RESOLUTION OF THE
NAABIK'IYATI'COMMITTEE OF THE
NAVAJO NATION COUNCIL

23RD Navajo Nation Council---First Year 2015

AN ACTION

RELATING TO HEALTH, EDUCATION AND HUMAN SERVICES AND NAABIK'ÍYÁTI' COMMITTEES; REQUESTING A TRIBAL CONSULTATION WITH THE CENTERS FOR MEDICARE AND MEDICAID SERVICES TO ADDRESS CREATING MORE FLEXIBLE STANDARDS AS PERTAINS TO TRADITIONAL PRACTICES IN TRIBALLY OWNED LONG-TERM CARE FACILITIES, AND PARTICULARLY CHINLE NURSING HOME

WHEREAS:

A. The Health, Education and Human Services Committee ("HESHC") is established as a standing committee of the Navajo Nation Council, which has oversight authority over health related activities of the Navajo Nation and its tribal organizations, enterprises, relating to the delivery of health services including research, planning and prevention. 2 N.N.C. §§ 400(A), 401(C)(2); *see also CJA-03-13*.

B. The Navajo Nation established the Naabik'íyáti' Committee as a Navajo Nation Council standing committee and as such empowered Naabik'íyáti' Committee to coordinate all federal programs, i.e. United States Department of Health and Human Services ("HHS"), to provide efficient services to Navajo members. 2 N.N.C. §§ 164 (A)(9), 700 (A), 701 (A)(4); *see also CJA-03-13*.

C. The Centers for Medicare & Medicaid Services ("CMS") is part of HHS that administers Medicare, Medicaid, the Children's Health Insurance Program, and parts of the Affordable Care Act (ACA). *See* Website at https://www.cms.gov/.

D. Navajoland Nursing Homes, Inc. ("Chinle Nursing Home" or "CNS"), operated out of Chinle, Arizona, is a tribally-operated Long-Term Services and Support program certified with CMS.

E. CNS currently provides a few tribally operated services, such as hospice care and speech therapy, and contract services such as cultural activities.

F. CNS is currently one of sixteen (16) established, tribally operated nursing home facilities in Indian Country. *See* LTSS Research: Nursing Home Facility Inventory attached as Exhibit A.

G. Due to a dilapidated building that lacks funding to be brought up to regulatory standards, CNS recently faced near closure for not meeting CMS requirements. *See* News Story attached as Exhibit B.

H. Amongst issues pertaining to CNS, such as the lack of adequate infrastructure, current regulations imposed on CNS and administered through CMS hinder cultural and traditional practices from being exercised.

I. There is a need to develop more flexible regulations as it pertains to the implementation of practicing traditional medicine in long-term care facilities at tribally operated nursing home facilities.

J. CMS has developed a Tribal Consultation Policy, which was developed with the objective to create opportunities for Indian Tribes to raise issues with CMS and for CMS to seek consultation with Indian Tribes and communication with the Tribal Technical Advisory Group ("TTAG") and Indian organizations when new issues arise. *See* Tribal Consultation Policy attached as Exhibit C.

K. The Tribal Technical Advisory Group serves as an advisory body to CMS to provide expertise on policies, guidelines and programmatic issues affecting the delivery of health care for American Indian and Alaska Natives served through programs funded by CMS. *See* Exhibit C.

L. Currently, President Russell Begaye is the Representative serving as the Navajo Area representative on TTAG. *See* TTAG Membership attached as Exhibit D.

M. It is in the best interests of the Navajo Nation to request tribal consultation with CMS on the issue of more flexible regulations as it pertains to traditional healing practices in tribally operated long-term care facilities, and

especially as relates to the Navajo Nation and Chinle Nursing Home.

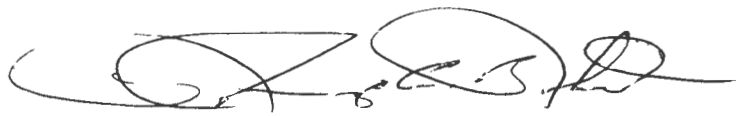
NOW, THEREFORE, BE IT RESOLVED:

A. The Navajo Nation hereby requests tribal consultation with the Centers for Medicare & Medicaid Services on the issue of more flexible regulations as it pertains to traditional practices in tribally operated long-term care facilities, and especially as it relates to the Navajo Nation and Chinle Nursing Home.

B. The Navajo Nation authorizes President Russell Begaye, as representative for TTAG or his designee or alternate to advocate for more flexible regulations as it pertains to traditional practices in tribally operated long-term care facilities, and in particular Chinle Nursing Home, and for a tribal consultation with CMS on the matter.

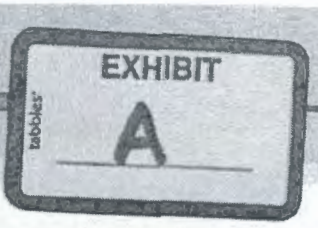
CERTIFICATION

I hereby certify that the foregoing resolution was duly considered by the Naabik'íyáti' Committee of the 23rd Navajo Nation Council at a duly called meeting in Window Rock, Navajo Nation (Arizona), at which a quorum was present and that the same was passed by a vote of in 15 favor and 0 oppose, this 12th Day of November, 2015.



Honorable LoRenzo C. Bates, Chairperson
Naabik'íyáti' Committee

Motion : Davis Filfred
Second : Dwight Witherspoon



Department of Health & Human Services, Centers for Medicare & Medicaid Services

LTSS Research: Nursing Home Facility Inventory

Nursing Homes in Indian Country

Submitted March 16, 2015

Background

American Indians and Alaska Natives (AI/ANs) have a unique relationship with the federal government. It is unlike any other population in the United States, based in part on treaties negotiated with sovereign Indian nations, beginning in the colonial period and continuing after the establishment of the United States into the late 1800s. These treaties have established a unique government-to-government relationship, based upon the cession of millions of acres of land in exchange for certain promises, benefits, and reserved rights. These treaties have helped secure the federal obligation to provide health services to AI/ANs. The Snyder Act[1] was authorized by Congress in 1921 to provide health care access to Indian people throughout the United States. Later, the Indian Health Service (IHS) was established under the U.S. Public Health Service to carry out this responsibility under the Transfer Act in 1955.[2]

Health programs funded through IHS serve more than 2 million AI/AN people from 566 federally recognized tribes and 34 urban Indian communities. While there has been steady progress in health care services since 1955, the health status of AI/AN populations still lags far behind that of other populations, worsened by poverty, poor nutrition, obesity, substance use disorders, violence, and injuries. Trends show that AI/AN populations suffer from higher rates of death and disease than their counterparts. As health services to AI/AN communities improve, so does the longevity of AI/AN populations. Ironically, as people live longer, they are more likely to grapple with issues of chronic disease[3] and comorbidity requiring 24-hour-a-day care late in life.

Compounding the health issues that AI/ANs face are geographic isolation, poverty, and a lack of access to health care and health insurance. It is because of this that AI/ANs are projected to seek care at later stages of disease, which lowers survival rates.[4] Delayed access to health care leads many to frailty, deteriorated health conditions, and the need for skilled nursing facility or hospice care. The lack of cultural sensitivity in facilities and hospitals serving AI/ANs might cause Native populations to seek care at later stages of their disease.[5]

Nursing Home Facilities in Indian Country

Within the continuum of care, nursing home facilities (NHFs) provide the most intensive care. Residents of this type of facility-based setting demand 24-hours-a-day care. Individuals who need assistance with three or more activities of daily living (ADLs) require a skilled nursing-level of care.[6] This type of care must be administered by staff who meet state regulations.[7] For tribal communities, available NHFs are often great distances from an elder's home and family. These

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[1] Public Law 67–85
[2] H.R. 303. Public Law 568
[3] Finke et al. 2004, Hampton 2005, Indian Health Service 2006, Kitzes 2003, Arenella et al. 2010
[4] Kitzes 2002, Arenella et al. 2010, Marr et al. 2012, Portman and Garret 2006, National Cancer Institute 2011
[5] Hendrix 2003
[6] National Resource Center on Native American Aging 2002
[7] McDonald 2005

facilities also often lack culturally sensitive tools and protocols. These combined factors contribute to elder loneliness, alienation, and isolation, especially if the elder is a non-English speaker.[8]

Currently, there are 16 established, tribally operated NHFs in the United States, as shown in Table I.

Table I. NHFs in the United States by Region

Region	State	Nursing Home
Southwest	Arizona	Caring House
		Chinle Nursing Home
		Archie Hendricks, Sr. Skilled Nursing Center
	New Mexico	Laguna Rainbow Nursing Facility
Alaska	Alaska	Utuqqanaat Inaat
		Quyanna Care Center
		Yukon Kuskokwim Elder's Home
Midwest	Minnesota	Jourdain/Perpich Extended Care Center
	Nebraska	Carl T. Curtis Health Education Center
	South Dakota	White River Health Care Center
	Wisconsin	Anna John Resident Centered Care Community
Eastern	Mississippi	Choctaw Residential Center
	North Carolina	Tsali Care Center
Northwest	Montana	Blackfeet Care Center
	Washington	Colville Tribal Convalescent Center
	Wyoming	Morning Star Manor

Over half of the tribally operated NHFs have a bed capacity at or under 50 beds, and two NHFs (the Choctaw Residential Center in Mississippi and the Caring House in Arizona) have a capacity for 100 or more beds. Ten NHFs have been in operation for more than 20 years, and only three NHFs have been established since 2000 (Archie Hendricks, Sr. Skilled Nursing Center in Arizona and Utuqqanaat Inaat Nursing Home and Yukon Kuskokwim Elder's Home in Alaska).

Table II, Tribally Operated Nursing Home Facilities (Appendix A), lists all of the tribally operated NHFs in Indian Country, along with detailed information about each facility. Three NHFs are in discussion or development phases: Native Veterans Nursing Home in Arizona, Edith

[8] Branch 2010

Kassanavoid Gordon Assisted Living Center in Oklahoma, and Whiteclay Nursing Home in Nebraska. The Whiteclay Nursing Home is an operation owned by the Oglala Sioux tribe. While the tribe's reservation is located in South Dakota, the nursing home is being constructed in Whiteclay, Nebraska.

The small number of nursing homes and their limited capacities point to an increasing need in Indian Country, especially as the aging AI/AN population grows. A lack of long-term care service and support options leads many to seek institutional care in the form of nursing homes.

Medicare Nursing Home Compare

In 2008, the Centers for Medicare & Medicaid Services (CMS), along with long-term care experts, developed the Medicare Nursing Home Compare (MNHC) website to provide nursing home comparisons for the public (http://www.medicare.gov/nursinghomecompare). The MNHC website offers nursing home comparison capability, and lists NHFs that are Medicare or Medicaid certified and provide "skilled" care.

The comparisons are based on CMS' Five-Star Nursing Home Quality Rating System.[9] The rating system "assigns each nursing home an overall rating and three component ratings for health inspections, staffing, and quality measures, based on the extent to which the nursing home meets CMS' quality standards and other measures."[10] Each rating can range from one to five stars, five stars indicating higher qualities and three indicating "average" qualities. Each nursing home identified on the MNHC has an overall rating, lists penalties within past 3 years, and provides a rating per the following categories:

- health and fire-safety inspections are annual inspections conducted by the state to ensure NHFs meet Congressional requirements on measures of nutrition and diet, pharmacy services, and resident rights, to name a few;
- NHF staffing comparisons that asses the number of NHF staff (registered nurse, licensed practical nurse, certified nursing assistant, and physical therapist) versus the number of hours staff make available per NHF resident, based on federal requirements;
- quality measures that analyze the Minimum Data Set (MDS), an annual assessment completed by NHFs detailing residents' health, physical functioning, mental status, and general well-being.

The MNHC website notes that nursing home profile data comes from annual comprehensive inspections plus the previous 3 years' complaint investigations with comparisons to state and national averages for each category. Specifically, the data comes from CMS' Health Inspection Database, and the MDS. CMS' Health Inspection database includes annual state NHF inspections and complaint investigations. The MDS assessment is completed by each Medicare

[9] Government Accountability Office 2012
[10] Government Accountability Office

or Medicaid-certified NHF for each resident to aid the NHF's development of individual care plans for residents. The MNHC website notes that NHFs provide all of the data, and that "nursing home inspectors review it, but don't formally check it to ensure accuracy."

The MNHC includes each of the 16 tribally operated nursing homes. Table III, NHF Five-Star Rating Summary (Appendix B), summarizes the five-star ratings for each tribally operated NHF, finding that:

- Two NHFs received a four-star overall rating (Archie Hendricks, Sr. Skilled Nursing Center and Anna John Resident Centered Care Community),
- Five NHFs were rated an overall three stars,
- Four NHFs were rated two stars, and
- Five NHFs received an overall rating of one star.

In the Staffing category, each NHF was rated at or above average, with eight NHFs receiving five stars. In the Health & Fire Safety Inspections and Quality Measures categories, more than half of the NHFs were rated at or below average. Only White River Health Care Center; Archie Hendricks, Sr. Skilled Nursing Center; and Laguna Rainbow Nursing Facility received a five-star rating in the Quality Measures category.

Nursing Home Facility Support and Development

Medicare and Medicaid certification has been identified as a longstanding barrier to tribal communities in the development of healthcare services and facilities—culturally and financially. The development of an NHF, in particular, is a costly endeavor due to operational expenses. Tracking changes that occur with each tribal NHF is important to better understand the field of long-term supports and services and, specifically, NHFs in Indian Country. An expanded review of the MNHC website would be useful to learn more about how NHFs in tribal communities meet state certifications and quality measures. The MNHC profiles of the 16 tribally operated NHFs overtime could be used to develop best practices, training materials, or tools for tribal communities looking to address long-term care needs and cultural considerations for patients.

Appendix A

Tribally Operated Nursing Home Facilities

Table II. Tribally Operated NHFs

An asterisk (*) indicates NHFs that are in discussion and development phases

Tribal Affiliation	NHF Name and Address	Contact	Beds, Year Opened
Alaskan Region			
Maniilaq Community Association	**Utuqqanaat Inaat** 436 Mission St. P.O. Box 510 Kotzebue, AK 99752	Valdeko Ivan Kreil Administrator valdeko.kreil@maniilaq.org P: (907) 442-3321 F: (907) 442-7250	18 beds, 2011
Stebbins Community Association	**Quyanna Care Center** 1100 Greg Kruschek Ave. P.O. Box 966 Nome, AK 99762	Angela Gorn Administrator agorn@nshcorp.org P: (907) 443-3357 F: (907) 443-3368	18 beds, 1988
Yukon Kuskokwim Health Corporation	**Yukon Kuskokwim Elder's Home** 1100 Chief Eddie Hoffman Hwy. P.O. Box 528 Bethel, AK 99559	Gerald Hodges Administrator gerald_hodges@ykhc.org P: (907) 543-6782 F: (907) 543-6780	18 beds, 2013
Northwestern Region			
Blackfeet Nation	**Blackfeet Care Center** 728 S Government Sq. P.O. Box 728 Browning, MT 59417	Martha Spotted Eagle Administrator mytanagirl@yahoo.com P: (406) 338-2686 F: (406) 338-7779	47 beds, 1970
Confederated Tribes of the Colville Reservation	**Colville Tribal Convalescent Center** 1 Convalescent Center Blvd. P.O. Box 150 Nespelem, WA 99155	Shoshannah Jordan Administrator shoshannah.jordan@colvilletribes.com P: (509) 634-2878 F: (509) 634-2889	44 beds, 1981

Nursing Homes in Indian Country

Tribal Affiliation	NHF Name and Address	Contact	Beds, Year Opened
Shoshone Tribe of the Wind River Reservation	**Morning Star Care Center** 4 N Fork Rd. P.O. Box 859 Fort Washakie, WY 82514	Kathy King Director, Tribal Health Programs esth.director@gmail.com P: (307) 332-6902 F: (307) 332-4279	45 beds, 1980
Southwestern Region			
Gila River Indian Community	**Caring House** 510 S Ocotillo Dr. Sacaton, AZ 85147	Christopher Daroczy Administrator cdaroczy@gricc.org P: (520) 562-7400 F: (520) 562-7406	100 beds, 1992
Navajo Nation	**Chinle Nursing Home** 5755 East Main St. P.O. Box 910 Chinle, AZ 86503	Wayne Claw CEO wynclaw@yahoo.com P: (928) 674-5216 F: (928) 674-5218	79 beds, 1968
Navajo Nation	**Native Veterans Nursing Home*** Chinle, AZ	NA	NA
Tohono O'odham Nation	**Archie Hendricks, Sr. Skilled Nursing Center** Federal Rte. 15, Milepost 9 HC 01 Box 9100 Sells, AZ 85634	Lee Olitzky Administrator lolitzky@toltc.org P: (520) 361-1803 F: (520) 361-3656	60 beds, 1998
Pueblo of Laguna	**Laguna Rainbow Nursing Facility** I-40 Exit 108 1/2 Mile S State Road 23 P.O. Box 490 Casa Blanca, NM 87007	Michael Banes Administrator mbanes@lagunarainbow.org P: (505) 552-6034 F: (505) 552-7645	58 beds, 1981
Midwestern Region			
Comanche Nation	**Edith Kassanavoid Gordon Assisted Living Center*** Lawton OK	NA	NA

Tribal Affiliation	NHF Name and Address	Contact	Beds, Year Opened
Red Lake Band of Chippewa Indians	**Jourdain/ Perpich Extended Care Center** 24856 Hospital Dr. P.O. Box 399 Red Lake, MN 56671	Gary Hjelmstad Interim Administrator P: (218) 679-3400 F: (218) 679-3434	47 beds, 1984
Omaha Tribe of Nebraska	**Carl T. Curtis Health Education Center** 100 Indian Hills Dr. P.O. Box 250 Macy, NE 68039	Kourtney Williams Administrator P: (402) 837-5381 F: (406) 837-4216	25 beds, NA
Oglala Sioux Tribe	**Whiteclay Nursing Home*** Whiteclay, NE	NA	NA
Rosebud Sioux Tribe	**White River Health Care Center** 515 E 8Th St. P.O. Box 310 White River, SD 57579	Carol Gregg Administrator wrhccbus@goldenwest.net P: (605) 259-3161 F: (605) 259-3106	52 beds, 1974
Oneida Nation	**Anna John Resident Centered Care Community** 2901 S. Overland Rd. P.O. Box 365 Oneida, WI 54155	Nola Feldkamp Administrator nfeldkamp@oneidanation.org P: (920) 869-2797 F: (920) 869-3238	48 beds, 1978
Eastern Region			
Mississippi Band of Choctaw Indians	**Choctaw Residential Center** 135 Hospital Cir. Philadelphia, MS 39350	Wendy Moran Administrator wendymoran.crc11@yahoo.com P: (601) 656-2582 F: (601) 656-0670	120 beds, 1987
Eastern Band of Cherokee Indians	**Tsali Care Center** 55 Echota Church Rd. Cherokee, NC 28719	David Hunt Administrator davihunt@nc-cherokee.com P: (828) 554-6506 F: (828) 497-5347	72 beds, 1995

Appendix B

NHF Five-Star Rating Summary Table

Table III. NHF Five-Star Rating Summary

N Name	Overall Rating	Health & Fire Safety Inspections	Staffing	Quality Measures	Penalties (Actual #)
Alaskan Region					
Utuqqanaat Inaat (AK)	3	2	5	2	2
Quyanna Care Center (AK)	3	2	5	2	1
Yukon Kuskokwim Elder's Home (AK)	2	1	5	NA	1
Northwestern Region					
Blackfeet Care Center (MT)	3	2	5	3	0
Colville Tribal Convalescent Center (WA)	1	1	3	4	0
Morning Star Care Center (WY)	1	1	3	3	0
Southwestern Region					
Caring House (AZ)	1	1	5	1	0
Chinle Nursing Home (AZ)	1	1	3	3	1
Archie Hendricks, Sr. Skilled Nursing Center (AZ)	4	2	5	5	0
Laguna Rainbow Nursing Facility (NM)	3	2	3	5	0
Midwestern Region					
Jourdain/Perpich Extended Care Center (MN)	1	1	4	1	0
Carl T. Curtis Health Education Center (NE)	3	2	5	2	0
White River Health Care Center (SD)	2	1	3	5	0
Anna John Resident Centered Care Community (WI)	4	3	4	2	0
Eastern Region					
Choctaw Residential Center (MS)	2	3	3	1	0
Tsali Care Center (NC)	2	1	5	3	0

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KRQE NEWS 13

Navajo nursing home faces closure

The Associated Press

Published: July 29, 2015, 8:01 am | Updated: July 29, 2015, 8:59 am

GALLUP, N.M. (AP) – The Navajo Nation's only nursing home, which caters to nearly 80 elderly patients, is at risk of being shut down as the facility faces a hefty fine over safety code violations.

The Gallup Independent (http://bit.ly/1MtJGQU) reports that Chinle Nursing Home CEO, Wayne Claw, says they owe nearly $200,000 because the aged building doesn't meet the Native American Center for Medicare/Medicaid Services requirements. The nursing home

may lose its license, which Claw says could force elderly patients to relocate off the Navajo Nation.

Navajo Nation President Russell Begaye in a statement said there are plans to build a new nursing home that could serve 120 Navajo elders and could cost about $29 million.

But Claw hopes something is done soon, as the nursing home may close sooner than the 2016 projection.

KRQE News 13

Centers for Medicare & Medicaid Services
Tribal Consultation Policy

1. INTRODUCTION

On November 5, 2009, President Obama signed an Executive Memorandum reaffirming the government to government relationship between the Indian Tribes and the Federal Government, and directing each executive department and agency to engage in regular and meaningful consultation and collaboration with Tribal officials in the development of Federal policies that have Tribal implications and a substantial direct effect on Indian Tribes. The importance of consultation with Indian Tribes was affirmed through Presidential Memoranda in 1994, 2004 and 2009, and Executive Order (EO) 13175 in 2000.

2. BACKGROUND

Since the formation of the Union, the United States (U.S.) has recognized Indian Tribes as sovereign nations. A unique government-to-government relationship exists between Indian Tribes and the Federal Government and this relationship is grounded in the U.S. Constitution, numerous treaties, statutes, Federal case law, regulations and executive orders that establish and define a trust relationship with Indian Tribes. This relationship is derived from the political and legal relationship that Indian Tribes have with the Federal Government and is not based upon race. This special relationship is affirmed in statutes and various Presidential Executive Orders including, but not limited to:

- Older Americans Act of 1965, Pub. L. 89-73, as amended;
- Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended
- The Indian Health Care Improvement Act, Pub. L. 94-437, as amended;-Native Americans Programs Act of 1974, Pub. L. 93-644, as amended
- Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104-193
- Presidential Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, November 6, 2000;
- Presidential Memorandum, Government-to-Government Relationship with Tribal
- Governments, September 23, 2004;
- Presidential Memorandum, Tribal Consultation, November 5, 2009;
- American Recovery and Reinvestment Act of 2009, Pub. L. 111-5, 123 Stat. 115 (Feb. 17, 2009);
- Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. 111-3, 123 Stat. 8 (Feb. 4, 2009);
- Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148, 124 Stat. 119 (Mar. 23, 2010).

3. PURPOSE

An integral element of the government to government relationship is that consultation occurs with Indian Tribes. In recognition of this special relationship, the Department of Health and Human Services (HHS) revised its Tribal Consultation Policy on December 14, 2010. Under the HHS Consultation Policy every operating Division of HHS shares the Department-wide responsibility to consult with Indian Tribes. The Centers for Medicare & Medicaid Services (CMS) Tribal Consultation policy hereby incorporates and fully adheres to the HHS Policy as revised on December 14, 2010. The purpose of the CMS Tribal Consultation policy is to build meaningful relationships with Indian Tribes and to establish a clear,

concise and mutually acceptable process through which consultation can take place between CMS and Tribes.

The CMS Tribal Consultation Policy was developed based upon:

- Presidential Executive Order 13175 (2000) and Executive Memorandum on Tribal Consultation (November 5, 2009)
- HHS Tribal Consultation Policy (December 14, 2010)
- Input from the CMS Tribal Technical Advisory Group (CMS TTAG)
- Input from Tribes to ensure a consultation policy that reflects the goals of all partners involved
- Input from the CMS components and CMS regional offices

4. OBJECTIVES

In order to fully effectuate this Consultation Policy, CMS will:

- Formalize CMS' policy to seek consultation and the participation of Indian Tribes in the development of policies and program activities that impact Indian Tribes;

- Create opportunities for Indian Tribes to raise issues with CMS and for CMS to seek consultation with Indian Tribes and communication with the TTAG and Indian organizations when new issues arise;

- Establish a minimum set of requirements and expectations with respect to consultation and participation for the levels of CMS management;

- Conduct Tribal consultation regarding CMS's policies and actions that have tribal implications;

- Establish improved communication channels with Indian Tribes, TTAG, and Indian organizations to increase knowledge and understanding of CMS' programs;

- Coordinate with IHS and other Divisions of HHS on issues of mutual concern;

- Coordinate among CMS Regional Offices and Central Office to assure consistent policy interpretations and interactions of all levels of CMS with Indian Tribes;

- Enhance partnerships with Indian tribes that will include technical assistance and access to CMS programs and resources.

5. TRIBAL CONSULTATION PRINCIPLES

CMS and Indian Tribes share the goals of eliminating health disparities for American Indians and Alaska Natives (AI/AN) and of ensuring that access to Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and Exchanges is maximized. To achieve these goals, and to the extent practicable and permitted by law, it is essential that CMS and Indian Tribes engage in open, continuous and meaningful consultation.

Consultation is an enhanced form of communication that emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues and better outcomes.

To establish and maintain a positive government to government relationship, communication and consultation must occur on an ongoing basis so that Indian Tribes have an opportunity to provide meaningful and timely input on issues that may have a substantial direct effect on Indian Tribes. Consultation with Tribal Governments is especially important in the context of CMS programs because Indian Tribes serve many roles in their tribal communities:

- Tribal members are beneficiaries of services provided by the Indian Health Services (IHS), by tribal health programs operating under the Indian Self-Determination and Educations Assistance Act, Pub. L. 93-638, as amended, and by urban Indian health programs operating under Title V of the Indian Health Care Improvement Act.
- Tribal members are also eligible to enroll in Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and Exchanges.
- Tribal governments operate businesses, are employers, and are health care providers, through administration of hospitals, clinics, and other health programs.

In 1976, Congress recognized the need for AI/ANs to have access to Medicare and Medicaid services in IHS and Tribal facilities located in Tribal communities and amended titles XVIII and XIX of the Social Security Act to authorize the IHS and Tribal health programs to bill Medicare and Medicaid for services provided in these facilities. Many of the IHS and Tribal facilities are located in remote and isolated locations, experience difficulty in recruitment and retention of health professionals, and endure challenging socio-economic conditions. The involvement of Indian Tribes in the development of CMS policy is crucial for mutual understanding and development of culturally appropriate approaches to improve greater access to CMS programs for AI/ANs, to enhance health care payment and resources to IHS and Tribal health providers, and to contribute to overall improved health outcomes for Indian people.

An action that triggers consultation is any policy that will significantly affect Indian Tribes. Although determined on a case by case basis, such issues could arise in any policy area for which the CMS has responsibility, such as program eligibility standards, changes in provider payment and reimbursement methodologies, or changes in services covered by CMS programs.

To the extent practicable and permitted by law, CMS shall not promulgate any regulation that has Tribal implications, or that imposes substantial direct compliance costs on Indian Tribe(s), or that is not required by statute, unless:

- Funds necessary to pay the direct costs incurred by the Indian Tribe or Indian health provider in complying with the regulation are provided by the Federal Government; or
- CMS, prior to the formal promulgation of the regulation,
    - Consulted with Indian Tribes throughout all stages of the process of developing the proposed regulation;

- Made available to the Administrator any written communications submitted to CMS by Tribal officials and Indian health providers;

- Provided a Tribal summary impact statement in a separately identified portion of the preamble to the regulation as it is to be issued in the *Federal Register* (FR), which consists of a description of the extent of CMS's prior consultation with Indian Tribes, a summary of the nature of their concerns and CMS's position supporting the need to issue the regulation, and a statement of the extent to which the concerns of Tribal officials have been met; and

To the extent practicable and permitted by law, CMS shall not promulgate any regulation that has Tribal implications and that preempts Tribal law, unless CMS, prior to the formal promulgation of the regulation,

- Consulted with Tribal officials throughout all stages of the process of developing the proposed regulation;

- Made available to the Administrator any written communications submitted to CMS by Tribal officials.

- Provided a Tribal summary impact statement in a separately identified portion of the preamble to the regulation as it is to be issued in the FR, which consists of a description of the extent of CMS's prior consultation with Tribal officials, a summary of the nature of their concerns and CMS's position supporting the need to issue the regulation, and a statement of the extent to which the concerns of Tribal officials have been met.

Nothing in this policy waives the Government's deliberative process privilege.

6. ROLES

The government-to-government relationship between the U.S. and Federally recognized Indian Tribes dictates that the principal focus for consultation by CMS is with Indian Tribes, individually or collectively. Consultation parties are:

- Indian Tribes represented by the Tribal President, Tribal Chair, or Tribal Governor, or an elected or appointed Tribal Leader, or their authorized representative (s).
- CMS Administrator, CMS Deputy Administrator, CMS Regional Administrators, or their designee.

Each party will identify his/her authorized representatives with delegated authorities to negotiate on his/her behalf.

CMS Central Office: All of the components at CMS Central Office play a major role in the Department-wide responsibility to consult, coordinate and communicate with Indian Tribes on issues that affect Indian Tribes and CMS programs, services and resources available to Indian Tribes. Within CMS Central, the Tribal Affairs Group, Office of Public Engagement, advises the CMS Administrator, senior staff, and other CMS components on matters affecting American Indian and Alaska Native health, including tribal consultation. The Tribal Affairs Group is the point of contact for compliance with the CMS tribal consultation policy and serves as a resource to assist CMS components and the Administrator in

determining whether a new or proposed change in policy or regulations could significantly affect Indian Tribes. The Tribal Affairs Group will assist in coordination of consultation between Indian tribes and various CMS components, including the Office of Strategic Operations and Regulatory Affairs.

CMS Regional Offices: The ten (10) CMS Regional Offices share in the Department-wide responsibility to consult, coordinate and communicate with Indian Tribes on issues that affect Indian Tribes and HHS programs, services and resources available to Indian Tribes through States. Through Regional Offices, CMS assists Indian Tribes by establishing or maintaining regular communication regarding Medicare, Medicaid, CHIP and Exchanges, policy development and implementation and operational issues, including eligibility, scope of covered services and providers, billing and reimbursement, adequacy of resources, effect of the program on improving health status, and other issues. Further, the CMS Regional Administrators work closely with the respective Indian Tribes and State Governments to ensure continuous coordination and communication between Tribes and States.

While not a substitute for Tribal Consultation, the following entities play an integral role in the identification of policies with substantial direct effect and in providing advice and input on complex technical issues that could assist CMS in determining and understanding the impact and scope of the critical event and the extent of and format for Tribal Consultation.

Tribal Organizations: Pursuant to the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, Indian Tribes have the authority to delegate their right to carry out programs of the Indian Health Service to a Tribal organization. To the extent this has occurred, as practicable and permitted by law, CMS may provide such Tribal organizations an opportunity to fully participate in Tribal consultation under this policy. Such participation will not substitute for direct consultation with Indian Tribes, but shall occur in addition to consultation with Indian Tribes.

Indian Organizations: At times it is useful that CMS communicate with Indian organizations to solicit Indian Tribe(s) advice and recommendations. These organizations represent the interest of Indian Tribes when authorized by those Tribes. These organizations by the sheer nature of their business serve and advocate Indian Tribal issues and concerns that might be negatively affected if these organizations were excluded from the process. Even though some of the organizations do not represent federally recognized Indian Tribe(s), CMS may communicate with these groups as part of the consultation process. While communication and interaction with Indian organizations is critical, it does not substitute for tribal consultation.

Urban Indian Organizations: Urban Indian organizations are funded under Title V of the Indian Health Care Improvement Act to provide health services to eligible Indians living in urban areas. As health care providers these organizations advocate for and provide services (directly and through referral) to urban Indians. Urban Indian organizations are represented on the TTAG. While communication with Urban Indian organizations is critical, it does not substitute for tribal consultation.

Tribal Technical Advisory Group: (TTAG): The TTAG serves as an advisory body to CMS, providing expertise on policies, guidelines, and programmatic issues affecting the delivery of health care for AI/ANs served through programs funded in whole or part by CMS. Interaction by CMS with the TTAG does not substitute for Tribal consultation, but assists CMS to make consultation more effective including advising on the type of consultation needed on particular issues. The TTAG plays an integral role in the CMS consultation process by providing technical assistance on complex issues faced by Tribal Governments.

7. CMS TRIBAL CONSULTATION PROCESS

Upon identification of a policy that has tribal implications and a substantial direct effect on Indian Tribes or on the relationship between Tribes and the Federal Government, CMS will initiate consultation regarding the policy. In order to initiate and conduct consultation, the following serves as a guideline to be utilized by CMS and Indian Tribes:

- Identify the applicable program, policy, rule, regulation, statute and authorizing legislation;
- Identify how the policy has Tribal implications and a substantial direct effect on one or more Indian Tribes or on the relationship between Tribes and the Federal Government or on the distribution of power and responsibilities between the Federal Government and Indian Tribes.
- Identify affected/potentially affected Indian Tribe(s).

Determine Consultation Mechanism – Upon determination by CMS that consultation is required, CMS will evaluate the nature of the critical event that may have a substantial impact on Indian Tribes to determine the appropriate level of and mechanism for consultation. Such evaluation should include, but is not limited to, a review of the complexity, implications, and time constraints at issue that may impact on policy, funding and/or budget development, programs, services, functions and activities. Consultation mechanisms include but are not limited to one or more of the following:

- Mailings;
- Teleconferences;
- Face-to-face meetings at the local, regional and national levels between the CMS and Indian Tribes;
- Roundtables
- Annual HHS Tribal Budget and Policy Consultation Sessions.
- Other regular or special program level consultation sessions.

Communication Methods: The determination of the critical event and the level of consultation mechanism to be used shall be communicated to affected or potentially affected Indian Tribe(s) using methods appropriate to the issue and with as much advance notice as practicable. These methods include but are not limited to the following:

Correspondence: Written communications exchanged between CMS and Indian Tribes that clearly provide affected/potentially affected Indian Tribe(s) with details of the critical event, and the manner and timeframe in which to identify concerns and potential impacts, and an opportunity to propose alternatives and other comments.

Meeting(s): CMS shall convene a meeting, which may occur by teleconference, webinar, or face-to-face, with affected/potentially affected Indian Tribe(s) to discuss all pertinent issues in a national, regional, and/or local forum, or as appropriate, to the extent practicable and permitted by law, when the critical event is determined to have substantial impact.

Official Notification: Upon the determination of the consultation mechanism, proper notice of the critical event and the consultation mechanism utilized shall be communicated to affected/potentially affected Indian Tribe(s) using all appropriate methods including mailing, broadcast e-mail, Federal Register, and other outlets as appropriate. The FR is the most formal CMS form of notice used for consultation.

Receipt of Tribal Comment(s): The CMS shall develop and use all appropriate methods to communicate clear and explicit instructions on the means and time frames for Indian Tribe(s) to submit comments on the critical event, whether in person, by teleconference, and/or in writing.

Reporting of Outcome: CMS shall report on the outcomes of the consultation within 90 calendar days of final consultation. Once the consultation process is complete and a proposed policy is approved and issued, the final policy must be broadly disseminated to Indian Tribes, posted on the CMS AI/AN webpage, and linked to appropriate Indian organization websites.

8. BUDGET FORMULATION

HHS conducts an annual, Department-wide Tribal budget consultation session to give Indian Tribes the opportunity to present their budget recommendations to the Department to ensure Tribal priorities are addressed. CMS will comply with section 11 of the HHS Tribal Consultation Policy regarding Budget Formulation.

CMS will fully consider all recommendations for funding priorities and amounts established by the TTAG in its annual plan. The TTAG develops and updates an American Indian and Alaska Native Strategic Plan which focuses on specific policy and annual budget priorities.

9. TRIBAL CONSULTATION PERFORMANCE EVALUATION

CMS is responsible for evaluating its performance under this Tribal Consultation Policy. To effectively evaluate the results of the consultation process and the ability of CMS to incorporate Tribal recommendations, CMS will assess its performance on an annual basis based on the reporting requirements outlined in Section 12 of the HHS consultation policy. CMS will include the Tribes and TTAG in this annual review process.

10. MEETING RECORDS AND ADDITIONAL REPORTING.

Meeting Records. CMS is responsible for making and keeping records of its Tribal consultation activity. All such records shall be made readily available to Tribes through the Annual HHS consultation report. CMS shall make and keep records of all TTAG proceedings and recommendations and will have these records readily available.

Reports to Tribes. CMS will comply with HHS annual reporting requirements as outlined in section 13 of the HHS Consultation Policy.

11. CONFLICT RESOLUTION.

The intent of this policy is to promote a partnership with Indian Tribes that enhances CMS' ability to address issues, needs and problem resolution. Nothing in this Policy shall be construed to preclude Indian Tribes from raising issues to responsible officials outside of the consultation process. Nothing in the Policy creates a right of action against CMS or the Department of Health and Human Services for failure to comply with this Policy.

12. TRIBAL SOVEREIGNTY

CMS will fully comply with Section 3 of the HHS Tribal Consultation Policy on Tribal Sovereignty. This policy does not waive any Tribal Governmental rights and authority, including treaty rights, sovereign immunities or jurisdiction. Additionally, this policy does not diminish any rights or protections afforded other American Indians or Alaskan Natives (AI/AN) or entities under Federal law.

13. TRIBAL WAIVER.

CMS will fully comply with Section 15 of the HHS Tribal Consultation Policy on Tribal waivers and process all requests routinely received for waivers under existing program authorities with the statutorily set timeframes.

14. EFFECTIVE DATE.

This Policy is effective on the date of signature by the CMS Administrator.

15. DEFINITIONS

Agency - Any authority of the United States that is an "agency" under 44 USC 3502(1) other than those considered to be independent regulatory agencies, as defined in 44 USC 3502 (5).

Communication – The exchange of ideas, messages, or information, by speech, signals, writing, or other means.

Consultation – An enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

Coordination and Collaboration – Working and communicating together in a meaningful government-to-government effort to create a positive outcome.

Critical Events – Planned or an unplanned event that has or may have a substantial impact on Indian Tribe(s), e.g., issues, polices, or budgets which may originate within CMS.

Deliberative Process Privilege – Privilege exempting the government from disclosure of government agency materials containing opinions, recommendations, and other communications that are part of the decision-making process within the agency.

Executive Order – An order issued by the Government's executive on the basis of authority specifically granted to the executive branch (as by the U.S. Constitution or a Congressional Act).

Federally Recognized Tribal governments – Indian Tribes with whom the Federal Government maintains an official government-to-government relationship; usually established by a Federal treaty, statute, executive order, court order, or a Federal Administrative Action. The Bureau of Indian Affairs (BIA) maintains and regularly publishes the list of Federally recognized Indian Tribes.

Indian – Indian means a person who is a member of an Indian Tribe as defined in 25 U.S.C. 479a. Throughout this policy, Indian is synonymous with American Indian/Alaska Native.

Indian Organizations -Those Federally recognized tribally constituted entities that have been designated by their governing body to facilitate CMS communications and consultation activities. Any regional or national organizations whose board is comprised of Federally recognized Tribes and elected/appointed Tribal leaders. The government does not participate in government-to-government consultation with these entities; rather these organizations represent the interests of Tribes when authorized by those Tribes.

Indian Tribe –an Indian or Alaska Native Tribe, Band, Nation, Pueblo, Village or Community that the Secretary of the Interior acknowledges to exist as an Indian Tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a.

Policies with Tribal Implications - Refers to regulations, statutes, legislation, and other policy statements or actions that have substantial direct effects on one or more Indian Tribes, on the relationship between the Federal government and Indian Tribes, or on the distribution of power and responsibilities between the Federal government and Indian Tribes.

Self-Government – Government in which the people who are most directly affected by the decisions make decisions, including Indian Tribes exercising self-determination and self-governance pursuant to the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended.

Sovereignty – The ultimate source of political power from which all specific political powers are derived.

Substantial Direct Compliance Costs – Those costs incurred directly from implementation of changes necessary to meet the requirements of a Federal regulation. Because of the large variation in Tribes, "substantial costs" is also variable by Indian Tribe. Each Indian Tribe and CMS, working through HHS, shall mutually determine the level of costs that represent "substantial costs" in the context of the Indian Tribe's resource base.

To the Extent Practicable and Permitted by Law – Refers to situations where the opportunity for consultation is limited because of constraints of time, budget, legal authority, etc.

Treaty – A legally binding and written agreement that affirms the government-to-government relationship between two or more nations.

Tribal Government – An American Indian or Alaska Native Tribe, Band, Nation, Pueblo, Village or Community that the Secretary of the Interior acknowledges to exist as an Indian Tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 USC 479a.

Tribal Officials – Elected or duly appointed officials of Indian Tribes or Tribal organizations.

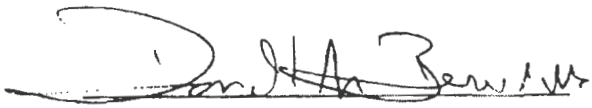
Tribal Organization – The recognized governing body of any Indian Tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities: Provided, That in

any case where a contract is let or grant made to an organization to perform services benefiting more than one Indian Tribe, the approval of each such Indian Tribe shall be a prerequisite to the letting or making of such contract or grant.

Tribal Resolution – A formal expression of the opinion or will of an official Tribal governing body which is adopted by vote of the Tribal governing body.

Tribal Technical Advisory Group – An advisory group comprised of individuals who are elected Tribal officials (and/or Tribal employees acting on their behalf), who provide advice and input on policies, guidelines, and programmatic issues affecting the delivery of health care for AI/ANs served by titles XVIII, XIX, and XXI of the Social Security Act or any other health program funded by CMS.

Urban Indian Organization – A program funded under title V of the Indian Health Care Improvement Act.



NOV 17 2010

Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

Date

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S1-05-06
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Division of Tribal Affairs/ Intergovernmental & External Affairs Group/ CMCS

Tribal Technical Advisory Group Membership

TTAG Leadership: as of 07/17/14
Chair: Ron Allen
Co-Chair: Dee Sabattus
Secretary: Vacant as of 07/15/15

Area Office	Representative	Alternate	Technical Advisor
Alaska	Gerald "Jerry" Moses Senior Director, Intergovernmnetal Affairs Alaska Native Tribal Health Consortium, LIGA Dept. 4000 Ambassador Drive Anchorage, AK 99508 Phone: (907) 729-1900 Email: gmoses@anthc.org	Jim Lamb Director of Revenue Cycle Southcentral Foundation 7033 E. Tudor Rd. Suite 202 Anchorage, AK 99507 Main: 907-729-5453 Direct: 907-830-1111 Email: jlamb@southcentralfoundation.com	Myra M. Munson Sonosky, Chambers, Sachse, Miller & Munson, LLP 302 Gold Street, Suite 201 Juneau, AK 99801 907-586-5880 Fax: 907-586-5883 Mobile: 907-250-4737 Email: myra@sonoskyjuneau.com
Albuquerque	David Antle CEO, Pueblo of Isleta Dept. of Health Services P.O. Box 580 Isleta, NM 87022 505-869-4094 Fax: 505-869-4584 Email: dantle@islclinic.net	Dave P. Panana, R.N. BSN Health Center Director Santo Domingo Health Center PO Box 340 Santo Domingo, NM 87052 (505) 465-3060 Email: dpanana@kp-hc.org	
Bemidji	Melinda J. Danforth, Vice Chairwoman Oneida Tribe of Indians of Wisconsin P.O. Box 365 Oneida, WI 54155 (920) 869-4461 mdanforj@oneidanation.org	Linda Triest, Business Office & PRC Manager Hannahville Indian Center N15019 Hannahville B1 Rd Wilson, MI 49896 Phone: 906-723-2520 linda.triest@hichealth.org	Jennifer Dupuis 927Trettel Lane Cloquet, MN 55720 218-879-1227 JenniferDupuis@FDLREZ.COM

Pursuant to section 5006(e)(1) of ARRA, Pub. L. 111-5, the CMS Tribal Technical Advisory Group (TTAG) was codified in accordance with requirements of the charter dated September 30, 2003 and expanded to include a representative of a national urban Indian health organization and a representative of the Indian Health Service.

Area Office	Representative	Alternate	Technical Advisor
Billings	Darwin St. Clair Jr., Chairman, Eastern Shoshone Business Council P.O. Box 538 Ft. Washakie, WY 82514 Phone: 307-332-3532 Email: darrell.oneal@northernarapaho.com Cc: sbc.exec.sec@gmail.com	VACANT	
California	Mark LeBeau Executive Director, California Rural Indian Health Board, Inc. 4400 Auburn Blvd., 2nd Floor Sacramento, CA 95840 916-929-9761 Fax: 916-929-7246 Email: mark.lebeau@crihb.org	Inder Wadhwa,Chief Executive Officer Northern Valley Indian Health 207 Butte Street Willows, CA 95988 (530)896-9400 Email: iwadhwa@nvih.org	
Great Plains Area Office	Rudy Papakee, MHA Health Director Meskwaki Tribal Health Clinic 1646 305th St Tama, IA 52339 641.484.4094 Email: director.mhc@meskwaki-nsn.gov	Kevin Yellow Bird Steele PO Box 2070 Pine Ridge, SD 57770 Phone: 605-867-8422 Cell: 605-454-1066 Email: kevybsteele@yahoo.com Email: Kevin@oglala.org	Jerilyn Church, CEO Great Plains Tribal Chairmen's Health Board 1770 Rand Road Rapid City, SD 57702 Phone: 605-721-1922 Fax: 605-721-1932 Email: jerilyn.church@gptchb.org
Nashville	Tihtiyas (Dee) Sabattus **{TTAG Co-Chair}** Director, Tribal Health Program Support United South and Eastern Tribes, Inc. (USET) 711 Stewarts Ferry Pike Nashville, TN 37214 V: (615) 467-1550 F: (615) 872-7417 Email: dsabattus@usetinc.org	Nancy Johnson Alabama Coushatta Tribe of Texas Chief Kina Health Clinic 129 Daycare Road Livingston, Texas 77351 P: 936-563-2058 F: 936-563-2731 Email: njohnson@nsacot.nashville.ihs.gov	Elliott A. Milhollin, Partner T 202.822.8282 | F 202.296.8834 HOBBS STRAUS DEAN & WALKER, LLP 2120 L Street NW, Suite 700 Washington, DC 20037 Email: EMilhollin@hobbsstraus.com

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Area Office	Representative	Alternate	Technical Advisor
Navajo	Russell Begaye, President of the Navajo Nation PO Box 7440, Window Rock, AZ 86515 Phone: (928) 871-7000, Email: russellbegaye@gmail.com Also email these staff members Robert Joe, Chief of Staff OPVP Email: rjoe@navajo-nsn.gov Perry Shirley, Executive Staff Assistant, OPVP Email: pshirley@navajo-nsn.gov	Norman Begay, Honorable Delegate of the 23rd Navajo Nation Council PO Box 3390, Window Rock, AZ 86515 Phone: (928) 871-6380, Email: nmbegay@navajo-nsn.gov Also email these staff members Carolyn M. Drouin, Leg Affairs Associate, NNWO Email: cdrouin@nnwo.org Barbara Ahasteen, Sr. Office Specialist, NDOH Email: barbara.ahasteen2@nndoh.org	Ramona Antone Nez, Acting Director Navajo Nation Department of Health PO Box 1390, Window Rock, AZ 86515 Phone: (928) 871-6350 Email: ramona.nez@nndoh.org
Oklahoma	Judy Goforth Parker Secretary of Health, Chickasaw Nation Department of Health Chickasaw Nation Medical Center 1921 Stonecipher Blvd. Ada, OK 74820 580-436-3980 Email: Judy.parker@chickasaw.net	Melissa Gower, TTAG Alternate for Oklahoma Area, Senior Advisory, Policy Analyst Chickasaw Nation15242 W. 850 Road Tahlequah, OK 74464 918-207-2043 Email: Melissa.gower@chickasaw.net	
Phoenix	Angie Wilson, Reno Sparks Tribal Health Director 1715 Kuenzli Street Reno, Nevada 89502 Phone: 775-329-5162 ext. 1900 Fax: 775-334-4357 Email: awilson@rsicclinic.org	VACANT	

Pursuant to section 5006(e)(1) of ARRA, Pub. L. 111-5, the CMS Tribal Technical Advisory Group (TTAG) was codified in accordance with requirements of the charter dated September 30, 2003 and expanded to include a representative of a national urban Indian health organization and a representative of the Indian Health Service.

Area Office	Representative	Alternate	Technical Advisor
Portland	Pearl Capoeman-Baller Quinault Indian Nation P.O. Box 189 1214 Aalis Drive Taholah, WA 98587 360-276-8215, ext. 206 Fax: 360-276-8256 Email: Pballer@quinault.org	Jim Roberts Policy Analyst, NPAIHB 527 SW Hall Street Suite 300 Portland, OR 97201 503-228-4185 Fax: 503-228-8182 Email: jroberts@npaihb.org	Joe Finkbonner NPAIHB 2121 SW Broadway, Suite 300 Portland, Oregon 97201 503-228-4185 Fax: 503-228-8182 Email: jfinkbonner@npaihb.org John Stephens Swinomish Tribal Health 11404 Moorage Way LaConner, WA 98257 Phone: (360) 466-7307 Email: jstephens@swinomish.nsn.us Ed Fox, Ph.D Director, Health Services Port Gamble Tribe 105 Maple Park Avenue SE Olympia, WA 98501 Phone: (360) 790-1164 Email: edfox_phd@yahoo.com
Tucson	Daniel Preston III Councilman, San Xavier District Tohono O'odham Legislative Council PO Box 837 Sells, AZ 85634 Phone: 520-993-1398 Email: daniel.preston@tonation-nsn.gov	Anthony J. Francisco Jr. Tohono O'odham Legislative Council Schuk Toak District Representative P.O. Box 837 Sells, Arizona 85634 Office: 520-383-5260 Cell: 520-993-1377 Anthony.Francisco@tonation-nsn.gov	

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Area Office	Representative	Alternate	Technical Advisor
Tribal Self Governance Advisory Committee (TSGAC)	**W. Ron Allen, {TTAG Chair}** Tribal Chairman, Jamestown S'Klallam Tribe 1033 Old Blyn Highway Sequim, WA 98382 360-681-4621 Fax: 360-681-4643 Email: rallen@jamestowntribe.org	Melanie Fourkiller, Policy Advisor Choctaw Nation Health Services Authority Choctaw Nation of Oklahoma 16th and Locust, P.O. Box 1210 Durant, OK 74702 Work: (580) 924-8280 Cell: (918) 453-7338 Email: mlknight@cnhsa.com	Cyndi Ferguson SENSE Incorporated 1133 – 20th Street NW, Suite 220 Washington, DC 20036-3462 Phone: 202.450.0013 Fax: 603.218.6995 Email: cyndif@senseinc.com Mim Dixon, Jamestown S'Klallam Tribe 4139 Dietz Farm Circle NW Albuquerque, NM 87107 P: (505) 345-2221 ~ F: (505) 345-2960 Email: mimdixon@hotmail.com Doneg McDonough 3245 Beech St. N.W. Washington, DC 20015 202-486-3343 DonegMcD@Outlook.com
National Indian Health Board ((NIHB)	H. Sally Smith, Chair, Board of Directors Bristol Bay Area Health Corporation P.O. Box 490 Dillingham, AK 99576 Phone: 907-842-2434 Fax: 907-842-4137 Email: ssmith1@gci.net 2nd Email: hsmith@bbahc.org	VACANT	
National Congress of American Indians (NCAI)	Jefferson E. Keel, Lt. Governor of the Chickasaw Nation of Oklahoma Embassy of Tribal Nations 1516 P Street NW Washington, DC 20005 202-466-7767 Lt.GovernorKeel@chickasaw.net CC: Dawnette Weaver -Assistant dawnette.weaver@chickasaw.net	VACANT	

Pursuant to section 5006(e)(1) of ARRA, Pub. L. 111-5, the CMS Tribal Technical Advisory Group (TTAG) was codified in accordance with requirements of the charter dated September 30, 2003 and expanded to include a representative of a national urban Indian health organization and a representative of the Indian Health Service.

Area Office	Representative	Alternate	Technical Advisor
Indian Health Services	Carl Harper, Director Office of Resource Access and Partnerships IHS Headquarters 12300 Twinbrook Pkwy. Suite 360 Rockville, MD 20857 301-443-1553 carl.harper@ihs.gov	Primary Alternate: Raho Ortiz, Director, Division of Business Office Enhancement 12300 Twinbrook Parkway Suite 360-38 Rockville, Maryland 29852 301-443-2419 Fax 301-443-0718 Raho.Ortiz@ihs.gov Second Alternate: Terri Schmidt, Director, Division of Contract Care Office of Resource Access and Partnerships 801 Thompson Avenue TMP 360-56 Rockville, MD 20852 301-443-1547 Fax: 301-443-0718 Terri.Schmidt@ihs.gov	
National Council of Urban Indian Health	Walter Murillo Native American Community Health Center 4520 N. Central Ave, Suite 350 Phoenix, AZ 85012 Phone: (602) 279-5262 Email: wmurillo@nachci.com	Moke Eaglefeathers North American Indian Alliance 55 East Galena Butte, MT 59701 Phone: (406) 490-6107 Email: meaglefeathers@naia-butte.org	Gregory Smith, Partner Hobbs, Straus, Dean & Walker 2120 L Street, N.W. Suite 700 Washington, D.C. 20037 Tel: 202.822.8282 Fax: 202.296.8834 Email: gsmith@hobbsstraus.com

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NAVAJO NATION

RCS# 197

11/12/2015
07:23:21 PM

Naa'bik'iyati Committee

Amd# to Amd#

MOT Filfred
SEC Witherspoon

Legislation No. 0357-15:
Requesting a tribal consultation with the Centers for Medicare and Medicaid Services ...

PASSED

Yea : 15 **Nay : 0** **Not Voting : 9**

Yea : 15

Begay, NM	Crotty	Hale	Tso
BeGaye, N	Damon	Phelps	Tsosie
Bennett	Daniels	Slim	Witherspoon
Chee	Filfred	Smith	

Nay : 0

Not Voting : 9

Bates	Brown	Perry	Shepherd
Begay, K	Jack	Pete	Yazzie
Begay, M			