MEMORANDUM

DATE: October 28, 2016

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

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

RE: Weekly NPAIHB "*News and Information*"

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

NPAIHB Delegates, Tribal Health Directors, Tribal Chairs and Interested Parties

- NPAIHB Quarterly Board Meeting, January 17-19, 2017, Centralia, Washington
- Job Announcement – Dental Health Aide Therapist Coordinator/Program Assistant, Confederated Tribes of Coos, Lower Umpqua, Siuslaw, Coos Bay, Oregon

NPAIHB Delegates, Tribal Health Directors

- Update announcement – Indian Health Service (IHS) updated Contract Support Costs (CSC) policy
- Follow-up to the QBM – Upcoming October comment deadlines
- TEMPLATE – *RIN 0905AC97: Comments on Proposed Rule: Catastrophic Health Emergency Fund: Published on January 26, 2016 (81 Federal Register 4239, et seq.)*
- TEMPLATE – *IHS Expansion of Community Health Aide Program Draft Policy Statement Consultation*
- TEMPLATE – *Comments on Purchasing Health Care Coverage (IHS Circular 2016-08)*
- Seeking Nominations – The Office on Violence Against Women (OVW), membership for the Task Force on Research on Violence Against American Indian and Alaska Native Women.
- Good Health and Wellness in Indian Country Tribal Resource Digest, Issue no. 92

Oregon Tribal Health Directors, NPAIHB Delegates, Tribal Chairs

- Save the Date – BUDGET FORMULATION FY19 MEETING, November 29, 2016, Portland, Oregon

Idaho Tribal Health Directors, NPAIHB Delegates, Tribal Chairs

- Notice – Idaho Medicaid intends to submit a State amendments to reflect changes to the Medicare-Medicaid Coordinated Plan

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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

QUARTERLY BOARD MEETING

January 17-19, 2017

Hosted by the Chehalis Tribe at

GREAT WOLF LODGE

20500 Old Highway 99 SW
Centralia WA 98531

Reservations: 1.866.941-9653

Rooms are blocked under the group name of **"1701NPAIHB"**. Hotel rooms are $109 plus tax and resort fees. Each individual guest must make their own reservations by calling the toll-free Central Reservations Department at **1-866-941-9653** by **Saturday December 17, 2016,** to receive the group rate. Reservations received after this date will be accepted on a space available basis and at the regular room rate. If you have any questions, please contact Lisa Griggs, Executive Administrative Assistant at (503) 416-3269 or email lgriggs@npaihb.org

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Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians

1245 Fulton Avenue, Coos Bay, OR 97420. Toll Free: 1-888-280-0726

Dental Health Aide Therapist Coordinator/Program Assistant

Job Tracking ID: 512409-550632
Job Level: Entry Level (less than 2 years)
Date Updated: October 04, 2016
Starting Date: ASAP
Job Type: Full Time
Job Location: Coos Bay, OR
Level of Education: 2 year degree
Years of Experience: 2 - 5 Years
Close Date: Until Filled
Starting Salary: $16.16/hour, DOE

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Job Description:

SUMMARY

This position is a dual role of DHAT Coordinator and Program Assistant for the CTCLUSI Dental Clinic. The DHAT Coordinator will work under the direct supervision of the Health & Human Services Director and in collaboration with the NPAIHB (Northwest Portland Area Indian Health Board) Dental Health Project Director and Project Assistant to implement the pilot program initiatives.

PRINCIPAL ACTIVITIES & RESPONSIBILITIES

- Assist Health & Human Services Director in managing sub-grant activities to develop pilot project activities at the CTCLUSI Dental Clinic.
- With oversight from the HHS Director, assists in managing and carrying out the project work plan including working with consultants and Tribal staff to ensure project milestones are met.
- Assists HHS Director and NPAIHB staff in managing and coordinating communications plan for Tribal staff, Tribal members, Clinic patients, and local and state communities.
- Develops materials, brochures, newsletter articles, and other relevant media to educate Tribal members and Clinic patients about the role of the DHAT as a member of the oral health team.
- Monitors implementation of the Oral Health Pilot Project at CTCLUSI Dental Clinic.
- Advocates for dental health coverage and access for American Indian/Alaska Native populations in the state of Oregon with particular focus on addressing oral health disparities and increasing access to dental care.
- Collaborates with partners in the Pilot Project, including consultants, government agencies, the local/state dental community and NPAIHB to implement state oral health policies.
- Provides administrative support to the HHS Director and the Dentist related to operation of the CTCLUSI Dental Clinic.
- Provides support and assistance to CTCLUSI Dental Clinic patients in accessing insurance/financial aid

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for dental needs, either through the Oregon Health Plan, the Marketplace, or other applicable programs.
- Maintain appearance standards as outlined in CTCLUSI policies.
- Must be able to interact with Tribal members and the general public in a courteous, professional, and efficient manner.
- Provide excellent customer service to clients and vendors of the CTCLUSI Dental Clinic.
- Communicate effectively both verbally and in writing.
- Maintain a good attendance record.
- Other duties as directed by management.

PHYSICAL & MENTAL DEMANDS

- Must be able to walk, talk, hear, use hands to handle, feel or operate objects, tools, or controls, and reach with hands and arms.
- Vision abilities required by this job include close vision and the ability to adjust focus.
- May be required to push, pull, lift, and/or carry up to 40 pounds.
- Must be willing and able to travel both locally and within the CTCLUSI service delivery area.

WORKING CONDITIONS & ENVIRONMENT

- Moderate noise level with frequent interruptions and distractions.
- Some travel (local, in-state and national) is required.

HOURS

- 40 hours per week.
- Generally Monday through Friday 8am to 5pm with possible occasional evening and weekend work.

JOB LOCATION

Tribal Administrative Office

1245 Fulton Avenue

Coos Bay, Oregon 97420

Experience and Skills:

MINIMUM JOB REQUIREMENTS

- Must be at least 18 years of age.
- An Associate's Degree in health/dental administration or a closely related field is preferred; however, 2 years of work experience as a medical/dental biller or receptionist may be accepted in lieu of degree; working knowledge of dentistry and oral health issues is preferred.
- Must obtain certification as a Certified Application Assistor as soon as training is available after hire.
- Valid Oregon driver's license, adequate transportation, and eligibility to operate GSA vehicles is required.
- Must demonstrate ability to communicate effectively with patients and staff.
- Must possess above-average writing and communications skills.
- Must demonstrate proficiency in computers, including MS Word, Excel, Access, Outlook, Publisher and PowerPoint.
- Must possess reasonable ability to communicate in English.
- This position is subject to pre-employment drug testing.
- This is a covered position which requires background check that includes fingerprinting.
- Must have employment eligibility in the U.S.
- Indian preference will be observed in the hiring process.

Apply Now

If you are having difficulties with the application process, please click here.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville, MD 20857

OCT 27 2016

Dear Tribal Leader:

Today I am pleased to announce that the Indian Health Service (IHS) has updated its Contract Support Costs (CSC) policy. It has been 10 years since the last CSC policy update. I want to extend my thanks and gratitude to Tribal Leaders and the CSC Workgroup for the hard work and collaboration that helped make this happen.

As part of this exciting news, I also want to inform you that the IHS will apply the medical inflation rate to calculate estimated annual increases to ongoing direct CSC. This provides Tribes with additional access to resources. This is a major accomplishment and has been a high priority for the IHS and for Tribes.

Another significant change I want to point out in the updated CSC policy relates to an option available to Tribes to reconcile and determine the full, final CSC expenditures within 90 days of the end of the annual performance period. In addition, the policy includes new tools, such as the CSC Negotiation Template, which provides a way to calculate CSC consistently and in a transparent manner. These updates are consistent with changes to the CSC appropriation, which allows the IHS to fully fund CSC.

The CSC policy serves as a guide for the IHS and Tribes in the preparation, negotiation, determination, payment, and reconciliation of CSC funding used to support new, expanded, and ongoing services provided through compacts and contracts pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA).

In accordance with the ISDEAA, CSC are costs associated with administering the compacts and contracts through which Tribes assume responsibility for the operation of IHS programs, services, functions, or activities (or portions thereof). CSC are the reasonable costs for activities that Tribes must carry on to ensure compliance with the terms of the contract and prudent management, but that normally are not carried on by the IHS in its direct operation of the program or are provided by the IHS from resources other than those under contract.

The IHS publishes its CSC policy in the IHS *Indian Health Manual* at Part 6, Chapter 3. Copies of the updated CSC policy will be mailed out soon. You may access the policy on the IHS Web site at: https://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p6c3.

Again, I extend my sincere appreciation to the IHS CSC Workgroup for all their hard work and dedication. The CSC Workgroup will continue its work on addressing policy issues that you will find footnoted in the updated policy. The CSC Workgroup will reconvene after the New Year to continue their work.

If you have any questions, please contact Ms. Roselyn Tso, Acting Director, Office of Direct Service and Contracting Tribes, IHS, by telephone at (301) 443-1104 or by e-mail at roselyn.tso@ihs.gov.

Sincerely,

Mary Smith

Mary Smith
Principal Deputy Director

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As a follow-up to the QBM, below are the upcoming October comment deadlines with available comment template letters:

1. **Community Health Aide Program (CHAP) Expansion: Comment deadline is October 27, 2016**

   The Principal Deputy Director writes to Tribal Leaders to inform them that the period to comment on the Community Health Aide Program letter has been extended until October 27, 2016. [PDF - 25 KB]

   A template letter is attached to this email.

2. **Tribal Premium Sponsorship: Comment deadline is October 31, 2016**

   The Principal Deputy Director writes Tribal Leaders to provide an update to the July 18 letter regarding the draft Circular that addresses the purchase of health care coverage, which is commonly referred to as Tribal Premium Sponsorship. [PDF - 53 KB]
   Enclosure: Draft IHS Circular No. 2016-08 Tribal Premium Sponsorship [PDF - 53 KB]

   A template letter is attached to this email.

3. **Catastrophic Health Emergency Fund (CHEF): Comment deadline is October 31, 2016**

   The Principal Deputy Director writes Tribal Leaders to provide an update to the June 1, Tribal Leader Letter on the Proposed Rule for the Catastrophic Health Emergency Fund (CHEF). [PDF - 39 KB]

   A template letter is attached to this email.

4. **Draft Tribal Behavioral Health Agenda: Comment deadline is October 30, 2016**

Link to webpage with Tribal Behavioral Health Agenda and for comment submission: http://store.samhsa.gov/TBHA/feedback/

NOVEMBER COMMENT DEADLINES:

Template comment letters will be circulated on these two proposed policies next week:

1. **VA DTLL on September 12, 2016: Comment deadline is November 5, 2016**

Download Dear Tribal Leader Letter [PDF]
Download Federal Register Notice [PDF]
Fact Sheet [DOCX]

2. **IHS Re-alignment: Comment deadline is November 5, 2016**

The Principal Deputy Director writes to Tribal Leaders about a proposed realignment of IHS Headquarters offices and a 30-day comment period that is open for input. [PDF - 53 KB]

- Enclosure 1: Current IHS Headquarters Organization Chart [PDF - 92 KB]

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- Enclosure 1a: Federal Register Notice on Proposed Functional Statement from October 17, 2005 [PDF - 437 KB]
- Enclosure 1b: Federal Register Notice on Proposed Functional Statement from July 17, 2008 [PDF - 105 KB]
- Enclosure 1c: Federal Register Notice on Proposed Functional Statement from July 1, 2010 [PDF - 61 KB]
- Enclosure 2: Realignment Organization Chart - October 2016 [PDF - 107 KB]
- Enclosure 2a: Draft Functional Statement Headquarters Realignment 2016 [PDF - 271 KB]
- Enclosure 3: Interim IHS HQ Realignment Organization Chart - October 2016[PDF - 70 KB]

For any additional information on the above please feel free to contact Laura Platero, Government Affairs/Policy Director at NPAIHB via lplatero@npaihb.org or by phone at (503) 407-4082.

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Submitted at http://www.regulations.gov

October 26, 2016

Ms. Betty Gould, Regulations Officer
INDIAN HEALTH SERVICE
Office of Management Services
Division of Regulatory Affairs
5600 Fishers Lane
Mailstop 09E70
Rockville, MD 20857

Re: RIN 0905AC97: Comments on Proposed Rule: Catastrophic Health Emergency Fund: Published on January 26, 2016 (81 Federal Register 4239, et seq.)

Dear Ms. Gould:

Our Tribe, [insert Tribe], appreciates the opportunity to submit these comments on the Proposed Rule governing the Catastrophic Health Emergency Fund (CHEF), RIN 0905AC97, published at 81 Federal Register 4239 (Jan. 26, 2016).

[Many of tribes in our area have agreements with the Indian Health Service (IHS) under Title I or V of the Indian Self-Determination and Education Assistance Act (ISDEAA)]. For decades, tribes have directly operated their own health programs, offering primary care programs at the ambulatory clinics located on their reservations. Tribes also operate Purchased/Referred Care (PRC) programs through which the tribes purchase health care services that are otherwise not available to their patients at their respective tribal clinics. Based on patient eligibility for PRC, the tribes authorize PRC/CHS from certain specified providers, normally on referral, based on medical necessity, priority of need and funding availability for such services.

We have four major concerns about this Proposed Rule. First, the language proposed in Section 136.501 and the alternate resources provision in Section 136.506, which would include tribal sources of payment as alternate resources to CHEF, exceeds the Secretary's rulemaking authority to adopt regulations governing the CHEF program. Second, the Proposed Rule, by adding tribal sources of payment to the list of alternate resources, is a major departure from longstanding IHS policy. Third, the Proposed Rule does not establish any procedure for making a determination to award CHEF funds. Rather, the decision to award or not award CHEF funds in a particular case is left entirely to the IHS's discretion. Finally, we are concerned that IHS developed and published this rule without first consulting with tribes as required by Executive Order 13175 and Departmental policies, including those of the IHS. While tribal consultation has taken place since the proposed rule was issued, it should have taken place before changes in IHS policy were proposed.

Rulemaking Authority

The rulemaking authority for this Proposed Rule is provided to the Secretary of the Department of Health and Human Services under Section 202(d) of the Indian Health Care Improvement Act, 25 U.S.C. § 1621a(d). Subsection 202(d) requires the Secretary to promulgate regulations consistent with the provisions of Section 202(d) to, among other things:

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

The proposed definition of "alternate resources" in Section 136.501, and the proposed restriction on CHEF payment in Section 136.506, add the word "tribal" to the list of alternate resources in Section 202(d)(5). However, Subsection 202(d)(5) requires the Secretary to establish a procedure to ensure that the IHS makes no CHEF payment when the patient is eligible for a "Federal, State, local, or private source" of payment—the list does not include "tribal" sources of payment and thus Section 202(d)(5) does not give the Secretary the authority to include tribal sources of payment in this CHEF regulation.

In a recent case in the U.S. District Court for the District of Columbia, the court struck down a regulation issued by the Secretary because the regulation exceeded similarly limited Secretarial rulemaking authority under a different statutory scheme. *Pharm. Research and Mfg. v. Department of Health and Human Services, 43 F. Supp. 3d 28 (D.D.C. 2014)* (finding that the Secretary's rulemaking authority for the 340B drug discount program was restricted to three distinct matters that did not include adopting a regulation governing 340B discounts for orphan drugs, thus striking down the orphan drug regulation as exceeding the Secretary's specific rulemaking authority). Here, the Secretary's specific rulemaking authority to issue regulations regarding alternate resources to the CHEF does not include tribal sources of payment. There is no language in Section 202(d)(5) that gives the Secretary the authority to add any other payment sources to this statutory listing of alternate sources to CHEF. As the court noted in the *Pharma* case, other general rulemaking authority cannot be relied on when the regulation concerns a specific program for which Congress provided specific authority to issue regulations. Thus, adding the word "tribal" to the list of alternate resources in the proposed Sections 136.501, 136.506 and 136.508 exceeds the Secretary's rulemaking authority in Section 202(d)(5) of the IHCIA.

Neither 25 C.F.R. Part 136 nor Section 2901 of the Patient Protection and Affordable Care Act provide the Department with any authority to make the CHEF program a payer of last resort to a health program operated by a tribe or tribal organization under the ISDEAA. Tribal health programs may not be included in the new CHEF regulation as alternate resources to CHEF.

We are equally concerned that the preamble to the Proposed Rule would separately categorize tribes' tribal member plans and any tribal self-insured plans as "private insurance," and thereby independently render tribal self-insured plans alternate resources as "private insurance." As discussed below, Congress distinguished tribal self-insured plans from private insurance when it enacted Section 206(f) of the IHCIA, which bars the IHS from seeking recovery against tribal self-insured plans. Tribal self-insured plans pay claims directly from the tribe itself, and as a result are not alternative, or third party resources. Categorizing tribal self-insured plans as private insurance would impermissibly shift the trust responsibility to provide CHEF services from the IHS to the tribes themselves.

Major Change in IHS Policy

IHS has never treated tribal health plans and programs as alternate resources under 42 C.F.R. Section 136.61, either for CHEF or for the underlying Purchased/Referred Care (PRC) program (formerly Contract Health Services (CHS)). Additionally, Subsection 206(f) of the IHCIA, 25 U.S.C. § 1621e(f), precludes the IHS from billing and recovering its expenses for treatment from self-insurance plans funded by tribes unless the tribe authorizes the IHS to do so in writing. This distinguishes tribal health plans from other third party sources of payment (Federal, State, local and private) that the IHS may bill and collect from under Section 206.

Tribes fought hard several years ago to get the Centers for Medicare and Medicaid Services to recognize tribal health plans as payers of last resort vis-a-vis Medicare. Tribes were successful in doing that and the IHS supported tribal efforts. Thus, this Proposed Rule and recent litigation contain major changes in longstanding IHS policy that raise the same issue with respect to CHEF and PRC/CHS. Must tribes now fight this same battle with the IHS?

The IHS is not given a special payer of last resort status vis-à-vis tribal plans and programs in Section 2901 of the Patient Protection and Affordable Care Act, which sets out a statutory alternate resource rule for IHS, tribal, and urban programs. However, we were dismayed to learn that in court litigation, IHS is arguing that Section 2901(b) of the Affordable Care Act (ACA), enacted in 2010, invalidated the IHS longstanding policy exempting tribal self-insured health plans from the payer of last resort rule. This argument is contained in a Memorandum supporting the Government's Motion for Summary Judgment filed on March 15, 2016 in the U.S. District Court for the District of Columbia in *Redding Rancheria v. Sylvia Burwell*, Civ. No. 14-2035 (RMC). This appears to be a new legal argument invented by IHS lawyers for litigation purposes. The IHS has not formally rescinded its longstanding policy exempting tribal self-insured plans from the payer of last resort rule; nor has IHS invoked this new interpretation as the reason to add tribal self-insured plans as alternate resources to CHEF in the Proposed Rule or consulted with tribes concerning this new interpretation. In fact, the Government's Memorandum filed in the *Redding Rancheria* case argues that this new interpretation of Section 2901(b) applies both to CHEF and to PRC/CHS programs operated by tribes under the Indian Self-Determination and Education Assistance Act (ISDEAA). This novel interpretation is fundamentally inconsistent with both the plain language and intent of Section 2901(b) of the ACA, 25 U.S.C. 1623(b). It does not by its terms exclude tribal self-insured health programs from the list of programs covered. Nor was that its intent, which was instead to

codify in statute longstanding IHS regulations and policies that ensured that all tribal health programs, including self-insured plans, were covered by the payer of last resort rule. The IHS's new litigation position is completely at odds with longstanding agency practice and the intent of tribal advocates who urged the Congress to enact Section 2901(b) of the ACA and it should be withdrawn.

Lack of Procedure Governing the Award of CHEF Funds

Sections 202(d)(3) and (4) of the IHCIA direct the Secretary to develop regulations that establish a procedure for the reimbursement of costs that exceed the statutory threshold amount, and a procedure for the payment of CHEF in cases where the exigencies of the medical circumstances warrant treatment prior to the authorization of CHEF. But the proposed reimbursement procedure at 136.504 only sets out how to submit a claim and the content that must be provided in a claim. The regulations identify the Area PRC programs as the entities that will review each claim, and provide that IHS headquarters will determine whether an alternate resource exists.

The proposed regulations do not, however, provide any criteria or procedures governing how the Area PRC directors are to review CHEF claims, or how the IHS headquarters will determine whether an alternate resource exists. Proposed Section 136.504(a) provides that Area PRC programs will review claims for "patient eligibility, medical necessity, notification requirements for emergent and non-emergent care, medical priorities, allowable expenditures, and eligibility for alternate resources." But the regulations provide no procedure for how the Area PRC programs will review such claims and decide which claims to award and which to deny, or how to address limitations on the availability of CHEF funds. Rather, such determinations are left entirely to the discretion of the Area PRC programs. Similarly, the determination as to whether an alternate resource exists is left entirely to the discretion of the IHS headquarters. We believe that procedures governing the reimbursement of CHEF funds should include procedures guiding the award making process as well as the submission process.

Tribal Consultation

The preamble to the Proposed Rule states: "This proposed rule serves as Tribal consultation with affected Tribes by giving interested Tribes the opportunity to comment on the regulation before it is finalized." Issuing a Proposed Rule is not tribal consultation. Tribal consultation requires more than just the notice and comment procedures that the Administrative Procedure Act provides for the general public in 5 U.S.C. § 553. Executive Order 13175 requires Federal agencies to consult with tribal officials in the development of "Federal policies that have tribal implications." The term "policies that have tribal implications" includes regulations that have substantial direct effect on one or more Indian tribes.

The preamble acknowledges that E.O. 13175 applies to this Proposed Rule and notes that E.O. 13175 was complied with by consultation at meetings of the IHS Director's Workgroup on Improving the Contract Health Services programs held on October 12-13, 2010, June 1-2, 2011,

and January 11-12, 2012. The Preamble also notes that IHS issued two "Dear Tribal Leader" letters on February 9, 2011 and May 6, 2013 "related to the development of these regulations."

However, if one looks closely at these Dear Tribal Leader letters and how they describe the recommendations of the Workgroup, it is clear that neither the Workgroup nor the Dear Tribal Leader letters afforded tribal consultation on this Proposed Rule. The Dear Tribal Leader letter dated February 9, 2011, discusses four recommendations made by the Workgroup, none of which concern this Proposed Rule. They are:

1. Creating a technical subcommittee charged with calculating total current CHS need and estimates of future CHS need;
2. Improve and promote current CHS business practices;
3. Evaluate parity of Current CHS formula; and
4. Making the IHS Budget Formulation Workgroup apply the true medical inflation index to distribution of future CHS appropriation increases.

The Dear Tribal Leader Letter dated May 6, 2013, was another update regarding accomplishments and recommendations of the Workgroup for Improving the CHS program. The letter noted the following accomplishments:

1. Implementation of an optional 2% of new CHS funds for prevention services;
2. Improved methodology for estimating data on CHS deferrals and denials;
3. Use of the Federal Disparity Index methodology to estimate unmet CHS need;
4. Development of a standard CHS curriculum to orient Federal and Tribal staff;
5. Establishment of a CHS Listserve to serve as a forum to network with Federal/Tribal CHS experts;
6. Designation of a CHS standing agenda item for National and Area Budget Formulation sessions;
7. Revision of the CHS Chapter of the Indian Health Manual; and
8. Partnering with IHS nursing to implement CHS Case Management guidelines.

The letter noted the following additional recommendations of the Workgroup to improve the CHS program:

1. Using the current CHS distribution formula only to distribute new CHS funding and not to redistribute base CHS funding;
2. Expansion of Medicare-Like Rates for non-Hospital services;
3. Creation of a new CHS Delivery Area for North Dakota, South Dakota, and Arizona;
4. Convening a Subcommittee of the Workgroup as soon-as-possible for a meeting in June 2013 to address short and long term improvements for the CHEF program including, (1) a definitive listing of CHEF covered services, (2) options for CHS programs to be reimbursed at 100 percent once a case is completed or receives 50

percent advance payment, (3) determine if CHEF should provide a higher percentage in advance, (4) identify approaches to better distinguish catastrophic case currently not submitted for reimbursement due to depletion of CHEF funds, (5) identify ways that the IHS can assist smaller clinics and CHS programs to increase access to CHEF, and (6) provide estimates for lowering the CHEF threshold to $19,000;[1]

5. Continue to include CHS as a standing agenda item for annual Area and National Budget Formulation sessions;
6. Establish consistent training on CHEF guidelines during the annual National IHS Director's Tribal Consultation Session and make this training accessible via the IHS training portal; and
7. Use of CHS funding for prevention services.

None of these accomplishments or recommendations can be considered consultation on this Proposed Rule. The Workgroup recommendations specific to CHEF listed in the May 6, 2013 Dear Tribal Leader letter say nothing about development of regulations for CHEF and there is no mention of changing IHS policy to make tribal health plans or programs alternate resources to CHEF.

E.O. 13175 requires a Federal agency, prior to the formal promulgation of a regulation that has tribal implications, to consult with tribal officials "early in the process of developing the proposed regulation." The above examination of the Workgroup recommendations and the Dear Tribal Leader letters indicate that the Workgroup was not formed or intended as a mechanism for tribal consultation on this Proposed Rule. The preamble notes that "IHS intends to consult as fully as possible with Tribes prior to publication of a final rule." This does not meet the requirements of the Executive Order, nor the Department's or IHS's tribal consultation policies. The Department must therefore suspend any further action on this Proposed Rule until the Department and the IHS have carried out meaningful consultation with tribes and tribal organizations as required by Executive Order 13175 and Departmental policies.

Conclusion

For the above reasons, we request that the word "tribal" be deleted from the definition of alternate resources in Section 136.501 and from Section 136.506, providing an alternate resource rule. Should you have any questions or if we can provide any additional information, please contact [insert contact name and phone number].

Sincerely,

[1] Subsection 202(d)(2) of the IHCIA provides that for year 2000 the threshold level is $19,000, and for any subsequent year, not less than the threshold cost of the previous year increased by the percentage increase in the medical care expenditure category of the consumer price index for all urban consumers (United States city average) for the 12-month period ending with December of the previous year. Setting the threshold at $19,000 for 2016 (or for whenever the regulation will become final) as proposed in Section 136.503 of the Proposed Rule is inconsistent with Section 202(d)(2).

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_____

[Name], [Title]
[Tribe]

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Letterhead

Submitted via email to: consultation@ihs.gov

Alec Thundercloud, M.D.
Director, Office of Clinical and Preventative Services
Indian Health Service
5600 Fishers Lane, Mail Stop: 08N34-A
Rockville, MD 20857

Re: IHS Expansion of Community Health Aide Program Draft Policy Statement Consultation

Dear Dr. Thundercloud:

TRIBE INTRODUCTION

Thank you for the opportunity to provide comments on the draft policy statement that proposes an expansion in the use of community health aides (CHAs) at Indian Health Service (IHS) facilities across the country. We also thank IHS for listening to tribes and coordinating the telephonic and in-person tribal consultations. The [TRIBE] is in full support of expanding health care opportunities under the new draft policy for these aides, and strongly supports the inclusion of the Dental Health Aide Therapists (DHATs) and Behavioral Health Aides (BHAs) as part of the expansion.

Summary of Recommendations:

1. Expansion of CHAP would benefit tribes in the Lower 48;
2. CHAP providers are currently utilized in a variety of clinical and village settings and the national policy should not limit where CHAP providers may deliver health services;
3. Nationalization of the CHAP program must be based in tribal community values and priorities, and should be reflective of the communities served;
4. Legislative fix is needed to expand DHATs in the lower 48;
5. Regional Federal CHAP Certification boards should be established with federal baseline standards;
6. Implement a full CHAP Pilot Project in the Portland Area;
7. National workgroup should be established for CHAP expansion; and
8. IHS must Foster an internal culture that supports mid-level providers to ensure the success of an expansion.

1. Expansion of CHAP Would Benefit the Tribes in the Lower 48

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[TRIBE] welcomes the IHS draft policy as a recognition of the value of community-recruited paraprofessionals and mid-level providers in all aspects of healthcare in the Indian Health System. CHAP is a model that was tribally created, tribally driven and for those reasons has unique features that resonates with tribes. Creating a workforce that comes from our communities and respects that we are sovereign and have authority to determine how to answer issues of access has proven benefits:

- Provides routine, preventive, and emergent care within the community;
- Respects the knowledge and resources in the Tribal community and grows providers from that source through accessible and achievable training programs;
- Involves community participation in the selection of the individual who will become a CHA provider;
- Delivers patient-centered quality care that comes from providers that understand the history, culture, and language of their patients;
- Fosters a team approach to delivering health care services;
- Increases the efficiency of the entire healthcare team, allowing each member to practice at the top of their scope;
- Provides continuity of care in communities that face recruitment and retention challenges; and
- Results in cost savings to tribes and individuals that no longer have to travel long distances or receive care outside of the IHS system.

Tribes are in the best position to understand the health, oral health, and mental health needs of their communities. The CHAP program was developed in Alaska to meet the specific needs of the Alaska Native and American Indian Communities because the current system was failing their population. We must use the opportunity of expanding CHAP nationally to break down the various barriers perpetuated by the current system.

Alaska CHA/Ps are the frontline of healthcare in their communities-- nearly 500 providers are responsible for over 300,000 encounters per year. The Alaska CHAP is community driven and noted for its role in both providing care in remote villages, and increasing access to care at their tribally managed hospitals and clinics, and village based care in the community.

The health care system as it is today is not meeting the needs of many tribal communities in the lower 48. This is an opportunity to look critically at the healthcare delivery system in Indian Country and make meaningful changes through the CHAP program. Tribes must be given the opportunity to tailor their health care delivery system to meet the needs in their communities and of their tribal members.

This is a clear opportunity for tribes in the lower 48 to benefit from the years of thoughtful adaptation and evolution of the CHAP program to create a better health system for American Indian and Alaska Natives (AI/AN) nationwide.

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Improving care and access is not just about bringing more providers to Indian Country but includes fixing the current system of training health professionals. We can and should "grow our own" providers. CHAP has created an education system that breaks down barriers to training health professionals from tribal communities. That should be replicated in the Portland Area.

a. DHATs are Critical to CHAP Expansion

One of the greatest areas of need in our tribal communities is access to reliable, high quality, affordable dental care. **That is why inclusion of the DHATs in this proposed CHAP expansion is a necessary element for [TRIBE] to support the policy.**

It is well documented that AI/AN carry a disproportionate burden of oral disease. According to the IHS 2014 Oral Health Survey, the majority of AI/AN children have tooth decay. Most adults have lost teeth because of dental disease, periodontal disease is a significant problem for adults, and there is limited access to both preventive and restorative dental care. Profound health disparities exist between the oral health status of AI/ANs compared to non-AI/ANs across the country. [ADD LOCAL DATA OR DETAILS OF CURRENT ORAL HEALTH ACCESS OF YOUR TRIBE]

It doesn't have to be this way. More than 40,000 Alaska Natives across 81 communities have gained access to dental care through the DHAT model in Alaska, and Alaska Native children are now being seen with no cavities. The DHAT model also builds community health care delivery capacity and creates jobs by training community members to become DHATs.

DHATs are a tribally-led solution that adopts an evidence-based, culturally – competent care model with over a decade of demonstrated oral health quality outcomes in tribal communities. The DHAT program is also economically efficient for Indian health programs because it increases access and lowers costs, while maintaining the same quality of care as that provided by a dentist.

Even though tribes do not need the expansion of CHAP in order to move forward with integrating DHATs into their dental programs, they currently require *state authorization* in order to use their Indian Health Service funding once DHATs are practicing. This funding is particularly important for tribes with fewer resources and the least access to care. The state authorization pathway has been blocked in most states by the American Dental Association at tremendous costs to tribes. The longer we are faced with this route as the only option, the longer our members will endure lack of access to care. This new draft policy and any required change of federal legislation or administrative rules could offer a more reliable and expedited pathway to proven oral health care solutions.

b. BHAs Play a Key Role in Addressing Mental Health and Substance Abuse Issues

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[TRIBE] also strongly supports the inclusion of BHAs in the expansion of the CHAP program. The high rates of alcohol and substance abuse, mental health disorders, suicide, violence, and behavior-related chronic diseases in our communities are well documented. Each of these serious behavioral health issues has a profound impact on the health of individuals, families, and communities. AI/ANs are significantly more likely to report past-year alcohol and substance use disorders than any other race, and suicide rates for AI/AN people are 1.7 times higher than the U.S. all-races rate. Domestic violence rates are also alarming, with 39 percent of AI/AN women experiencing intimate partner violence, the highest rate in the U.S. [ADD LOCAL DATA OR DETAILS OF CURRENT BEHAVIORAL HEALTH SERVICES ACCESS AT YOUR TRIBE]

AI/AN communities face behavioral health service delivery issues that are complicated by personnel shortages and limited resources. AI/AN often have to travel long distances to obtain behavioral health services not offered at their IHS or tribal clinic. In addition, AI/AN who have participated in inpatient substance abuse treatment programs often return to their communities without adequate services to maintain their behavior change. Tribal communities throughout Indian country are struggling under the weight of providing behavioral health care to their members and BHAs are part of the solution.

We strongly support the expansion of BHAs as part of the CHAP expansion.

[PROVIDE DETAILS HERE ABOUT HOW CHAP WITH CHA/P, DHA/T, AND BHA/P COULD ENRICH THE CURRENT HEALTH DELIVERY SYSTEM AT YOUR TRIBE. WHAT PROVIDERS ARE YOU INTERESTED IN INTEGRATING, HOW COULD THIS ALLOW YOU TO BREAK DOWN THE CURRENT BARRIERS TO CARE EXPERIENCED BY YOUR COMMUNITY. HOW WILL THIS EXPANSION ALLOW YOU TO TAILOR THE HEALTH DELIVERY SYSTEM TO MEET YOUR TRIBAL MEMBERS WHERE THEY ARE. HOW EXCITED ARE YOU FOR THE CAREER PATHWAYS FOR YOUR TRIBAL MEMBERS]

2. **CHAP providers are currently utilized in a variety of clinical and village settings and the national policy should not limit where CHAP providers may deliver health services.**

The Dear Tribal Leader Letter (DTLL) states, "Community health aides are proven partners, and utilizing them to the fullest extent permissible in hospitals and clinics operated by the IHS and Tribes...." [Emphasis added]. The statute and current practice is broader than described in the DTLL and allows CHA/P to provide services "...to Alaska Natives living in villages in rural Alaska". The statute also allows for telehealth in health clinics located in or near those villages for use by CHA/P providers. At the core of the CHAP program is the provision of services at the village and community level and access to that type of primary care is missing currently in many communities.

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3. **The nationalization of the CHAP program must be based in Tribal community values, priorities, and should be reflective of the communities served.**

The success of the CHAP program in Alaska has been to understand the role of the village-based communities and its recognition to build on these strengths to develop the program. There are aspects of the Alaska CHAP program that are likely to be universal and other aspects of the Alaska CHAP program that will need to be tailored by region and even by tribe. The role of the tribal community is critical to meeting the unique health needs and addressing health disparities for each of the Tribes involved. The nationalization of the CHAP program must be community driven to reflect the priorities, needs, and values of the communities served.

Any program developed by local areas should promote shared decision making among the program's governing body, staff, and CHAP practitioners. The local area programs should have established partnerships and referral protocols with Indian health programs and community-based social service agencies. The local area programs should also provide opportunities for career mobility and professional development.

4. **Legislative Fix needed to Expand DHATs in the Lower 48.**

We strongly urge the IHS to address legislative barriers to carrying out a full expansion of the CHAP program, particularly in regards to the expansion of mid-level providers and to eliminate those barriers. For example, there is language in the Indian Health Care Improvement Act (IHCIA) that limits the ability of tribes outside of Alaska to use DHAT services unless such services are authorized under state law.

IHCIA supports increasing the number of American Indians and Alaska Natives entering health professions and allows AI/AN communities to have MAXIMUM voice in shaping their health care delivery system. The preemptive language in the IHCIA that excludes DHAT services from a national CHAP violates the very foundation of tribal sovereignty. Tribes have the inherent right to address the health and well-being of its citizens. Moreover, it perpetuates paternalism and cements it into law. That paternalism has no place in our health programs.

The full expansion of the CHAP program including all levels of CHA/P, DHA/T and BHA/P allows tribes (tribal leaders) to choose from a full suite of paraprofessionals to intelligently tailor their healthcare delivery system to meet the needs of their tribe/area.

5. **Regional Federal CHAP Certification Boards Should Be Established with Federal Baseline Standards**

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We support the establishment of regional federal CHAP certification boards (regional certification boards). Tribes in some areas may be better positioned to proceed with establishing a CHAP than others so allowing pilot regional certification boards for those ready to proceed early would provide guidance for regional certification boards in other areas. In addition, regional certification boards would be familiar with the tribes in their area and would have a more manageable certification caseload than establishing a national federal CHAP certification board.

However, there must be federal baseline standards for consistency of services provided by any CHAP program that the regional federal CHAP certification boards follow. IHS must ensure that regional certification boards and CHAP programs have a common baseline structure, curriculum, and standards to ensure consistency in the CHAP professions across all of IHS, tribal, and urban Indian programs. No single CHAP model is applicable to all tribal communities, however, individuals seeking care from providers within the CHAP program must be allowed to have some basic expectations for the care that they will receive. Without some federal baseline standards, we leave all CHAP providers (CHA/P, DHA/T, BHA/P) vulnerable to the whims of powerful non-native provider associations, and attacks on the quality and consistency of care provided at every level.

6. Implement Full CHAP Pilot Project in the Portland Area

Tribes in the Portland Area are already beginning to use DHATs in their dental programs. We have a close relationship with the Alaska Native Tribal Health Consortium due to the work related to expanding the use of DHATs in the Portland Area.

We urge the IHS to build a pilot program in the Portland Area to establish a FULL CHAP (including all levels of CHA/P, DHA/T, and BHA/P). The lessons learned from such a pilot program may translate to establishing a CHAP on a larger scale across the Indian health system.

The close proximity to Alaska and good working relationship with ANTHC will allow tribes in the Portland Area to begin exploring training sites in Washington, Oregon, and Idaho. DHATs are the most controversial provider in the CHAP program and there is general acceptance for that provider in the Portland Area. There is an existing excitement around CHAP due to the expansion of DHATs so the Portland Area is a natural fit as some of the groundwork has already been laid.

7. National Workgroup Should Be Established for CHAP Expansion

Due to the magnitude of the proposed transformation of the health care delivery system in Indian country in the lower 48, we suggest that IHS continues the national dialogue with tribal leaders. The CHAP program is well known in Alaska but less understood in the rest of Indian country. Tribal leaders and providers all over

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Indian country need adequate time to become educated in order to foster meaningful participation.

We believe that having the right expertise in the room through the nationalization process is of paramount importance. We suggest a nationalization workgroup be immediately formed that includes at a minimum the following individuals and/or expertise:

- Indian Health Law experts familiar with the CHAP program
- Indian Health Policy experts familiar with the CHAP program
- Indian Health Policy experts from each of the IHS Areas
- Providers or individual representing different provider disciplines, including a Community Health Practitioner, a Dental Health Aide Therapist, and a Behavioral Health Practitioner, alongside a doctor, dentist, and behavioral health provider.
- Representatives from the Alaska CHAP board
- A representative from the Swinomish licensing board
- A representative from the National Congress of American Indians
- A representative from the National Indian Health Board
- A representative from the American Indian Higher Education Consortium, the National Indian Education Association, or a similar body representing tribal colleges.

8. IHS Must Foster an Internal Culture that Supports Mid-Level Providers to Ensure the Success of an Expansion

As with any significant change to the health care delivery system. There are professions with a vested interest in maintaining the status quo. The expansion of the CHAP program to the lower 48 will upset that status quo. It will be of paramount importance that the culture of professionals within the agency and serving tribal communities throughout the country be one of acceptance. Without the support and advocacy of providers within the IHS, any expansion will be vulnerable to failure, obstructed, and potentially unsuccessful. The IHS leadership must begin to lay the ground work now to change the culture of providers within the agency and insist that they accept and embrace new ideas to foster reformation of the health care delivery system in Indian country.

9. Conclusion

Please accept these comments with our sincere request to work together with the Indian Health Service to increase access to healthcare for our members through the successful implementation of this draft policy.

Please contact XXX if you have any questions or to discuss these comments.

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Sincerely,

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Submitted via: consultation@ihs.gov

October __, 2016

Mary Smith, Principal Deputy Director
Indian Health Service
The Reyes Building
801 Thompson Avenue, Suite 400
Rockville, MD 20852

RE: Comments on Purchasing Health Care Coverage (IHS Circular 2016-08)

Dear Principal Deputy Director Smith:

I write on behalf of [Insert Tribe] to comment on IHS Circular 2016-08, Purchasing Health Care Coverage (Draft Circular). The Draft Circular addresses the purchase of health care coverage, commonly referred to as Tribal Premium Sponsorship (TPS or Sponsorship). Specifically, the draft Circular seeks to provide further detailed guidance to IHS Area Offices regarding the current IHS policy if IHS, Tribes or Tribal organizations, or an urban Indian organization (I/T/U) wishes to purchase coverage for IHS beneficiaries with funding provided under the Indian Self-Determination and Education Assistance Act (ISDEAA) or the Indian Health Care Improvement Act (IHCIA).

Our Tribe supports efforts by the IHS to facilitate inclusion of Sponsorship activities in a contract or compact. However, we have a number of concerns about the Draft Circular. Many of these concerns were communicated, in person, by Tribal leaders to IHS staff at the consultation sessions held over the past couple of months. Primarily, we are concerned that the Circular unreasonably limits the IHS and participating Tribes from exercising full authorities available in the ISDEAA and IHCIA.

We request that IHS take the following actions:

- Withdraw the Draft Circular.
- Rescind the October 24, 2013, Dear Tribal Leader Letter, which incorrectly interpreted section 402(b) of the Indian Health Care Improvement Act (as added by section 152 of the Indian Health Care Reauthorization and Extension Act of 2009).

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- Coordinate a workgroup of I/T/U representatives to make recommendations to IHS to address the issues raised in the Draft Circular and other Sponsorship-related issues, including determining the preferred mechanism(s) for providing guidance to the I/T/U programs on Sponsorship.

We appreciate the opportunity to provide comment and our recommendation on the Draft Circular. Despite the above recommendation that the Draft Circular be withdrawn, we appreciate the efforts of the Agency to facilitate access to health care services. We all recognize that such programs help to improve access to care for Tribal members and also provide needed revenue for I/T/U programs.

If you have any questions or wish to discuss these comments further, please contact me at [insert contact name and phone number].

Sincerely,

U.S. Department of Justice

Office on Violence Against Women

Office of the Director

Washington, DC 20530

September 26, 2016

Dear Tribal Representative:

The Office on Violence Against Women (OVW) is seeking nominations for membership for the Task Force on Research on Violence Against American Indian and Alaska Native Women. Officially chartered on March 31, 2008, the Task Force has assisted the United States Department of Justice's National Institute of Justice (NIJ) and OVW in the implementation of a program of research that addresses Title IX, the Safety of Indian Women, examines violence against Indian women in Indian Country, including domestic violence, dating violence, sexual assault, stalking and murder, and evaluates the effectiveness of Federal, state, tribal and local responses to these crimes. The Task Force was authorized by Section 904 (a)(3) of the Violence Against Women Act of 2005 (VAWA 2005), Pub. L. No. 1209-162, and is subject to the requirements of the Federal Advisory Committee Act. To ensure that the Department of Justice continues to receive timely advice from the Task Force, the Attorney General signed a re-charter for the Task Force, which was filed with Congress on July 13, 2016. Additional information on the Task Force can be found on the OVW and NIJ websites.

Task Force members have provided valuable feedback on NIJ's program of research priorities, research design strategies, research and evaluation protocol issues, and research and evaluation findings from studies conducted to date, as well as assisting with recommendations resulting from study findings and the development of new research questions to be addressed. Task Force input has been and continues to be invaluable to ensuring the program's success. Moving forward, the Task Force will continue to play an important role in shaping the program, and will assist NIJ and OVW with disseminating results that will influence policy and practice.

As required by authorizing legislation, Task Force nominees must be representatives of one of the following entities:

(1) tribal governments;
(2) national tribal domestic violence and sexual assault non-profit organizations; or
(3) national tribal organizations.

Nominations should be submitted to OVW by no later than Wednesday, October 26th. The names of all nominees will be forwarded to the Attorney General for review (which will include a telephone interview and public records search as part of the vetting process) and those nominees who have been selected to serve on the Task Force will be contacted later this year. .

For each nominee, the nominating entity should submit a cover letter recommending the individual to serve as the entity's representative and explaining the individual's qualifications to serve on the Task Force, as well as a copy of the individual's résumé or *curriculum vitae*. The

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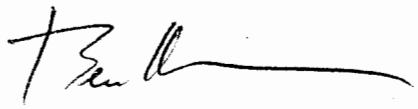
cover letters and supporting documentation should be submitted by e-mail to OVW.VAIW@usdoj.gov. or by fax to 202-307-3911.

Federal advisory committees play such an important role in government. With the expertise of advisory committee members, Federal officials have access to information and advice on a broad range of issues affecting Federal policies and programs. The public, in return, is afforded an opportunity to provide valuable input in an open forum on matters of importance to the Federal Government. The Task Force is intended to be a working body that will produce reports or other documents as necessary. Task Force members are expected to attend meetings that usually last 1-2 days, be prepared to discuss topics and materials distributed in advance of each meeting, and draft written recommendations and reports as necessary. OVW and NIJ have discussed convening a meeting in late Spring or early Summer of 2017, should NIJ have information to present to Task Force members. A determination will be made based on the status of the projects that comprise NIJ's program of research and the need for input from Task Force members.

Please feel free to contact me at (202) 514-9556 or Lorraine Edmo, the Deputy Director for Tribal Affairs, at (202) 514-8804 if you have questions about the nomination process. I look forward to hearing from you in the near future and working with a new nominee on the Task Force. Thank you for your continued dedication to addressing violence against American Indian and Alaska Native women.

Sincerely,



Bea Hanson
Principal Deputy Director

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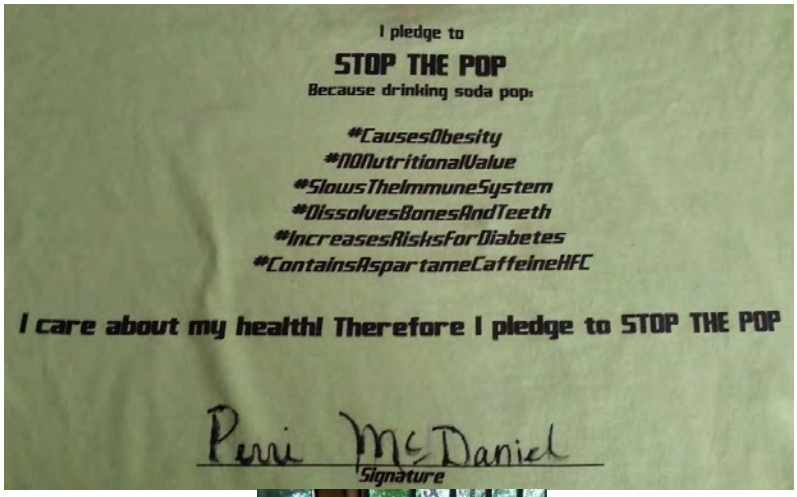
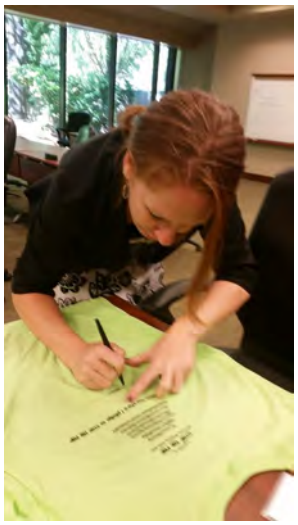
2016-ISSUE 92

NCCDPHP
GOOD HEALTH AND WELLNESS IN INDIAN COUNTRY
TRIBAL RESOURCE DIGEST

Welcome to the Centers for Disease Control and Prevention's (CDC) tribal resource digest for the week of October 24, 2016. The purpose of this digest is to help you connect with the tools and resources you may need to do valuable work in your communities.





Stop the Pop Campaign at the Klamath Tribes

Left: Perri McDaniel, Klamath Tribal Health and Family Services Food Security Program Coordinator
Right: Nanette Yandell signing the pledge
Middle: Nora Alexander signing the pledge

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Request for Photos

Please send any photos of GHWIC work (community gardens, events, team meetings, etc.) to Anisha Quiroz, AQUIROZ@cdc.gov with a short description of the photo!

Announcements

5th Annual Student Research Paper Contest

Preventing Chronic Disease (PCD) is looking for high school, undergraduate and graduate students, medical residency and recent post-doctoral fellows to submit papers relevant to the prevention, screening, surveillance, and/or population-based intervention of chronic diseases, including but not limited to arthritis, asthma, cancer, depression, diabetes, obesity, and cardiovascular disease. Papers must be received electronically no later than 5:00 PM EST on January 20, 2017. Complete contest rules and details are available Learn more here.

Deadline: January 20, 2017 5:00pm EST

Traditional Food Showcase

In celebration of Native American Heritage Month, submit a poster for the Traditional Food Story Showcase. Create a poster describing a food or recipe that is important to your family's tribe(s) and enter today!

Learn more here.

4 Digital Stories and Discussion Guides on Commercial Tobacco in Navajo Ceremonial Settings

This educational video series depicting traditional Navajo healers' views on the history, role, and impact of commercial tobacco in ceremonial settings, as well as solutions and policies for controlling the use of commercial tobacco within these settings, is now available online. These free videos and corresponding discussion guides can be used by health educators, community health and tobacco control practitioners, school teachers, community leaders and others working towards healthy Indigenous communities. Learn more here.

A Historical Overview of Commercial Tobacco in American Indian Life

Differences Between Commercial Tobacco and Dził Nát'oh (traditional mountain smoke)

The History and Impact of Commercial Tobacco in Ceremonial Settings

Creating Smoke-free Ceremonial Environments: Thoughts on Solutions and Policies

Articles

Family-Centered Diabetes Program Reduces Risk Factors in Young American Indians

New findings published in The Diabetes Educator this month show that a family-centered diabetes prevention and management program effectively decreased body mass index and high blood pressure in American Indian adolescents diagnosed or at risk for type 2 diabetes. This study is the first to examine the impact of a home-based intervention on diabetes prevention and management for American Indian youth.

Learn more here.

Sustainable Food System Policy

The Lower Sioux Indian Community and the American Indian Cancer Foundation have developed a sustainable food system policy t hat encourages growing indigenous foods in community gardens.

Learn more here.

Trainings and Conferences

National Conference on Tobacco or Health

The National Conference on Tobacco or Health (NCTOH) is one of the largest, long-standing gatherings of the United States tobacco control movement. It attracts a diverse set of public health professionals to learn about best practices and policies to reduce tobacco use—the leading preventable cause of disease and death in the United States. Learn more here.

When: March 22-24, 2017
Where: Austin, TX

Webinars

Native STAND Program

A one-hour live webinar will be offered to those interested in learning more about the Native STAND program, curriculum, the dissemination project, eligibility, application process and implementation timeline. Learn more here.

When: November 17, 2016 11am PST

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American Indian Youth Summer Medical Wellness Camp

Obesity has become a major health problem among American Indians. Lifestyle risk behaviors include nutrient-poor food and drink choices, larger food portions, and physical inactivity. This program will describe an American Indian Youth Summer Medical Wellness Camp that addresses the growing number of Arizona's Indian youth who are at risk for or who have been diagnosed with type 2 diabetes. Components of the Camp that will be explained include an intensive week-long experience focused on healthy eating, exercise, nutrition education and fun! All camp activities take place in an American Indian context, deeply rooted in culture. Learn more here.

Title: Children's Healthy Living Program in the Pacific Islands
When: November 8, 2016, 12:00pm PDT

Title: Tohono O'odham Nation and Pasqua Yaqui Diabetes Program
When: December 13, 2016, 12:00pm PDT

Introduction to CDC Diabetes Prevention Programs in Tribal Communities

CDC's Division of Diabetes Prevention is offering two introductory webinars.

When: Monday, November 7 2:00 – 3:30 p.m. EST
&
Tuesday, November 15 4:00 – 5:30 p.m. EST

Join to hear more about:
Overview of the National DPP and DPRP
Shared testimony from Tribal applicants

Click link to: Join Skype Meeting *All can access the Skype for Business Web App for free and then follow the instructions in the Web browser window to join the meeting.*
Join by phone: (855) 644-0229 Conference ID: 2351261
Email Kavitha Muthuswamy at ihs8@cdc.gov for questions. No registration is required. All welcome, please distribute widely through your networks.

"Did Our Ancestors Eat Buffalo Chicken?: Decolonizing Practices in Urban Health"

The Inter-Tribal Council of Michigan's National Native Network and the Indian Health Services Clinical Support Center (Accredited Provider) present a webinar series: Cancer Risk Reduction in Indian Country.

Register here.
Date: October 31, 2016 3:00pm EST
Contact Mike Willette at mwillette@itcmi.org for a copy of the flier or more information.

Funding Opportunities

USDA Community Facilities Direct Loan and Grant Program

Direct USDA loans and/or grants to construct, enlarge, or improve essential community facilities for healthcare, public safety, education, and public services in rural areas. This program provides affordable funding to develop essential community facilities in rural areas. An essential community facility is defined as a facility that provides an essential service to the local community for the orderly development of the community in a primarily rural area, and does not include private, commercial or business undertakings.

Read more here.

Healthy Places for Healthy People

Provides direct technical support for communities to work with healthcare facilities to promote preventive healthcare and help create vibrant, thriving communities. Eligible applicants are organizations and agencies proposing to work in a neighborhood, town, or city located anywhere in the United States, including Tribes. Special consideration will be given to:

- Applications that include representatives from both the community and a healthcare facility
- Applications that demonstrate existing or new partnerships among multi-sector partners and a healthcare facility to promote community revitalization and economic development
- Communities that are economically distressed and/or underserved, including those in rural Appalachia

Learn more here.
Deadline: November 6, 2016

National Native Health Research Training Initiative

The Indian Health Service today announced the funding opportunity for a new project, the National Native Health Research Training Initiative. When awarded, this cooperative agreement will help build capacity and share best practices in American Indian and Alaska Native health research and will promote tribally driven research through education and training opportunities. The award amount is approximately $225,000 per year for a project period of up to five years. To read the full announcement, please click here.

Deadline: October 30, 2016
To read more about the deadline, application and review process please click here.

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Contact Information

National Center for Chronic Disease Prevention and Health Promotion

Office of the Medical Director
4770 Buford Highway, MS F80
Atlanta, GA 30341
(770) 488-5131
http://www.cdc.gov/chronicdisease/index.htm

The digest serves as your personal guide to repositories of open and free resources where you can find content to enrich your program or your professional growth. Please note that CDC does not endorse any materials or websites not directly linked from the CDC website. Links to non-Federal organizations found in this digest are provided solely as a courtesy. CDC is not responsible for the content of the individual organization web pages found at these links. If you have comments or suggestions about this weekly update, please email Anisha Quiroz at AQUIROZ@cdc.gov with the words "TRIBAL DIGEST" in the subject line.

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BUDGET FORMULATION FY19 MEETING

NOVEMBER 29, 2016 | 8:30 a.m.—3:00 p.m.

Embassy Suites by Hilton

7900 NE 82nd Ave

Portland, Oregon

This meeting is for Tribes and Indian Health Service to come together to exchange information and determine the health priorities for the FY19 Portland Area Indian Health Service budget submission. More details to follow.

Questions? Call CAPT Ann Arnett (503) 414-5555 or e-mail ann.arnett@ihs.gov

Our Mission... *to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.*

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

MATT WIMMER - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

October 31, 2016

Dear Tribal Representative:

The purpose of this letter is to give notice that Idaho Medicaid intends to submit a State Plan Amendment (SPA) and an amendment to the Aged and Disabled 1915(c) waiver in order to reflect changes to the Medicare-Medicaid Coordinated Plan. We intend to submit the SPA and waiver amendment no later than December 31, 2016.

The Medicare-Medicaid Coordinated Plan (MMCP) is a voluntary managed care plan available to Idaho residents over age 21 that are dually eligible for Medicare Parts A and B and full Medicaid benefits. Currently, the plan is available in 42 out of Idaho's 44 counties. The health plan administering the MMCP, Blue Cross of Idaho Care Plus, Inc., received approval from the Centers for Medicare and Medicaid Services (CMS) to reduce the service area effective January 1, 2017. The service area will include the following counties: Ada, Bannock, Bingham, Boise, Bonner, Bonneville, Boundary, Canyon, Cassia, Clark, Elmore, Fremont, Gem, Jefferson, Kootenai, Madison, Minidoka, Nez Perce, Owyhee, Payette, Power, Twin Falls. The MMCP Alternative Benefit Plan and Aged and Disabled waiver must be updated to reflect the geographic availability of the program.

Idaho Medicaid's development of the proposed SPA will be reviewed as part of the Policy Update at the next quarterly Tribal meeting scheduled for November 3, 2016. Idaho Medicaid is interested in receiving your comments, questions or suggestions relating to this change. Should you have questions about this letter or the upcoming SPA submission, please contact Ali Fernández at (208) 287-1156 or by email at FernandA@dhw.idaho.gov prior to November 30, 2016.

Sincerely,

MATT WIMMER
Administrator

MW/tm