
Regional Contact Info:
Sam Gabuzzi
Email: Sam.Gabuzzi@hhs.gov

Region 6 & 7:
Date: **April 26-27, 2016**
Location: **Albuquerque, NM**
IHS Area: **Albuquerque, Nashville, and Oklahoma City Areas**
Regional Contact Info:
Julia Lothrop (Region 6)
Email: Julia.Lothrop@hhs.gov

Adele Sink (Region 7)
Email: Adele.Sink@hhs.gov

Region 7 & 8:
Date: **March 22-23, 2016**
Location: **Denver, CO**
IHS Areas: **Billings and Great Plains Areas**
Regional Contact Info:
Adele Sink (Region 7)
Email: Adele.Sink@hhs.gov

Kim Gillan (Region 8)
Email: Kim.Gillan@hhs.gov

Region 9:
Date: **April 14-15, 2016**
Location: **Phoenix, AZ**
IHS Areas: **California, Phoenix, and Tucson Areas**
Regional Contact Info:
Kenneth Shapiro
Email: Kenneth.Shapiro@hhs.gov

Region 10:
Date: **May 12-13, 2016**
Location: **Suquamish, WA**
IHS Areas: **Alaska and Portland Areas**
Regional Contact Info:
Barbara Greene
Email: Barbara.Greene@hhs.gov

Navajo Regional Session:
Date: **TBD**
Location: **TBD**
IHS Area: **Navajo**
Regional Contact Info:
Julia Lothrop
Email: Julia.Lothrop@hhs.gov

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
18th HHS ANNUAL TRIBAL BUDGET CONSULTATION
WASHINGTON, D.C.

The U.S. Department of Health and Human Services (HHS) will host the 18th Annual Tribal Budget Consultation (ATBC) for Fiscal Year 2018 in March. The two-day session will include **one-on-one sessions *on Wednesday, March 2, 2016,*** and the ***Annual Tribal Budget Consultation session on Thursday, March 3, 2016***. Below is a summary of the 2015 ATBC session, as well as the planning call schedule.

Summary of the 17th HHS Annual Tribal Budget Consultation

On February 25-26, 2015, HHS hosted the 17th ATBC in Washington, D.C. The participants were tribal leaders and representatives, Indian organization leadership and staff, such as the National Congress of American Indians and the National Indian Health Board, as well as HHS leadership and staff.

On February 25, HHS held one-on-one sessions between tribal leaders and HHS agency leadership from ACF, ACL, CDC, CMS, HRSA, IHS, NIH, and SAMHSA. The one-on-one format allowed direct dialogue on issues specific to each participating tribe. In addition, HHS hosted a half-day Tribal Resource Day that included presentations on topics selected to assist tribes in understanding HHS, the federal government, and the resources available. The HHS presentations included budget, performance and congressional appropriations, Affordable Care Act 101, as well as an introduction to the HHS grants tool.

Tribal leaders and other attendees convened in the Great Hall of the Hubert H. Humphrey Building on February 26 to listen and respond to updates from HHS federal representatives regarding the HHS budget, human service priorities, the Affordable Care Act, and the IHS budget formulation. Secretary Burwell and members of the HHS Budget Council attended the afternoon session to provide updates and listen to comments from tribal leaders.

Impact of the 2015 Consultation

At last year's consultation, tribal leaders expressed the need for full funding of Contract Support Costs, increased behavioral health funding, and greater attention to issues of youth and children. HHS leadership reported that all three priorities received funding increases in the FY 2016 President's Budget, demonstrating the importance of the recommendations presented at the consultation.

18th ATBC Planning Conference Call Schedule

- January 27, 2016 @ 3:00 PM EST
- February 3, 2016 @ 3:00 PM EST
- February 10, 2016 @ 3:00 PM EST
- February 17, 2016 @ 3:00 PM EST
- February 24, 2016 @ 3:00 PM EST

Conference Call Number (for every call)

Call-In Number: 1-866-893-7107
Participant Code: 6693884

Deadline for ATBC Testimony Submission

Please submit your testimony to the Office of Intergovernmental and External Affairs no later than ***Friday, February 19, 2016***. Testimony can be emailed to consultation@hhs.gov. Please note that if you do not meet the submission deadline, we will accept the testimony, but you will need to bring 200 copies to the session for distribution. The consultation record will remain open for 30 days after the formal face-to-face consultation session wherein additional testimony will also be accepted.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JAN 0 8 2016

Dear Tribal Leader:

The Department of Health and Human Services (HHS) Secretary's Tribal Advisory Committee (STAC) currently has vacancies. I would like to solicit your recommendation for nominations to serve on this committee as the delegate for open seats located in your Indian Health Service (IHS) area and/or for one of the National At-Large openings.

The STAC was established in 2010 by HHS in an effort to create a coordinated, Department-wide strategy to incorporate tribal guidance on HHS priorities, policies, and budget. In working closely with tribal leadership on this committee, the Department has elevated the attention given to the government-to-government relationship with Indian tribes and has developed mechanisms for continuous improvement in our collaborative partnership focus on issues affecting tribes across Indian Country.

Nineteen meetings of the STAC have been held to date. The STAC's tribal representation is comprised of seventeen positions: one delegate (and one alternate) from each of the twelve IHS areas and one delegate (and one alternate) for the five National At-Large Members positions. We recently concluded our fourth cycle of staggered terms for our membership and have several vacancies to fill. I am writing to request your support in nominating candidates for these vacancies. They include a primary delegate and an alternate from each of the following regions as well as three National At-Large delegate vacancies and one National At-Large Alternate vacancy. Those selected will serve a two-year term. The vacancies open for nomination are:

1. Albuquerque Area
2. Bemidji Area
3. California Area
4. Nashville Area
5. Oklahoma Area
6. Portland Area
7. National At-Large Primary Delegate (3)
8. National At-Large Alternate

All nominees must either be elected or appointed tribal officials acting in their official capacity as elected officials of their tribes, or be designated by an elected tribal official with the designee having authority to act on behalf of the tribal official. Nominations *must be* made by an elected or appointed official from a federally recognized tribe acting in his or her official capacity.

Area Representatives

Area Representatives should be an elected tribal official or be designated by an elected tribal official, with the designee having authority to act on behalf of the tribal official, who is qualified to represent the views of the nominating tribe and Indian tribes in the respective area for which they are being nominated.

National At-Large Members

In order to achieve the broadest coverage of HHS-related national perspectives and views, the STAC includes five positions for National At-Large Members. A National At-Large Member should be an elected or appointed tribal official or designated representative having authority to act on behalf of the tribal official that is qualified to represent the views of the nominating tribe and of tribes on a national, collective perspective, including, but not limited to, such views expressed by groups like the National Congress of American Indians, National Indian Health Board, Tribal Self Governance Advisory Committee, Direct Service Tribes Advisory Committee, National Indian Child Welfare Association, National Indian Head Start Director's Association, and National Tribal Environmental Council.

Nominations will be considered for selection in the priority order listed below. In the event that there is more than one nomination in the priority list, individuals who have a letter of support from tribal officials acting in their official capacity shall have priority and letters of support from tribal organizations will be taken into consideration when selecting the primary and alternate delegates.

1. Tribal President/Chairperson/Governor
2. Tribal Vice-President/Vice-Chairperson/Lt. Governor
3. Elected or Appointed Tribal Official
4. Designated Tribal Official

HHS will support the travel of the primary representative to attend in-person meetings of the STAC or, if the primary delegate cannot attend, will pay for the alternate's travel. We encourage you to submit your nomination letter, no later than **February 5, 2016** to:

Emily Barson, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 620-E
Washington, DC 20201
Fax: (202)205-2727
E-mail: STAC@hhs.gov

I will make the selections and notify the selected individuals by **February 8, 2016**. Detailed information about the STAC can be found at http://www.hhs.gov/iea/tribal/aboutstac/index.html.

Thank you for your continued hard work and support of our efforts to build healthier communities. If you have further questions or concerns, please feel free to contact Stacey Ecoffey, Principal Advisor for Tribal Affairs, at Stacey.Ecoffey@hhs.gov or by phone at (202) 690-6060.

Sincerely,

Sylvia M. Burwell