
# FACA COMMITTEES GENERAL INFORMATION

RMTLC December 2017

*Abstract*

*An overview of on-line information about FACA (Federal Advisory Committees Act) Committees on which the Rocky Mountain Tribal Leaders' Council has an elected tribal official or a designated alternate to represent the RMTLC Affiliated Tribes in negotiations with the federal government.*

## FACA COMMITTEE INFORMATION DECEMBER 2017

| | COMMITTEE | Acronym |
|---|---|---|
| 1 | Office of Minority Health – American Indian/Alaska Native – Health Research Advisory Committee | OMH-AIANHRAC |
| 2 | Centers for Disease Control and Prevention Agency for Toxic Substances and Disease Registry Tribal Advisory Committee | CDC/ATSDR TAC |
| 3 | Centers for Medicare & Medicaid Services Tribal Technical Advisory Group | CMS-TTAG |
| 4 | Direct Service Tribal Advisory Committee | DSTAC |
| 5 | Facilities Appropriations Advisory Board | FAAB |
| 6 | IHS Budget Formulation Workgroup | BFWG |
| 7 | IHS Director's Tribal Advisory Workgroup on Consultation | DTAWC |
| 8 | National Tribal Advisory Committee on Behavior Health | NTACBH |
| 9 | IHS Purchased & Referred Care (formerly CHS) Workgroup | PRC-WG |
| 10 | Catastrophic Health Emergency Funds Workgroup | CHEF-WG |
| 11 | IHS Contract Support Costs Workgroup | CSC WG |
| 12 | SAMHSA Tribal Technical Advisory Committee | STTAC |
| 13 | Secretary's Tribal Advisory Committee | STAC-HHS |
| 14 | Tribal Leaders Diabetes Committee Representative | TLDC |
| 15 | Tribal Self-Governance Advisory Committee | TSGAC |
| 16 | IHS Information Systems Advisory Committee | ISAC |
| 17 | National Indian Health Board Representative | NIHB |
| 18 | National Congress of American Indians | NCAI |
| 19 | BIA Budget Formulation Workgroup | DOI |

**1 Office of Minority Health – American Indian/Alaska Native – Health Research Advisory Committee** **OMH-AIANHRAC**

https://minorityhealth.hhs.gov/hrac/

IMPROVING NATIVE HEALTH

The American Indian and Alaska Native Health Research Advisory Council (HRAC) addresses health disparities in Indian Country by supporting collaborative research efforts between HHS and tribal partners.

HRAC Eligibility and Nomination Guide

As a federal agency, the Office of Minority Health (OMH), U.S. Department of Health and Human Services (HHS) recognizes the United States' unique legal and political relationship with Indian tribal governments, and is committed to fulfilling its critical role in promoting tribal health. The American Indian/Alaska Native (AI/AN) Health Research Advisory Council (HRAC) was established in 2006 to serve as an advisory committee to HHS. The HRAC supports collaborative research efforts between HHS and tribal partners by providing input and guidance on policies, strategies, and programmatic issues affecting Indian tribes.

The HRAC consists of 16 delegates: one delegate from each of the 12 Indian Health Service (IHS) Areas; and four national-at-large delegates. Additionally, each delegate has an alternate to serve when the delegate is not able to participate in meetings.

Vacancies

The HRAC is seeking nominations for terms ending June 30, 2017 and other vacancies including the following positions:

SAMPLE LETTER FOR HRAC NOMINEE NOMINATION OF AN ELECTED TRIBAL OFFICIAL. Use this sample letter when nominating a tribal official who holds an elected tribal position.

SAMPLE LETTER FOR HRAC NOMINEE NOMINATION OF AN APPOINTED OR DESIGNATED TRIBAL OFFICIAL Use this sample letter when nominating someone who does not hold an elected tribal position.

**2 Centers for Disease Control and Prevention Agency for Toxic Substances and Disease Registry Tribal Advisory Committee** **CDC/ATSDR TAC**

https://www.cdc.gov/tribal/index.html

The Tribal Support Unit, housed within CDC's Office for State, Tribal, Local and Territorial Support (OSTLTS), is the primary link between CDC, the Agency for Toxic Substance and Disease Registry (ATSDR), and tribal governments. CDC's Tribal Support Unit focuses on activities that reflect the agency's role in helping to ensure that American Indian/Alaska Native (AI/AN) communities receive public health services that keep them safe and healthy.

CDC/ATSDR policy requires that all agency programs consult with tribal governments when they develop programs and activities that will affect Native populations. CDC is committed to working with federally recognized tribal governments on a government-to-government basis, and strongly supports and respects tribal sovereignty and self-determination for tribal governments in the United States.

**Our Mission**

Our mission is to affirm the government-to-government relationship between CDC and AI/AN tribes by advancing connections, providing expertise, and increasing resources to improve tribal communities' public health.

**Our Role**

- Principal advisor to policy-level officials about AI/AN public health issues
- Principal contact for all public health activities affecting AI/AN communities
- Coordinator for CDC and the Agency for Toxic Substances and Disease Registry (ATSDR) programs and policies that benefit or affect AI/AN tribes

**Our Work**

- Serve as CDC's principal point of contact for tribes and tribal-serving organizations
- Manage the CDC/ATSDR Tribal Advisory Committee
- Connect tribes and tribal-serving organizations to CDC and ATSDR programs
- Develop communication and information resource for tribes and tribal-serving organizations
- Support and collaborate with tribal-serving organizations and public health partners to improve tribal public health capacity
- Educate about tribal health issues, policies, activities, and strategies, while serving as a principal advisor to CDC leaders and staff
- Guide and coordinate CDC's tribal-related partnerships and activities with the US Department of Health and Human Services and other federal agencies

## 3 Centers for Medicare & Medicaid Services Tribal Technical Advisory Group CMS-TTAG

https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/index.html

The Center for Medicare and Medicaid Services (CMS) Tribal Affairs Group works closely with American Indian and Alaskan Native communities and leaders to enable access to culturally competent healthcare to eligible Medicare and Medicaid recipients in Indian Country. CMS collaborates with the Indian Health Service and other federal partners to facilitate access to high quality and timely healthcare.

Through the Medicare, Medicaid and Children's Health Insurance Programs, CMS provides for the delivery of healthcare to American Indian and Alaskan Native (AI/AN) people. Funding from these program accounts for a significant portion of the Indian health care budget. Due to the special relationship between the federal government and Indian Tribes, CMS frequently has special rules when working with the Indian Health Service, Tribes and Urban Indian programs (I/T/Us).

Click on **The Role of CMS in Indian Health Care** to view highlights of the history of Indian Health Care, CMS Tribal Consultation and the significant impact that CMS programs have in Indian Country. CMS established a Tribal Technical Advisory Group (TTAG) in 2004 to seek input and advice on policies and strategies to increase AI/AN access to CMS programs. TTAG adopted a 2010-2015 Strategic Plan that sets out three targets: (a) establishing and improving access to CMS funded long term care services; (b) implementing strategies to increase AI/AN enrollment in CMS programs; and (c) identifying current and future administrative, regulatory, and legislative policies that affect AI/AN beneficiaries and providers.

Since 2004, there have been significant changes in Federal healthcare legislation. The American Reinvestment and Recovery Act (ARRA) codified the TTAG/CMS relationship, strengthening the already well-established collaboration between CMS and I/T/Us. The Children's Health Insurance Program Reauthorization Act (CHIPRA) added new provisions to eliminate barriers and fund innovative strategies to increase enrollment in Medicaid and CHIP, specifically for AI/AN beneficiaries. And most recently, the Patient Protection and Affordable Care Act of 2010 (PPACA) was enacted, representing historic reform by expanding health coverage to millions of the uninsured, strengthening the coverage of those already insured, and dramatically expanding programs like Medicaid, CHIP, and Medicare. Within the vast reforms in PPACA, AI/AN populations will be affected not only by the general provisions, but through specific, explicit provisions, including the permanent reauthorization of the Indian Health Care Improvement Act.

CMS has funded a number of initiatives to improve healthcare services to American Indian and Alaskan Native individuals who are eligible for Medicare and Medicaid. This site provides background, practical tools and evidence-based strategies for AI/AN communities to navigate through federal and state requirements to provide for healthcare services. For more information about CMS initiatives in Indian Country, contact TribalAffairs@cms.hhs.gov or visit your regional CMS Native American Contact (NAC).

**Downloads**

NACTAGlist [PDF, 182KB]

Cost Sharing Protections for Indians in Medicaid and CHIP, and CHIPRA Citizenship Documentation Requirement Guidance Letters [PDF, 47KB]

**Related Links**

American Indian/Alaska Native Center


### 4 Direct Service Tribal Advisory Committee DSTAC

https://www.ihs.gov/odsct/dst/dstac/

The Direct Service Tribes Advisory Committee (DSTAC) was established in 2005 to provide leadership that advises the Indian Health Service (IHS) Director on the development of health policy and participates in IHS decision-making that affects the delivery of health care. DSTAC also offers advocacy and policy guidance by regularly providing recommendations to the Agency. The DSTAC is comprised of elected/appointed Tribal Leaders from ten (10) IHS Areas with Direct Service Tribes. Technical assistance for the DSTAC is provided by IHS Headquarters and Area-level staff.

| | |
|---|---|
| **DSTAC 1st Quarterly Meeting**<br>When: October 24, 2017<br>Location: Arlington, VA<br>Hotel: Holiday Inn Rosslyn at Key Bridge<br><br>900 N. Fort Myer Drive. Arlington, Virginia. 22209<br>Room Block: IHS<br>Holiday Inn Rosslyn @ Key Bridge | **DSTAC 2nd Quarterly Meeting**<br>When: February, 2018<br>Location: Washington, D.C.<br>Hotel: TBD<br><br>**DSTAC 3rd Quarterly Meeting**<br>When: April, 2018<br>Location: Albuquerque, NM<br>Hotel: TBD |

| DSTAC 4th Quarterly Meeting | Direct Service Tribes National Meeting |
|---|---|
| When: July, 2018<br>Location: Minneapolis, MN<br>Hotel: TBD | When: July, 2018<br>Location: Minneapolis, MN<br>Hotel: TBD |

**Indian Health Service**
**DIRECT SERVICE TRIBES ADVISORY COMMITTEE (DSTAC) MEMBERS**
**TRIBAL REPRESENTATIVES**
**(Updated February 10, 2017)**

| | | | |
|---|---|---|---|
| **Billings** | Donovan Archambault<br>Council Member<br>Fort Belknap Indian Community Council | Primary | 656 Agency Main Street<br>Harlem, Montana 59526<br>Phone: 406-673-7272<br>Email:<br>donovan.archambault@ftbelknap.org |
| | Dana Buckles<br>Tribal Executive Board<br>Fort Peck Assiniboine & Sioux Tribes | Alternate | 501 Medicine Bear Road<br>P.O. Box 1027<br>Poplar, Mt. 59255<br>Phone: 406-768-2300<br>Email: dbuckles@fortpecktribes.net |
| **Great Plains** | Willie Bear Shield | Primary | P.O. Box 719 |

**Billings Area Direct Service Tribes Advisory Committee 1st Quarter Report-FY 2018**

Area Tribal Representatives:

1. Mr. Donovan Archambault Sr., Council Member, Fort Belknap Community Council
2. Mr. Dana Buckles, Tribal Executive Board, Fort Peck Tribes
3. Mr. Clint Wagon, Chairman, Eastern Shoshone Business Council

Area Federal Liaison:

4. Ms. Rikki Salazar, Supervisory Accountant, Office of Tribal Programs, BAIHS
5. Mr. Ivan MacDonald, Public Health Advisor, Office of Tribal Programs, BAIHS

**People:**

- Mr. Garland Stiffarm, Associate Area Director, Office of Tribal Programs has been detail to the Blackfeet Service Unit, Browning, Montana as Chief Executive Officer. Ms. Rikki Salazar, Supervisory Accountant is the Point of Contact for the Office of Tribal Programs.
- Blackfeet Service Unit: CEO requested to be on the Blackfeet Tribal Business Council Agenda; items addressed Operating Plan, Access (i.e. appointments, waiting time), Third Party Revenue and Customer Service.
    - CEO presented at Tribal Health Meth Symposium.
    - Mobile Surgical Unit has been in use since August 25th.
- Fort Belknap Service Unit: Addressing MU deficiencies, the FBSU has trained 15 personnel at FBSU and Hays Clinic to enroll members into PHR. Ongoing enrollment along with Flu Drive (October 18, 2017).
- FBSU has established a cohesive on-boarding/orientation for all new employees to include EHR/CAC, Safety, EEO, Culture (representative(s) from Tribal community), RN/Provider specific information, CEO tour.

- Fort Peck Service Unit: Created a Culture of Safety; monthly meetings are held in 1) Emergency Preparedness 2) Quality Council (compliance), and 3) Performance Improvement.
- FPSU emergency preparedness topics during the July 2017 meeting included COOP plan changes, discussion on the recent Active Shooter training, Codes Blue and Lockdown, and paging capability through the phones updates.
- Two medical providers was hired at the Fort Peck Service Unit in August 2017.

**Partnerships:**

- The Billings Area IHS Urban Program Review Team is completing the FY 2016 Urban Program Reviews.
- Rocky Mountain Tribal Leaders Council Quarterly Board Meeting, October 18-19, 2017, KwaTaqNuk Resort, Polson, MT
- Billings Area Office held the Service Unit's Quarterly Governing Board meetings in October.
- Blackfeet Service Unit: Purchase Referred Care has been meeting with Benefits Health Care to resolve issues concerning patient's accounts, this has been very beneficial for both entities to get patients accounts paid in timely manner.
- Fort Belknap Service Unit met with Tribal Council members to provide a weekly update and design a fostering relationship built on trust and transparency.
- Fort Belknap Service Unit hosted 45 soldiers from Active Duty Army as well as the Army Reserve (Walking Shield) to provide clinical and support services from July 24 to August 4, 2017.
- Fort Peck Service Unit hosted 35 military reservists for 2 weeks through Operation Walking Shield. The reservists worked alongside staff to provide health care to the service unit patients.
- Fort Peck Service Unit is providing VA tele psych care within the Service Unit facility.

**Quality:**

- All Tribes are invited to attend local service unit governing board meetings held on-site throughout FY 2017. This gives an opportunity for the Tribes to acquire direct knowledge of the operations in the provision of services at their respective service unit. Official agenda topics include Quality of Care, Access, Financial and Administration achievements and interests for the quarter.
- Blackfeet Service Unit: Quality Director is meeting with tribal directors and supervisors on improving GPRA numbers at the Service Unit.
- PRC Supervisor, Blackfeet Service Unit submitted acquisition documents to implement contracts for Cardiology, Echocardiogram, Audiology, Neurology, Nephrology and Urology. These contracts will be for a base year with four years additional option years (total five years contracts). Also, implemented requisition to purchase Hearing Aids through a government contract for Fiscal Year 2018.
- The Service Unit is in process of renovating the North Clinic and Emergency Department triage area. The renovations are being completed to improve patient access as well as improved visual observation of patient waiting area.
- Fort Belknap Service Unit has relocated Behavioral Health to Outpatient Clinic. Working with Tribal Leadership and Tribal Programs as well as Billings Area Office to put a building/space use agreement in place ensuring background and credentialing is occurring for new Tribal employees. Ensuring new clinical spaces are suitable and able to accommodate the needs of our patients utilizing Behavioral Health Services.
- Fort Peck Service Unit ended the 2017 GPRA year meeting nine objectives, an improvement over the previous year.
- 21 CHEF cases have been submitted this fiscal year.

- Fort Peck Service Unit Infection Control Officer continues to do an Antibiotic sensitivity surveillance. Quarterly data has been collected and reported at the Governing Board meeting.
- Fort Peck Service is increasing preventive care screenings & care:
    - Optometry and dental are providing time in their schedules for dental appointments/screenings during Wolf Point diabetic clinics.
    - Public Health Nursing continues with their PDSA on reaching prenatal patients in their first trimester. Attendance at a Native American Women's Health Conference resulted in valuable info being brought back to the department.
    - Public Health Nurses are attending Flu Kickoff webinars and planning strategy for accessing individuals for flu shots.

**Resources:**

- Billings Area effectively managed over $79,300,000 in Tribal and Urban Contracts/Compacts for FY 2017:
- Tribal – Total $75,700,000
    - Contract Support Costs - $14,200,000
    - Buy Back and Tribal Reimbursements - $2,600,000
- Urban – Total $3,600,000
- Funding for the Special Diabetes Program for Indians has been authorize until 2019.

## 5 Facilities Appropriations Advisory Board FAAB

https://anthc.org/news/indian-health-services-facilities-appropriation-advisory-board-meets-at-anthc/

The Facilities Appropriation Advisory Board (FAAB) is established as a standing committee of Tribal and Indian Health Service (IHS) representatives. The primary purpose of the FAAB is to make recommendations to the IHS Director on matters involving all Office of Environmental Health and Engineering (OEHE) programs. OEHE operates comprehensive programs that are funded under the Facilities Appropriation portion of the IHS budget. The funding allocation for these programs is updated annually, based on need and/or workload. Funds are identified for comprehensive environmental health services, maintenance of existing buildings, equipment, and construction programs for new and existing health care and sanitation facilities.

The FAAB was established to ensure there is input from Alaska Native and American Indian communities prior to taking actions that affect federally recognized Tribes. ANTHC is pleased to host this group doing important work on behalf of our Tribal partners. The IHS Alaska Area is represented by ANTHC Board Vice Chair and Alaska Native Health Board Chair Lincoln Bean, Sr. of the SouthEast Alaska Regional Health Consortium.

FAAB members conducted business June 21-22, which included an introduction to work across the Consortium and tours of the ANMC campus, clinics and the patient housing facility.

For more information about FAAB, see the IHS Circular No. 2015-04 online.

https://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_circ_main&circ=ihm_circ_1504

1. Purpose. The Facilities Appropriation Advisory Board (FAAB) is established as a standing committee of Tribal and Indian Health Service (IHS) representatives. The primary purpose of the FAAB is to make

recommendations to the Director, IHS on matters involving all Office of Environmental Health and Engineering (OEHE) programs.

2. Background. The OEHE operates comprehensive programs that are funded under the Facilities Appropriation portion of the IHS budget. The funding allocation for these programs is updated annually, based on need and/or workload. Funds are identified for comprehensive environmental health services, maintenance of existing buildings, equipment, and construction programs for new and existing health care and sanitation facilities. The Director, OEHE is responsible for establishing overall policy for the operation of these programs and for the distribution of resources.

3. Policy. It is the IHS policy to consult with Tribal governments to the extent practicable, and to the extent permitted by law, prior to taking actions that affect federally-recognized Tribes

6. Membership. The FAAB total size is 14 individuals that shall be composed of 12 Tribal members and 2 IHS members.

   A. Tribal Nomination. The FAAB members/alternates are appointed by the Director, IHS from elected Tribal officials' nominations from each of the 12 IHS Areas. This will ensure that each member of the FAAB is officially representing a Tribal government.

   B. Selection.

      1. The Director, IHS, will select the FAAB Tribal members from the names submitted by Tribes and will seek members from a range of healthcare settings so that the concerns of all American Indians/Alaska Natives health delivery systems are presented on the FAAB.
      2. The Director, IHS will appoint the two IHS members to the FAAB.
      3. As vacancies on the FAAB occur, they will be filled in a similar manner.

   C. Tenure. There shall be no term limit placed upon FAAB membership. Membership terms are at the sole discretion of the Director, IHS. The membership shall be determined by tenure in elected office or continuing appointment by each member's Tribe.

   D. Chairperson and Vice Chairperson. The FAAB will select a Chairperson and a Vice Chairperson annually from the membership. In the absence of the Chairperson, the Vice Chairperson will act as Chairperson.

7. Alternates and Technical Needs Assessment Workgroup.

   A. Alternates. Alternates are nominated using the same process as members. The Director, IHS shall provide a letter to each nominee approving Alternate status

**6 IHS Budget Formulation Workgroup** **BFWG**

https://www.ihs.gov/tribalconsultation/workgroups/

There is no formal charge (see Tribal Consultation Policy). The workgroup provides input and guidance to the IHS Headquarters budget formulation team throughout the remainder of the budget formulation cycle for that fiscal year.

**Members:** 1 from each IHS Area with an alternate; 2 co-chairs with an alternate.

**Contact:** Christina Francisco, Staff Analyst
Division of Budget Formulation
(301) 945-3237

**7 IHS Director's Tribal Advisory Workgroup on Consultation DTAWC**

https://www.ihs.gov/tribalconsultation/workgroups/

The Workgroup is charged with working in partnership with the IHS Director to recommend improvements on the IHS Tribal Consultation process to make it more meaningful, effective, and accountable. The Workgroup will also meet to review progress on consultation efforts and provide the Director with guidance on general consultation issues.

**Members:** Composed of 24 tribal leaders, 2 from each of the 12 IHS areas.

**Contact:** CAPT Sandra Pattea, Deputy Director for Intergovernmental Affairs
Office of the Director
301-443-1083

**8 National Tribal Advisory Committee on Behavior Health NTACBH**

https://www.ihs.gov/ihscalendar/calendar/national-tribal-advisory-committee-ntac-on-behavioral-health-virtual-meeting/

**Description November 16, 2017**

The National Tribal Advisory Committee (NTAC) on Behavioral Health was formed in 2008 to assist specifically with the tribal consultation aspect of behavioral health policy and programming, so that IHS and Tribal governments would have an official channel to consult about the governmental impacts of behavioral health programming and Tribal communities' behavioral health care needs. The council is composed of a representative and an alternate from each IHS Area, along with a federal and tribal co-chair. The council meets on a quarterly basis, including three virtual meetings and one annual face-to-face meeting.

**Contact Info**

Andrea Czajkowski
Division of Behavioral Health, OCPS
Indian Health Service
3014434320

https://www.ihs.gov/dbh/ntac/

NTAC consists of the following members:

- One primary representative from each of the 12 IHS areas
- One alternate representative from each of the 12 IHS areas
- One federal representative
- One tribal representative

Members are nominated by IHS Area Directors, in consultation with Tribal leaders. All nominees must be elected Tribal leaders or a designee selected by Tribal leaders.

**Billings Area Representative:**

Eric Birdinground - Primary Representative
Chairman of HHS Committee and Center Lodge District Senator
Crow Tribe Legislative Branch

*Alternate - Vacant, Pending Nomination*

**9 IHS Purchased & Referred Care (formerly CHS) Workgroup PRC-WG**

https://www.ihs.gov/prc/?module=dsp_prc_dir_workshop_improving_prc

Director's Workgroup on Improving Purchased/Referred Care (PRC)

The purpose of the Director's Workgroup on Improving PRC (Workgroup) is to provide recommendations to the Indian Health Service (IHS) Director on strategies to improve and reform the Agency's PRC program. The Workgroup reviews input received to improve the PRC program; evaluates the existing formula for distributing PRC funds; and recommends improvements in the way PRC operations are conducted within the Indian Health Service (IHS) and the Indian health system. They are also responsible for looking at the FY 2001 CHS distribution formula to determine if changes are needed for the new funding beginning in FY 2011.

Membership/Meetings - The Workgroup consists of two Tribal representatives from each of the 12 IHS Areas, meets 2-3 times per year.

Recommendations - The Workgroup submits formal recommendations to the IHS Director. Once approved, a Dear Tribal Leader Letter is issued to, communicate the actions and recommendations to the public.

**10 Catastrophic Health Emergency Funds Workgroup CHEF-WG**

https://www.federalregister.gov/documents/2016/01/26/2016-01138/catastrophic-health-emergency-fund

SUMMARY: The Indian Health Service (IHS) administers the Catastrophic Health Emergency Fund, The purpose of CHEF is to meet the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service. This proposed rule: Proposes definitions governing the CHEF; establishes that a Service Unit shall not be eligible for reimbursement for the cost of treatment until the episode of care's cost has reached a certain threshold; establishes a procedure for reimbursement for certain services exceeding a threshold cost; establishes a procedure for payment for certain cases; and, establishes a procedure to ensure payment will not be made from CHEF if other sources of payment (Federal, state, local, private) are available.

https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/2014_Letters/IHCIAprogressUpdateMay2014.pdf

Sec. 122. Catastrophic Health Emergency Fund { 25 U.S.C. § 1621a }

Amends certain provisions in current law establishing CHEF and the thresholds for reimbursement of costs connected with catastrophic illness and regulations to implement the requirements of CHEF.

- CHEF provisions were explained in a 2/9/2011 Dear Tribal Leader Letter.
- The IHS and Tribal workgroup on improving Contract Health Services (CHS) recommended setting the CHEF threshold at $19,000 for the fiscal year of a regulation and index to medical inflation annually in subsequent years thereafter.
- The IHS Director's Workgroup on Improving CHS (workgroup) designated a sub-group to make recommendations on improving CHEF. The sub-group's recommendations are pending review by the workgroup.

**11 IHS Contract Support Costs Workgroup** **CSC WG**

https://www.ihs.gov/tribalconsultation/workgroups/

The CSC Workgroup meets to further the federal government's administration of CSC within the IHS. The Agency, in active participation with Tribes, has developed a comprehensive CSC policy to implement the statutory provisions of the ISDA.

**Members:** The IHS/tribal CSC Workgroup is an open, informal workgroup. Participants include, but are not limited to, federal, tribal, and tribal organization representatives with an interest in CSC.

**Contact:** Roselyn Tso,
(301) 443-1083

**12 SAMHSA Tribal Technical Advisory Committee** **STTAC**

https://www.samhsa.gov/tribal-ttac/training-technical-assistance/advisory-committee

The Tribal Technical Advisory Committee helps build and maintain SAMHSA's government-to-government relationship with American Indian and Alaska Native tribes. In 2008, in recognition of presidential executive orders and memoranda on tribal consultation, SAMHSA formed the Tribal Technical Advisory Committee (TTAC) to enhance the government-to-government relationship and honor the federal trust responsibilities and obligations to tribes and American Indian and Alaska Native people. SAMHSA TTAC membership, made up of 14 elected tribal leaders from federally recognized tribes, provides a venue where tribal leadership and SAMHSA staff can:

- Exchange information about public health issues
- Identify urgent mental health and substance abuse need
- Discuss collaborative approaches to addressing behavioral health needs

Billings Area (MT, WY)

*Primary Delegate –* ***Vacant*** *Alternate Delegate -* ***Vacant***

**13 Secretary's Tribal Advisory Committee STAC-HHS**

https://www.hhs.gov/about/agencies/iea/tribal-affairs/about-stac/index.html

**Secretary's Tribal Advisory Committee**

The Secretary's Tribal Advisory Committee signals a new level of attention to Government-to-Government relationship between HHS and Indian Tribal Governments.

The STAC's primary purpose is to seek consensus, exchange views, share information, provide advice and/or recommendations; or facilitate any other interaction related to intergovernmental responsibilities or administration of HHS programs, including those that arise explicitly or implicitly under statute, regulation or Executive Order. This purpose will be accomplished through forums, meetings and conversations between Federal officials and elected Tribal leaders in their official capacity (or their designated employees or national associations with authority to act on their behalf).

**14 Tribal Leaders Diabetes Committee Representative TLDC**

https://www.ihs.gov/diabetes/about-us/tribal-leaders-diabetes-committee-tldc/

Tribal Leaders Diabetes Committee (TLDC)

The IHS Director established the Tribal Leaders Diabetes Committee (TLDC) in 1998 after the successful Tribal consultation process helped determine the mechanism for distributing Special Diabetes Program for Indians (SDPI) funds.

The TLDC makes recommendations to the IHS Director on broad-based policy and advocacy priorities for diabetes and related chronic conditions. The TLDC also plays a key role in ensuring that the IHS consults with Tribes before making decisions on diabetes treatment and prevention efforts.

The Committee consists of the following people:

- One elected Tribal Leader from each of the 12 IHS Areas
- One federal representative
- One technical advisor from each of the following groups: Direct Service Tribes Advisory Committee, National Congress of American Indians, National Council of Urban Indian Health, National Indian Health Board, and Tribal Self-Governance Advisory Committee

**15 Tribal Self-Governance Advisory Committee TSGAC**

https://www.ihs.gov/selfgovernance/advisorycommittee/

The Tribal Self-Governance Advisory Committee (TSGAC) plays no direct role in individual TSGP negotiations. The Committee advocates for Self-Governance Tribes, suggests policy guidance on the implementation of the TSGP,

and advises the IHS Director on issues of concern to all Self-Governance Tribes. The TSGAC consists of tribally elected officials representing a cross section of Self-Governance Tribes. One delegate and one alternate are nominated by each Area Director to represent the views and issues of the Area's Self-Governance Tribes. The IHS Director selects the representatives and formally appoints them to the TSGAC. The TSGAC members confer, discuss, and reach consensus on specific self-governance issues and provide verbal and written advice about self-governance issues to the IHS Director and the OTSG Director. As a result of active participation by TSGAC members, the committee advances self-governance objectives within the IHS by providing advice and input before final decisions on policy issues are made.

**16 IHS Information Systems Advisory Committee ISAC**

https://www.ihs.gov/isac/

The Information Systems Advisory Committee (ISAC) is established to guide the development of a co-owned and co-managed Indian health information infrastructure and information systems. The goal of the ISAC is to assure the creation of flexible and dynamic information systems that assist in the management and delivery of health care and contribute to the elevation of the health status of Indian people. The ISAC will assist in insuring that information systems are available, accessible, useful, cost effective, and user friendly for local level providers, while continuing to create standardized aggregate data that supports advocacy for Indian health programs at the national level.

Billings Area IHS Committee member - Bryce Redgrave IHS 406-247-7102

**17 National Indian Health Board Representative NIHB**

https://www.nihb.org/docs/05222015/What%20is%20the%20National%20Indian%20Health%20Board%202015.pdf

What is the National Indian Health Board?

Our Mission: One Voice affirming and empowering American Indian and Alaska Native Peoples to protect and improve health and reduce health disparities.

What is the National Indian Health Board?

The National Indian Health Board (NIHB) is a 501(c) 3 not for profit, charitable organization serving all 566 Federally recognized Tribal governments for the purpose of ensuring that the federal government upholds its trust responsibilities to provide health care to the Tribes. NIHB also works to elevate health care status, services and systems of the Tribes and our Peoples. NIHB provides policy analysis and advocacy on American Indian and Alaska Native (AI/AN) health and public health services, facilitates Tribal budget consultation, develops policy analysis, leads national Tribal public health programs and policy, is the coalition lead for the NIHB National Tribal Health Information Technology Extension Center (HITEC), and delivers timely information and other services to all Tribal Governments. Whether Tribes operate their own health care delivery systems through contracting and compacting or receive health care directly from the Indian Health Service (IHS), NIHB is their national advocate. NIHB also conducts research; provides policy analysis; assists with Tribal capacity building in health program development, management and assessment; provides national and regional Tribal health events; and provides training and technical assistance in a variety of Tribal health areas. These services are provided to Tribes, Area

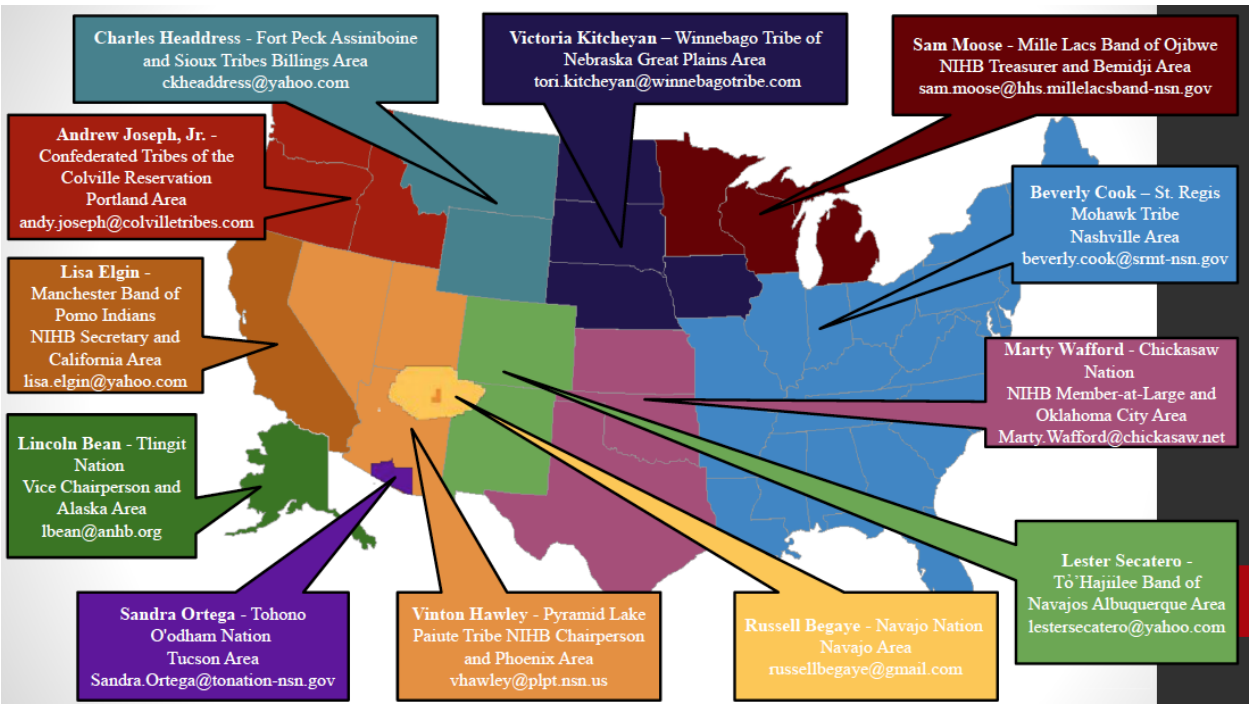
Health Boards, Tribal organizations, Tribal Leaders and members as well as federal agencies and private foundations.

The NIHB presents the Tribal perspective while monitoring, analyzing, reporting on and responding to federal legislation, policy, law and regulations. NIHB works collaboratively with the Tribes, through the Tribal health organizations, in the 12 IHS geographic Service Areas. NIHB also serves as a conduit to open opportunities for the advancement of AI/AN health care with other national and international organizations, foundations, corporations, academic institutions and others in its quest to build support for, and advance, Indian health care issues. Raising Awareness Elevating the visibility of Indian health care and public health issues has been a struggle shared by Tribal governments for hundreds of years. For more than 40 years, NIHB has played a central role in focusing national attention on Indian health care and public health needs. These efforts continue to gain results and momentum. The Tribes formed NIHB to serve as the unified advocate to the U.S. Congress, IHS and other federal agencies, private foundations and potential friends and allies about health disparities, public health and health care issues experienced in Indian Country. The future of health care for AI/AN remains grounded in the Federal Trust Responsibility between AI/AN and the federal government. It is intertwined with policy decisions at the federal level and changes in mainstream health care management.

The NIHB provides Tribal governments with timely information in order to assist Tribes in effectively making sound health care policy decisions. Our Board of Directors Because the NIHB serves all federally-recognized Tribes, it is vital that the work of the NIHB reflects the unity and diversity of Tribal values and opinions in an accurate, fair, and culturally-sensitive manner. This objective is accomplished through the efforts of the NIHB Board of Directors and through working with the regional health boards, Tribes and health organizations located in the 12 IHS Service Areas.

The NIHB is governed by a Board of Directors consisting of representatives elected by the Tribes in each of the twelve IHS Areas, through their regional Tribal Health Board or health-serving organization. Each Area Indian Health Board elects a representative and an alternate to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative.

The Board of Directors elects an Executive Committee comprised of Chairperson, Vice-Chair, Treasurer, and Secretary, who serve staggered, two-year terms and a Member-at-Large who serves a one year term. The Board of Directors meets quarterly. NIHB Membership The membership of NIHB is comprised of all Federally Recognized Tribes through the 12 regional Tribal health organizations: Aberdeen Area: Great Plains Tribal Chairmen's Health Board California Rural Indian Health Board Alaska Area: Alaska Native Health Board Navajo Nation Albuquerque Area Indian Health Board Oklahoma City Area Intertribal Health Board Bemidji Area: Midwest Alliance of Sovereign Tribes Phoenix Area: Intertribal Council of Arizona Billings Area: Montana/Wyoming Tribal Leaders Council Portland Area: Norwest Portland Area Indian Health Board Nashville: United South and Eastern Tribes, Inc. Tucson Area: Tohono O'odham Nation & Pascua Yaqui Tribe




**18 National Congress of American Indians** **NCAI**

http://www.ncai.org/about-ncai/ncai-governance

**NCAI at Work**

NCAI represents a diverse network of tribal nations, tribal citizens, and Native organizations. As a member-based representative Congress, NCAI is governed by voting members who determine NCAI's consensus positions expressed in resolutions, which are developed in committees and sub-committees and then voted on at national conventions. NCAI members also elect the organization's Executive Committee - the NCAI President, 1st Vice President, Recording Secretary, and Treasurer. These are elected by the entire membership. The 12 Regional Vice Presidents are elected by their respective regions. All board members serve for two-year terms. The current President of NCAI is Brian Cladoosby (*Swinomish Indian Tribal Community*).

**19 BIA Budget Formulation Workgroup** **DOI**

https://www.google.ca/search?rlz=1C1GCEA_enCA747CA747&ei=wtAuWu-6H4W2jwP89qjYDg&q=BIA+Budget+Formulation+Workgroup+&oq=BIA+Budget+Formulation+Workgroup+&gs_l=psy-ab.3..33i160k1.2992.24509.0.25776.91.24.2.0.0.0.290.3219.0j9j7.17.0....0...1c.1.64.psy-ab..84.7.1165.6..35i39k1.214.RC_IdOxYSes

**Budget Formulation**

Indian Affairs will solicit the active participation of Indian Tribes and organizations in the formulation of the IA budget request. Regional budget formulation teams will provide ongoing support to the budget formulation activities at the region level. Each team shall consist of TIBC members or their designee, and regional staff.

Indian Affairs Central Office provides standard instructions to the regions for the development of tribal initiatives:

- The team solicits Region-wide input in establishing tribal initiatives for the Region.
- The tribal initiatives provide the basis for developing the Indian Affairs budget request.

**Central Office Budget Formulation Work Team**

Provides staff support to the Deputy Assistant Secretary – Management, Director, Bureau of Indian Affairs, and Director, Bureau of Indian Education for budget formulation.

- Develops the Indian Affairs budget request in accordance with DOI and Office of Management and Budget guidelines.
- Provides information on the formulation process and budget requests as needed.
- Ensures tribal initiatives are included at the National Budget Meeting and provides recommendations to the working sessions of the tribal budget sub-committee.
- Ensures tribal initiative packages are provided to Central Office programs for use in formulating their budgets.
- Ensures the consolidated tribal initiative package is provided to the Assistant Secretary – Indian Affairs for use in making budget decisions.
- Team includes budget, performance, and program staff.

**National Budget Meeting**

The National Budget Meeting is conducted yearly in March to allow the regions to present their recommendations for the Indian Affairs proposed budget request.

**TIBC Tribal Budget Sub-Committee**

The workgroup consists of a diverse group of 638, direct service, and self-governance tribal volunteer representatives from TIBC as identified at the National Budget Meeting. The sub-committee will:

- Provide input and recommendations to develop a consolidated Indian Affairs budget submission and testimony.
- Meet with the Assistant Secretary and present the consolidated budget and testimony.

Costs incurred by the Tribe(s) for the purpose of participating in the TIBC Budget Sub-Committee shall be the responsibility of Indian Affairs.

**Indian Affairs Budget Formulation Process**

Regional Budget Formulation Teams ensure tribal programs input to begin the Indian Affairs (IA) budget formulation process. Each Region convenes on an annual basis, sometime during September through December

to determine their respective budget recommendations. A unified regional submission is prepared to reflect those recommendations.

Regional submissions are collected and compiled by the Central Office Budget Formulation Work Team to review during the Tribal Interior Budget Council (TIBC) National Budget Meeting. At this session, regional representatives agree on a set of national recommendations for the upcoming budget year to advocate for the IA budget.

Tribal testimony is formally presented to the Department of the Interior during the TIBC National Budget Meeting, in March.

The Budget Subcommittee convenes and develops the national budget submission and testimony, presenting these to the Assistant Secretary – Indian Affairs, based on consolidated rankings and recommendations from TIBC.

**Regional Budget Formulation Team**

The role of regional representatives during the National Budget Meeting:

- Attend and participate in the National Budget Meeting.
- Be familiar with the details of their regional recommendations and be prepared to present and actively discuss recommendations.
- Have authority to negotiate regional tribal proposals in order to produce National budget recommendations and initiatives to the Assistant Secretary – Indian Affairs and the Secretary of the Interior.

**Regional Instructions**

All Regions will assist their tribes in preparing regional and agency budget tables using the spreadsheets provided. The Region Table includes a column to outline proposed increases and a column to outline unfunded obligations. Following the instructions outlined in this guide will ensure that the data used at the National Budget Meeting is complete and comparable; assisting the Regional Budget Teams in accomplishing their charge of producing a national set of FY 2018 tribal focus areas for IA funded programs.

The Central Office Budget Formulation Work Team will provide training materials on the Federal budget process and Performance Measures and Assessments; additional training may be provided by the regional team member designated.

**Each Region will provide:**

- Annual training on the Federal Budget Process as necessary;
- Performance Measures/Assessments.

All funding outlined in the tables is in thousands and each table reflects the funding at the regional level. The agency tables are regional level funding, not agency level funding.

Note on the IHCIF **– *"25 percent alternate resources factor"*** from the CFR

D. Alternate Resources

In accordance with section 202(d)(5) of IHCIA [25 U.S.C. 1621a (d)(5)], alternate resources must be exhausted before reimbursement is made from CHEF. No reimbursement shall be made from CHEF to any Service Unit to the extent the patient is eligible to receive payment for treatment from any other Federal, State, Tribal, local, or private source of reimbursement. Medical expenses incurred for catastrophic illnesses and events will not be considered eligible for reimbursement if they are payable by alternate resources, as determined by IHS, whether or not such resources actually make payment. IHS is the payor of last resort and, if the provider of services is eligible to receive payment from other resources, the medical expenses are only payable by PRC and reimbursable by CHEF to the extent IHS would not consider the other resources to be ''alternate resources'' under the applicable regulations and IHS policy. Expenses paid by alternate resources are not eligible for payment by PRC or reimbursement by CHEF. However, if the patient becomes eligible for alternate resources, the Service Unit shall return all funds reimbursed from CHEF to the Headquarters CHEF account.