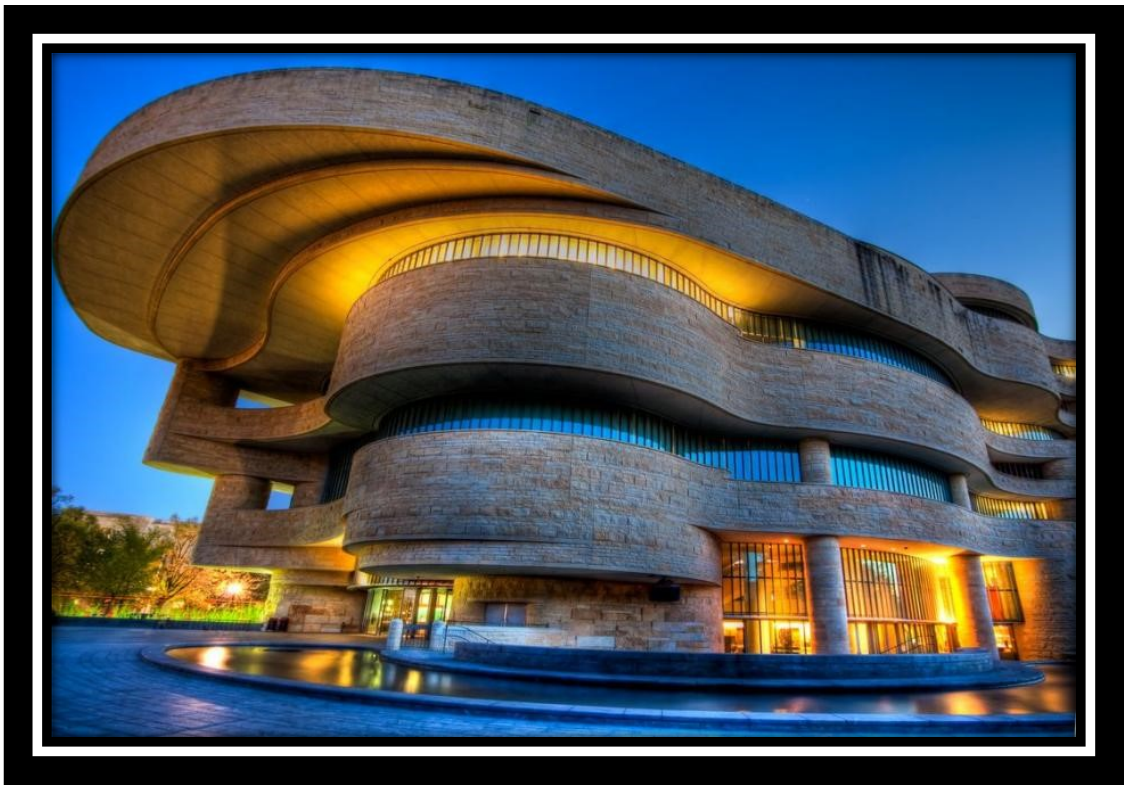
IHS SELF-GOVERNANCE ADVISORY COMMITTEE (TSGAC)

QUARTERLY MEETING

March 24-25, 2015



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

Tuesday, March 24, 2015 (8:00 am to 5:00 pm)
Wednesday, March 25, 2015 (8:30 am to 2:00 pm)

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

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TAB 1: AGENDA

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, March 24, 2015 (8:00 am to 5:00 pm)
Wednesday, March 25, 2015 (8:30 am to 2:00 pm)

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900-10th Street NW
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Phone: (202) 739-2001

AGENDA

Tuesday, March 24, 2015 (8:00 am to 5:00 pm)
Meeting of TSGAC and Technical Workgroup with IHS Acting Director Robert McSwain

8:00 am **Tribal Caucus**
Facilitated by: Chief Marilynn (Lynn) Malerba, Mohegan Tribe of Indians of Connecticut and Chairwoman, Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC)

- OIG Alert
- FACA

Legislative Update:

- Special Diabetes Program for Indians
- Title VI Update
- CSC Mandatory
- Medicare-Like Rates

9:00 am **Opening Remarks**
Chief Marilynn (Lynn) Malerba, Mohegan Tribe of Indians of Connecticut and Chairwoman, IHS TSGAC

9:10 am **Opening Remarks**
Robert McSwain, Acting Director, Indian Health Service

9:30 am **OIG Alert to Tribes on use of ISDEAA and Third Party Funds**
Melinda Golub, Senior Counsel, Office of Counsel to the Inspector General, Department of Health and Human Services
Amitava "Jay" Mazumdar, Senior Counsel, Office of Counsel to the Inspector General, Department of Health and Human Services
Rhonda Harjo, Majority Deputy Chief Counsel, Senate Committee on Indian Affairs, U.S. Senate
Anthony Walters, Minority Deputy Chief Counsel, Senate Committee on Indian Affairs, U.S. Senate
Nick Matiella, Legislative Assistant, for The Honorable John McCain, U.S. Senate

10:30 am **Break**

10:45 am **Office of Tribal Self-Governance Update**
P. Benjamin Smith, Director, Office of Tribal Self-Governance

11:15 am **Discussion and Update on Budget Issues**
- Status of FY 2017 Budget Formulation
- Budget Summit Recommendations and Implementation

Elizabeth Fowler, Deputy Director of Management Operations, IHS
Melanie Fourkiller, TSGAC Technical Co-Chair and Policy Analyst
Chief Marilynn (Lynn) Malerba, Mohegan Tribe of Indians of Connecticut and Chairwoman, Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC)

12:00 pm **Lunch and TSGAC Members' Executive Session with IHS Acting Director Robert McSwain and Senior Advisor for American Indians and Alaska to the HHS Secretary, Dr. Yvette Roubideaux**

1:30 pm **Contract Support Cost Workgroup Update and Discussion**
- Mandatory Contract Support Cost Proposal
- Update from February CSC Meeting
- CSC for MSPI and DVPI *[See SouthCentral Foundation Letter]*

Mickey Peercy and Rhonda Butcher, IHS Contract Support Costs Workgroup Members
Dr. Yvette Roubideaux, Senior Advisor to the Secretary, HHS

2:15 pm **Joint TSGAC and IHS Acting Director Discussion**

3:30 pm **Break**

3:45 pm **Joint TSGAC and IHS Acting Director Discussion**

5:00 pm **Wrap Up and Preparation for Wednesday, March 25, 2015**

Wednesday, March 25, 2015 (8:30 am – 2:00 pm)
Meeting of TSGAC and Technical Workgroup

8:30 am **Welcome**
Invocation
Roll Call
Introductions – All Participants & Invited Guests

9:15 am **Opening Remarks**
Chief Marilynn (Lynn) Malerba, Mohegan Tribe of Indians of Connecticut and Chairwoman, IHS TSGAC and

TSGAC Committee Business
- Approval of Meeting Summary (January 28, 2015)
- Approval of the Strategic Plan
- Annual Consultation Conference Update and Finalizing Agenda

10:00 am **Interfacing RPMS with Proprietary Systems and OIT Survey Results**
CDR Mark Rives, MBA, MSCIS, Acting Director, Chief Information Officer, Office of Information Technology, Indian Health Service
Dr. Yvette Roubideaux, Senior Advisor to the Secretary, HHS

10:30 am **ACA Implementation and Update**
Doneg McDonough, Consultant, Tribal Self-Governance Advisory Committee
Cyndi Ferguson, Self-Governance Specialist/Policy Analyst, SENSE Incorporated

11:00 am **CSC Calculation Tool Demonstration**
Rhonda Butcher, Self-Governance Director, Citizen Potawatomi Nation and CSC Technical
Roselyn Tso, CSC Lead, IHS
Ashley Metcalf, IHS CSC Team Member, IHS

12:00 pm **Adjourn TSGAC Meeting**

1:00 pm **TSGAC Technical Workgroup Meeting**

2:00 pm **Adjourn TSGAC Technical Workgroup Meeting**

2015 TSGAC Calendar

Date	Event	Location
March 24-25	2nd Quarterly Meeting	Washington, DC
April 26-30	Tribal Self-Governance Annual Consultation Conference	Reno, NV
July 21-22	3rd Quarterly Meeting	Washington, DC
August 11-12	Self-Governance Finance Training	Nashville Area
September 9-10	Tribal Self-Governance Strategy Session	Flagstaff, AZ
October 6-7	4th Quarterly Meeting	Washington, DC

2016 TSGAC Proposed Calendar

Date	Event	Location
January 27-28	1st Quarterly Meeting	Washington, DC
March 30-31	2nd Quarterly Meeting	Washington, DC
April 24-29	Tribal Self-Governance Annual Consultation Conference	Orlando, FL
July 20-21	3rd Quarterly Meeting	Washington, DC
September 13-14	Tribal Self-Governance Strategy Session	TBD
October 26-27	4th Quarterly Meeting	Washington, DC

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

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(March 2, 2015)

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TAB 2: COMMITTEE BUSINESS

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education
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INDIAN HEALTH SERVICE TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE AND TECHNICAL WORKGROUP QUARTERLY MEETING AND TRIBAL SELF-GOVERNANCE STRATEGY SESSION

Embassy Suites
900 10th Street NW
Washington, DC 20001
Phone: (202) 739-2001 ~~~ Fax: (202) 739-2099

Meeting Summary

Wednesday, January 28, 2015 (8:00 pm to 5:00 pm)
Meeting of TSGAC and Technical Workgroup

Tribal Caucus
Facilitated by: Chief Marilynn (Lynn) Malerba, Mohegan Tribe of Indians of Connecticut and Chairwoman, Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC)

Invocation, Roll Call and Introduction of All Participants

Alaska:	Jaylene Peterson-Nyren, Executive Director, Kenaitze Indian Tribe
Albuquerque:	Luis Romero, Governor, Taos Pueblo
California:	Glenna Moore, Health Director, Hoopa Valley Indian Tribe
Nashville:	Lynn Malerba, Chief, The Mohegan Tribe
Oklahoma:	Jefferson Keel, Lieutenant Governor, Chickasaw Nation of Oklahoma
	Rhonda Butcher, Director, Citizen Potawatomi Nation
	Mickey Peercy, Executive Director, Choctaw Nation of Oklahoma
	Vickie Hanvey, Self-Governance Director, Cherokee Nation of Oklahoma
	George Thurman, Chief, Sac and Fox Nation
Phoenix:	Virginia M. Sanchez, Chairwoman, Duckwater Shoshone Tribe
Portland:	W. Ron Allen, Chairman/CEO, Jamestown S'Klallam Tribe
	Tyson Johnston, First Councilman, Quinault Indian Nation

Opening Remarks
Chief Marilynn (Lynn) Malerba, Mohegan Tribe of Indians of Connecticut and Chairwoman, IHS TSGAC

Welcomed Tribal leadership and thanked those in attendance for work during the Tribal Strategic planning. She also thanked Dr. Roubideaux and IHS for supporting the 2014 IHS Budget Summit. She discussed some of the outcomes and said the workgroup would begin working with the Administration to consider the Summit recommendations.

Dr. Yvette Roubideaux, Acting Director, Indian Health Service

Dr. Roubideaux reported that leadership appreciated the IHS Budget Summit recommendations and looks forward to working collaborative to implementing recommendations through coordination with the workgroup.

Dr. Roubideaux also asked presented the Self-Governance National Indian Health Outreach and Education workgroup with the IHS Tribal Organization and Tribal Leader Director's award.

TSGAC Committee Business

MOTION: Chief Malerba requested approval of the October TSGAC meeting summary.

The meeting summary was approved by unanimous consent.

Chief Malerba requested that TSGAC nominate a representative to provide testimony at the HHS Budget Consultation on February 26, 2015. The TSGAC appointed Melanie Fourkiller, Tribal Technical Co-Chair as the TSGAC representative.

TSGAC also appointed Gloria Simmeon from Alaska to become a Self-Governance representative for the NIH Tribal Advisory Committee.

Office of Tribal Self-Governance Update

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

New Tribes

OSG reported that in 2015 there are 86 Self-Governance Compacts and 111 Funding agreements. 40% of the Indian Health Service budget, and when combined with contracting Tribes, Tribes control more than 50% of the IHS budget. Nearly, 350 Tribes are currently participating.

Staff Changes

Mary Beardsley is currently serving all of the administrative functions within OTSG and OTSG is currently seeking a new staff assistant to relieve some of her responsibilities.

Payment to Tribes

OTSG finance staff is working to get payments out the door this week and will not be in attendance at the TSGAC meeting due to the more pressing matter. These payments will only reflect the services apportionment. When the facilities apportionment is approved additional payments will go out. OTSG believes that will be within 30 days.

OTSG is working to improve its responsiveness and communication.

Chairman Allen noted that IHS is still one of the fastest in getting money out the door.

Recent delegation meeting

During recent delegation meetings OTSG has heard a few recurring discussion items, including patient safety, health care access and health care services expansion.

IHS Listening Sessions

IHS Director is scheduling listening session in all twelve areas. Please check the IHS calendar and area correspondence for the IHS listening session in your area.

Discussion and Update on Budget Issues

Chief Marilynn (Lynn) Malerba, Mohegan Tribe of Indians of Connecticut and Chairwoman, IHS TSGAC

Chief Malerba briefly reviewed the full set of recommendations in the meeting materials and asked Tribal leaders to review and consider them during their testimony, listening sessions, and delegations meetings.

She noted that one thing Self-Governance Tribes need to think about is how the IHS Director gets the best data for Congressional testimony, etc.

Dr. Roubideaux request TSGAC's assistance in developing and collecting study stories and examples of successes including improving patient care program, GPRA measurements, and ACA implementation.

She particularly needs information about denied and deferred care to support legislative initiatives and Administrative budget priorities.

She also recommended that TSGAC participate in the National Budget Formulation Process during the last week of February.

Medicare-Like Rates Proposed Rule

TSGAC is developing comments for the proposed rule. The committee is concerned about balancing efficiency and flexibility for Tribes. TSGAC comments will include recommended changes to the rule to allow maximum flexibility.

Dr. Rouideaux also requested that the TSGAC also way in on the question below:

- Do Tribes prefer that IHS issues an interim final rule or a simple final rule?
- The interim final rule will extend the timeline and allow for additional comments.

Lack of Medicaid Expansion

TSGAC would like IHS to consider what it can do assist in continuing to pursue a fix to the Medicaid expansion issue.

Dr. Roubideaux encouraged TSGAC to keep this issue on the agenda for the STAC and reported that Secretary Burwell is meeting with Governors in states where there are opportunities to change the state legislation.

Contract Support Cost Workgroup Update and Discussion

Andy Joseph, Councilman, Colville Indian Tribe

CSC Workgroup Co-Chair reported that the meetings are helping and the technical workgroup has been critical in proposing solutions. However, he hopes that decisions can be made quickly as action is needed soon.

Mickey Peercy and Rhonda Butcher, IHS Contract Support Costs Workgroup Members

The Self-Governance representatives recommended that the CSC Workgroup meet more often and regularly to help the Agency make changes to the policy more quickly. The also recommended that IHS provide access to the CSC Data to allow tribal representatives to project FY 2016, 2017, and 2018.

Additional recommendations included:

- More consistency between DCA and NBC

- Setting a deadline be to submit negotiated rates
- Make changes to the policy sooner rather than later

Dr. Yvette Roubideaux, Acting Director, Indian Health Service
IHS is working to make sure CSC claim settlements are fair and consistent across regions. However, they are relying on TSGAC and other workgroups to provide feedback when it seems things are off track.

She was looking forward to more discussion and the data issue needed a little debate before moving forward to make projections. She recognized that TSGAC leadership is very helpful and provides critical, direct, constructive feedback.

ACA Implementation and Update

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

Webinars are scheduled throughout the year. There is a webinar scheduled for February and hearing discussion from TSGAC it will focus on latest ACA Implementation.

Instead of doing a separate training at the 2015 Annual Consultation Conference, all of the ACA topics will be covered during breakout sessions.

Collecting Success Stories

The group members have identified three Tribes to participate in the success stories piece for the final project.

Qualified Health Plans

Each health plan has to create a document to explain coverage for Indians. However, there's no mechanism to review and evaluate the efficiency of these contracts. IHS is collecting data about offers to contract and "Indian" plans for IHS facilities, but CMS is not collecting this data from Tribes so there is no data to support pieces of the project.

TSGAC should request the CMS provide the state level data that is collected about QHPs and enrollment.

Clinical and Preventive Services Update

Dr. Jeff Salvon-Harmon, Director for the Improving Patient Care Program, Office of Clinical and Preventative Service, Indian Health Service

The Improving Patient Care Program encourages IHS, Tribal and Urban Health Programs to implement a quality model, which encourages a patient-centered medical home.

IPC focuses on:

- The patient-centered medical home, which began around 2007 and focuses on care for the patients desires and needs vs. standard medical practices for care.
- Reduce inefficiencies in care and access.
- Provide better primary care and access to care to transition from care to health of the entire patient.
- IPC teams work with the community and Tribal leaders to address community care as whole. Engage the entire community regularly. Community engagement includes

participation with Tribal council to determine needs, share standards of care to meet those needs, and find middle ground between needs, ability, and willingness.

There are 179 Tribes who have adopted and continued to their improvement journeys. Additional opportunities to enroll will be open in the future.

Ability to Integrate Data

Dr. Yvette Roubideaux, Acting Director, Indian Health Service

- Tribes can now integrated their data into the National Data Warehouse.
- The functionality to integrate data into RPMS is coming.
- IHS is working to upgrade RPMS so that it works better with other private entities.
    - In the future Tribes should be able to share internally and externally with greater ease.

Executive Session with the Acting Director and TSGAC Members

TSGAC Technical Workgroup Meeting

Strategic Plan Discussion

TSGAC members continued working on the priorities identified during the Strategic Planning Session January 27, 2015. The top priorities identified were:

Budget Priorities:

- Restore Fiscal Year 2013 sequestration cuts and exempt Tribal funding from future sequesters.
- Authorize mandatory funding and fully fund Contract Support Costs and expedite payments to Tribes.
- Enact Advanced Appropriations for the Indian Health Service.

Legislative Priorities:

- Permanently reauthorize and provide full funding for the Special Diabetes Program for Indians.
- Enact Medicare-Like Rates for IHS outpatient services for IHS, Tribal and Urban facilities.
- Amend Title VI of ISDEAA to expand Self-Governance to other Health and Human Services agencies and programs.

Policy Priorities:

- Revise and streamline each agency's Contract Support Costs policy.
- Include Purchase and Referred Care in all VA-IHS reimbursement agreements.
- Institute a Tribal Advisory Committee for Office of Management and Budget.
- Update an IHS Facilities Policy that includes broad Tribal input.
- Evaluate the Indian provisions of the Affordable Care Act and continue consultation to implement outstanding provisions.

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education
P.O. Box 1734, McAlester, OK 74501
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Technical Workgroup
Assignment Matrix – January 2015 Quarterly Meeting
Updated: March 3, 2015

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	FYI for reference 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	
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	July 10, 2013	In progress. Include on future TSGAC agenda.
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	
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 term 'fix' for Contract Support Cost appropriations (alternatives to Mandatory Appropriations).	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 funding on September 5, 2014; held Budget Summit on Oct 13-14, 2014. Need to plan next steps.
6.	Develop a Tribally-driven protocol for applying the FACA exemption for Workgroups and Tribal Advisory Committees (TACs).	Jody Jeffers Melanie Fourkiller NCAI	October 9, 2014	In progress, next call being scheduled
7.	SGCE letter to Congress to advocate for	Terra Branson	TBD	On Hold

	reauthorization of Special Diabetes Program for Indians.			
8.	Provide orientation to the new members of TSGAC and Technical Workgroup.	TSGAC Co-Chairs Melanie Fourkiller	July 31, 2014	
9.	Meeting Summary for January 28, 2015 Quarterly TSGAC Meeting	SGCE	January 28, 2015	Completed.
10.	MLR Comments to IHS re: Proposed Rule	SGCE	January 28, 2015	Completed.
11.	Send invitation to OIG Alert Authors for the March Quarterly Meeting. Request information regarding what triggered the alert, guidance to auditors, and impact in Tribal communities.	Pitt	January 28, 2015	Completed.
12.	Letter to CMS requesting timely contract provider data and collection of future data.	Mim Dixon	January 28, 2015	TTAG sent a letter received negative response. Might still require TSGAC action.
13.	Call to discuss FACA Position Paper	Jody Jeffers SGCE	January 28, 2015	Completed, next call being scheduled.
14.	Letter to Office of Clinic and Preventative Services to discuss Self-Governance participation in Improving Patient Care	SGCE	January 28, 2015	Completed.
15.	Letter to IHS Director support Mandatory CSC, requesting consultation immediately and to implement Mandatory CSC in FY2016	Melanie Fourkiller	January 28, 2015	Completed.
16.	Letter commending Acting Director Robert McSwain on rates of CSC settlement and claim resolutions.	Clint Hastings	January 28, 2015	
17.	Resend letter to IRS and Treasury regarding employer mandate and ask for a meeting.	Mim Dixon	January 28, 2015	
18.	Letter from SGCE to Congress supporting nomination for Director due to change in leadership.	SGCE	January 28, 2015	Completed.
19.	Develop one-pager talking points and schedules hill visit for Tribal leaders in conjunction with NIHB and NCAI	SGCE	January 28, 2015	Completed.

Summary of IHS Tribal Self-Governance Advisory Committee (TSGAC) Correspondence
Year: 2014

Updated: December 22, 2014

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
1	12/22/14	DHHS/CMS-Regulations.gov	Comments on CMS-9944-P;Notice of Benefits and Payment Parameters for 2016		
2	12/19/14	Ms. Marilyn Tavenner,Administrator, CMS	TSGAC-TTAG letter of Request for Information on Contract Offers made by Issuers of Qualified Health Plans	Continued support and additional information for guidance on these contract offers on QHP	
3	12/2/14	IHS Director,Dr. Y. Roubideaux	Consistency and Information Sharing to Facilitate Contract Support Costs Negotiations	Continued support and resolving all CSC claims in the past year	
4	11/24/14	Mark Rives ,MBA, MSCIS, Acting Director, OIT/IHS	Tribal Use of Resource and patient Management System and Invitation to TSGAC Quarterly Meeting in January 2015	Continued support to improve healthcare services provided to AI/AN Patients	
5	11/19/14	Jacob Lew,Secretary of the Treasury	Request for Tribal Consultation Regarding Implementation of Tribal General Welfare Exclusion Act	Needs government-to-government Consultation as soon as possible	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
6	11/10/14	IHS Director,Dr. Y. Roubideaux	Tribal Consultation on Medicare-like Rates (MLR) Regulations and/or Guidance	Request Tribal Consultation on MLR before the IHS or CMS publish any notices of proposed rule-making or any guidance on this topic.	
7	11/7/14	CMS, Director, Ms Kitty Marx	Reappointment of Primary & Alternate Representative to serve on CMS Tribal Technical Advisory Committee	Appreciate collective work of the TTAG provide advice and input to the CMS	
8	10/31/14	ORAP, Director, Mr. Carl Harper	Transmittal of Final Report for Self-Governance National Indian Health Outreach and Education & Evaluation of SG Health Reform Training and Technical Assistance Plan	Continued support and collaboration	
9	10/3114	OTSG, Director, Mr. P. Benjamin Smith	Transmittal of Final Report for Self-Governance National Indian Health Outreach and Education & Evaluation of SG Health Reform Training and Technical Assistance Plan	Continued support and collaboration	
10	10/3114	IHS Director,Dr. Y. Roubideaux	Transmittal of Final Report for Self-Governance National Indian Health Outreach and Education & Evaluation of SG Health Reform Training and Technical Assistance Plan	Continued support and collaboration	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
11	10/30/14	IHS Director,Dr. Y. Roubideaux	Revised TSGAC Organizational Protocols	Continued support and collaboration	
12	10/17/14	Kathy Etz, Ph.D. Senior Advisor Tribal Affairs to NIH, DHHS	National At-Large Representative Nominations to the NIH Tribal Consultation Advisory Committee	Recommend and support Councilman Marshall's nomination to the NIH TCAC	
13	10/17/14	IHS Director,Dr. Y. Roubideaux	Deployment and use of IHS Resources for Ebola	Expect US to honor its trust responsibilities and obligations and consider our concerns and recommendations	
14	10/16/14	Sylvia Burwell,Secretary DHHS and Jacob Lew,Secretary DoTreasury	Appreciation for Recent Announcement on Exemption from Tax Penalty for American Indian/Alaska Natives	Continued partnership to improve health and welfare for Tribal citizens	
15	9/19/14	Dr. Elaine Buckberg,DAS for Policy, Dept of Treasury	Announcement Regarding Applying for Exemption through Tax Filing	Continued collaboration to improve health and welfare of all tribal members	
16	9/5/14	Shaun Donovan, Director OMB/EOP	Indian Health Service Contract Support Costs Anomaly Request for 2015 Appropriations Legislation	Continued collaboration to address CSC issues and fully funded in the appropriations process	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
17	8/28/14	IHS Director,Dr. Y. Roubideaux	Long Term Solutions for Contract Support Cost Funding	Continue to collaborate on any new policies and procedures that facilitate negotiation and development for CSC payments and reconciliation	
18	8/28/14	Sylvia Burwell, Secretary DHHS	IHS Tribal Self-Governance Advisory Committee Priorities and Strategic Plan	Prepared to meet and discuss issues and recommendations at your convenience	Response received 12/8/14 from Sylvia Burwell, DHHS re: HHS supports efforts to increase AI/AN enrollment in Medicaid, CHIP and the Marketplace.re;CSC continue to make progress on resolving claims
19	8/25/14	Mary Wakefield, Ph.D. RN ,Administrator Health Resources & Services Administration, DHHS	Request for Tribal Consultation on 340B Drug Pricing Program	Considered attending Tribal Consultation on this matter	
20	8/15/14	Dr. Caroyln Clancy, Interim Under Secretary Health-Veterans Affairs IHS Director, Dr. Y.Roubideaux	Request for VA and IHS to Revisit the VA-IHS Reimbursement Agreement	Considered attending TSGAC Quarterly meeting during Oct 8-9 and discuss recommendations in greater details.	
21	7/24/14	IHS Director,Dr. Y. Roubideaux	Request for Additional Information at TSGAC July Quarterly Meeting	Considered request and prepare to discuss in further details at the meeting on July 31, 2014	
22	7/7/14	The Honorable Secretary Sylvia Burwell, DHHS	IHS Tribal Self-Governance Advisory Committee Priorities and Strategic Plan	Continued collaboration and partnership with HHS to strengthen and advance health and welfare for AI/AN people	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
23	6/24/14	IHS Director,Dr. Y. Roubideaux	Indian Health Service Contract Support Cost FY 2014 Workplan	On-going productive discussion on agreeing with CSC plan now and in the future	
24	6/9/14	Committee Members on Appropriations the Honorable Harold Rogers and Nita Lowey. Chair and Ranking Member of Interior Subcommittee Honorable Ken Calvert and Jim Moran	Appropriations Increases Requested in FY 2015 Interior Appropriations Bill for BIA and IHS	Consider restoring sequestered funds to Tribal programs promised made when treaties between nations were signed	
25	6/3/14	IHS Director,Dr. Y. Roubideaux	Briefing Paper- Tribal Priorities to Improve Enrollment in the Marketplace Plans	On-going collaboration and support on these activities	
26	5/27/14	IHS Director,Dr. Y.Roubideaux	Recommendations on FY2015 Scope of Work- Self Governance Affordable Care Act Outreach Activities	On-going collaboration and cooperation on these activities	
27	5/23/14	DHHS Secretary, The Honorable Kathleen Sebelius	Delaying Meaningful Use Electronic Health Record Program-Stage 3	Consider our concerns and implement administrative measures extend deadlines imposed by ONC	Response received 9/12/14 from Marilynn Tavenner, CMS re: HER Incentive Programs, CMS updated the hardship exception application to add another option for extreme circumstances
28	5/20/14	Mandy Cohen	Request for Action on Outstanding Issues for AI/AN under ACA	Reconsider recommendations, consult with TSGAC, TTAG and SG Tribes to address current deficiencies in enrollment	Response received 6/13/14 from Mandy Cohen, MD MPH, letter sent by TSGAC dated 5/20/2014 re request for action on issues for AI/AN under ACA

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
29	5/20/14	DHHS Secretary, The Honorable Kathleen Sebelius	Request for Action on Outstanding Issues for AI/AN under ACA	Appeal to reconsider an administrative fix for definition of Indian under ACA	
30	4/30/14	IHS Director,Dr. Y.Roubideaux	Transmittal of Mid-Year Report for "Self-Governance National Indian Health Outreach and Education"	On-going support and excellent cooperation and collaboration	
31	4/30/14	OTSG Director, P. Benjamin Smith	Transmittal of Mid-Year Report for "Self-Governance National Indian Health Outreach and Education"	On-going support and excellent cooperation and collaboration	
32	4/30/14	ORAP Director, Carl Harper	Transmittal of Mid-Year Report for "Self-Governance National Indian Health Outreach and Education"	On-going support and excellent cooperation and collaboration	
33	4/28/14	DHHS Secretary, The Honorable Kathleen Sebelius	Appreciation, Regrets and Farewell and Re-Invite to SGCE Consultation Conference May 4-8, 2014	Reconsider SGCE invitation to attend Consultation Conference during May 4-8, 2014	
34	4/15/14	IHS Director, Dr. Y.Roubideaux	Response Ltr Interpreting Section 402 of the Indian Health Care Improvement Act	On-Going discussions and provide comments	
35	3/31/14	CMS-DHHS Attn: CMS Desk Officer	CMS-3178-P; Comment on Proposed Emergency Preparedness Rule	On-Going collaboration and recommendations provided	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
36	3/26/14	Chief Lynn Malerba, Mohegan Tribe	Thank you letter regarding process submitting application for exemption from tax penalty	On-Going collaboration and provide comments	Response received 3/26/14 from the Honorable Kathleen Sebelius to letter sent by TSGAC dated 12/18/2013 re Additional Comments on Exemption on Tax Penalty
37	3/14/14	IHS Director, Dr. Y.Roubideaux	Response and recommendations to December 20, 2013, DTLL Letter on Special Diabetes Program for Indians (SDPI)	Recommended TLDC conduct evaluation of Data Infrastructure and Reprogram the CDC Native Diabetes Wellness Program Set-Aside to the SDPI	
38	2/25/14	CCIIO/CMS/DHHS	Comments on Draft 2015 CCIIO letter to issuers in the Federally-facilitated Marketplaces	On-Going collaboration and further discussions and recommendations	
39	2/7/14	Chief Lynn Malerba Mohegan Tribe	Thank You Letter regarding suggestions for new tribal/federal workgroup within the HHS	On-Going Collaboration and further discussions and recommendations	Response and Final Report on DHHS/SGTFW Received from the Honorable Kathleen Sebelius on 2/7/14: Suggestions for New Tribal/Federal Workgroup identifying technical and/or legislative issues related to tribally-proposed legislation for SG Expansion and other tribal and federal concerns
40	2/7/14	IHS Director, Dr.Y. Roubideaux	Follow Up to TSGAC Call February 6, 2014-FY 2014 Consolidated Appropriations Act	Continued input and discussions re CSC issues, healthcare disparities and other challenges with Tribal Programs	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
41	2/4/14	DOI/BIA Assistant Secretary, Kevin Washburn	Operating Plans- FY 2014 Consolidated Appropriations Act	Continued partnership and collective consult and coordination in the process with Tribal Programs	Response received 4/21/14 from Thomas Thompson,DAS-IA re: full funding for CSC, FY 15 budget request included and increase that provide full funding for CCS and program implementation and allows tribes deliver services effectively.
42	2/4/14	IHS Director, Dr.Y. Roubideaux	Operating Plans- FY 2014 Consolidated Appropriations Act	Continued partnership and collective consult with tribal programs	
43	1/31/14	IHS Director, Dr.Y. Roubideaux	December 6,2013 DTLL on Expanding the Medicare-Like-Rate Cap to Non-Hospital Services	On-Going collaboration and further discussions and recommendations	
44	1/29/14	DOT, Office of Economic Policy, Dr.Elaine Buckberg	Follow-up from January 22,2014 IHS/TSGAC Quarterly Meeting	On-Going collaboration and participation in work groups establish to fashion approach implementing exemption	
45	1/22/14	CMS/DHHS Attn: CMS-3288-N	Comments on CMS-2380-PN; Basic Health Program Proposed Federal Funding Methodology for 2015	Recommend CMS modify proposed funding formula in determine amount of federal payment to states for AI/AN enrollees	
46	1/22/14	IHS Director, Dr.Y. Roubideaux	Immediate Tribal Consultation Needed on Contract Support Cost Funding	On-Going collaboration to address immediate and ongoing challenges related to CSC funding	
47	1/22/14	DOI/BIA Assistant Secretary, Kevin Washburn	Immediate Tribal Consultation Needed on Contract Support Cost Funding	On-Going collaboration to address immediate and ongoing challenges related to CSC funding	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
48	1/10/14	The Honorable Arlan Melendez: Reno-Sparks Indian Colony	Congratulation to Reno-Sparks on joining Title V, Tribal Self-Governance		

TAB 3: WORKGROUP REPORT

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: Feb 18-19, 2015 MMPC: Feb 17, 2015	**LOCATION OF MEETINGS**	The February MMPC and TTAG meetings were held in Washington, DC.
COMMITTEE CHAIRMAN	W. Ron Allen		
COMMITTEE RECORDER	Mim Dixon		

ATTENDANCE *(please list all present during the meeting)*

W. Ron Allen, Melanie Fourkiller	Mim Dixon, Doneg McDonough, Technical Advisors		

AGENDA ITEM	SUMMARY/HIGHLIGHTS *(Committee action should be noted in this section)*
Medicaid national leadership	Vicki Wacchino, was appointed Acting Director for Medicaid following Cindy Mann's departure in January 2015, met with TTAG on Feb 18 and said there would be a smooth transition in leadership and all priorities being advanced by TTAG/CMS remain.
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. This revised policy has not yet been completed.
Managed Care Regulations	The Managed Care regulations are being revised by Medicaid for the first time since 2003, and a lot of changes are expected. TTAG has requested Tribal Consultation.
Tribal Employer insurance mandate	The Employer Mandate in ACA requires all employers with more than 100 full time employees to offer them health insurance. Some Tribes feel that this is creating an economic hardship and is not consistent with the federal trust responsibility. One Tribe has filed a lawsuit. MMPC has discussed the problem with high ranking officials in IRS. Along with other national Indian organizations, MMPC is seeking a White House meeting on this issue.
AI/AN Enrollment in Medicaid, CHIP and Marketplace plans	The open enrollment period for Marketplaces for 2015 has been extended to April 15. Medicaid and CHIP enrollment is year round, and people with Indian status and their families can enroll monthly. Jim Lamb is the new chair of TTAG Outreach & Education Subcommittee.
CCIIO Tribal Workgroup	At the TTAG meeting on November 19, 2014, CCIIO Director Kevin Counihan offered to establish a joint CCIIO/Tribal Workgroup. He reiterated that offer when he met with the TTAG on Feb 18, 2015, and requested that group identify and focus on the top three priorities. No meetings have been scheduled or held to date.
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 Indian Addendum to all I/T/Us. TTAG is concerned about how CMS will monitor and enforce this provision. In addition, TTAG would like this provision: 1) put into regulations; and, 2) extended to state-operated Marketplaces. CMS has reported that all QHPs have provided contracts with the Indian Addendum to all I/T/Us. CMS and the TTAG have asked the I/T/Us to let them know if there are cases where this is not true. TSGAC is doing a research project on this issue.

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WORKGROUP REPORTING FORM

ACA performance metrics	The TTAG held a Data Symposium in Washington, DC, on Feb 19, 2015, where the enrollments in the FFM were presented: approximately 20,000 people enrolled in zero cost sharing plans and 4,000 in limited cost sharing plans. TTAG asked for a written report with more specific data. There is an issue of the TTAG Data Subcommittee subcontractors having to pay for Medicaid data. NIHB has funding to evaluate the outreach and enrollment during the first 6 months of implementation in 2014; however, their research is in the initial phases.
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, but the prospects are not good at this time. Two recent developments have reduced the need for the fix in the definition of Indian: 1) While the law provides that AI/AN can enroll monthly throughout the year, CMS provided guidance stating that non-Indian family members can also enroll at the same time; and, 2) IRS will treat people who meet the statutory definition of Indian the same as people who are eligible for IHS for purposes of exemption from the tax penalty for not having insurance. The remaining disparity between Tribal members and descendants is eligibility for limited cost sharing and zero cost sharing plans, including cost sharing reductions at the bronze level. A regulatory fix has been suggested by TTAG to partially address this by keeping family members in the same plan with Indian-specific cost sharing reductions if one has ACA Indian status and the others are eligible for IHS.
The Use of IHS Data for The Federal Data Services Hub	This is still being recommended by TTAG to simplify processing of hardship exemptions through the Marketplace (even though the need has been diminished by IRS rules that allow IHS beneficiaries to claim the exemption through the tax filing process).
Payment for Services provided by Tribes	On Feb 18, 2015, CMS said closed panel plans do not have to meet ECP requirements for QHPs. TTAG asked CMS to make QHP payments under Sec. 206 of IHCIA to be a condition of participation for QHPs.
Medicare Provider-based rules	Southern Ute Indian Tribe has requested, and TTAG has supported their request, to have Tribal Consultation on grandfathering the use of the Encounter Rate for Medicare for hospital-based provider services. Recent interpretation that hospital and clinic have to have same operating Board is a threat to Tribal sovereignty and the 638 process.
Medicare Part B premiums	It was suggested that TTAG work on getting Medicare to allow group payment from Tribes for Part B premiums (similar to Part D).
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 ACTION

1. Legislative advocacy:
   a. Make the definition of Indian in ACA the same as in Medicaid.
   b. Medicare-like rates for ambulatory services provided through CHS/PRC.
   c. Support reauthorization of CHIP, to include funding for I/T/U enrollment and outreach.
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.
4. Advocate for implementation of the CMS AI/AN Strategic Plan, 2015-2018, as revised Feb 20, 2014.

TAB 4: STRATEGIC PLAN

National Tribal Self-Governance 2015-2017 Strategic Plan & Priorities

"TRIBAL SELF-GOVERNANCE – A LEGACY FOR THE FUTURE"

APPROVED: March XX, 2015

Our Vision

Preserve and Protect Tribal and Indigenous Sovereignty, Culture, History, Treaty and Self-Governing Rights.

Our Mission

Fully Implement and Advance Tribal Self-Governance Authorities.

Our Guiding Principles

- Tribes are sovereign nations, and, as such, all relations between the United States and Tribes are of a formal government-to-government nature;

- As sovereign nations, Tribal governments have the inherent authority and control over their territories, Treaty rights, natural resources and the welfare of their citizens. Further, Tribal governments have the authority to set internal priorities (without federal interference); and, under Self-Governance, may redesign programs and reassign federal funds to more efficiently meet their local needs;

- Tribal governments are accountable to their citizens and this is intrinsic in any accountability model on the utilization of federal funds;

- The devolution of federal funds and service delivery allows Tribal governments increased programmatic and administrative responsibility and minimizes federal reporting burdens, monitoring and oversight; and,

- Tribes have the right to choose the institutional arrangement by which they receive federally funded services. For Self-Governance Tribes, federal agencies become advisors and providers of technical assistance rather than day-to-day managers of service delivery. This principle is congruent with the current Administration's directive for transparency and accountability.

Development of the Strategic Plan

Each year, Self-Governance Tribes conduct their Strategic Planning Session to review and identify top priorities for the upcoming year. These priorities are further discussed and advanced in the quarterly meetings of the DOI Self-Governance Advisory Committee (SGAC) and the IHS Tribal Self-Governance Advisory Committee (TSGAC), the Annual Self-Governance Conference and other workgroup and committee meetings.

The 2015-2017 National Tribal Self-Governance Strategic Plan and Priorities for the 114th Congressional Session (hereafter referred to as the Strategic Plan) is intended to be fluid and the issues and strategies will be updated as needed by Tribal leadership. The Strategic Plan includes 3 main objectives:

Objective #1:	Advance Self-Governance Policy, Budget & Legislative Priorities
Objective #2:	Strengthen Self-Governance Advocacy Efforts
Objective #3:	Implement and Track Goals/Actions in the Strategic Plan

Executive Summary

Self-Governance is a Tribally-driven, Congressional legislative option, whereby Tribal governments are authorized to negotiate annual appropriated funding and assume management and control of programs, services, functions and activities (or portions thereof) that were previously managed by the federal government. Self-Governance represents the expansion and growth of the historical legislation, P.L. 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), in that it allows Tribes, as sovereign nations, to exercise their right to be self-governing and to take program funds and manage them to best fit the needs of their citizens and Tribal communities.

Since initiation of the first Self-Governance agreement more than two decades ago, the number of Tribes and the amount of programs and funding managed under this legislation has steadily increased. Today there are 262 Self-Governance Tribes within the Department of the Interior and 351 Tribes operating Health Programs within the Indian Health Service.

2015-2017 Top Tribal Self-Governance Priorities

In January 2015, the Self-Governance Tribes held their annual Strategic Planning Session in conjunction with the SGAC and TSGAC quarterly meetings in Washington, DC. During the strategic plan, a series of White Papers provided an overview of the top issues and proposed actions for Tribal leaders' consideration. Based on these papers, group discussion and input, the following top budget, legislative, and policy priorities were identified:

Budget Priorities:

- Restore Fiscal Year 2013 sequestration cuts and exempt Tribal funding from future sequesters.
- Authorize mandatory funding and fully fund Contract Support Costs and expedite payments to Tribes.
- Preserve authority to include one-time or short-term resources in Self-Governance Funding Agreements.
- Enact Advanced Appropriations for the Indian Health Service.

Legislative Priorities:

- Amend Title IV of the Indian Self-Determination and Education Assistance Act.
- Reauthorize the Native American Housing Assistance and Self-Determination Act.
- Enact legislation that strengthens and reaffirms the original tenants of the Public Law 102-477.
- Expand Self-Governance to the Department of Transportation.
- Permanently reauthorize and provide full funding for the Special Diabetes Program for Indians.
- Enact Medicare-Like Rates for IHS outpatient services for IHS, Tribal and Urban facilities.
- Amend Title VI of ISDEAA to expand Self-Governance to other Health and Human Services agencies and programs.

Policy Priorities:

- Revise and streamline each agency's Contract Support Costs policy.
- Expand Tribal consultation on allocation and formula distribution of Bureau of Indian Affairs.
- Foster greater transparency announcing new DOI funding opportunities.
- Include Purchase and Referred Care in all VA-IHS reimbursement agreements.
- Institute a Tribal Advisory Committee for Office of Management and Budget.
- Update an IHS Facilities Policy that includes broad Tribal input.
- Evaluate the Indian provisions of the Affordable Care Act and continue consultation to implement outstanding provisions.

BUDGET PRIORITIES SUMMARY

Restore Fiscal Year 2013 sequestration cuts and exempt Tribal funding from future sequesters.
Tribal governments experienced heavy budgetary cuts as a result of the 2012 sequester. These cuts affect direct services to Tribal citizens, that include, but are not limited to, public safety, social welfare, and health care services. As Congressional members debate the Fiscal Year (FY) 2016 appropriations, Self-Governance Tribes first, urge Congress to restore Tribal funding cuts and, second, to uphold the Tribal trust responsibility and amend the Budget Control Act of 2011 to exempt Tribal funding from future sequesters.

Authorize mandatory funding and fully fund Contract Support Costs and expedite payments to Tribes.
Self-Governance Tribes support the President's proposal to fully fund Contract Support Costs (CSC) in FY 2016 and its shift from discretionary funding to mandatory funding. Self-Governance Tribes expressly support the shift in funding to remedy the need for Administrators to make fiscal decisions without consultation from Congressional members and Tribal leaders. Additionally, mandatory funding protects appropriations that are allocated for direct services in Tribal communities.

Preserve authority to include one-time or short-term resources in Self-Governance Funding Agreements.
Self-Governance Tribes have noticed a troubling trend that Department of the Interior (DOI) is moving one-time funding to grants that cannot be included in Self-Governance Funding Agreements and are restrictive in nature – undermining core Self-Governance tenants. This trend allows DOI to heavily regulate and restrict the inclusion of indirect costs to administer Tribal programs; and hinders Tribal governments' ability to re-design programs to better meet the needs at the local level.

Enact Advanced Appropriations for the Indian Health Service.
Since FY 1998, there has been only one year (FY 2006) when the Interior, Environment and Related Agencies budget, which contains the funding for Indian Health Service (IHS), has been enacted by the beginning of the fiscal year. Late funding creates significant challenges to Tribes and IHS provider budgeting, recruitment, retention, provision of services, facility maintenance and construction efforts. Providing sufficient, timely, and predictable funding is needed to ensure the federal government meets its obligation to provide health care for American Indian and Alaska Native people. Enacting advanced appropriations will provide more stable funding and sustainable planning for the entire Indian Health Care system by appropriating funding two years in advance.

LEGISLATIVE PRIORITIES SUMMARY

Amend Title IV of the Indian Self-Determination and Education Assistance Act.
Amending Title IV of the Indian Self-Determination and Education Assistance Act (ISDEAA) is a top legislative priority for Self-Governance Tribes. Over the past thirty-five years, the ISDEAA has been one of the most successful mechanisms allowing Tribes to develop the capacity for government-building activities. However, Title IV of the ISDEAA, the Self-Governance program within the DOI, has serious gaps and problems. Self-Governance Tribes must continue to advance the vision of the ISDEAA by working to amend Title IV of the ISDEAA to create consistency between Title IV Self-Governance in the DOI and Title V Self-Governance in the Department of Health and Human Services (HHS) to create administrative efficiencies for Self-Governance Tribes.

Reauthorize the Native American Housing Assistance and Self-Determination Act.
Current authorization of the Native American Housing Assistance and Self-Determination Act of 1996 (NAHASDA) expired on September 30, 2013. NAHASDA is the main authorization of Tribal housing programs. Tribal programs under NAHASDA have been successful in allowing Tribes the self-determination necessary to provide effective programs for Tribal citizens. Tribes are now exercising

their right to self-determination by designing and implementation their own housing and other community development infrastructure programs. Reauthorization of NAHASDA is critical to continue to support Tribal housing authorities that build keystone housing and community infrastructure in Tribal communities.

Enact legislation that strengthens and reaffirms the original tenants of Public Law 102-477.
The 477 Program provides tribal governments with the flexibility to design employment, training, and economic development plans that utilize funding from several federal programs to best meet the needs of their local communities. While PL 102-477 is still technically a "demonstration project," the 477 Program has existed for over two decades and currently over 250 tribes and tribal organizations consolidate multiple programs into a single 477 Plan. Despite nearly two decades of success, the viability of the 477 Program was jeopardized by two federal agency actions. Legislation is necessary to make the 477 Program permanent and remove administrative burdens for Self-Governance Tribes.

Expand Self-Governance to the Department of Transportation.
Congress has sought to address transportation infrastructure deficiencies in Indian Country by increasing funding available to Tribes, broadening eligibility for direct Tribal participation in federal transportation programs and by extending the ISDEAA to several of those programs. With increased funding and expanded authority, Tribes have demonstrated that they are best positioned to ensure the effective and efficient use of federal transportation infrastructure funds. Despite these results, the Departments of Transportation (DOT) and Interior have been unwilling to extend the ISDEAA framework into new program areas, such as transit and highway safety. However, reauthorization of transportation legislation expires in May 2015 and Tribal advocates are urging Congressional members to expand Self-Governance tenants to the DOT.

Permanently reauthorize and provide full funding for the Special Diabetes Program for Indians.
Congress established the Special Diabetes Program for Indians (SDPI) in 1997 as part of the Balanced Budget Act to address the growing epidemic of diabetes in American Indians and Alaska Natives communities. SDPI programs have become the nation's most strategic and comprehensive effort to combat diabetes. Self-Governance Tribes believe the success of these programs require the permanent reauthorization and supporting funding for SDPI.

Enact Medicare-Like Rates for IHS outpatient services for IHS, Tribal and Urban facilities.
IHS, Tribes and Tribal organizations currently cap the rates they will pay for hospital services to what the Medicare program would pay for the same service (the "Medicare-Like Rate" or "MLR"). Currently, this MLR cap applies only to hospital services, which represent only a fraction of the services provided through the Purchase and Referred Care system. Proposed legislative fixes would amend Section 1866 of the Social Security Act to expand application of the MLR Cap. It would direct the Secretary to issue new regulations to establish a payment rate cap applicable to medical and other health services in addition to the current law's cap on services provided by hospitals. It would make the MLR cap apply to all Medicare-participating providers and suppliers. Self-Governance Tribes support this legislative fix to leverage the limited resources provided to IHS, Tribal and Urban health programs.

Advance legislation to expand Self-Governance to other Health and Human Services agencies and programs.
Title VI of the ISDEAA required HHS to determine the feasibility of a demonstration project extending Tribal Self-Governance to HHS agencies other than the Indian Health Service. HHS determined it was feasible, convened the Self-Governance Tribal Federal Workgroup (SGTFW) and issued a final report in September 2014. After repeated attempts to reconstitute the SGTFW to continue working on the report recommendations, Self-Governance Tribes will seek out legislative proposals to implement recommendations outlined in the report.

POLICY PRIORITIES SUMMARY

Revise and streamline each agency's Contract Support Costs Policy.
After years of advocacy, CSC funding has changed monumentally in the last twelve months. As a result of full funding and Presidential support for mandatory funding, each agency must identify, assess, and implement modifications to each agency's CSC policy that reflects recent legislative and funding changes. Each agency has a Tribal-Federal Workgroup that made several recommendations to update the CSC policy. Self-Governance Tribes urge each agency to review those recommendations begin updating the policy as quickly as possible.

Expand Tribal consultation on allocation and formula distribution of Bureau of Indian Affairs.
In 2012, Self-Governance Tribes published the Program Formulas Matrix Report, which identifies areas where the formulas and methodologies currently used by the Bureau of Indian Affairs (BIA) for distribution can be improved and provide recommendations for eleven programs. Action on these recommendations has stalled in the last several years. However, as DOI seeks to move funding to one-time grants, the Formula Matrix Report recommendations are increasingly important. Continued consultation and discussion with BIA officials and Tribes is needed to implement changes recommended in the report.

Foster greater transparency announcing new DOI funding opportunities.
Access to program and initiative funding is critical as Tribes work to meet the needs of their citizens locally. As such, Self-Governance Tribes encourage DOI agencies to streamline their grant and funding announcements so that all Tribes have equal opportunity for one-time funding and support.

Include Purchase and Referred Care in all VA-IHS reimbursement agreements.
When the IHS and the Veterans Administration negotiated the first national agreement, required under the Indian Health Care Improvement Act (IHCIA), the agencies only included reimbursement for direct care provided by IHS facilities. This agreement has become the model for Tribal programs in negotiating with local VA facilities. However, it does not adequately address the specialty care Tribal systems provide eligible veterans. After two years of implementation and changes to the Veterans Administration health care delivery, Self-Governance Tribes believe the time is right to revisit the reimbursement agreement and include specialty and referred care.

Institute a Tribal Advisory Committee for Office of Management and Budget.
Given the role the Office of Management and Budget (OMB) plays in the Tribal funding – from guiding the President's annual budget request to distributing appropriations to all federal agencies – a Tribal Advisory Committee could prioritize Tribal needs and requests. Other advisory committees have assisted in educating and building momentum within agencies and departments to further Tribal sovereignty and priorities.

Update the IHS Facilities Construction Policy to include broad Tribal input.
The IHS Health Care Facilities Design and Construction Policy does not currently reflect new authorities available under IHCIA, nor does it accurately reflect the tenants of Self-Governance. Additionally, the Facilities Appropriations Advisory Board (FAAB) recently decided to review and possibly update the Policy to reflect new authorities and make recommendations to the prioritization system. Self-Governance Tribal leadership believes the time is ripe to make changes that have broad Tribal support and allow for greater flexibility in construction projects.

Evaluate the Indian-specific provisions of the Affordable Care Act and continue consultation to implement outstanding provisions.
After nearly five years of implementation, an assessment is needed to ensure that Indian-specific provisions of the Affordable Care Act (ACA) are working effectively and efficiently. Additionally, some provisions continue to require Tribal consultation and technical fixes that may be successful through negotiated rulemaking process.

Key Goals & Objectives

OBJECTIVE #1: Advance Self-Governance Policy, Budget & Legislative Priorities

- Mobilize Self-Governance Tribal leaders to actively advance priority issues
- Develop common messages and themes
- Coordinate and strengthen advocacy efforts with all Self-Governance Tribes

Department of the Interior (DOI)/Indian Affairs Issues	
DOI/Indian Affairs Budget Issues:	**Strategy and Actions Items**
Restore Fiscal Year 2013 sequestration cuts and exempt Tribal funding from future sequesters.	• Include sequestration exemption requests as a preamble to all budget-related communication and requests. • Collect impact narratives from Tribal communities about sequestration cuts and program delivery.
Authorize mandatory funding, fully fund Contract Support Costs (CSC) and expedite payments to Tribes.	• Create and implement campaign to support Mandatory CSC funding proposal. • Monitor resolution of CSC claims process. • Request opportunity to negotiate Direct CSC.
Increase funding to support Self-Governance priorities issues and programs. Programs include, but are not limited to: • Land into Trust Program • TLOA implementation priorities areas. • Natural Resources Management • Tribal Priority Allocations • Transportation and Infrastructure	• Concentrate advocacy efforts on Congressional action, including message and theme development. • Include Self-Governance in all funding increases. • Collect, analyze and present data to support budget requests. • Provide training to encourage and assist Tribal leaders and experts to strengthen advocacy on the Hill. • Invite Office of Management and Budget (OMB) to SGAC Meetings. • Establish a liaison or representative at the OMB. • Advocate for full transparency in all funding formulas. • Include requests that the $19 billion identified in the OMB Crosscut Funding document for Tribes be distributed to directory to Tribes via a negotiated formula.
Preserve authority to include one-time or short-term resources in Self-Governance Funding Agreements for Self-Governance Tribes choosing to assume operation of these programs.	• Request Tribal consultation with BIA officials regarding unilateral funding decisions, specifically one-time funding and transfer to www.grants.gov.
DOI/Indian Affairs Legislative Issues:	**Strategy and Actions Items**
Amend Title IV of the Indian Self-Determination and Education Assistance Act.	• Organize specific advocacy activity for Title IV amendments to engage support of Tribal leadership.
Reauthorize the Native American Housing Assistance and Self-Determination Act	• Collaborate with national organizations to support ongoing and previously developed priorities.
Enact legislation that strengthens and reaffirms the original tenants of Public Law 102-477	• Identify a Congressional champion to support enactment of legislation similar to S1574 introduced in the 113th Congress.
Expand and modernize the trust relationship through contracting and compacting in other Departments and Bureaus.	• Work in partnership with other regional and national organizations to advance trust modernization legislation and policy.

Department of the Interior (DOI)/Indian Affairs Issues	
Enact a clean Carceri-fix legislation.	• Support ongoing legislative efforts to introduce and enact legislation that reverses the Supreme Court's decision.
DOI/Indian Affairs Legislative Issues:	**Strategy and Actions Items**
Empower Tribal Education Agencies' (TEAs) authority to take over education of Native children.	• Consider and identify possible legislation to advance TEA's authority. • Advocate for the inclusion of Tribal Colleges in the President's Community College initiative.
Include Self-Governance tenants in future comprehensive tax reform.	• Participate in the Tribal Tax Workgroup to ensure Self-Governance tenants are included in national priorities.
Develop and pass legislation to reverse the Oliphant decision.	• Collect local stories for Congressional member that describe the negative impact that the Oliphant decision has on Tribal communities.
DOI/Indian Affairs Legislative Issues:	**Strategy and Actions Items**
Revise and streamline BIA CSC Policy.	• Continue work with the Self-Governance CSC Sub-Workgroup to maintain SG Priorities in the policy revision.
Expand Tribal consultation on allocation and formula distribution of BIA.	• Advance recommendations developed under the Program Matrix Report.
Foster greater transparency in announcing new DOI funding opportunities.	• Monitor how new funding and grant announcements are shared.
Remove Barriers to Self-Governance Implementation in DOI/BIA.	• Conduct SG Training of DOI/IA Senior Officials. • Invite Senior Staff to Annual SG Conference. • Fully implement the Self-Governance Title IV regulations requiring the identification of Inherent Federal Functions and Tribal Shares including all BIA Regions and Central Office.
Increase Non-BIA agreements.	• Share Tribal success stories at the Annual Consultation Conference. • Tie federal performance factor to increase in non-BIA agreements.
Demand consultation, reinforce EO 13175, and hold BIA accountable.	• Conduct a review of the BIA Tribal Consultation Policy and develop a system of accountability, including development of an Annual Report.

Department of Health and Human Services (HHS)/Indian Health Service (IHS) Issues	
HHS/IHS Budget Issues:	**Strategy and Actions Items**
Enact Advanced Appropriations for IHS	• Identify a Congressional champion. • Continue to collaboration with other national and regional organization to advance legislative efforts.
Restore Fiscal Year 2013 sequestration cuts and exempt Tribal funding from future sequesters.	• Include sequestration exemption requests as a preamble to all budget-related communication and requests. • Collect impact narratives from Tribal communities about sequestration cuts and program delivery. • Enact an amendment to the Budget Control Act of 2011 to fully exempt Tribal programs from implementation of a government-wide sequestration of FY 2016 and 2017 appropriations.
Authorize mandatory funding, fully fund Contract Support Costs (CSC) and expedite payments to Tribes.	• Create and implement campaign to support Mandatory CSC funding proposal. • Monitor resolution of CSC claims process.
Support 2014 IHS Budget Summit recommendations.	• Monitor and advance recommendations developed during the 2013 IHS Budget Summit. • Ensure Self-Governance representation at all HHS/IHS Budget Formulation Mtgs.
Increase funding to support Self-Governance priorities issues and programs including, but not limited to: • Facilities construction • Mental and behavioral health • ACA and IHCIA Implementation	• Prepare reports/analysis on unfunded and critical ACA and IHCIA provisions where funding is necessary. • Create transparency in formula methodology and formulas. • Invite OMB to TSGAC Meetings. • Advocate for an OMB Asst. Director for Native American Programs. • Educate Congressional members who do not represent Tribes directly. • Request and encourage Tribes to include “common” testimony. • Include requests that the $19 billion identified in the OMB Crosscut Funding document for Tribes be distributed to directory to Tribes via a negotiated formula.
Move IHS funding to Mandatory funding.	• Develop a research paper to support the Mandatory funding proposal.
HHS/IHS Legislative Issues:	**Strategy and Actions Items**
Permanently reauthorize and provide full funding for the Special Diabetes Program for Indians.	• Collaborate with national organizations to support national campaign.
Enact Medicare-Like Rate for IHS outpatient services for IHS, Tribal and urban facilities.	• Build on the agency proposed rule. • Gain broader support from IHS, Tribal and urban facilities.
Amend Title VI of ISDEAA to expand Self-Governance to other Health and Human Services agencies and programs.	• Establish a workgroup to draft legislation that supports expansion. • Identify Congressional leadership to support legislation. • Work in coordination with Title IV amendments group.
Evaluate ACA Indian-specific provisions to ensure the Tribes have maximum flexibility for implementation.	• Exempt Tribal Employers from employer insurance coverage mandate. • Streamline the ACA definition of “Indian” for purposes of health care delivery.

Department of Health and Human Services (HHS)/Indian Health Service (IHS) Issues	
HHS/IHS Legislative Issues:	**Strategy and Actions Items**
Write and enact legislation the supports Tribal administration of Medicaid.	• Share Navajo Nation Feasibility Study. • Develop proposal that supports Tribal administration. • Identify national partners to support the Self-Governance proposal.
Exempt Tribal members from Medicaid Estate Recovery.	• Develop white paper to describe issue and proposed solutions.
HHS/IHS Policy Issues:	**Strategy and Actions Items**
Revise and streamline IHS CSC Policy.	• Continue to monitor the IHS CSC Workgroup to ensure SG Priorities in policy changes.
Include Purchase and Referred Care in all VA-IHS reimbursement agreements.	• Invite VA representatives to the annual Self-Governance Conference. • Clarify new opportunities Veterans Access, Choice, and Accountability Act of 2014.
Institute a Tribal Advisory Committee for OMB.	• Determine if OMB has a Tribal Consultation Policy and recommend adoption of a policy in accordance with EO 13175.
Update the IHS Facilities Construction Policy to include broad Tribal input.	• Identify Self-Governance priorities and recommendations. • Participate in FAAB meetings. • Change policy to incorporate new authorities under IHCIA.
Evaluate Indian-specific provisions of the ACA and continue consultation to implement outstanding provisions.	• Create Tribal certification for ACA contractors who are to assist Tribal members with ACA Indian-specific provisions.
Streamline SDPI granting process and create a long-term solution for grant reporting and funding.	• Translate administrative hours required to conduct grant administrative requirements to time that could be used to provide patient care.
Terminate administrative caps across all HHS programs.	• Include Self-Governance representation on all HHS Tribal Advisory committees.
Create a uniform Federal Advisory Committee Statement to build consistency across departments.	• Establish a workgroup to develop statement and recommendations for implementation.
Develop relationship with HHS OIG regarding utilization of 3rd party billing.	• Invite OIG authors to Annual Meeting. • Educate Self-Governance Tribes about tracking and reporting on their revenue. • Request that documentation behind the report be shared with Tribes.

Objective #2: Strengthen Self-Governance Advocacy Efforts

- Improve Coordination and Advocacy
- Develop Communications Strategy
- Collaborate with other National and Regional Tribal Organizations on mutual issues

Goals	Strategies & Actions
Develop a coordinated Self-Governance education campaign to provide accurate information to the Administration, Congress, non-Self-Governance Tribes and other interested parties about Self-Governance.	• Self-Governance Communication & Education Office (SGCE) to work with Tribal leadership and other subject matter experts to develop briefing documents. • SGCE to assist in gathering Tribal examples of how Self-Governance works at the local level and identify challenges, including quotes, excerpts and slogans to strengthen message. • Develop targeted educational materials (briefing packages, brochures, videos, digital storytelling, photos, etc.) for new legislators. • Organize a social media campaign.
Improve communication and information sharing.	• Develop a Communication Plan and Strategy to track and monitor Strategic Plan Goals. • Identify a representative group to orchestrate, track and coordinate strategy and messages. Potential groups to assist include SGCE, SENSE Incorporated, SGAC, TSGAC, the National Congress of American Indians (NCAI), the National Indian Health Board (NIHB) and other National/Regional Tribal organizations. • SGCE to share updated information via established communication channels, such as newsletters, websites, broadcast e-mails, and meetings. • Use Social Media (Twitter, Facebook, Constant Contact, etc.) to assist in outreach to Self-Governance Tribes. • Create a plan to support new Self-Governance Tribes.
Support proactive Tribally-driven measures to advance and expand Self-Governance throughout the Federal system.	• Expand Self-Governance to other federal agencies. • Identify and address obstacles and barriers to advancing Self-Governance.
Encourage Tribal communities to host voter registration.	• Partner with Native Vote to Get Out the Vote.

Objective #3: Implementation of the Strategic Plan

- Review and Monitor Strategic Plan
- Track and Update Issues
- Monitor Congressional appropriations and advocate for legislative priorities, budget increases, etc.

Goals	Strategies & Actions
Advance Self-Governance goals identified in the Strategic Plan, including budget, policy and legislative priorities.	• Request meetings with the Administration and Congress and present Self-Governance priorities in a unified message. • Report back to the SGAC/TSGAC, SGCE office and share with other Self-Governance Tribes on-going outreach and feedback. • Provide training for Tribal leaders to become regional and national advocates.
Monitor, track and update issue "white papers" as needed.	• Review Strategic Plan at each SGAC/TSGAC Quarterly Meeting. • Assign SGAC/TSGAC Technical Workgroup to update white papers as needed. • Include key priorities and develop related panels and update at 2013 Annual Self-Governance Conference.
Leverage graduate students and other experts as a think tank to develop white papers and recommendations.	• Develop partnerships with academic and research institutions. • Identify research needs and projects that need long-term support. • Distinguish databases and sources to support legislative, policy and budget requests.
Identify and urge legislators to champion Self-Governance legislative priorities.	• Develop relationships with new members of Congress and build upon existing relationships with the Obama Administration and the 114th Congress and staff. • Collaborate with other national and regional organization to build national strategies that support and encourage Congressional champions.

TAB 5: OIG

OIG ALERT

Office of Inspector General
330 Independence Ave., SW
Washington, DC 20201
News Media: (202) 619-0088

For Immediate Release
November 24, 2014

OIG Alerts Tribes and Tribal Organizations To Exercise Caution in Using Indian Self-Determination and Education Assistance Act Funds

Tribes[1] that enter into ISDEAA contracts and Title V Self-Governance compacts with IHS must protect IHS funds from misuse. Further, all tribes that receive Medicare, Medicaid, and Children's Health Insurance Program (CHIP) reimbursements must ensure that those funds are used in accordance with applicable Federal law, including the ISDEAA and the Indian Health Care Improvement Act (IHCIA).[2]

Recent OIG investigations have revealed that some tribes and tribal organizations, or their officials, have not adequately protected these funds; as a result, the funds have been misappropriated or misused. In some cases, health care services for tribal members have been jeopardized.

Tribes may negotiate ISDEAA contracts with IHS, under which the tribes receive funds to provide health-care-related services directly to tribal members.[3] Similarly, qualifying tribes may sign Self-Governance compacts with IHS and thereby exercise even more flexibility to use the compact funding for those programs, services, and functions that the tribes have agreed to provide. Tribes must use ISDEAA funds only to carry out activities that are authorized by law and included in the contract, compact, or funding agreements entered into with IHS.[4] Use of ISDEAA funds for unallowable purposes is subject to disallowance by the Department of Health and Human Services (HHS).

The Affordable Care Act reaffirmed authority for tribal health programs to seek direct reimbursement from Medicare, Medicaid, and CHIP for health care services provided to

[1] For purposes of this alert, we use the word "tribes" to encompass all recipients of Indian Self-Determination and Education Assistance Act (ISDEAA) contracts and compacts with the Indian Health Service (IHS), including tribal organizations.
[2] 25 U.S.C. § 1601 et seq.
[3] ISDEAA funds are distributed pursuant to Public Law 93-638, codified at 25 U.S.C. § 450 et seq.
[4] 25 U.S.C. §§ 450j-1 and 458aaa-4. In limited circumstances, a tribe may obtain prior approval from IHS for additional uses. 25 U.S.C. §§ 450j-1(k) and 458aaa-15(a).

individuals who are also eligible for those programs.[5] Importantly, these reimbursements must be reinvested in health care services or facilities.[6] With respect to compacts, Medicare and Medicaid reimbursements are to be treated as supplemental funding to the tribe's Self-Governance compact.[7] Tribes that improperly use reimbursements may lose their authority to directly bill Medicare, Medicaid, and CHIP.[8]

Recent OIG investigations have uncovered instances in which tribes used ISDEAA funds to support unauthorized activities. In some cases, shared costs were not allocated correctly between IHS and other activities. In others, ISDEAA funds were "borrowed" to meet other tribal expenses. Sometimes Medicare or Medicaid reimbursements were not reinvested in activities furthering the purposes of the original contract or compact and were not even expended for health care services, but instead were used to cover general tribal deficits. In the most egregious cases, funds were converted to personal use, leaving the tribes with dangerous shortages in health care funding for its members.

The purpose of the limitations on uses of ISDEAA funds and Medicare/Medicaid/CHIP reimbursement is to direct urgently needed funding to health care services for American Indians and Alaska Natives. Tribes should be mindful of these restrictions and take steps to ensure that the funding and reimbursements are properly invested in this vital purpose.

Those who commit fraud involving HHS programs are subject to possible criminal, civil, and/or administrative sanctions.

# # #

[5] Sections 1880 and 1911 of the Social Security Act and 25 U.S.C. §§ 1641(c) and (d).
[6] 25 U.S.C. § 1641(d)(2).
[7] 25 U.S.C. § 458aaa-7(j).
[8] 25 U.S.C. § 1641(d)(5).

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

Sent electronically Melinda.Golub@oig.hhs.gov and Amitava.Mazumdar@oig.hhs.gov
Original sent USPS

February 3, 2015

Ms. Melinda Golub, Senior Counsel
Mr. Amitava "Jay" Mazumdar, Senior Counsel
Office of Counsel to the Inspector General
Department of Health and Human Services
Room 5527 Cohen Building
330 Independence Avenue, SW
Washington, DC 20201

Re: Invitation to the Tribal Self-Governance Advisory Committee Quarterly Meeting, March 24, 2015

Dear Ms. Golub and Mr. Mazumdar:

On behalf of the Indian Health Service Tribal Self-Governance Advisory Committee (IHS-TSGAC), I invite you to meet with us at our next Quarterly Meeting to discuss the *Office of Inspector General (OIG) Alert to Tribes on use of Indian Self-Determination and Education Assistance Act (ISDEAA) and Third Party Funds* issued November 24, 2014. The meeting will be held on Tuesday, March 24, 2015 at the Embassy Suites Washington, D.C. – Convention Center, 900 – 10th Street, NW, Washington, DC. We have scheduled you for 10:00 a.m. but will be as flexible as necessary to accommodate your availability.

We would like to discuss how the TSGAC can assist the OIG with your communication and outreach to Tribes and to review the process how alerts and other information is disseminated to Tribes in a manner that will allow us to engage in dialogue prior to the OIG issuing an alert or other time sensitive information. Actions such as the November 2014 Alert generate undue scrutiny of Tribal governance, management and accountability and we would like to discuss how issues and/or concerns could be addressed in a less intimidating and corrective manner.

In FY 1992, the Indian Health Service (IHS) was instructed by Congress to initiate planning activities with Tribal governments with approved Department of the Interior Self-Governance compacts for the development of a Self-Governance Demonstration Project as authorized by P.L. 100-472, the Indian Self-Determination Act Amendments of 1988 – Title II & III. Through enactment of P.L. 102-573, the Indian Health Care Amendments of 1992, authority to fund the Tribal Self-Governance Demonstration Project (TSGDP) was extended to IHS and the Office of Tribal Self-Governance was established.

In April 1996, Self-Governance Tribes recommended the establishment of a Self-Governance Advisory Committee within the Indian Health Service (IHS). After review by Self-Governance Tribes and the IHS Area Offices, the IHS Director approved the Tribes'

request and the guidelines were drafted. The guidelines provided advocacy and policy guidance for the implementation of the tenets of Self-Governance.

The Tribal Self-Governance Advisory Committee (TSGAC) was established to represent Self-Governance Tribes by acting on their behalf to clarify issues that affect all compacting Tribes specific to (1) issues relevant to the delivery of health care for American Indians and Alaska Natives; (2) confer, discuss, and come to consensus on specific Self-Governance issues; and (3) provide verbal and written advice about Self-Governance issues to the Director of the IHS and the Director of the Office of Tribal Self-Governance (OTSG).

Tribes participating in TSGDP agree that Self-Governance has had a significant positive impact on the health and well-being of their citizens. The administration and management of the health programs are in the hands of Tribal governments and they are able to be flexible and design their health programs to meet the diverse and unique needs of their communities. Federal funds are more effectively and efficiently used in addressing the local health needs of American Indians and Alaska Natives. The TSGDP also facilitates improved program and fiscal accountability in that the Tribal governments and health administrators are held directly accountable by and to their service population.

We hope that your schedule will allow you to join us so that we can begin to collaborate on building a working relationship that benefits not just Self-Governance Tribes but all of Indian Country. If you have questions or would like to discuss this invitation in further detail, please contact me at (860) 862-6192, or via email lmalerba@moheganmail.com. You can also follow-up on the status of your availability with C. Juliet Pittman at pitt@senseinc.com or (202) 628-1151.

Thank you.

Sincerely,

Lynn Malerba

Chief Lynn Malerba, Mohegan Tribe
Chairwoman, TSGAC

cc: Dr. Yvette Roubideaux, Acting Director, IHS
Nick Matiella, Legislative Assistant for Senator John McCain
Rhonda Harjo, Majority Deputy Chief Counsel, Senate Committee Indian Affairs
Benjamin Smith, Director, Office of Tribal Self-Governance, IHS
TSGAC and Technical Workgroup Members

TAB 6: BUDGET UPDATE

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 (580) 920-3138 ~ Website: www.tribalselfgov.org

Testimony of
The Honorable Chief Marilynn Malerba, Mohegan Tribe
& Chairwoman of the IHS Tribal Self-Governance Advisory Committee (TSGAC)

Submitted at the
Department of Health and Human Services 17th Annual Tribal Budget Consultation Session on the FY 2017 Budget Request

February 25-26, 2015, Washington, DC

I. Introduction

On behalf of the Tribal Self-Governance Advisory Committee (TSGAC), I am writing to formally submit the top budget and legislative priorities identified by the Self-Governance Tribes. Self-Governance is a Tribally-driven, Congressional legislative option, whereby Tribal governments are authorized to negotiate annual appropriated funding and assume management and control of programs, services, functions and activities that were previously managed by the Federal government. Self-Governance allows Tribes, as sovereign nations, to exercise their right to be self-governing and to take Federal program funds and manage them to best fit the needs of their citizens and Tribal communities. It is important to note that many of our recommendations include initiatives that protect all Indian Health Programs, Direct, Urban and Self-Governance. Our goal is to ensure that all American Indian/Alaska Native Health Programs are considered a top priority regardless of the administrative arrangement or delivery system.

The growth and success of Self-Governance, **within the Department of Health and Human Services - Indian Health Service (HHS-IHS),** is best documented by the 350 Tribes currently participating in Self-Governance compared to the 14 Tribes who signed agreements in 1992. Self-governance now represents 62% of Tribal governments who operate $1.8 billion in healthcare programs each year. In addition, the Tribal-Federal relationship has improved under this authority and Self-GovernanceSG has become the most successful nation-to-nation policy to ever exist in the United States.

Since 2000, Self-Governance Tribes have held meetings with the Administration and Congress regarding ways to improve and advance Self-Governance within HHS. In 2012, Secretary Sebelius created the Self-Governance Tribal-Federal Workgroup (SGTFW) to identify legal and logistical barriers to expand Self-Governance, as well as to develop detailed recommendations to overcome such barriers. The SGTFW final report is complete, but implementation of the recommendations has stalled. As recently as January, 2015, Self-Governance Tribes reiterated a request to advance this initiative, a request that has been supported by the Secretary's Tribal Advisory Committee (STAC). This remains a high legislative priority for the TSGAC.

The Self-Governance Tribes, along with our Federal partners, IHS and the Department of the Interior – Indian Affairs (DOI-IA) conduct an Annual Consultation Conference in the spring. Self-Governance Tribes also convene a Tribal Strategic Planning Session, usually in the fall to

discuss and identify goals, budget, legislative and policy priorities. The budget and legislative priorities identified in the 2015-2017 National Tribal Self-Governance Strategic Plan have been included in this testimony.

II. Top Budget Priorities

The TSGAC is supportive of the Indian Health Services I/T/U budget formulation process and priorities. Within that overall process, the TSGAC has identified the following top budget priorities:

1. Support IHS current services;
2. Protect the IHS budget from sequestration;
3. Support mandatory appropriations for Contract Support Costs (CSC) and continue to resolve previous claims; and,
4. Request full funding for streamlined implementation of the Patient Protection and Affordable Care Act (PPACA) and the Indian Health Care Improvement Act (IHCIA).

III. Top Legislative Priorities

The TSGAC has identified the following top legislative priorities for this Administration:

1. Support legislation to expand Self-Governance under a Demonstration Project within HHS, by amending the Indian Self-Determination and Education Assistance Act (ISDEAA);
2. Expand Medicare-Like Rates for Contract Health Service (CHS);
3. Support Advance Appropriations for the Indian Health Service in the FY 2016 Budget Request; and,
4. Advocate for the reauthorization of the Special Diabetes Program for Indians (SDPI).

IV. Description of Top Budget Priorities

1. **Support IHS current services.**
   Current services include mandatory cost increases necessary to maintain those services at current levels. These "mandatories" are unavoidable and include medical and general inflation, pay costs, contract support costs, phasing in staff for recently constructed facilities, and population growth. If these mandatory requirements are not funded, Tribes have no choice but to cut health services, which further erodes the quantity and quality of health care services available to American Indian/Alaskan Native (AI/AN) people. Although the IHS budget has grown in the last four years, the net increases of 17% were swallowed by the negative impacts of reduced purchasing power due to inflation and population growth, which were also 17%.

   Recommended Action: We urge the Administration to fully fund the IHS Budget Formulation Workgroup recommendations to maintain current services.

2. **Protect the IHS budget from sequestration.**
   FY 2015 is the final year of the Ryan-Murray Bipartisan Budget Act of 2013. Under the Budget Control Act of 2011, sequestration for the IHS was to have been limited to two percent (2%). However, an estimated $220 million reduction occurred in the IHS' budget authority for FY 2013, the consequence being a reduction of 3,000 inpatient admissions and 804,000 outpatient visits for American Indians and Alaska Natives (AI/AN). While the Ryan-Murray deal replaced nearly half of the sequestration cuts to defense and non-

defense discretionary spending in 2014, only a fourth is replaced in 2015. Consequently, health services for AI/AN continue to be funded at only 56% of benchmarked need.

Recommended Action: We urge the Department to take any steps necessary to ensure that the setback in suffered by critical healthcare services to Indian Country in FY 2013 by sequestration never be repeated.

3. **Transition Contract Support Costs to a mandatory appropriation and continue to resolve previous claims.**

The President's Budget Request to Congress for Fiscal Year 2016 included a proposal to reprogram CSC from discretionary to a mandatory appropriation, effective in FY 2017. The TSGAC supports CSC becoming a mandatory appropriation, which we view as an effective solution to fund CSC for the long-term. This recommendation protects all Indian Health Programs throughout the system including Direct Service, Urban Programs and Tribal Self-Governance Programs. The TSGAC recommends, however, that Tribal Consultation on the matter be expedited and that mandatory appropriations for CSC would be optimally implemented in FY 2016, rather than FY 2017. Until CSC appropriations become mandatory, the IHS must reallocate from elsewhere within the Services appropriation should funding for CSC be inadequate to satisfy obligations – an issue about which Tribes are universally concerned. Achieving full funding for CSC has long been a top priority of Self-Governance Tribes and now, collectively, Tribes and IHS have the opportunity to solve a decades-long issue wherein Tribes had to choose between providing services and ensuring proper administration. Much progress has been made through partnership between the IHS and the Tribes to bring consistency and reliability to calculation and projection of future CSC requirements, all of which benefits self-governance and direct service Tribes alike. As the Administration looks at its final budget request to Congress we recommend that the agency continue to seek full funding for CSC and resolve previous claims that remain as expeditiously as possible.

Recommended Action: We request that the Department move forward in implementing mandatory appropriations for Contract Support Costs as soon as practicable; continue to resolve remaining prior-year claims; ensure full CSC funding moving forward; and uphold an open and inclusive process for any changes to agency policies and practices.

4. **Request full funding for streamlined implementation of the Patient Protection and Affordable Care Act and the Indian Health Care Improvement Act.**

Health reform represents a significant opportunity for Tribal and IHS programs to sustain, improve, and build innovative health systems in Tribal communities. However, to date, there are more than twenty-five unfunded authorities in the IHCIA, each representing an unleveraged opportunity to increase and improve services for American Indians and Alaska Natives across the Nation. Therefore, successful implementation of the law is of great importance to Tribes and hinges on the full funding of the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA) and the overarching Affordable Care Act (ACA).

Recommended Action: Request funding increases to begin implementing the twenty-five unfunded authorities in IHCIA and countless others in the ACA.

V. Description of Top Legislative Priorities

1. **Support legislation to Expand Self-Governance under a Demonstration Project, by amending the Indian Self-Determination and Education Assistance Act (ISDEAA).**
The expansion of Self-Governance within the HHS would greatly aid Tribes in serving their citizens. In 2000, P.L. 106-260, Title VI of ISDEAA required HHS to conduct a study to determine the feasibility of a demonstration project extending Tribal Self-Governance to HHS agencies other than the Indian Health Service. The HHS study which was submitted to Congress in 2003 determined that a demonstration project was feasible. Expanding Self-Governance tenets translates to greater flexibility for Tribes to redesign programs that provide critical social services within agencies such as the Administration on Aging, Administration on Children and Families, Substance Abuse and Mental Health Administration, and Health Resources and Services Administration. In addition, Tribes could reallocate program funding and design service delivery systems to better meet the needs of their citizens.

   Recommended Action: Develop and adopt a plan that advances recommendations of the Self-Governance Tribal-Federal Workgroup (SGTFW) to expand Self-Governance in the agencies listed above.

2. **Advocate for the expansion of Medicare-Like Rates to Purchased and Referred Care (Contract Health Service).**
A 2013 Government Accountability Office (GAO) report revealed a majority of Federal Contract Health Service program payments were made at non-negotiated rates and, on average, the payments are nearly 70 percent more than negotiated rates. GAO also found that Federal CHS programs paid non-contracted physicians two and half times more than what it estimates Medicare would have paid for the same services. Further, GAO estimated that implementing Medicare-like rates for Contract Health Service programs could have saved the entire Indian Health Service (IHS) system, including Tribal programs, approximately $126.4 million. We believe that this figure is vastly underestimated given that this figure represents only Direct Service programs and is not inclusive of Self-Governance Programs. Indian Health Service is the only Federal health program that does not have negotiated rates lower than fully billed charges which creates further health inequality for our citizens due to the unfortunate need to prioritize care based on funding. Negotiating lower rates will provide better access to care at no additional cost to the Federal government.

   The Department has issued proposed rules that would require Medicare-like rates for these non-hospital services. However, Tribes and Tribal organizations continue to advance legislation amending Section 1866 of the Social Security Act to aid the Secretary in enforcing a payment rate cap for non-hospital Medicare participating providers and suppliers. The legislation is designed to ensure continued access to care, will allow for Tribal consultation as it is implemented, is budget neutral, and would bring IHS in line with other Federal agencies who already cap the rate they pay for non-hospital services.

   Recommended Action: Support a legislative solution to cap the rate IHS pays for non-hospital services.

3. **Support Advance Appropriations for the Indian Health Service.**

Considering that Congress has enacted appropriations by the beginning of the fiscal year only once since 1998, funding IHS one fiscal year in advance, otherwise known as advance appropriations, would go a long way to allow the IHS and Tribal health providers adequately plan and deliver health care to Tribal citizens without unnecessary disruption. Legislation in support of this budget option has been introduced in both chambers during the last Congress (HR. 3229 and S. 1570). This strategy stabilizes the funding environment for Indian health programs. While Self-Governance Tribal leaders continue to advocate for 100% level of need funded, advance appropriations addresses the chronic lateness in appropriations to the IHS, and is supported by the American Medical Association. This recommendation incurs no additional cost to the Federal government.

Late funding and successive Continuing Resolutions undermine IHS and Tribal abilities to effectively budget, recruit, and deliver healthcare services, in addition to constructing and maintaining facilities. In recognition of a similar systemic issue, Congress passed legislation in 2010 to provide advance appropriations for health care accounts of the Veterans Administration (VA). Similar in operations, the VA and the IHS are the only agencies to provide direct, Federally-funded healthcare to specific populations, and should thus have similar access to advance appropriations.

Recommended Action: We urge the Department to support advanced appropriations for the IHS.

4. **Advocate for the reauthorization of the Special Diabetes Program for Indians (SDPI).**

SDPI is currently funded until the end of FY 2015 at $150 million a year, and has been level-funded since 2002. $150 million in 2002 translates to a current spending power of $115 million in 2014 – or a reduction of 23 percent. This is a critically important program for many Self-Governance Tribes and supports 404 diabetes treatment and prevention programs in 35 states. The results of this program have been tangible and are well documented. However, there is a need to work on ensuring that Congress enacts legislation this Session that will provide that this successful program is funded in future years.

Self-Governance Tribes, like many other Tribes in Indian Country, support a multi-year, increased appropriation for the program and need the Department's support to ensure the program will continue to be effective in Tribal communities.

Recommended Action: We urge the Department to advocate for a five-year, $200 million reauthorization of SDPI and permanent authority.

VI. Summary

The TSGAC truly appreciates the opportunity to work with you and others to move Indian Country's top budget, legislative, and policy priorities forward.

Thank you.

All Purpose Table
Indian Health Service
(Dollars in Thousands)

Jan 10, 2015

Program	FY 2014 Final	FY 2015 Enacted [3]	FY 2016 President's Budget	FY 2016 +/- FY 2015
SERVICES				
Hospitals & Health Clinics	1,773,931	1,836,789	1,936,323	99,534
Dental Services	165,260	173,982	181,459	7,477
Mental Health	77,980	81,145	84,485	3,340
Alcohol & Substance Abuse	186,378	190,981	227,062	36,081
Purchased/Referred Care	878,575	914,139	984,475	70,336
Total, Clinical Services	3,082,124	3,197,036	3,413,804	216,768
Public Health Nursing	70,829	75,640	79,576	3,936
Health Education	16,926	18,026	19,136	1,110
Community Health Representatives	57,895	58,469	62,363	3,894
Immunization AK	1,826	1,826	1,950	124
Total, Preventive Health	147,476	153,961	163,025	9,064
Urban Health	40,729	43,604	43,604	0
Indian Health Professions	28,466	48,342	48,342	0
Tribal Management Grants	1,442	2,442	2,442	0
Direct Operations	65,894	68,065	68,338	273
Self-Governance	4,227	5,727	5,735	8
Contract Support Costs	612,484	662,970	717,970	55,000
Total, Other Services	753,242	831,150	886,431	55,281
TOTAL, SERVICES	3,982,842	4,182,147	4,463,260	281,113
FACILITIES				
Maintenance & Improvement	53,614	53,614	89,097	35,483
Sanitation Facilities Construction	79,423	79,423	115,138	35,715
Health Care Facilities Construction	85,048	85,048	185,048	100,000
Facilities & Environmental Health Support	211,051	219,612	226,870	7,258
Equipment	22,537	22,537	23,572	1,035
TOTAL, FACILITIES[1]	451,673	460,234	639,725	179,491
TOTAL, BUDGET AUTHORITY	**4,434,515**	**4,642,381**	**5,102,985**	460,604
COLLECTIONS / MANDATORY				
Medicare	225,165	226,338	226,338	0
Medicaid	737,744	771,179	781,179	10,000
Subtotal, M / M	*962,909*	*997,517*	*1,007,517*	*10,000*
Private Insurance	90,246	90,303	95,303	5,000
VA Reimbursement[2]	6,622	18,244	28,062	9,818
Total, M / M / PI	*1,059,777*	*1,106,064*	*1,130,882*	*24,818*
Quarters	8,000	8,000	8,500	500
TOTAL, COLLECTIONS	*1,067,777*	*1,114,064*	*1,139,382*	*25,318*
Special Diabetes Program for Indians	147,000	150,000	150,000	0
TOTAL, MANDATORY	147,000	150,000	150,000	0
TOTAL, PROGRAM LEVEL	**5,649,292**	**5,906,445**	**6,392,367**	485,922

[1] The facilities scheduled to be constructed in FY 2016 include the Gila River Southeast Health Center, Salt River Northeast Health Center, Rapid City Health Center, and Dilkon Alternative Rural Health Center, depending on the availability of funding and construction schedules

[2] Estimates are revised from the FY 2015 PB. Please see Public and Private Collections narrative for discussion on the

[3] P.L. 113-235, Continuing and Consolidated Appropriations Act, 2015 signed December 16, 2014

INDIAN HEALTH SERVICE
FY 2016 President's Budget
Detail of Changes
(Dollars in Thousands)

Jan 26, 2015

Sub Sub Activity	FY 2014 Final	FY 2015 Enacted	Current Services: Federal Pay	Current Services: Tribal Pay	Current Services: Pay Total	Current Services: Medical Inflation 3.8%	Current Services: Population Growth	Curr Svcs Subtotal	Increases: Staffing for New Facilities	Increases: H&HC 3rd Party Improvemt	Increases: Purchased/ Referred Care	Increases: H&HC Health IT	Increases: ASA Behavioral Health	Increases: Contract Support Costs	Increases: M&I SFC HCFC	Increases Subtotal	FY 2016 President's Budget
SERVICES																	
Hospitals & Health Clinics	1,773,931	1,836,789	5,050	7,777	12,827	22,806	34,614	70,247	9,287	10,000	0	10,000	0	0	0	29,287	**1,936,323**
Dental Services	165,260	173,982	678	722	1,400	1,869	2,500	5,769	1,708	0	0	0	0	0	0	1,708	**181,459**
Mental Health	77,980	81,145	243	373	616	1,006	1,285	2,907	433	0	0	0	0	0	0	433	**84,485**
Alcohol & Substance Abuse	186,378	190,981	177	1,157	1,334	2,869	3,888	8,091	2,990	0	0	0	25,000	0	0	27,990	**227,062**
Purchased/Referred Care	878,575	914,139	0	0	0	35,249	8,362	43,611	1,208	0	25,517	0	0	0	0	26,725	**984,475**
Total, Clinical Services	3,082,124	3,197,036	6,148	10,029	16,177	63,799	50,649	130,625	15,626	10,000	25,517	10,000	25,000	0	0	86,143	**3,413,804**
Public Health Nursing	70,829	75,640	282	323	605	1,755	1,076	3,436	500	0	0	0	0	0	0	500	**79,576**
Health Education	16,926	18,026	33	100	133	547	334	1,014	96	0	0	0	0	0	0	96	**19,136**
Comm. Health Reps	57,895	58,469	6	431	437	2,223	1,234	3,894	0	0	0	0	0	0	0	0	**62,363**
Immunization AK	1,826	1,826	0	15	15	70	39	124	0	0	0	0	0	0	0	0	**1,950**
Total, Preventive Health	147,476	153,961	321	869	1,190	4,595	2,683	8,468	596	0	0	0	0	0	0	596	**163,025**
Urban Health	40,729	43,604	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**43,604**
Indian Health Professions	28,466	48,342	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**48,342**
Tribal Management	1,442	2,442	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2,442**
Direct Operations	65,894	68,065	212	61	273	0	0	273	0	0	0	0	0	0	0	0	**68,338**
Self-Governance	4,227	5,727	8	0	8	0	0	8	0	0	0	0	0	0	0	0	**5,735**
Contract Support Costs	612,484	662,970	0	0	0	0	0	0	0	0	0	0	0	55,000	0	55,000	**717,970**
Total, Other Services	753,242	831,150	220	61	281	0	0	281	0	0	0	0	0	55,000	0	55,000	**886,431**
Total, Services	3,982,842	4,182,147	6,689	10,959	17,648	68,394	53,332	139,374	16,222	10,000	25,517	10,000	25,000	55,000	0	141,739	**4,463,260**
FACILITIES																	
Maintenance & Improvement	53,614	53,614	0	0	0	0	483	483	0	0	0	0	0	0	35,000	35,000	**89,097**
Sanitation Facilities Constr.	79,423	79,423	0	0	0	0	715	715	0	0	0	0	0	0	35,000	35,000	**115,138**
Health Care Fac. Constr.	85,048	85,048	0	0	0	0	0	0	0	0	0	0	0	0	100,000	100,000	**185,048**
Facil. & Envir. Hlth Supp.	211,051	219,612	1,026	731	1,757	1,931	1,986	5,674	1,584	0	0	0	0	0	0	1,584	**226,870**
Equipment	22,537	22,537	0	0	0	825	210	1,035	0	0	0	0	0	0	0	0	**23,572**
Total, Facilities	451,673	460,234	1,026	731	1,757	2,756	3,394	7,908	1,584	0	0	0	0	0	170,000	171,584	**639,725**
TOTAL, IHS	**4,434,515**	**4,642,381**	**7,715**	**11,690**	**19,405**	**71,150**	**56,726**	**147,282**	**17,806**	**10,000**	**25,517**	**10,000**	**25,000**	**55,000**	**170,000**	**313,323**	**5,102,985**

INDIAN HEALTH SERVICE
STAFFING AND OPERATING COSTS
FOR NEWLY-CONSTRUCTED HEALTHCARE FACILITIES -- Estimates
FY 2016 Budget Request
(Dollars in Thousands)

Jan 8, 2014

	Hemet, CA Southern California Youth Treatment Center		Choctaw, MS Choctaw Alternative Rural Healthcare Center (JV)		Winterhaven, CA Ft. Yuma Health Center (Replacement)		TOTAL	
Sub Sub Activity	FTE	Amount	Pos	Amount	FTE	Amount	**FTE/Pos**	**AMOUNT**
Hospitals & Health Clinics	0	$0	73	$7,609	16	$1,678	89	$9,287
Dental Health	0	$0	15	$1,504	2	$204	17	$1,708
Mental Health	0	$0	3	$339	1	$94	4	$433
Alcohol & Substance Abuse	32	$2,888	1	$102	0	$0	33	$2,990
Purchased/Referred Care	0	$0		$0	0	$1,208	0	$1,208
Total, Clinical Services	32	$2,888	92	$9,554	19	$3,184	143	$15,626
Public Health Nursing	0	$0	3	$378	1	$122	4	$500
Health Education	0	$0	1	$96	0	$0	1	$96
Total, Preventive Health	0	$0	4	$474	1	$122	5	$596
Total, Services	32	$2,888	96	$10,028	20	$3,306	148	$16,222
Facilities Support	3	$311	4	$930	1	$203	8	$1,444
Environmental Health Support	0	$0	0	$0	1	$140	1	$140
Total, FEHS	3	$311	4	$930	2	$343	9	$1,584
Total, Facilities	3	$311	4	$930	2	$343	9	$1,584
Grand Total [1]	**35**	**$3,199**	**100**	**$10,958**	**22**	**$3,649**	**157**	**$17,806**

[1] Includes utilities

Above data reflect **estimates** for new facilities anticipated to open in FY 2015 and 2016.

Statement of Personnel Resources
INDIAN HEALTH SERVICE

	FY 2014 Final	FY 2015 Enacted	FY 2016 Request
Direct:			
Hospitals & Health Clinics	6,232	6,557	6,573
Dental Health	633	701	703
Mental Health	196	222	223
Alcohol & Substance Abuse	176	224	256
Purchased/Referred Care	0	0	0
Total, Clinical Services	7,237	7,704	7,755
Public Health Nursing	190	223	224
Health Education	34	42	42
Community Health Reps	9	9	9
Immunization, AK	0	0	0
Total, Preventive Health	233	274	275
Urban Health	5	5	5
Indian Health Professions	19	19	19
Tribal Management	0	0	0
Direct Operations	268	268	268
Self Governance	13	13	13
Contract Support Costs	0	0	0
Total, SERVICES	7,775	8,283	8,335
Maint. & Improvement	0	0	0
Sanitation Facilities	161	161	161
Hlth Care Facs Construction	0	0	0
Facil. & Envir. Hlth Support	1,007	1,058	1,063
Equipment	0	0	0
Total, FACILITIES	1,168	1,219	1,224
Total, Direct FTE	8,943	9,502	9,559
Reimbursable:			
Buybacks	1,230	1,230	1,230
Medicare	813	813	813
Medicaid	3,662	3,662	3,662
Private Insurance	544	544	544
Quarters	29	29	29
Total, Reimbursable FTE	6,278	6,278	6,278
Trust Funds (Gift)	23	23	23
Health Reform non -add:	0	0	0
TOTAL FTE	**15,244**	**15,803**	**15,860**
Total, Civilian FTE	**13,163**	**13,722**	**13,779**
Total, Military FTE	**2,081**	**2,081**	**2,081**

FY 2014 Crosswalk
Budget Authority
Final Distribution
(Dollars in Thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								FY 2014 Final
	Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES																	
Hospitals & Health Clinics	710,975	0	0	0	0	0	0	710,975	1,062,956	0	0	0	0	0	0	1,062,956	1,773,931
Dental Health	57,326	0	0	0	0	0	0	57,326	107,934	0	0	0	0	0	0	107,934	165,260
Mental Health	23,170	0	0	0	0	0	0	23,170	54,810	0	0	0	0	0	0	54,810	77,980
Alcohol & Substance Abuse	36,339	0	0	0	0	0	0	36,339	150,039	0	0	0	0	0	0	150,039	186,378
Purchased/Referred Care	310,313	0	0	0	0	0	0	310,313	568,262	0	0	0	0	0	0	568,262	878,575
Subtotal (CS)	1,138,123	0	0	0	0	0	0	1,138,123	1,944,001	0	0	0	0	0	0	1,944,001	3,082,124
Public Health Nursing	0	0	21,516	0	0	0	0	21,516	0	49,313	0	0	0	0	0	49,313	70,829
Health Education	0	0	3,299	0	0	0	0	3,299	0	13,627	0	0	0	0	0	13,627	16,926
Community Health Repr.	0	0	4,117	0	0	0	0	4,117	0	53,778	0	0	0	0	0	53,778	57,895
Immunization AK	0	0	0	0	0	0	0	0	0	1,826	0	0	0	0	0	1,826	1,826
Subtotal (PH)	0	0	28,932	0	0	0	0	28,932	0	118,544	0	0	0	0	0	118,544	147,476
Urban Health Project	0	15,911	0	0	0	0	0	15,911	0	0	24,818	0	0	0	0	24,818	40,729
Indian Health Professions	0	0	0	28,466	0	0	0	28,466	0	0	0	0	0	0	0	0	28,466
Tribal Management	0	0	0	143	0	0	0	143	0	0	0	1,299	0	0	0	1,299	1,442
Direct Operations	0	0	0	0	46,971	0	0	46,971	0	0	0	18,923	0	0	0	18,923	65,894
Self-Governance	0	0	0	0	0	2,654	0	2,654	0	0	0	0	1,573	0	0	1,573	4,227
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	612,484	0	612,484	612,484
Subtotal (OS)	0	15,911	0	28,609	46,971	2,654	0	94,145	0	0	24,818	20,222	1,573	612,484	0	659,097	753,242
Total, Services	1,138,123	15,911	28,932	28,609	46,971	2,654	0	1,261,200	1,944,001	118,544	24,818	20,222	1,573	612,484	0	2,721,642	3,982,842
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	23,702	23,702	0	0	0	0	0	0	29,912	29,912	53,614
Sanitation Facilities Constr.	0	0	0	0	0	0	27,798	27,798	0	0	0	0	0	0	51,625	51,625	79,423
Health Care Facs. Constr.	0	0	0	0	0	0	72,548	72,548	0	0	0	0	0	0	12,500	12,500	85,048
Facs. & Env. Health Sup	0	0	0	0	0	0	96,323	96,323	0	0	0	0	0	0	114,728	114,728	211,051
Equipment	0	0	0	0	0	0	7,712	7,712	0	0	0	0	0	0	14,825	14,825	22,537
Total, Facilities	0	0	0	0	0	0	228,083	228,083	0	0	0	0	0	0	223,590	223,590	451,673
TOTAL, IHS	1,138,123	15,911	28,932	28,609	46,971	2,654	228,083	1,489,282	1,944,001	118,544	24,818	20,222	1,573	612,484	223,590	2,945,233	4,434,515
% Federal Health Admin.								33.6%									
% Tribal and Urban Health Admin.																	66.4%

FY 2015 Crosswalk
Budget Authority
Estimated Distribution
(Dollars in Thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								FY 2015 Enacted
	Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES																	
Hospitals & Health Clinics	725,644	0	0	0	0	0	0	725,644	1,111,145	0	0	0	0	0	0	1,111,145	1,836,789
Dental Health	57,356	0	0	0	0	0	0	57,356	116,626	0	0	0	0	0	0	116,626	173,982
Mental Health	23,170	0	0	0	0	0	0	23,170	57,975	0	0	0	0	0	0	57,975	81,145
Alcohol & Substance Abuse	36,339	0	0	0	0	0	0	36,339	154,642	0	0	0	0	0	0	154,642	190,981
Purchased/Referred Care	324,120	0	0	0	0	0	0	324,120	590,019	0	0	0	0	0	0	590,019	914,139
Subtotal (CS)	1,166,629	0	0	0	0	0	0	1,166,629	2,030,407	0	0	0	0	0	0	2,030,407	3,197,036
Public Health Nursing	0	0	21,596	0	0	0	0	21,596	0	54,044	0	0	0	0	0	54,044	75,640
Health Education	0	0	3,374	0	0	0	0	3,374	0	14,652	0	0	0	0	0	14,652	18,026
Community Health Repr.	0	0	4,567	0	0	0	0	4,567	0	53,902	0	0	0	0	0	53,902	58,469
Immunization AK	0	0	0	0	0	0	0	0	0	1,826	0	0	0	0	0	1,826	1,826
Subtotal (PH)	0	0	29,537	0	0	0	0	29,537	0	124,424	0	0	0	0	0	124,424	153,961
Urban Health Project	0	16,877	0	0	0	0	0	16,877	0	0	26,727	0	0	0	0	26,727	43,604
Indian Health Professions	0	0	0	48,342	0	0	0	48,342	0	0	0	0	0	0	0	0	48,342
Tribal Management	0	0	0	143	0	0	0	143	0	0	0	2,299	0	0	0	2,299	2,442
Direct Operations	0	0	0	0	48,971	0	0	48,971	0	0	0	19,094	0	0	0	19,094	68,065
Self-Governance	0	0	0	0	0	3,154	0	3,154	0	0	0	0	2,573	0	0	2,573	5,727
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	662,970	0	662,970	662,970
Subtotal (OS)	0	16,877	0	48,485	48,971	3,154	0	117,487	0	0	26,727	21,393	2,573	662,970	0	713,663	831,150
Total, Services	1,166,629	16,877	29,537	48,485	48,971	3,154	0	1,313,653	2,030,407	124,424	26,727	21,393	2,573	662,970	0	2,868,494	4,182,147
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	23,702	23,702	0	0	0	0	0	0	29,912	29,912	53,614
Sanitation Facilities Constr.	0	0	0	0	0	0	27,798	27,798	0	0	0	0	0	0	51,625	51,625	79,423
Health Care Facs. Constr.	0	0	0	0	0	0	82,322	82,322	0	0	0	0	0	0	2,726	2,726	85,048
Facs. & Env. Health Sup	0	0	0	0	0	0	96,323	96,323	0	0	0	0	0	0	123,289	123,289	219,612
Equipment	0	0	0	0	0	0	7,712	7,712	0	0	0	0	0	0	14,825	14,825	22,537
Total, Facilities	0	0	0	0	0	0	237,857	237,857	0	0	0	0	0	0	222,377	222,377	460,234
TOTAL, IHS	1,166,629	16,877	29,537	48,485	48,971	3,154	237,857	1,551,509	2,030,407	124,424	26,727	21,393	2,573	662,970	222,377	3,090,872	4,642,381
% Federal Health Admin.								33.4%									
% Tribal and Urban Health Admin.																	66.6%

FY 2016 Crosswalk
Budget Authority
Estimated Distribution
(Dollars in Thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								FY 2016 PB
	Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES																	
Hospitals & Health Clinics	749,612	0	0	0	0	0	0	749,612	1,186,711	0	0	0	0	0	0	1,186,711	1,936,323
Dental Health	58,872	0	0	0	0	0	0	58,872	122,587	0	0	0	0	0	0	122,587	181,459
Mental Health	23,780	0	0	0	0	0	0	23,780	60,705	0	0	0	0	0	0	60,705	84,485
Alcohol & Substance Abuse	40,796	0	0	0	0	0	0	40,796	186,266	0	0	0	0	0	0	186,266	227,062
Purchased/Referred Care	349,551	0	0	0	0	0	0	349,551	634,924	0	0	0	0	0	0	634,924	984,475
Subtotal (CS)	1,222,611	0	0	0	0	0	0	1,222,611	2,191,193	0	0	0	0	0	0	2,191,193	3,413,804
Public Health Nursing	0	0	22,587	0	0	0	0	22,587	0	56,989	0	0	0	0	0	56,989	79,576
Health Education	0	0	3,526	0	0	0	0	3,526	0	15,610	0	0	0	0	0	15,610	19,136
Community Health Repr.	0	0	4,614	0	0	0	0	4,614	0	57,749	0	0	0	0	0	57,749	62,363
Immunization AK	0	0	0	0	0	0	0	0	0	1,950	0	0	0	0	0	1,950	1,950
Subtotal (PH)	0	0	30,726	0	0	0	0	30,726	0	132,299	0	0	0	0	0	132,299	163,025
Urban Health Project	0	16,877	0	0	0	0	0	16,877	0	0	26,727	0	0	0	0	26,727	43,604
Indian Health Professions	0	0	0	48,342	0	0	0	48,342	0	0	0	0	0	0	0	0	48,342
Tribal Management	0	0	0	143	0	0	0	143	0	0	0	2,299	0	0	0	2,299	2,442
Direct Operations	0	0	0	0	49,183	0	0	49,183	0	0	0	19,155	0	0	0	19,155	68,338
Self-Governance	0	0	0	0	0	3,162	0	3,162	0	0	0	0	2,573	0	0	2,573	5,735
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	717,970	0	717,970	717,970
Subtotal (OS)	0	16,877	0	48,485	49,183	3,162	0	117,707	0	0	26,727	21,454	2,573	717,970	0	768,724	886,431
Total, Services	1,222,611	16,877	30,726	48,485	49,183	3,162	0	1,371,043	2,191,193	132,299	26,727	21,454	2,573	717,970	0	3,092,217	4,463,260
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	38,296	38,296	0	0	0	0	0	0	50,801	50,801	89,097
Sanitation Facilities Constr.	0	0	0	0	0	0	40,298	40,298	0	0	0	0	0	0	74,840	74,840	115,138
Health Care Facs. Constr.	0	0	0	0	0	0	121,364	121,364	0	0	0	0	0	0	63,684	63,684	185,048
Facs. & Env. Health Sup	0	0	0	0	0	0	98,569	98,569	0	0	0	0	0	0	128,301	128,301	226,870
Equipment	0	0	0	0	0	0	7,994	7,994	0	0	0	0	0	0	15,578	15,578	23,572
Total, Facilities	0	0	0	0	0	0	306,521	306,521	0	0	0	0	0	0	333,203	333,203	639,725
TOTAL, IHS	1,222,611	16,877	30,726	48,485	49,183	3,162	306,521	1,677,565	2,191,193	132,299	26,727	21,454	2,573	717,970	333,203	3,425,420	5,102,985
% Federal Health Admin.								32.9%									
% Tribal and Urban Health Admin.																	67.1%

NCAI Analysis of the President's FY2016 Budget Request

Administration Releases FY 2016 Budget

This broadcast provides a preliminary analysis of the President's fiscal year (FY) 2016 budget request, highlighting impacts on funding for Indian programs. In the coming weeks, the President's budget will be reviewed by Congress, and appropriations committees will begin holding hearings on the proposals. Overall, tribes have a significant opportunity to increase appropriations for Indian programs this year, and we urge tribal leaders to support tribal budget requests with direct communication to the Appropriations Committee and Subcommittee leadership and members in both the House and Senate. While the Interior Appropriations Subcommittees remain important, we encourage tribes to send testimony on the Department of Justice budget, which is handled by the Commerce-Justice-Science and Related Agencies subcommittees in both chambers, the Health and Human Services (HHS) budget handled by the Labor-HHS-Education appropriations subcommittee, Housing and Urban Development budget in the Transportation-Housing subcommittees, and energy programs in the Energy-Water subcommittees, for instance. The Native American Programs hearing deadline to request to testify before the House Interior Appropriations Subcommittee is February 13, 2015. Look up deadlines to submit testimony on the House side at http://appropriations.house.gov/. The Senate will announce deadlines soon as well at http://www.appropriations.senate.gov/.

Overall Budget Request: The President released his FY 2016 budget on February 2, 2015. The Administration proposes to do away with the sequester established under the 2011 deficit law (PL 112-25) by reducing the deficit $1.8 trillion over the next 10 years, a request similar to ones made in previous budgets. The President's budget would increase discretionary spending in FY 2016 by seven percent, or $75 billion, split evenly between defense and non-defense programs; yet, adjusted for inflation, non-defense appropriations would be 11 percent below their FY 2010 level overall. The sequester will remain in effect for FY 2016 if Congress does not adhere to the defense and nondefense spending caps or pass a law to adjust the across-the-board cuts. The Administration's sequester replacement would cut mandatory and discretionary programs by $600 billion over 10 years, with about 70 percent of the savings coming from health overhaul proposals. Nearly $640 billion in new tax revenue would pay for the sequester replacement plan, including reducing benefits for high-income households and implementing the Buffett Rule, which would require that millionaires pay no less than 30 percent of income in taxes after accounting for charitable contributions.

Highlights of Proposed Funding for Tribal Programs: In preparation for the President's budget, some agencies consulted with tribes about programs in the budget, and many recommendations from Indian Country are included in the FY 2016 proposal. Below are a few highlights from NCAI's initial analysis of the President's budget. Additional department summaries are addressed below, as well as links to many of the agency budget documents for even more in-depth analysis. In January of this year, NCAI released its FY 2016 tribal budget recommendations, which can be compared to the Administration's budget proposals.

Significant proposals in the President's FY 2016 Budget include:

- **Mandatory Contract Support Costs**: The FY2016 budget includes a legislative proposal to reclassify contract support costs as permanent funding beginning in FY 2017. NCAI and tribes have called for this in resolutions across Indian Country and in NCAI's tribal budget requests. The FY 2016 request also will fully fund contract support costs, based on the most recent BIA and IHS analysis.
- **Generation Indigenous** is an initiative in the budget to address Native youth Issues. The Generation Indigenous, or "Gen-I", initiative takes a comprehensive approach to help improve the lives of and opportunities for Native youth. The initiative crosses multiple agencies, including the Departments of the Interior, Education (ED), Housing and Urban Development (HUD), Health and Human Services (HHS), Agriculture (USDA), Labor (DOL) and Justice (DOJ). Increases include: (1) $34.2 million at DOI to extend broadband internet and computer access to all BIE-funded schools

and dormitories; (2) $10 million at HUD and $8 million at DOI to address teacher housing needs; (3) $50 million at HHS to provide youth-focused behavioral, mental health, and substance abuse services; and (4) $53 million for Native Youth Community Projects at ED to support comprehensive strategies to improve college and career-readiness of Native youth.

- **Significant Increases**: the budget proposes an overall an increase of **12 percent for BIA** over the FY 2015 enacted level, the largest increase in more than a decade (excluding Recovery Act funding). The **Indian Health Service** would receive a **nine percent increase**.
- Acknowledging the important role BIA plays as a broad provider of Federal services, the President's budget proposes $4.0 million to establish the **One-Stop Tribal Support Center** to support Tribes in accessing hundreds of services across the Federal government.
- The FY 2016 budget includes $4.5 million to establish an **Indian Energy Service Center** to facilitate vital energy development in Indian Country.
- In the BIA, **a data initiative** of $12.0 million is proposed to establish an Office of Indian Affairs Policy, Program Evaluation, and Data which will help the Interior Department collect, analyze, and use evidence to support effective policy making and program implementation. The funds also will assist the Department in working with Tribes to improve Interior and BIA data quality and availability and will support efforts with the Census Bureau to identify and address data gaps in Indian Country.
- The BIA budget builds on the **Tiwahe (Family) Initiative**: a comprehensive and integrated approach to address the inter-related problems of poverty, violence, and substance abuse faced by Indian communities. The FY16 budget would provide $15 million to expand the Tiwahe Initiative, $6 million more for Social Services, $4 million more for law enforcement for alternatives to incarceration, and $5 million more for aid to tribal family courts.
- **Public Safety**: The budget includes $417.4 million for the Department of Justice (DOJ) public safety initiatives in Indian Country, which is a $102 million increase compared to the FY 2015 DOJ enacted total for Indian Country.
- **Tax provisions**: Treasury includes a proposal to exclude from income **student loan forgiveness and certain scholarship amounts** for participation in the IHS health professions program; a modification of the **adoption tax credit** to allow Indian Tribal Governments to make a status determination of a "child with special needs"; modifications of **Tax Exempt Bonds for Indian Tribal Governments** that include the repeal of the "essential government function" for tax exempt bond financing on par with state and local governments, and new flexibility in project location for those financed by Tribal Economic Development Bonds.
- **Carcieri**: Language to provide a no-cost economic development and jobs creation solution for restoring land to tribal governments impacted by the *Carcieri* Supreme Court decision is again included in the Department of Interior general provisions of the President's budget.

The White House has also released a fact sheet on tribal programs in the FY 2016 budget, "Standing With Indian Country." NCAI will work to ensure that the federal programs that fulfill the trust responsibility to tribes receive bipartisan support in the appropriations process.

Contents

BIA Construction

	2014 Actual	2015 Enacted	2016 Request	Change	%
Education Construction	55,285	74,501	133,245	58,744	78.8%
Public Safety and Justice Construction	11,306	11,306	11,306	0	0.0%
Resources Management Construction	32,759	34,427	34,488	61	0.2%
Other Program Construction	10,774	8,642	9,934	1,292	15.0%
TOTAL APPROPRIATION	110,124	128,876	188,973	60,097	46.6%

For more information, visit: http://www.doi.gov/budget/appropriations/2016/index.cfm

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

The Indian Health Service budget (IHS) request for FY 2016 of $5.103 billion in budget authority is an increase of $460.6 million (9.9 percent) above the FY 2015 enacted level. The FY 2016 Budget requests $6.4 billion for the Indian Health Service (IHS), an increase of $486 million (8 percent) above FY 2015 and 49 percent above FY 2008. The FY 2016 budget includes an increased investment for the Purchased/Referred Care Program to cover increases in health care services costs due to medical inflation, population growth, and pay costs; provides funding for staffing and operating costs for new and replacement tribal and IHS health care facilities; proposes significant investments in IHS health care facilities; includes an increase for Health Information Technology to help modernize IHS systems; and includes funding to help improve collections from public and private insurance at IHS and tribally operated facilities.

The funding increases include **Current Services**: $147.3 million to fully fund medical inflation, pay raises and partially fund population growth.

- **Medical Inflation**: +$71.2 million
- **Population Growth**: +$56.7 million
- **Pay Costs**: +$19.4 million Increases for current services are needed annually to maintain service levels.

Program Increases: +$313.3 million to fund priority programs.

- **Staffing/Operating Costs** for Newly-Constructed Healthcare Facilities and Youth Regional Treatment Centers: +$17.8 million
- **Purchased/Referred Care** (PRC): +$25.5 million, in addition to $43.6 million in PRC medical inflation and $1.2 million for staffing/operating costs (total PRC increase of $70.3 million)
- **Hospital & Health Clinics**
  - Improvements in Third Party Collections: +$10.0 million
  - Health Information Technology (under H&HC): +$10.0 million
- **Tribal Behavioral Health** for Native Youth as part of the **Generation Indigenous** (under Alcohol/Substance Abuse): $25 million
- **Contract Support Costs**: +$55.0 million to fund the estimated CSC need for new and expanded contracts and compacts.
- **Maintenance and Improvement**: +$35.0 million to address critical maintenance backlog of approximately $467 million.
- **Sanitation Facilities Construction**: +$35.0 million to address sanitation deficiencies and construct sanitation projects; provide sanitation facilities to approximately 7,200 Indian homes and reduce the backlog of sanitation deficiencies of feasible projects totaling $1.93 billion.
- **Health Care Facilities Construction**: +$100.0 million for a total funding level of $185 million.
  - Gila River Southeast Health Center, Chandler, AZ to complete construction.
  - Salt River Northeast Health Center, Scottsdale, AZ to design and begin construction.
  - Rapid City Health Center, Rapid City, SD to design and begin construction.
  - New Dilkon Alternative Rural Health Center, Dilkon, AZ to design and construct the infrastructure.

Contract Support Costs: The Budget fully funds the estimated need for Contract Support Costs (CSC) at $718 million, an increase of $55 million above FY 2015. The estimated increase includes funding for new and expanded contracts and compacts. The Budget also requests that CSC be reclassified to a mandatory appropriation beginning in FY 2017.

IHS Dollars in Thousands	FY14 Enacted	FY15 Enacted	FY16 Pres. Bud	16-'15
Services				
Hospitals & Health Clinics	1,773,931	1,836,789	1,936,323	99,534
Dental Services	165,260	173,982	181,459	7,477
Mental Health	77,980	81,145	84,485	3,340
Alcohol & Substance Abuse	186,378	190,981	227,062	36,081
Purchased/Referred Care	878,575	914,139	984,475	70,336
Total, Clinical Services	3,082,124	3,197,036	3,413,804	216,768
Public Health Nursing	70,829	75,640	79,576	3,936
Health Education	16,926	18,026	19,136	1,110
Community Health Representatives	57,895	58,469	62,363	3,894
Immunization AK	1,826	1,826	1,950	124
Total, Preventive Health	147,476	153,961	163,025	9,064
Urban Health	40,729	43,604	43,604	0
Indian Health Professions	28,466	48,342	48,342	0
Tribal Management Grants	1,442	2,442	2,442	0
Direct Operations	65,894	68,065	68,338	273
Self-Governance	4,227	5,727	5,735	8
Contract Support Costs	612,484	662,970	717,970	55,000
Total, Other Services	753,242	831,150	886,431	55,281
TOTAL, SERVICES	3,982,842	4,182,147	4,463,260	281,113
FACILITIES				
Maintenance & Improvement	53,614	53,614	89,097	35,483
Sanitation Facilities Construction	79,423	79,423	115,138	35,715
Health Care Facilities Construction	85,048	85,048	185,048	100,000
Facilities & Environmental Health Support	211,051	219,612	226,870	7,258
Equipment	22,537	22,537	23,572	1,035
TOTAL, FACILITIES1	451,673	460,234	639,725	179,491
TOTAL, BUDGET AUTHORITY	**4,434,515**	**4,642,381**	**5,102,985**	**460,604**
Collections/Mandatory				
Medicare	225,165	226,338	226,338	0
Medicaid	737,744	771,179	781,179	10,000
Subtotal, M / M	962,909	997,517	1,007,517	10,000
Private Insurance	90,246	90,303	95,303	5,000
VA Reimbursement2	6,622	18,244	28,062	9,818
Total, M / M / PI	1,059,777	1,106,064	1,130,882	24,818
Quarters	8,000	8,000	8,500	500
TOTAL, COLLECTIONS	1,067,777	1,114,064	1,139,382	25,318
Special Diabetes Program for Indians	147,000	150,000	150,000	0
TOTAL, MANDATORY	147,000	150,000	150,000	0
TOTAL, PROGRAM LEVEL	**5,649,292**	**5,906,445**	**6,392,367**	**485,922**

[1] The facilities scheduled to be constructed in FY 2016 include the Gila River Southeast Health Center, Salt River Northeast Health Center, Rapid City Health Center, and Dilkon Alternative Rural Health Center, depending on the availability of funding and construction schedules.
[2] Estimates are revised from the FY 2015 PB.
[3] P.L. 113-235, Continuing and Consolidated Appropriations Act, 2015 signed December 16, 2014.

For more information, see the IHS Congressional Justification at http://www.ihs.gov/budgetformulation/includes/themes/newihstheme/documents/FY2016CongressionalJustification.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA)

The FY 2016 Budget Request includes a new braided program, **Tribal Behavioral Health Grants**, which draw on funds from the Mental Health and Substance Abuse Prevention appropriations. As a braided program, SAMHSA will track this activity through the distinct appropriations and any amounts spent or awarded and will only be used for purposes consistent with legislative direction and intent of the appropriation. The braided program, Tribal Behavioral Health Grants, is described below.

Tribal Behavioral Health Grants (increase of $25.0 million)
The FY 2016 Budget Request for the Tribal Behavioral Health Grant (TBHG) program is $30 million, including $15 million in the Mental Health appropriation and $15 million in the Substance Abuse Prevention appropriation. The request provides an increase over the FY 2015 enacted level of $10 million in the Mental Health appropriation and $15 million for a newly established line in the Substance Abuse Prevention appropriation. This funding is part of **Generation Indigenous**. This funding will allow SAMHSA to expand activities that are critical to preventing substance abuse and promoting mental health and resiliency among youth in tribal communities. The additional funding will expand these activities to approximately 103 additional tribes and tribal entities. With the expansion of the TBHG program, SAMHSA aims to reduce substance use and the incidence of suicide attempts among Native youth and to address behavioral health conditions which impact learning in Bureau of Indian Education-funded schools. The TBHG program will support mental health promotion and substance use prevention activities for high-risk Native youth and their families, enhance early detection of mental and substance use disorders among Native youth, and increase referral to treatment.

In FY 2014, Congress appropriated $5 million in the Mental Health appropriation to SAMHSA to address the high incidence of substance abuse and suicide among AI/AN populations. The Appropriations Committee recommended that HHS award 20 competitive grants to tribal entities with the highest rates of suicide for effective and promising strategies that address substance abuse and suicide and promote mental health among AI/AN young people.

Programs of Regional and National Significance

(Dollars in millions)	FY2014	FY2015	FY2016	Change from 2015
Suicide Prevention				
Mental Health Appropriation				
AI/AN Suicide Prevention Initiative	2.9	2.9	2.9	0
Tribal Behavioral Health Grants	4.9	4.9	15	10
Substance Abuse Prevention Appropriation				
Tribal Behavioral Health Grants	--	--	15	15

For more information on the SAMHSA budget, visit http://www.samhsa.gov/sites/default/files/samhsa-fy2016-congressional-justification.pdf

Administration for Community Living

(Dollars in millions)	FY2014	FY2015	FY2016	Change from 2015
Health and Independence				
Native American Nutrition & Supportive Services	26	26	29	+3
Caregiver Services				
Native American Caregiver Support Services	6	6	7	+1

For more information, visit http://acl.gov/About_ACL/Budget/docs/FY_2016_ACL_CJ.pdf

Administration for Children and Families (ACF)

Early Head Start: The Budget requests an increase of $150 million above FY 2015, to support and expand Early Head Start – Child Care Partnerships. Further expansion of these Partnerships is supported by the Budget which will provide funding to Early Head Start programs to expand and work with child care providers in an effort to provide high-quality, full-day services for tens of thousands of children.

Head Start: The FY 2016 request includes an additional $1.5 billion above FY 2015 to strengthen services for children by Head Start.

(Dollars in millions)	FY2014	FY2015	FY2016	Change from 2015
Head Start	8,598	8,598	10,118	1,520
Child Care & Development Block Grant (discretionary)	2,358	2,435	2,805	370
Child Welfare Programs	345	335	338	4
Chafee Education & Training for Foster Youth	43	43	43	--
Family Violence Prevention	138	140	162	23
Adoption Incentives	38	38	38	--
Runaway and Homeless Youth Programs	114	114	123	9
Child Abuse Prevention	93	94	114	20
Promoting Safe and Stable Families (discretionary)	60	60	90	30
LIHEAP	3,390	3,390	3,190	-200
LIHEAP Contingency Fund	--	--	--	--
Energy Assistance Innovation Fund	--	--	200	200
ANA	47	47	50	3

For more information on the HHS budget request, visit http://www.hhs.gov/budget/fy2016/fy-2016-budget-in-brief.pdf.

TAB 7: CSC WORKGROUP

Southcentral Foundation

February 27, 2015

Lynn Malerba, Chairwoman
IHS Tribal Self-Governance Advisory Committee
c/o Self-Governance Communication and Education
P.O. Box 1734
McAlester, OK 74501

Re: CSC associated with MSPI and DVPI awards

Dear Chairwoman Malerba,

Southcentral Foundation (SCF) writes to request TSGAC's assistance in raising an issue that is critically important for self-governance Tribes: the right to additional contract support cost (CSC) funding associated with the funds provided by IHS for the Methamphetamine and Suicide Prevention Initiative (MSPI) and Domestic Violence Prevention Initiative (DVPI) programs. We believe the agency's approach to this issue in prior years and its recent assertions that these programs are not eligible for CSC funding are concerning and undermine the goals of self-governance.

I. Background.

Congress first appropriated funds for the MSPI in 2008, and first appropriated DVPI funds in 2009. Congress directed that both of these funds "shall be allocated at the discretion of the Director of the Indian Health Service." The point of that phrase was to ensure these funds would go to the areas that needed them the most. Dr. Roubideaux echoes this sentiment in her recent "Dear Tribal Leader Letter," stating "[t]he goal of MSPI and DVPI was to ensure that the limited funding available goes to those with the greatest need." IHS distributed these funds to contracting and compacting Tribes and tribal organizations through amendments to each Tribe's annual funding agreement. These amendments always occurred late in the fiscal year after the agency had already spent its entire CSC appropriation. Therefore, the agency agreed to recognize the Tribe's CSC need associated with these programs, although it could not provide additional CSC funding at the time the amendments were issued.

TSGAC was concerned with this situation and former TSGAC Chairman Jefferson Keel wrote directly to Dr. Roubideaux in 2009, asking her to adjust the MSPI funding timeline and to provide full CSC associated with these program funds. Dr. Roubideaux responded with a letter of her own, stating "[t]he language required for the MSPI awards is the same language IHS requires for other new and expanded programs." (Emphasis added.) In other words, Dr. Roubideaux agreed these program funds were just as eligible for CSC funding support as are any other new or expanded program funds. But Dr. Roubideaux also noted the practical problem posed by the fact that the capped

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appropriation had already been spent. She said "However, in the case of the MSPI, additional contract support cost (CSC) funds were not available because the IHS had allocated all available CSC funds to existing Tribal contracts and compacts." To be clear, the only reason Dr. Roubideaux gave for not providing more CSC funding involved the statutory cap on CSC, and that all the capped funds had already been spent. Dr. Roubideaux assured then-Chairman Keel that the "MSPI CSC need will be included in the annual CSC Shortfall Report to Congress."

As time passed—but without any consultation with TSGAC—the agency made an about face and developed a new theory that no CSC funding was due. The agency took the position that because these programs were special initiatives they were not covered by the ISDA and therefore were not eligible for any additional CSC funding. Eventually, SCF litigated the issue to establish that these funds were definitely covered by the ISDA, and to force the agency to accept that our CSC need associated with these programs went beyond the amounts specified in our program budgets.

II. IHS's Request for Comments

Dr. Roubideaux recently issued a "Dear Tribal Leader Letter," requesting input on all aspects of the MSPI and DVPI programs. One portion of the letter requests comments on the funding mechanisms used to distribute these funds. The letter again proclaims that "[b]ecause these are special initiatives, they are not funded through the 'Secretarial amount' which comprises funding for recurring [PSFAs]." Based upon this flawed premise, Dr. Roubideaux now concludes that these funds are not entitled to CSC funding. This is, of course, 180 degrees contrary to what Dr. Roubideaux wrote to Chairman Keel in 2009.

Why is this approach problematic?

First, it is contrary to the commitments Director Roubideaux made to the TSGAC.

Second, it is contrary to the ISDA. As self-governance Tribes we have a statutory right to receive program funds and an additional award for CSC. 25 U.S.C. § 450j-1(a). Nowhere does the ISDA limit CSC funding to recurring PSFAs. Nowhere does the ISDA exempt special initiative funding from the CSC mandate. Nowhere does the ISDA grant the Secretary discretion to decide which funds are "Secretarial amount" funds and which funds do not fall in that category.

Third, this is a dangerous precedent. By IHS's new reckoning, the agency could easily eliminate CSC funding for all new programs and for all nonrecurring programs. Just as Tribes have voiced concern that the BIA is seeking to convert new programs into "grants.gov" programs exempt from the CSC mandate, self-governance Tribes should be concerned with IHS's attempt to do the same with MSPI/DVPI funds. Again, if IHS succeeds in establishing that these "special initiatives" are exempt from the ISDA's funding provisions, it can easily extend that interpretation to many other types of funds.

IHS is on thin ice. No doubt for that reason, last year IHS required that Tribes waive their statutory CSC rights as a condition to getting MSPI/DVPI funding—something that is absolutely antithetical to the entire principle of tribal self-governance.

IHS has clearly gone back on its 2009 commitment to the self-governance Tribes. It must be held accountable. Now that we are in an era of full funding, IHS should be compelled to pay our full CSC needs required to carry out our MSPI and DVPI programs.

III. Conclusion.

IHS's shift in the management of MSPI and DVPI programs is deeply concerning. We encourage TSGAC to raise this issue with the agency and convey to IHS that controlling law requires payment of CSC funds on these critically needed program funds.

Sincerely,

Lee Olson
Vice President of Finance