Northwest Portland Area Indian Health Board

Idaho State Tribes Meeting
Plummer, Idaho
May 5& 6, 2008

Distributed Handouts

Tribe of Idaho - Nez Perce Tribe - NW Band of Shoshone - Shoshone/Bannock Tribes - Coeur d'Alene Tribe - Kootenai

Idaho State/Tribes Meeting
Benewah Wellness Center
1115 B Street, Plummer, ID 83851
May 5, 2008
Business Day Agenda

Time	Topic	Speaker
1:00 PM		
1:15 PM		
1:30 PM	MAM Review	Pam Mason
2:00 PM	Billing the Encounter Rate	Pam Mason, EDS
4:00 PM	Adjourn	

Tribe of Idaho - Nez Perce Tribe - NW Band of Shoshone
Shoshone-Bannock Tribes - Coeur d'Alene Tribe - Kootenai

Idaho State/Tribes Meeting
Benewah Wellness Center
1115 B Street, Plummer, ID 83851
May 6, 2008
Agenda

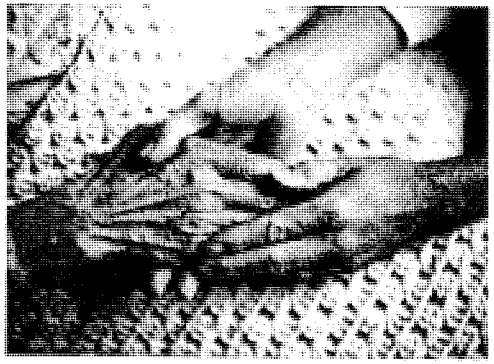
Time	Topic	Speaker
8:30 AM	Welcome Review Agenda	Pam Mason Verné Boerner
8:35 AM	GAIN, Credentialing of Providers	Connie Miller
~~9:30 AM~~ 8:50	Update on Birth Certificate Issue Regions 1 & 2	Susie Cummins Div of Welfare
~~10:00 AM~~ 9:10am 9:40am ~~10:15 AM~~	Update on Mental Health & Substance Abuse Issues: Peggy Biery	Pam Mason
~~10:30 AM~~ 9:50	Break	
~~10:45 AM~~ 10:10	Access to American Indian Recovery	Erik Kakuska, NPAIHB AAIR Liaison
~~12:00 PM~~ 11:40 am 11:00	Working Lunch: Hospital Bill Re-Pricing – Medicare-Like Rates	The Mahoney Group Sponsored by NPAIHB
~~1:00 PM~~	Idaho Legislative Update	Pam Mason
~~1:45 PM~~ 12:40pm	NPAIHB Update • Legislative & Budget Update • Follow Up on Cost Sharing Issue (Susanville Case) • Update on CMS Final Rule 2237 – IFC Impact on Tribes	Jim Roberts
1:45 ~~2:45 PM~~	Agenda Planning & Evaluation	All
~~3:00 PM~~ 2:15	Adjourn	

WHAT SHOULD I DO IF I DON'T HAVE ANY OF THESE THINGS?

- Inquire at your local Health & Welfare office about other ways to document your citizenship and prove your identity.
- Tell us why you cannot get documentation, and give us any documents you may have. We may be able to help you.

HOW MUCH TIME DO I HAVE TO SUBMIT THIS DOCUMENTATION TO MEDICAID?

You will be given a reasonable amount of time to provide documentation; "reasonable" is determined on a case-by-case basis. Contact your case worker for more information.



If you have questions, contact the Idaho CareLine at 2-1-1, or the Federal Medicare Hotline at 1-800-MEDICARE (1-800-926-2588). TTY Users should call 1-877-486-2048.

Information is also available on the Centers for Medicare & Medicaid Services Web site:
http://www.cms.hhs.gov

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Our mission is to promote and protect the health and safety of all Idahoans.

http://www.healthandwelfare.idaho.gov

Providing Documentation of Citizenship for Medicaid

IDAHO DEPARTMENT OF
HEALTH & WELFARE

CHANGE IS IN THE AIR!

In the past, if an individual was enrolled in or applied for Medicaid, that individual had to declare that they were a citizen or national of the United States of America.

The State of Idaho now requires all Medicaid applicants and recipients to provide *proof* not only of their citizenship, but also of their identity in order to comply with new Federal regulations. Read further to find out more.

WHAT CHANGED?

Effective July 1, 2006, Congress passed a new law: Anyone who applies for or currently receives Medicaid must be able to provide the following:

- Documentation that proves they are a U.S. citizen or U.S. national
- Documentation that proves their identity

Individuals enrolled in Medicare, receiving Social Security Supplemental Income (SSI), Social Security Disability Insurance (SSD), or a child in Foster Care, do not have to provide additional documentation.

WHAT KIND OF DOCUMENTATION DO I NEED?

Each document must be an original or a certified copy of the original. You may not use a notarized copy of your document.

You may prove your identity and citizenship with <u>one</u> of the following:

- U.S. Passport
- Certificate of Naturalization (DHS Forms N–550 or N–570)
- Certificate of U.S. Citizenship (DHS Forms N–560 or N–561)

If you do not have any of the items listed above, you will need <u>two</u> documents; one document to prove your identity and one document to prove your citizenship.

You may prove your identity with <u>one</u> of the following:

- Current state driver's license or state identity card complete with photograph
- School identification card
- Federal, state, tribal or local government identification card
- U.S. Military identification card

You may prove you are a citizen with <u>one</u> of the following:

- Birth Certificate
- Report or Certification of Birth Abroad of a U.S. Citizen (Form FS–240 or FS–545)
- U.S. Citizen I.D. Card (DHS Form I–197)
- Adoption papers
- Military records that show your place of birth

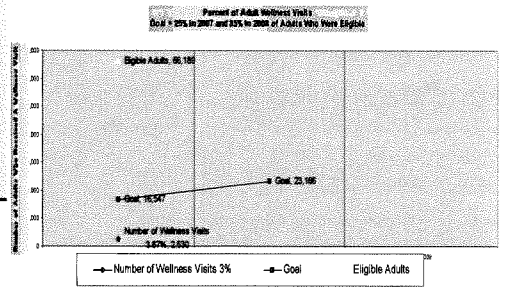
Idaho Medicaid Performance Goals

Medicaid Reform

Preventive Care & Wellness

Wellness Visits

Adult Physicals



66 189

July '06 to June '07

23 166

16 547

3.87 2530

won't have next date until 6 mo later providers have upto 1yr to bill

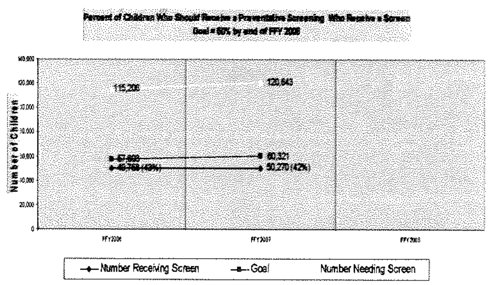
to July '07 - June '08

accurate until Dec. '08

Billing manual → needs to be kept up to date

rpt run in April
Source 416 report
for prior fiscal yr Oct '06 - Sept '07

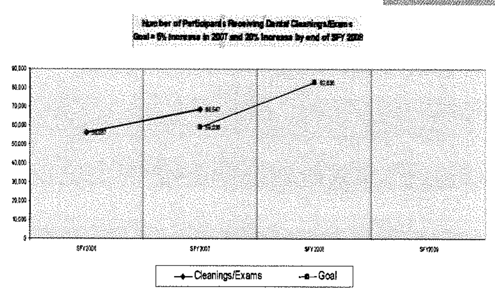
Children Receiving Prevention Screening (EPSDT Screens)



115 206 – 120643 ; 57,603 – 60321
49,758 (43%) – 50270 (42%)
should have at least one screen received one screen.
Hypothesis wrong coding contributes to low # Feds want to see ~~upto~~ up in the (70% area)
Copay for those 150% of pov. lvl (tribal ~~mem~~ members don't)

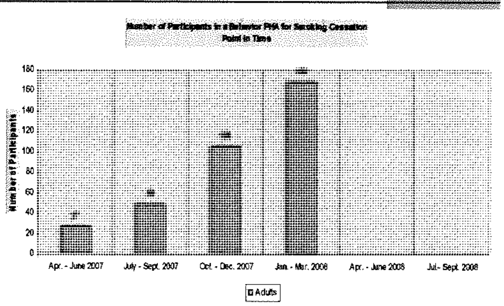
July 06 – June 07

Number of Eligibles Receiving Annual Dental Cleanings/Exams



achieved goal of 20% increase
5% ↑ 2007   20% ↑ 2008

Number of Individuals who Participate in a Tobacco Cessation Program



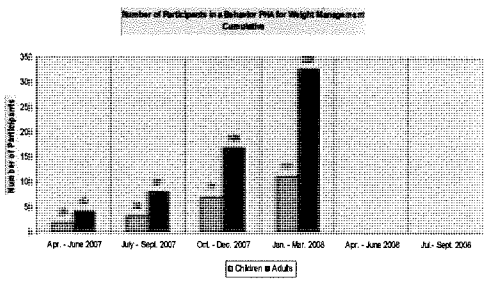
what will the goal be? Used BRFSS data will use that
only using 169 people

voucher has to be/use providers/vendors

any tribal providers

Cindy Brock if you want to become a provider.

Number of Individuals who Participate in a Weight Management Program



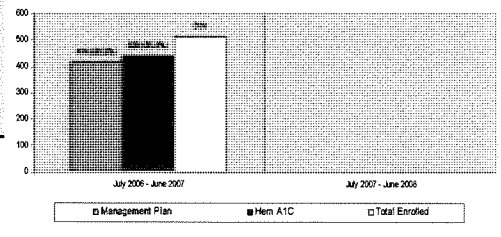
vouchers can be used to pay

Good not set yet here either

Chronic Care

Pay for Performance

Enrolled Diabetic Patients who Had a Diabetes Management Plan & Received a Hemoglobin A1C Annually



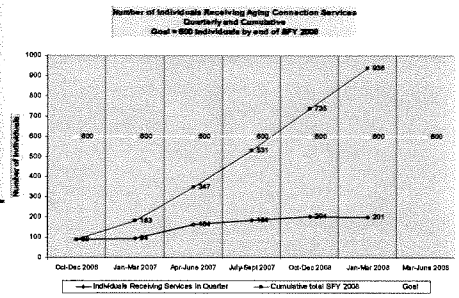
Non-Public Options for Long Term Care

Aging Connection Pilot

Number of Resource Centers in Operation

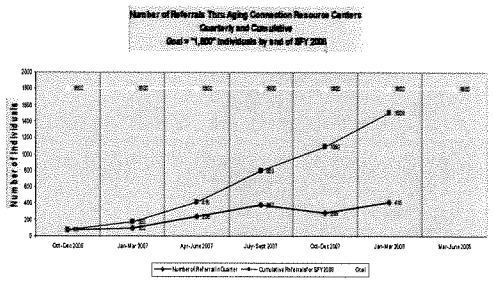
- Under the Pilot for this program there are 3 Resource Centers operating in Northern Idaho

Number of Individuals Receiving Aging Connection Services

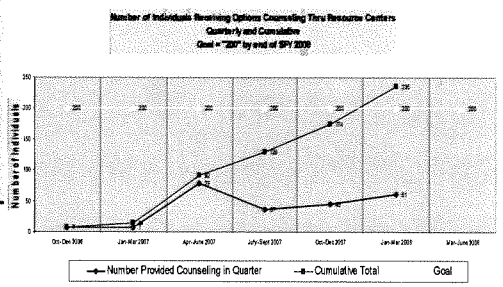


Susie Cummings has more info.
exp. Oct
extra wk under the grant
wkg on a way to move some wk to the community start at Region I provide trngs to partners in the community
Orientation @ application readiness training certified Proposed agreement staff rev'd by dept. Put to the top of the pile as they are ready to divert
How many new pnk cumulative
none eligibility parties
211 enter point of contact two closed only one open isn CDA
reverse mortgages on house

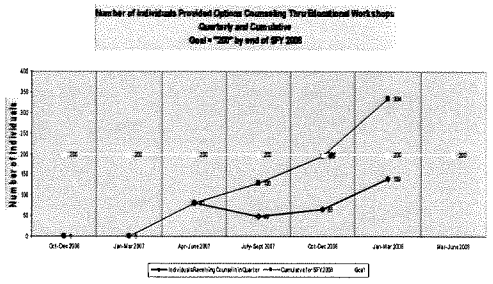
Number of Referral Services through Aging Connection Resource Centers



Number of Individuals Provided Options Counseling through Resource Centers



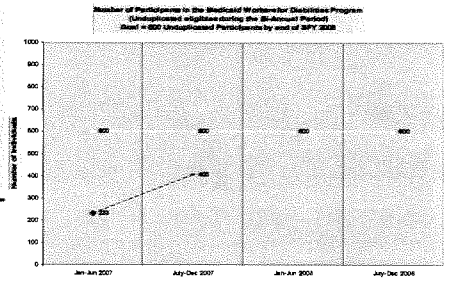
Number of Individuals Provided Options Counseling through Educational Workshops



Provide Opportunities for Employment for Persons with Disabilities

Medicaid Workers with Disabilities Program

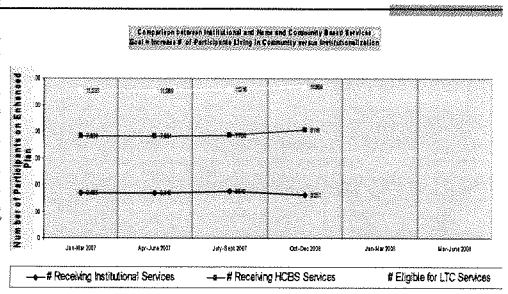
Number of Participants in the Medicaid Workers with Disabilities Program



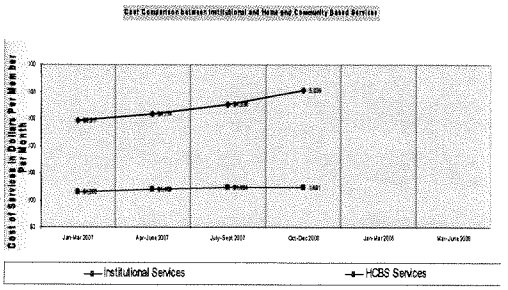
Increase Participant's Ability to Receive Care in the Community

Home and Community Based Services

Number of Participants who Receive HCBS versus Institutional Care



Cost of HCBS versus Institutional Care



Medicaid's Performance Review Updates – April 2008

Preventive Care & Wellness	Goal
Percent of Adult Wellness Visits (Annual) **3.87%** 2,562 of 66,189 Adults Who Were Eligible for a Wellness Visit Received a Wellness Exam	**≥ 25%**
Percent of Children Receiving Preventive Screenings (Annual) **42%** 50,270 of 120,643 Children Who Should Receive @ least One Screening Received a Preventative Screen	**≥ 50%**
% of Children Earning Points for Wellness PHA Activity (Cumulative Quarterly)	TBD
46%	
Percent of Eligibles with Delinquent Premiums Not Offset by Wellness PHA Activity (Annual) **36%** Premiums for 527 participants of 1450 total with delinquent premiums were not offset with PHA activity = Potential # of participants who are at risk to loose Medicaid eligibility due to non – payment of premiums	**≤20%** **0**
Number of Eligibles Closed due to Delinquent Premiums Not Offset by Wellness PHA Activity (Annual)	**0**
6 (≤1%)	
6 of 527 eligibles who had delinquent premiums over 60 days who were closed (lost Medicaid) for premiums not satisfied	
Number of Grants Awarded to Schools for Prevention Services (Annual) **10** No new Contracts for SFY 2007	**10**
Number of Dental Providers Providing Care Medicaid Patients (Annual) **618**	**10% increase Per SFY**
Number of Eligibles Receiving Annual Dental Cleanings/Exams (Annual) **68,079** 18% Increase from SFY 2006	**5% Increase Per SFY**
Number of Basic Plan Participants Receiving Annual Dental Cleanings/Exams (Annual)	

55,886
Baseline for Idaho Smiles Comparison

Chronic Care	Goal
Percent of Diabetic Participants Enrolled in Disease Management that have a Diabetic Management Plan (Annually) **80.5% (July 2006 thru June 2007)**	**90%**
Percent of Diabetic Participants Enrolled in Disease Management that received at least one Hemoglobin A1C annually	**90%**
85.4% (July 2006 thru June 2007)	

Healthy Connections Enrollment	Goal
Average Number of Days Between Eligibility Approval and Enrollment in Healthy Connections (Quarterly - 60 days After End of Calendar Quarter) **30 Days**	**<30 Days**

Increase Awareness of Non-Public Options for Financing Long-Term Care	Goal
Number of Resource Centers In Operation (Quarterly – 15th of the Month After the End of the Calendar Quarter) 3 (No change from previous quarter)	3
Number of Individuals Receiving Aging Connection Services (Quarterly and Cumulative) 201/936	600 by end of SFY 2008
Number of Referral Services Made Through Aging Connections Resource Centers (Quarterly and Cumulative) 416/1,508	900 by end of SFY 2008
Number of Individuals Provided Options Counseling Through Resource Centers (Quarterly and Cumulative) 61/235	200 by end of SFY 2008
Number of Individuals Provided Options Counseling Through Educational Workshops (Quarterly and Cumulative) 139/334	100 by end of SFY 2008

Encourage Medicaid Participants to Make Good Health Choices	Goal
Number of Individuals Who Participate in a Behavior PHA for Weight Management (Quarterly – Point in Time Data) 326 Adults/111 Children	TBD
Number of Individuals Who Participate in a Behavior PHA for Tobacco Cessation (Quarterly – Point in Time Data) 169 Participants	TBD

Strengthen the Employer Based Health Insurance System	Goal
Average Number of Adults Receiving Premium Assistance (Annual) 265 Undergoing Program Evaluation to look at policy changes	1,000
Average Number of Children Receiving Premium Assistance (Annual) 172 Undergoing Program Evaluation to look at policy changes	1,000
Average Number of Small Business Employers Participating in AHI (Annual) 55 Undergoing Program Evaluation to look at policy changes	100

Provide Opportunities for Employment for Persons with Disabilities	Goal
Number of Participants in the Medicaid Workers for Disabilities Program (Bi-Annual – Number of Unduplicated Participants During the Previous 6 Month Period) 405	600 by end of SFY 2008

Given similar state Medicaid program experience, we can expect approximately 2% of the total SSDI recipients (25,690) to sign up for this program in the first year of operations.

Increase Participants Ability to Receive Care in the Community or Least Restrictive Setting	Goal
Number of Adults Who Have Identified Interest in Self-Determination Services (Quarterly – 15th of the Month After the End of the Calendar Quarter) 71	100
Number of Participants Receiving Institutionalized Care (Quarterly – 15th of the Month After the End of the Calendar Quarter) 3,183 29% of Participants Eligible for Long Term Care Services	
Number of Participants Receiving HCBS Waiver Services (Quarterly – 15th of the Month After the End of the Calendar Quarter) 7,929 71% of Participants Eligible for Long Term Care Services	
PMPM for Institutional Care (Quarterly – 15th of the Month After the End of the Calendar Quarter) $4,786	
PMPM for Waivered Services (Quarterly – 15th of the Month After the End of the Calendar Quarter) $1,485	

Improve Coordination Between Medicaid and Medicare	Goal
Number of Individuals who participate in the Coordinated Plan (Quarterly) 1059 (6.9%)	1,275 by end of SFY 2008

2008 LEGISLATIVE SESSION

2008 LEGISLATIVE SESSION

APPROVED LEGISLATION

APPROPRIATIONS

House Bill 0622

This appropriations bill includes five adjustments

- Increase of $221,700 in General Funds and a reduction of $228,700 in federal funds for positions that were determined by the federal government as administrative
- Increase $350,000 in one-time funding for the Idaho Health Data Exchange
- Additional dedicated spending authority for the Multi-state Prescription Drug Purchasing Pool
- $313,500 of dedicated spending authority for the Chip B and Access Card receipts
- A budget rescission from the General Fund in the amount of $17,379,500 and $1,000,000 from dedicated funds for a total of $18,379,500 due to a reduction in caseload growth within the Medicaid program.

House Bill 0625

Appropriates $1,407,245,800 to the Department of Health and Welfare for Medical Assistance Services for fiscal year 2009

House Bill 0695

Appropriates an additional $12,932,000 to the Department of Health and Welfare for the Substance Abuse Treatment and Prevention Program for fiscal year 2009. (Includes $3,211,857, State and Federal, to pay for Medicaid Participants)

- Effective 7-1-08
- First couple of years will use the existing services (except safe and sober housing and child care) and networks (Behavior Psychology Associates).
- Division of Behavioral Health will define the services and standards.
- Will be for existing priority populations which are:
  - court ordered
  - pregnant women
  - women with children
  - children

Possible need to get more info on how to access these services

APPROVED LEGISLATION

OTHER THAN APPROPRIATIONS

House Bill 0591aa

- MANAGED CARE – REFORM

  Amends existing law to provide that the Managed Care Reform Act shall not apply to certain programs administered by the Department of Health and Welfare. This legislation gives the ability to Health and Welfare Substance Abuse Disorder Bureau, in collaboration with the Interagency Committee on Substance Abuse Prevention and Treatment ,to engage in preferred contracting with private treatment providers.

House Bill 0442

- VULNERABLE ADULTS

  This legislation modifies Sections 18-1505(4)(c) and 39-5302(7), Idaho Code ,to clarify that unjust or improper use of a vulnerable adult's financial power of attorney falls within the definition of exploitation because it is a misuse of a vulnerable adult's funds, property, or resources.

ADMINISTRATIVE RULES

APPROVED BY THE 2008 LEGISLATURE

RULES RELATING TO COST SHARING

- 16-0309-0701
- 16-0318-0701

Imposes a cost-sharing requirement for Medicaid participants as directed by HB 663. Co-pays apply to inappropriate use of emergency room visits and emergency transportation. It also clarifies that providers may charge Medicaid participants for missed appointments if it is the provider's policy to charge all patients for missed appointments.

RULES RELATING TO REIMBURSEMENT

- 16-0309-0702

Reimbursement Methodologies for Federally Qualified Health Centers

Adds a description and clarifies the reimbursement methodologies for Federally Qualified Health Centers. (Allows Re-Basing)

RULE CLARIFYING EXISTING PRACTICE

- 16-0309-0704

Non-implantable and Implantable Hearing Aids

This rule change will clarify the guidelines for audiology services covered by Medicaid. The current rule was intended to pay for audiometric services and supplies for non-implantable hearing aids only. Language is being added that clearly states the policy for obtaining a non-implantable versus a surgically implantable hearing aid in order to prevent delays in the prior authorization of medically necessary hearing aids.

RULE RELATING TO EXISTING PRACTICE

- 16-0309-0705

Chronic Disease Management – Pay for Performance

This rulemaking adds a Chronic Disease Management benefit for Medicaid participants with certain chronic illnesses. Primary care providers who participate in the Healthy Connections program and who also enroll in the Chronic Disease Management program receive an enhanced case management fee for effectively managing their Medicaid patients' chronic illness. To receive the enhanced fee, the provider must identify the patients with the targeted illness and report specified evidence-based quality indicators to the Department. The required reporting criteria differ by disease and are determined by the Department. The amount of reimbursement is specified in the provider agreement.

RULES RELATING TO NEW BENEFIT

- 16-0309-0706 AND 16-0310-0704

Independent Billing – Therapy Services (SLP and OT)

The Idaho Occupational Therapy Association and the Idaho Speech and Hearing Association approached the Department and reported concerns about a lack of access and/or long waiting lists for occupational therapy (OT) and speech therapy (ST) in some parts of the state. While physical therapists (PT) can practice and bill Medicaid directly, occupational therapists and speech-language pathologists cannot. It has been confirmed that with the current service location limitations in place; the waiting time for children to obtain needed speech and occupational therapy ranges from two weeks to nine months across the state. These rules will improve access to therapy services for Medicaid participants.

RULES RELATING TO NEW BENEFIT – SERVICE DELIVERY

- 16-0309-0707 AND 16-0310-0705

Dental service by selective contract

Deletes current dental rules from the basic plan and adds that these benefits are provided by a selective (managed) contract. Adds Medicaid dental rules to the Enhanced plan.

RULES RELATING TO NEW BENEFIT

- 16-0309-0708

Telehealth Mental Health Services

Adds new telehealth services and locations that service can be provided.

- 16-0309-0709 and 16-0310-0707

Family Psychotherapy – Enhanced Mental Health Benefits

Adds new benefit for family psychotherapy and clarifies collateral contact.

Collateral Contact → Bill fee for Svc related

RULES RELATING TO NEW BENEFIT

- 16-0317-0701

Implement MMCP

This chapter implements a benefit plan for individuals eligible for both Medicare and Medicaid. Individuals who choose the Medicare/Medicaid Coordinated Plan enroll in an integrated benefits program offered by participating Medicare Advantage Plans.

RULE CLARIFYING EXISTING PRACTICE

- 16-0310-0702

Eligibility Criteria for Enhanced Plan mental health services

The 2007 Legislature rejected certain subsections of rules relating to eligibility criteria for mental health services for children and adults. This rule change establishes eligibility criteria for mental health services ensure qualified participants get services that match their health needs.

RULE CHANGING PRACTICE

- 16-0310-0703 AND 16-0323-0701

Changes to use of Minimum Data Set (MDS) and Uniform Assessment Instrument (UAI)

Medicaid will no longer convert MDS scores to UAI scores. MDS scores will be used directly to determine medical eligibility for nursing facility care. This change streamlines the process and results in more rapid eligibility determination while maintaining the same degree of accuracy.

Rules requiring use of UAI scoring for nursing home level of care determinations have been removed from the Nursing Facility section of the rules to the Aged or Disabled (A&D) waiver section.

RULES MEETING STATUTE

- 16-0310-0706

Personal Assistance Agency and Fiscal Intermediary

Clarifies Personal Assistance Agency and Fiscal Intermediary roles consistent with HB167 passed by the 2007 legislature.

RULES RELATING TO FACILITIES

- 16-0314-0801

Free Standing Emergency Rooms

The proposed additions to these rules will establish criteria for hospitals operating an emergency department located other than on the hospital campus. The Department committed to promulgate rules re: free standing emergency department minimum requirements.

Recovery works

People heal… families reconnect… lives are restored… what was lost is found again.

Access to Recovery makes a difference in the lives of Native people. How?

In their own words:

"It allowed me to get into a treatment center when I did not have the resources to do so on my own."

"I was able to go to a center that offered a cultural program with healing in Native ways."

"I have a relationship with my family again now that I am clean and drug free."

"I have a new life now!"

Recovery can make a difference in your life too… a chance to connect… to trust others and be trusted… and play a part in the life of your community.

You deserve that chance.

AAIR Believes

AAIR believes that American Indian and Alaska Native (AI/AN) communities in California, Oregon, Washington and Idaho have the knowledge and capability to identify needs and solutions to substance abuse problems within their own communities. AAIR supports this work by coordinating a network of community-based providers to help individuals and families access high quality treatment and recovery support services.

AAIR funding

The California Rural Indian Health Board, Inc. (CRIHB), administers Access to American Indian Recovery (AAIR) in California, Oregon, Washington, and Idaho, with funding provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) under funding notice number: 1H79TI019501.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Erik M. Kakuska, BA
(Zuni Pueblo)
AAIR Project Specialist

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Portland, Oregon 97201

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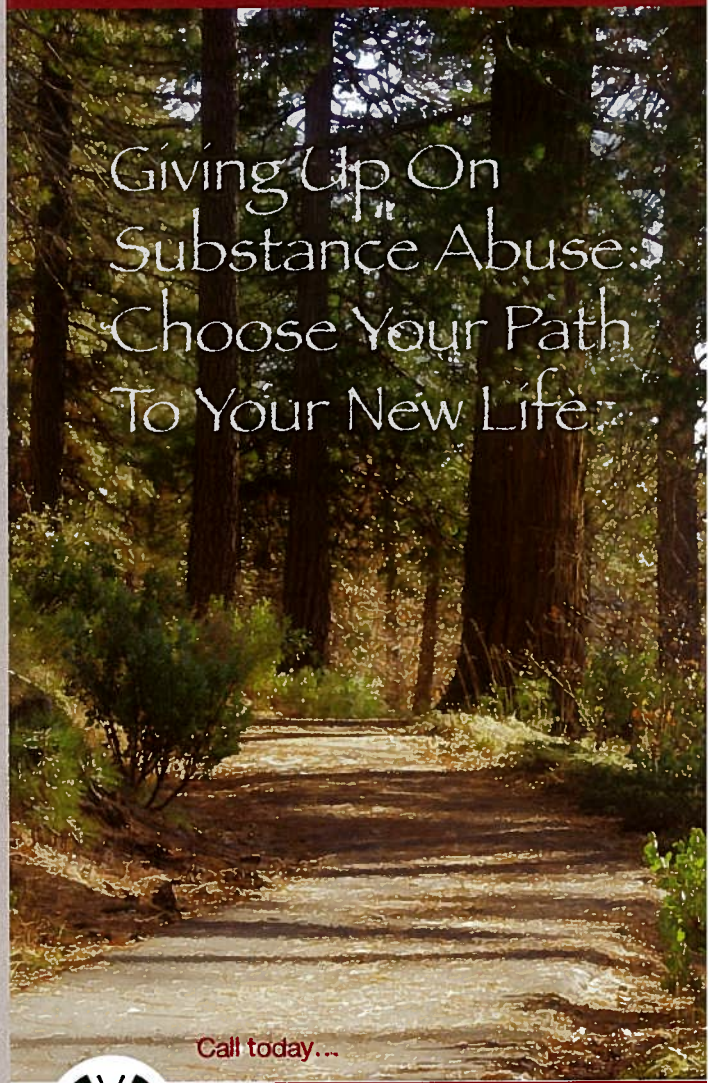
Fax: 503-228-8182
Email: ekakuska@npaihb.org
www.npaihb.org



Call today...

AAIR

Access to American Indian Recovery

Call toll-free: (866) 350-8772
Or visit: www.crihb.org/AAIR

How AAIR helps

AAIR supports eligible American Indian and Alaska Native people (AI/AN) on the road to recovery by:

- Helping AI/AN people create their own unique pathway with traditional, faith-based, or community-based services.
- Allowing people to choose from a statewide network of Native and non-Native providers.
- Providing access to recovery support services, including transportation to and from treatment, transitional or clean and sober housing, and traditional healing activities.
- Identifying barriers to treatment and helping people overcome them, and paying for some services when no other funds are available.
- Strong emphasis on meth recovery.

AAIR offers help to AI/AN people looking for a way out of substance abuse, to restore health, harmony, and balance.

AAIR client eligibility

Do you qualify for help? You may be eligible for AAIR assistance if you are:

- an enrolled member of an AI/AN Tribe, a descendant of an AI/AN, or a non-Indian minor living in an AI/AN household;
- a resident of California, Oregon, Washington, or Idaho;
- and you believe that you have a drug and/or alcohol problem.

If you answered "yes" to these three questions, contact an AAIR provider to schedule an assessment. Call AAIR toll-free weekdays (8 a.m. – 4 p.m.) or visit our website.

Call free: (866) 350-8772 and ask for a referral to a provider near you.

Find approved AAIR providers on our website: www.crihb.org/aair/Provider Directory.

Call today… to find a provider and schedule your free assessment.

It's up to you

The choice is yours, the path is yours, and you don't have to walk it alone anymore.

Sometimes the path to recovery seems long, lonely, and confusing, but AAIR providers are dedicated to supporting your new life, health, and wellness. AAIR providers offer a variety of options for you to choose from.

Depending on your eligibility and assessment, AAIR may be able to pay for some or all of the services you need.

Choose the provider that works best for you: traditional, faith-based, or community-based services.

Even If you find you are not eligible for AAIR, there are still resources available to assist you in recovery. For a list of other recovery services and support organizations that may be able to help you, go to our website: www.crihb.org/aair and click on "other ways to get help" on the "Eligibility" page.

Idaho State Tribes Meeting
May 5&6, 2008

AAIR

Access to American Indian Recovery

Welcome to the AAIR Program

Erik Kakuska
AAIR Project Specialist

Northwest Portland Area Indion Health Board

AAIR

Access to American Indian Recovery

Introduction

- **Access to American Indian Recovery (AAIR)**
- **Substance abuse treatment and recovery support program**
  Funded by SAMHSA
- **$14.5 Million over a 3year Term**

Northwest Portland Area Indian Health Board

AAIR

Access to American Indian Recovery

History

- **Started by CRIHB**
  CAIR – May 2005
- **Under CAIR**
  Out of 15 grantees, CAIR was the only tribal organization
  13.5 Million to 6,600 Indian clients
  Benefits toward 43 tribal health programs
- **Name change**
  CAIR to AAIR due to the expansion of NW

Northwest Portland Area Indian Health Board

AAIR

Access to American Indian Recovery

Design of ATR

- **Capacity-Oriented**
  Increases number and types of providers eligible for funding and expands array of services
- **Consumer-Driven**
  Creates opportunity for clients to choose programs and providers
- **Outcome-Focused**
  Emphasizes measurement of client outcomes (i.e. employment, stable housing, etc.)

Northwest Portland Area Indian Health Board

AATR

Access to American Indian Recovery

Project Specialist Duties

- **Increases the number and types of clinical providers**
- **Liaison between administration and providers**
- **Point man for Northwest Tribes**

Northwest Portland Area Indian Health Board

AATR

Access to American Indian Recovery

Client Choice

- **Clients have the ability to choose Provider**
  100% Client Choice
- **Community-based providers**
  Native and non-native health centers

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AAIR

Access to American Indian Recovery

Client Eligibility

- **Each client must**

  Either be an American Indian/Alaska Native (AI/AN) person who meets the Indian eligibility requirements of the AAIR program; or a non-Indian youth living in an Indian household which includes as enrolled member of a federally recognized tribe

  A resident of California, Oregon, Washington, Idaho

  11years or older

  Believed to have or be recovering from a substance abuse disorder

Northwest Portland Area Indian Health Board

AAIR

Access to American Indian Recovery

The VMS

- **Voucher Management System (VMS)**
  - To be used via internet
  - System managed by MAXIMUS
- **VMS functions**
  - Client enrollment
  - GPRA (Intake, discharge and 6 month follow-up)
  - Vouchers (Residential, Outpatient/Recovery Support & Clean and Sober Housing)
  - Entering services for payment

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AATR

Access to American Indian Recovery

The GPRA

- **Government Performance Results Act (GPRA)**
  - Report outcomes
  - Conduct evaluations
- **Intake GPRA**
- **Discharge GPRA**
- **Six month post intake follow-up GPRA**

Northwest Portland Area Indian Health Board

AATR

Access to American Indian Recovery

Vouchers

- **Residential:**
  - One voucher per client. Allows the client to be admitted into a residential program for up to 30 days
- **Outpatient/Recovery Support/Clean & Sober:**
  - Maximum of two vouchers per client.
- **Voucher Expiration**
  - All vouchers expire 60 days after issuance, with 30 day grace period for final billing

Northwest Portland Area Indian Health Board

AAIR

Access to American Indian Recovery

Methamphetamine

- **Mandated by SAMHSA:**
  30% of funding will go to methamphetamine users

- **Qualifications for Meth users**

  For those clients that are *not* coming from a restricted setting:
  A meth client is a client who has used meth in the last 90 days (prior to intake) AND who will be receiving services through ATR specifically related to meth use

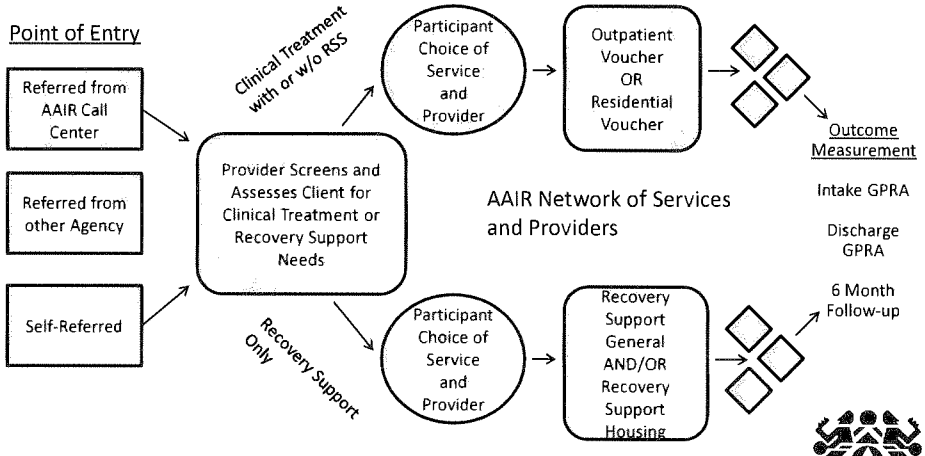
  For those clients that *are* coming from a restricted setting:
  A meth client is a client who has used meth in the 90 days prior to entry onto the restricted setting AND who will be receiving services through ATR specifically related to meth use

Northwest Portland Area Indian Health Board

AAIR

Access to American Indian Recovery

AAIR Voucher System Framework



Northwest Portland Area Indian Health Board

AAIR

Access to American Indian Recovery

How to Get Started

- **To become an AAIR Provider:**
  www.crihb.org/aair
- **All new applicants are required to complete and submit a Provider Enrollment Application**
  Takes a few weeks to process
- **More than a few weeks, call:**
  Darla Pikyavit
  (916)-929-9761

Northwest Portland Areo Indian Health Board

AAIR

Access to American Indian Recovery

Contact Information

Websites:
www.crihb.org/aair
www.npaihb.org

AAIR Call Center
(866) 350-8772

Erik Kakuska
AAIR Project Specialist
(503) 416-3296
ekakuska@npaihb.org

Northwest Portland Area Indian Health Board

AAIR

Access to American Indian Recovery

Your Invitation to AAIR

The Northwest Portland Area Indian Health Board and the California Rural Indian Health Board invites you to visit the AAIR website to learn more about this voucher funding program.

Access to American Indian Recovery allows American Indian/Alaska Native clients to independently choose where and how they receive treatment for their drug/alcohol addiction.

Information can be obtained at either one of these websites or call AAIR Project Specialist Erik Kakuska

Northwest Portland Area Indian Health Board

Erik Kakuska
AAIR Project Specialist
www.crihb.org/aair (503) 416-3296 www.atr.sahmsa.gov
ekakuska@npaihb.org

AAIR - Access to American Indian Recovery
Vouchers, Services, Rates
(2-21-2008)

Voucher Value $	Vouchers & Service Types	Rate $	Per	Max Units	Max $
$255	**Screening, Assessment, Diagnosis, & Treatment Planning-Clinical**				
	Client eligibility, substance abuse screening, locator information	**95.00**	**Eligib/Screen**	**1**	**$95**
	Substance abuse assessment and diagnosis	**100.00**	**Assessment**	**1**	**$100**
	Substance abuse treatment plan	**60.00**	**Plan**	**1**	**$60**
$95	**Recovery Support Services Assessment**				
	Recovery Support Eligibility, Needs Assessment & Locator Information	**95.00**	**Eligib/Assess**	**1**	**$95**
$120	**Six-Month Follow-up GPRA**				
	GPRA – Six-Month Follow-up - **Client Incentive (successful contact & completion)**	**20.00**	**Incentive**	**1**	**$20**
	GPRA - Six-Month Follow-up - **Provider Incentive (successful contact & completion)**	**100.00**	**Incentive**	**1**	**$100**
$800	**Outpatient/Clinical Treatment**				
	Case management-Clinical	**60.00**	**Session**	**999**	**$800**
	Pharmacological assessment	**100.00**	**Session**	**999**	**$800**
	Mental health assessment and diagnosis	**125.00**	**Session**	**999**	**$800**
	Individual substance abuse counseling	**85.00**	**Session**	**999**	**$800**
	Group substance abuse counseling	**32.00**	**Session**	**999**	**$800**
	Substance abuse education	**30.00**	**Session**	**999**	**$800**
	Single family/marriage substance abuse counseling	**85.00**	**Session**	**999**	**$800**
	Multiple family/marriage substance abuse counseling	**35.00**	**Session**	**999**	**$800**
	Alcohol and drug testing	**25.00**	**Test**	**999**	**$800**
	Positive Reinforcement for Clean Drug/Alcohol Tests **($ 10 Max. per clean test ($100 Max. per voucher)**	**5.00**	**RE ***	**100**	**$100**
	Spiritual/Cultural support (single client)	**95.00**	**Session**	**999**	**$800**
	Spiritual/Cultural support (multiple clients)	**45.00**	**Session**	**999**	**$800**
	Transportation-Provider supplied client transportation	**0.445**	**per Mile**	**999**	**$800**
	Public Transportation for client to and from treatment	**1.00**	**RE ***	**999**	**$800**

AAIR

$600	**Recovery Support Services**				
	Alcohol and drug testing	**25.00**	**Test**	**999**	**$600**
	Licensed Childcare (while attending treatment)	**6.00**	**per hour, RE***	**999**	**$600**
	Family Services (single family)	**60.00**	**Session**	**999**	**$600**
	Family Services (multiple families)	**40.00**	**Session**	**999**	**$600**
	Self-help and support groups, Provider hosted	**30.00**	**Session**	**999**	**$600**
	Relapse Prevention/Recovery Coaching	**25.00**	**Session**	**999**	**$600**
	Case Management-Recovery Support	**30.00**	**Session**	**999**	**$600**
	Spiritual/Cultural support (single client)	**95.00**	**Session**	**999**	**$600**
	Spiritual/Cultural support (multiple clients)	**45.00**	**Session**	**999**	**$600**
	Transportation-Provider supplied client transportation	**0.445**	**per Mile**	**999**	**$600**
	Public Transportation for client to and from treatment	**1.00**	**RE ***	**999**	**$600**
	Recovery Support Services must directly support recovery, have a direct link to the treatment plan with impact of participation clearly documented in the client's file.				
$2,700	**Residential Treatment**				
	Residential Treatment (adult or adolescent)	**90.00**	**per Day**	**30**	**$2,700**
$750	**Recovery Support - Transitional/Sober Living Assistance**				
	Transitional/Sober Living Assistance provided by a sober living facility	**1.00**	**Actual cost**	**999**	**$750**
	RE * = Reimbursable Expense; Provider must purchase item(s) for client Provider must retain all receipts in clients file. No services may be entered into the VMS until after they have been provided and the provider has the receipt(s).				

Provider Enrollment Application
Outpatient/Residential/Recovery Support/Transitional Housing or Sober Living

Welcome to the Access to American Indian Recovery program (AAIR). To participate as an AAIR provider, each provider organization must complete a provider application. The following five (5) parts of the application must be complete for it to be processed by AAIR:

Part 1 – Provider Organization Information (SECTIONS A – H)

- ❑ All applicable questions are answered. If an item is not applicable, write N/A.
- ❑ Cooperate fully with SAMHSA's data collection and evaluation requirements. Ensure that all GPRAs (Intake, Discharge, and the five-month post intake follow-up) are completed accurately and on time. Failure to complete GPRAs accurately and on time will result in the Provider Organization's suspension from the AAIR Program.
- ❑ The organization participation agreement is signed and dated by an authorized individual (i.e., executive director) on behalf of the organization.

Part 2 – Individual Provider Information

- ❑ Provide credential information for each individual who will provide service(s).
  Please refer to the Provider Qualification Standards located in the instructions section.
- ❑ Signed and dated by an authorized individual (i.e., executive director) on behalf of the Provider Organization.

Part 3 – Provider Attestation Questions

- ❑ Each provider has completed, signed, and dated the attestation statement.

Part 4 – Provider Information Release and Acknowledgments

- ❑ Each provider has signed and dated the release and acknowledgments.

Part 5 – Supporting Documentation (Attach copies of the following documents)

- ❑ License and/or certification for the provider organization or program (if applicable).
- ❑ W-9 – Request for Taxpayer Identification Number and Certification for the provider organization or sole provider.
- ❑ Current resume for each individual provider.
- ❑ Current license, certification, and/or registration for each individual provider.
- ❑ Provide appropriate business license and liability insurance.

General Instructions and Provider Qualification Standards are Included

Once the application is complete, the application and supporting documentation must be mailed to:

AAIR Administration - Provider Enrollment
California Rural Indian Health Board, Inc.
4400 Auburn Boulevard, 2nd Floor, Sacramento, CA 95841
Phone: (916) 929-9761, Facsimile: (916) 263-0207

General Instructions and Provider Qualification Standards

Part 1

Section A – Provider Organization Information

1. **Organization Name and Type** – Provide the name of the corporation, partnership, or sole-proprietorship.
2. **Physical Address** – Provide the street, city, state, and ZIP code of the administrative office for the corporation, partnership, or sole-proprietorship.
3. **Mailing Address** – Provide the street or post office box, city, state, and ZIP code where mail is received by the corporation, partnership, or sole-proprietorship administration.
4. **Contact Name and Title** – Provide the name and title of the individual who is authorized to represent the corporation, partnership, or sole-proprietorship administratively.
5. **Telephone Number** – Provide the area code and telephone number for the corporation, partnership, or sole-proprietorship where the administrative representative can be reached.
6. **Facsimile Number and Email** – Provide the area code, facsimile number and Email for the corporation, partnership, or sole proprietorship where the administrative representative can be reached.

Section B – Fiscal/Payment Information

1. **Organization Name** – Provide the name of the corporation, partnership, or sole-proprietorship.
2. **Mailing Address** – Provide the street or post office box, city, state, and ZIP code where mail is received by the fiscal office.
3. **TIN/SSN** – Provide the tax identification number (TIN) or social security number (SSN) for the corporation, partnership, or sole-proprietorship. Identify if your organization is profit or non-profit.
4. **Fiscal Contact Name and Title** – Provide the name of the individual who is authorized to provide and receive fiscal information (billing, payment, records, etc.).
5. **Telephone Number** – Provide the area code and telephone number for the fiscal office.
6. **Facsimile Number and Email** – Provide the area code, facsimile number and email for the fiscal office.

Section C – Business License, Liability Insurance

1. Provide current appropriate business license and liability insurance information for the provider organization.

Section D – Hours of Operation

1. Provide the hours that services may be delivered to clients.

Section E – Program/Department Information

1. **Program/Department Name** – Provide the name of the program/department that may provide service(s).
2. **Contact Name and Title** – Provide the name of the individual who is authorized to provide and receive information on behalf of the program/department.
3. **Physical Address** – Provide the street, city, state, and ZIP code where service(s) will be delivered.
4. **Mailing Address** – Provide the street or post office box, city, state, and ZIP code where mail is received by the program/department.
5. **Telephone Number** – Provide the area code and telephone number for the program/department.
6. **Facsimile Number and Email Address** – Provide the facsimile number and email address for the program/department.

Section F – Program/Department License and/or Certification

If the program/department is a licensed and/or certified program/department in the state of jurisdiction, provide the information requested in section F. A copy of the license and/or certification must be provided with the application. If a program/department has more than one license and/or certification, make a copy of section F and provide the additional information.

Section G – Program/Department Services

Check the boxes of all of the (1) types of service, (2) service populations, (3) services, (4) substances qualified to treat, and (5) language options that each program/department will offer to AAIR clients.

Section H – Organization Participation Agreement

The individual who is authorized to sign the application (i.e., executive director) on behalf of the corporation, partnership, or sole-proprietorship must sign section G to certify that the information provided in the application is correct.

Part 2 – Individual Provider Information

Provide credential Information for each individual within the organization that will provide clinical service(s)

Please refer to the Provider Qualification Standards located in the instructions section.

Part 3 - Provider Attestation Questions

Must be completed, signed, and dated by each individual provider.

Each provider is required to complete, sign, and date this form. For programs that have more than one provider, please make a copy of this form for each provider. An application will not be considered complete unless a completed attestation question form is submitted for each provider who is identified to provide services in the provider application.

Part 4 - Provider Information Release and Acknowledgments

Must be completed, signed, and dated by each provider.

Each provider is required to sign and date this form. For programs that have more than one provider, please make a copy of this form for each provider. An application will not be considered complete unless a completed information release and acknowledgment form is submitted for each provider who is identified to provide services in the provider application.

Part 5 – Supporting Documentation

Provider Qualification Standards (Attach copies of required documents.)

- State License, Certification, and Registration
- Psychiatrist
- Psychologist
- Clinical Social Worker
- Marriage and Family Therapist
- Chemical Dependency Counselor
- Pastoral Counselor
- Clinical Interns
- Traditional Medicine/Spirituality
- Recovery Support Service Coordination

All licenses, certificates, and registrations must be located at the providing organization's place of business and available for inspection.

State License, Certification, and Registration

Each clinical provider must hold a current and valid license, certification, or registration to practice in the state where the service(s) will be rendered. The provider must also be in good standing with the licensing, certifying, or registering board. The license, certification, or registration must be at the full and unrestricted clinical level of practice.

License, Certification, or Registration: Each provider shall possess and maintain, as applicable, the appropriate license, certification, or registration as required by AAIR even if it is not required by the state where the service is rendered. If the site of service is on Tribal land, the provider must be licensed in a state.

Excluded Parties: No individual providing AAIR services or having oversight of AAIR services or providers may be excluded from participation by the OIG, GSA, Medicare or Medicaid.

Psychiatrist

A psychiatrist is a medical doctor who specializes in the diagnosis and treatment of behavioral abnormalities and mental diseases. A psychiatrist may be reimbursed for providing services when practicing within the scope of his or her license. The psychiatrist must meet all of the following criteria:

1. License Required: Is licensed as a physician in his/her jurisdiction.
2. Education and Experience: Graduation from an approved medical school and possession of an M.D. or D.O. degree, supplemented by completion of a recognized internship.
3. Is in good standing with the licensing board in his/her jurisdiction.

Psychologist

A psychologist may provide covered services when practicing within the scope of his or her license or registration. The psychologist must meet all of the following criteria:

1. Is licensed or registered as a psychologist at the independent practice level in his/her jurisdiction.
2. Is in good standing with the licensing or registering board in his/her jurisdiction.
3. Has a doctoral degree in psychology from a regionally accredited university.
4. Has two (2) years or 3,000 hours of supervised clinical experience in psychological health services of which at least one (1) year is post-doctoral and one (1) year (may be the post-doctoral year) is in an organized psychological health service training program, and 100 hours of face-to-face supervision.
5. If required, provides services under the supervision qualified in the jurisdiction.

Clinical Social Worker

A clinical social worker may provide covered services independent of physician referral and supervision when practicing within the scope of his or her license or certification. The clinical social worker must meet all of the following criteria:

1. Is licensed as a clinical social worker at the independent practice level in his/her jurisdiction; or, if the jurisdiction does not provide for licensure of clinical social workers, is certified by the National Association of Social Workers (NASW). If a provider is eligible for full clinical membership in the NASW but is not a member, he/she must submit documentation obtained from the NASW of such eligibility.
2. Is in good standing with the licensing board in his/her jurisdiction.
3. Has at least a master's degree in social work from an accredited graduate school.
4. Has a minimum of two (2) years or 3,000 hours of supervised clinical social work practice under the supervision of a master's level social worker in an appropriate clinical setting and 100 hours of face-to-face supervision.
5. If required, provides services under the supervision qualified in the jurisdiction.

Marriage and Family Therapist

A marriage and family therapist may provide covered services independent of physician referral and supervision when practicing within the scope of his or her license or certification. The marriage and family therapist must meet all of the following criteria:

1. Is licensed or certified as a marriage and family therapist by the jurisdiction where practicing; or, if the jurisdiction does not provide for licensure of marriage and family therapists, is certified by the American Association for Marriage and Family Therapy (AAMFT). If a provider is eligible for full clinical membership in the AAMFT but is not a member, he/she must submit documentation obtained from the AAMFT of such eligibility.
2. Is in good standing with the licensing or certification board in his/her jurisdiction.
3. Has at least a master's degree in marriage and family therapy from an accredited graduate school.
4. Has a minimum of two (2) years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate clinical setting and 100 hours of face-to-face supervision.
5. If required, provides services under the supervision qualified in the jurisdiction.

Chemical Dependency Counselor

A chemical dependency counselor may provide covered services independent of physician referral and supervision when practicing within the scope of his or her certification. The chemical dependency counselor must meet all of the following criteria:

1. Is certified as a chemical dependency counselor by a certification board authorized by the state where services will be rendered.
2. Is in good standing with the certification board in his/her jurisdiction.
3. If required, provides services under the supervision qualified in the jurisdiction.

Pastoral Counselor

A pastoral counselor may provide covered services upon request of the client. The pastoral counselor must meet all of the following criteria:

1. Is licensed or certified as a pastoral counselor by the jurisdiction where practicing; or, if the jurisdiction does not provide for licensure of pastoral counselors, is certified by the American Association of Pastoral Counselors (AAPC). If a provider is eligible for full clinical membership in the AAPC but is not a member, he/she must submit documentation obtained from the AAPC of such eligibility.
2. Is in good standing with the licensing or certification board in his/her jurisdiction.
3. Has at least a master's degree in an appropriate behavioral science field or mental health discipline from an accredited graduate school.
4. Has a minimum of two (2) years or 3,000 hours of supervised clinical practice of pastoral counseling under master's level supervision in an appropriate clinical setting and 100 hours of face-to-face supervision.
5. If required, provides services under the supervision qualified in the jurisdiction.

Clinical Interns

Clinical interns may provide covered services when practicing within the scope of his or her intern registration or license. Clinical interns must meet all of the following criteria:

1. Is licensed or registered as an intern in the field of medicine, psychology, marriage and family therapy, or clinical social work.
2. Is in good standing with the licensing or registering board in his/her jurisdiction.
3. Has at least a master's degree from a regionally accredited university.

Clinical interns may only provide services under the direct supervision of a licensed psychologist, board-certified psychiatrist, or other licensed clinician qualified in the jurisdiction.

Providers of Traditional Medicine/Spirituality

Providers of traditional medicine/spirituality must be in good standing with the community and recognized as a traditional healer/spiritual advisor in the community where services are to be provided.

Providers of traditional medicine/spirituality must have a minimum of two (2) years of experience as a recognized traditional healer/spiritual advisor in the community where services are to be provided. To demonstrate a provider's qualifications, a written letter of good standing and recognition must be signed and submitted to the provider organization and AAIR by a tribal chairperson or by the board of directors of an Indian health organization in the community where services will be provided **(see c5.a1 – Letter Verifying Community Recognition and Good Standing to Serve as a Traditional Healer/Spiritual Advisor).**

Recovery Support Service Coordination

Recovery support service coordination may be rendered by an employee of a provider organization when:

1. The provider organization, as the employer, pays a salary, social security taxes, worker's compensation, etc.
2. The service(s) are performed under the provider's general supervision
3. The service(s) are authorized by AAIR

Part 1 - Provider Organization Information

Your Organization Will Provide – (check all that apply)

❑ Outpatient/Clinical ❑ Residential ❑ Recovery Support ❑ Transitional/Sober Living Facilities

A - Organization Information

1. Organization Name and Type ❑ Corporation ❑ Partnership ❑ Sole Proprietor

2. Physical Address (Street, City, State, ZIP Code)

3. Mailing Address (Street/P.O. Box, City, State, ZIP Code)

4. Contact Name and Title (Executive Director)

5. Telephone Number 6. Facsimile Number 7. Email

B Fiscal/Payment Information

Provide Payment Information for Payment of Service(s)

1. Organization Name

2. Mailing Address – (Street/P.O. Box, City, State, ZIP Code)

3. Tax ID #/ SSN

4. Fiscal Contact Name and Title

❑ Profit
❑ Non-Profit

5. Telephone Number 6. Facsimile Number Email

C Business License, Liability Insurance

Provide current appropriate business license and liability insurance information for the provider organization. Liability insurance must be a minimum of $1,000,000.

1. Insurance Company and Policy Number

2. Insurance Liability Amount 3. Insurance Policy Dates (Effective) (Expiration)

D Hours of Operation

Provide the hours that services may be delivered to clients.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

E - Program/Department Information (If Applicable)

Provide information for the program/department that will provide service(s).

1.Program/DepartmentName

2. Program Contact Name and Title

3. Physical Address (Street/P.O. Box, City, State, ZIP Code)

4. Mailing Address (Street/P.O. Box, City, State, ZIP Code)

5. Telephone Number 6. Facsimile Number Email

F - Program/Department License and/or Certification (Clinical and Residential)

Provide licensing and/or certification information for each program/department that will provide service(s). Must be licensed and certified by the applicant's State Department of Licensing and Certification or the Department of Alcohol and Drug Programs if required by state.

1. State Licensing/Certifying Agency Name

2. State Licensing/Certification Classification

3. State Licensing/Certification Number

4. State Licensing/Certification Dates

(Effective) (Expiration)

G - Program/Department Services (If Applicable)

1. Type of organization

❑ Primary health care facility (Tribal health program)

❑ Primary health care facility (Urban Indian Health Program)

❑ Other primary health care facility

❑ Specialized outpatient or residential substance abuse treatment facility (not housed at a primary health care clinic)

❑ Social service organization (e.g., food banks, family service organizations, legal assistance, employment and training organizations)

❑ Faith-based institution (e.g., church, synagogue, mosque)

❑ Traditional healing interventionist or Native American cultural organization

❑ Other _____

2. Culturally-based services

Do the services offered by your organization incorporate traditional American Indian/Alaskan Native (AI/AN) customs and cultural beliefs?

❑ Yes ❑ No

3. Sources of Payment

Which of the following sources of payment are usually used to cover the cost of direct services to your clients?"

- ❑ Private health insurance,
- ❑ MediCal/MediCare,
- ❑ Tribal funds,
- ❑ IHS funds,
- ❑ Government or foundation grants,
- ❑ Private donations,
- ❑ Fee-based services (out-of-pocket),
- ❑ Fee-based services with sliding scale,
- ❑ Other sources _____

5. Identify the Gender and Age of Clients that Your Program/Department Serves

- ❑ Adults (Specify gender and age range): _____ _____
- ❑ Youth (Specify gender and age range): _____ _____

6. Service(s) that your Program/Department provides (Check all that apply)

Screening, Assessment, and Diagnosis Services

- ❑ Client eligibility and substance abuse screening
- ❑ Substance abuse assessment and diagnosis
- ❑ Substance abuse treatment planning
- ❑ Clinical case management
- ❑ Pharmacological assessment
- ❑ Alcohol and drug testing

Substance Abuse Services

- ❑ Individual substance abuse counseling
- ❑ Group substance abuse counseling
- ❑ Single family/marriage substance abuse counseling
- ❑ Multiple family/marriage substance abuse counseling
- ❑ Substance abuse education
- ❑ HIV/AIDS/STD/HEPC education
- ❑ HIV/AIDS/STD/HEPC counseling

Mental Health Services (for co-occurring mental health disorders)

- ❑ Mental health assessment and diagnosis
- ❑ Mental health treatment planning
- ❑ Individual psychotherapy
- ❑ Group psychotherapy
- ❑ Single family/marriage counseling
- ❑ Multiple family/marriage counseling
- ❑ Pharmacological management

Recovery Support Services

- ❑ Relapse prevention
- ❑ Recovery coaching
- ❑ Supportive transitional drug-free housing services
- ❑ Nutritional Counseling
- ❑ Acupuncture
- ❑ Exercise Activity Support
- ❑ Single family services
- ❑ Multiple family services
- ❑ Employment services
- ❑ Traditional activities
- ❑ Spiritual support
- ❑ Peer coaching or mentoring
- ❑ Self-help and support groups
- ❑ Childcare
- ❑ Transportation

7. Substances that your program is qualified to treat (check all that apply)

❑ Methamphetamine	❑ Heroin	❑ Crack	❑ Cocaine
❑ Marijuana/Hashish	❑ Alcohol	❑ Stimulants	❑ Other (Specify)
❑ Depressants	❑ Hallucinogens	❑ Nicotine	_____

II Organization Participation Agreement

Must be signed and dated by an authorized individual on behalf of the provider organization. To participate as a provider under AAIR, our organization, as the provider of services agrees to:

1. Not charge a client for the following:
   a. Services for which the provider is entitled to payment from AAIR;
   b. Services for which the provider could have been entitled to payment from AAIR had the provider complied with certain procedural requirements;
   c. Services not necessary and appropriate for the clinical management of the presenting problem(s);
   d. Services for which the provider could have been entitled to payment from AAIR had the provider not been charged with a reduction or denial in payment as a result of quality review; and
   e. Services rendered during a period in which the provider was not authorized to provide services.
2. Not charge AAIR for services paid for by other funding sources.
3. Comply with the applicable provisions related to AAIR policy.
4. Accept the AAIR allowable payment combined with any cost share or other health insurance amounts payable by, or on behalf of, the client, as full payment for authorized services.
5. Collect from the client those amounts that the client has a liability to pay for.
6. Allow AAIR to review the clinical records of AAIR clients, the financial and organizational records of the provider, and the reports of evaluations and inspections conducted by state, private agencies, or organizations.
7. Cooperate fully with utilization and clinical quality management reviews conducted by AAIR.
8. Cooperate fully with SAMHSA's data collection and evaluation requirements. Ensure that all GPRAs (Intake, Discharge, and the Five-Month post intake follow-up) are completed accurately and on time. Failure to complete GPRAs accurately and on time will result in the Provider Organization's suspension from the AAIR Program.
9. Obtain authorized Assessment or Treatment Voucher from AAIR before rendering services.
10. Maintain clinical and other records related to clients for whom payment was made for services rendered by the provider or otherwise under arrangement, for a period of 7 years from the date of service.
11. Maintain clinical records that substantiate the clinical rationale for each course of treatment, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation of treatment.
12. Notify AAIR within five (5) business days when a client's eligibility status has changed.
13. Notify AAIR immediately of suspected fraud and abuse and notify AAIR immediately if either the provider or one of the provider's employees becomes excluded from participation in federal programs.
14. Notify AAIR immediately when an employee who serves as a provider is no longer employed by the organization or their eligibility status changes.
15. Not use AAIR program funds for clinical research involving human subjects, and not enroll clients in clinical research involving human subjects.
16. Maintain malpractice insurance in the amounts specified by AAIR and notify AAIR if the malpractice insurance falls below the required limit.
17. Provide quality services within the appropriate standards of care for each provider's profession.
18. Meet all AAIR reporting requirements.
19. Meet future requirements established by AAIR.

The AAIR program agrees to make this agreement effective until terminated by either party. The effective date shall be the date the agreement is signed below:

Print, Organization Name (corporation, partnership, or sole-proprietor name)

Print, Authorized Signer's Name | Print, Authorized Signer's Title

Signature, Authorized Signer's Name *(Stamped signature is not acceptable)* | Date

Part 2 – Individual Provider Information

Provide Credential Information for Each Individual who will Provide Service(s)

Please refer to the Provider Qualification Standards located in the instructions section.

1. Provider Name

2. Education/Credentials & Specialty

3. Date of Birth

4. TIN/SSN

5. Email

6. License/Certification/Registration Board Name

7. License/Certification/Registration Number

8. License/Certification/Registration Dates
   (Effective) (Expiration)

1. I understand that I/we have a right to appeal any decision regarding the disposition of this application.
2. I declare under the penalty of perjury that the statements on this application are correct to the best of my knowledge.
3. I am authorized to sign this application on behalf of the named applicant.

Signature _____ Title _____ Date _____

Authorized representative organization

Part 3 - Provider Attestation Questions

Must be completed, signed, and dated by each individual provider.

Each provider is required to complete, sign, and date this form. For programs that have more than one provider, please make a copy of this form for each provider. An application will not be considered complete unless a completed attestation question form is submitted for each provider who is identified to provide services in the provider application.

Please answer "YES" or "NO" to the questions below. If you answer "YES" to questions A through K, or if you answer "NO" to question L, please provide a full explanation on a separate sheet of paper referencing the section number.

A. Has your license, registration, or certification to practice in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license, registration, or certification or voluntarily or involuntarily accepted any such actions or conditions, or have been fined or received a letter of reprimand or is such action pending?

❑ Yes ❑ No

B. Have you ever been charge, suspended, fined, disciplined, or otherwise sanctioned, subject to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any other public program, or is any such action pending?

❑ Yes ❑ No

C. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association [IPA], health plan, health maintenance organization [HMO], preferred provider organization [PPO], medical society, professional association, medical school faculty possession, or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct, or breach of contract, or is any such action pending?

❑ Yes ❑ No

D. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association [IPA], health plan, health maintenance organization [HMO], preferred provider organization [PPO], medical society, professional association, medical school faculty possession, or other health delivery entity or system) while under investigation for possible incompetence, improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?

❑ Yes ❑ No

E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, or other clinical education program?

❑ Yes ❑ No

F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?

❑ Yes ❑ No

G. Have you ever been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)?

❑ Yes ❑ No

H. Have you ever been convicted of any crime (other than a minor traffic violation)?

❑ Yes ❑ No

I. Do you presently use any drugs illegally?

❑ Yes ❑ No

J. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending?

❑ Yes ❑ No

K. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g., reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with a written notice of any intent to deny, cancel, or renew, or limit your professional liability insurance or its coverage of any procedures?

❑ Yes ❑ No

L. Are you able to perform all of the services required by your agreement with, or the professional staff bylaws of the health organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance standards and without posing a direct threat to the safety of clients?

❑ Yes ❑ No

I hereby affirm that the information submitted in this Part 3 – Provider Attestation Questions, and any attached addendums is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that omissions and misrepresentations may result in denial of my application or termination of my privileges as a provider under AAIR.

Print, Provider Name

Signature, Provider Name
(Stamped signature is not acceptable)

Date

Part 4 - Provider Information Release and Acknowledgments

Must be completed, signed, and dated by each provider.

Each provider is required to sign and date this form. For programs that have more than one provider, please make a copy of this form for each provider. An application will not be considered complete unless a completed information release and acknowledgment form is submitted for each provider who is identified to provide services in the provider application.

1. I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between CRIHB or its agent and other healthcare organizations (e.g., hospital medical staff, medical groups, independent practice associations [IPA], health plans, health maintenance organizations [HMO], preferred provider organizations [PPO], and other health delivery systems or entities, medical societies, professional associations, schools, training programs, professional liability insurance companies [with respect to certification of coverage and claims history], licensing, registration, and certification authorities, and businesses and individuals acting as their agents, for the purpose of evaluating this application and any re-application regarding my professional training, experience, character, conduct, and judgment, ethics, and ability to work with others.

2. I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for acts and/or communications in connection with evaluating qualifications of healthcare providers. I hereby release all persons and entities, including CRIHB, engaged in quality assessment, peer review and credentialing on behalf of AAIR, and all persons and entities providing credentialing information to such representatives of CRIHB or AAIR, from any liability incurred for acts and/or communications in connection with the evaluation of my qualifications for participation in AAIR, to the extent that those acts and/or communications are protected by state and federal law.

3. I understand that I shall afford such fair procedures with respect to my participation in AAIR as may be required by state and federal law and regulation. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. During such time as this application is being processed, I agree to update the application should there be any changes in the information provided.

4. In addition to any notice required by AAIR, I agree to notify CRIHB immediately in writing of the occurrence of any of the following: (i) the suspension, revocation or non-renewal of my license, registration, and/or certification to practice; or (ii) any cancellation or non-renewal of my professional liability insurance coverage.

5. I further agree to notify CRIHB in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the licensing, registration, and/or certification board taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license, registration, and/or certification; or (ii) the denial, revocation, suspension, reduction, limitation, non-renewal or voluntary relinquishment by resignation of my privileges; or (iii) any material reduction in my professional liability insurance coverage; or (iv) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (v) my conviction of any crime (excluding minor traffic violations); (vi) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

6. This release of information pertains to records directly related to my professional qualifications and conduct, and specifically excludes personal medical and mental health records.

I hereby affirm that the information submitted in this application and any attached addendums (including my curriculum vitae, resume, etc.) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions and misrepresentations may result in denial of my application or termination of my privileges as provider under AAIR. A photocopy of this document shall be as effective as the original.

Print, Provider Name

Signature, Provider Name
(Stamped signature is not acceptable)

Date

Part 5 – Supporting Documentation

Attach copies of the following documents

- ❑ License and/or certification for the provider organization or program (if applicable)
- ❑ W-9 – Request for taxpayer identification number and certification for the provider organization
- ❑ Current resume for each individual provider
- ❑ Current license, certification, and/or registration for each individual provider
- ❑ Current business license and liability insurance for each provider organization

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

QUARTERLY BOARD MEETING
JULY 15-17, 2008

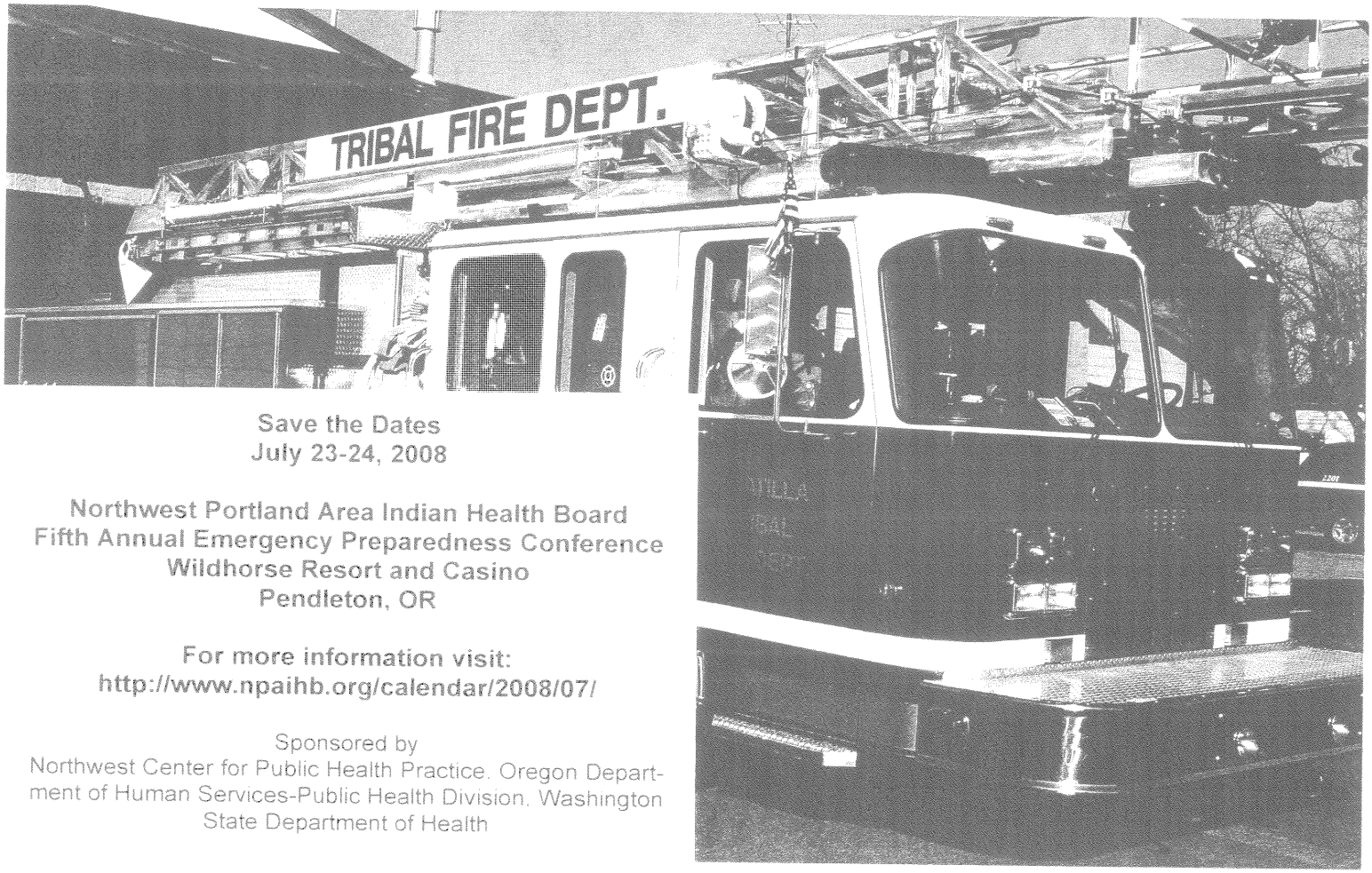
AT

QUINAULT BEACH RESORT & CASINO
78 STATE ROUTE 115
OCEAN SHORES, WA 98569

888/461-2214 RESERVATIONS

Rooms are blocked under the group name of **"NW Portland Area Indian Health Board Meeting"**. Rooms are $109/night. Please call the hotel by **June 13, 2008** to receive the group rate. Reservations received after this date will be accepted on a space available basis and at the regular room rate.

If you have any questions, please contact Elaine Dado, Executive Administrative Assistant at (503) 416-3268 or email edado@npaihb.org



Save the Dates
July 23-24, 2008

Northwest Portland Area Indian Health Board
Fifth Annual Emergency Preparedness Conference
Wildhorse Resort and Casino
Pendleton, OR

For more information visit:
http://www.npaihb.org/calendar/2008/07/

Sponsored by
Northwest Center for Public Health Practice, Oregon Department of Human Services-Public Health Division, Washington State Department of Health

Northwest Portland Area
Indian Health Board

Fifth Annual Emergency Preparedness Conference
July 23-24, 2008 Pendleton, Oregon
Wildhorse Resort and Casino

The Emergency Preparedness Conference is an annual event that brings together tribal, state, local and federal agencies to discuss collaboration efforts and training to improve tribal emergency preparedness. Previous topics covered at the Emergency Preparedness Conference include:

- Pan Flu and Avian Flu
- Natural Disaster Tabletop Exercise
- Tribal Best Practices
- Pharmaceutical Stockpiles and Mass Dispensing

Public Health Professionals, Emergency Management Professionals, Community Health Professionals, First Responders, and Community Members are encouraged to attend.

For more information, visit our website:
http://www.npaihb.org/epicenter/bioterrorism_preparedness_links
Or contact NPAIHB Training and Outreach Coordinator at
vshortbull@npaihb.org

In Collaboration with Northwest Center for Public Health Practice, Oregon Department of Human Services–Public Health Division, Washington State Department of Health.

Northwest Center for Public Health Practice

University of Washington Subcontract No. 483671

20th Anniversary
2008 Annual Native Health Research Conference

August 25-28, 2008
Red Lion Hotel, Jantzen Beach
Portland, OR

Northwest Portland Area Indian Health Board
in collaboration with the
Native Research Network *Promoting Integrity and Excellence in Research*

Exploring the Interface Between Science and Tradition in Native Health Research

20th Anniversary
2008 Annual Native Health Research Conference
August 25-28, 2008

This year's conference brings together many different stakeholders involved in the conception, production, translation, and use of health research in American Indian/Alaska Native/Native Hawaiian communities from across the country. Conference participants will include health care providers, administrators, educators, policy-makers, and tribal leaders, as well as researchers. It is anticipated that the conference will enhance our collective ability to advance biomedical, psychosocial, and health services research for the benefit of Native communities, and to showcase recent health research projects and efforts undertaken in Indian Country.

For more information and registration, please visit:
http://www.npaihb.org/epicenter/2008_national_native_american_research_conference_on_health1/
Or contact Nichole Hildebrandt at nhildebrandt@npaihb.org or (503) 416-3285

Hotel Reservations:
Red Lion on the River
(800) RED-LION or (503) 283-4466
info@redlionontheriver.com

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

1B

Indian Health Service
Rockville MD 20852

MAR 2 0 2008

TO: Area Directors

FROM: Acting Director

SUBJECT: Request for Representatives to the Behavioral Health Tribal Advisory Committee

The Tribal Leaders Diabetes Committee (TLDC) guides the Chronic Care Initiative, and the Health Promotion/Disease Prevention (HP/DP) Policy Advisory Committee (PAC) leads the HP/DP Initiative. Both advisory groups support sharing their ideas and strategies to fully integrate all of the Indian Health Service (IHS) Director's health initiatives. The purpose of this memo is to request representatives for a Behavioral Health Advisory Committee (BHAC) to direct the Behavioral Health Initiative, which focuses on preventing suicide, reducing methamphetamine abuse, protecting families from violence, and improving data quality. Specifically, I envision the following:

- The BHAC will include two Tribal Leaders from each Area: one primary, who will relate Tribal concerns about mental health, alcohol and substance abuse issues; and one alternate, who will serve in the absence of the primary.

- The BHAC will meet at least 3 times annually to discuss the behavioral health priorities for their Tribal communities, recommending strategies and resources for the Behavioral Health Initiative.

Please forward the names and contact information for the primary and alternate nominees from your Area for the BHAC no later than April 30, 2008, to Mr. Gary Quinn, Behavioral Health Initiative, IHS Headquarters. If you have any further questions, please feel free to contact Mr. Quinn at (301) 443-2038 or gary.quinn@ihs.gov.

Robert G. McSwain

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service **1C**

PORTLAND AREA
INDIAN HEALTH SERVICE
1220 SW 3rd AVENUE, Room 476
PORTLAND,OREGON 97204

APR 10 2008

Dear Tribal Leader:

In recent months events have occurred that have raised the issue of whether or not Tribes can bill eligible Indian Health Service (IHS) beneficiaries for services they receive through their IHS funded Tribal Health Programs. There was a recent district court decision in California that held that the IHS could not prohibit the Tribe from billing its members for pharmacy services provided by the Tribe through its Title V annual funding agreement. In addition, the Indian Health Care Improvement Act reauthorization legislation, S. 1200, recently passed by the Senate includes a provision that would give Title V, Self-Governance Tribes the option to bill their Tribal members for services received at their Tribal Health Program. While the IHS chose not to appeal the district court decision, we are evaluating potential policy and funding implications of the decision. Both of these events have prompted the IHS to consult with all Tribes.

I have been asked by Mr. Robert McSwain, Acting Director, IHS, to consult with Portland Area Tribes on the issue of charging eligible patients for services. On this very important issue I want to ensure that Tribes are consulted before the IHS makes any changes to its current policy and approach. Consequently, this Tribal consultation will be held May 14, 2008, from 1 PM to 4 PM, at the Mid-Year Conference of Affiliated Tribes of Northwest Indians at the Chehalis Tribe's Great Wolf Lodge, 20500 Old Highway 99 SW, Centralia, WA, 98531. Pending this consultation, the existing IHS policy, which prohibits Tribes from charging eligible beneficiaries, remains unchanged.

If you have any questions on this matter, please call the Portland Area Office of Tribal and Service Unit Operations at (503) 326-4123.

Sincerely,

Roselyn Tso
Acting Area Director

NORTHWEST
PORTLAND
AREA
INDIAN
HEALTH
BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Suislaw, &
Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispell Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshoni Tribe
Port Gamble S'Klallam
Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

527 S.W. Hall
Suite 300
Portland, OR 97201
Phone: (503) 228-4185
Fax: (503) 228-8182
www.npaihb.org

March 24, 2008

10A

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2244-P
P.O. Box 8016
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

To whom it may concern:

The Northwest Portland Area Indian Health Board (NPAIHB) is a P.L. 93-638 Tribal organization[1] that represents forty-three federally-recognized Tribes in the states of Idaho, Oregon, and Washington. We have reviewed the proposed rule (CMS-2244-P) and are seriously concerned about the impact on Tribal programs and the lack of Tribal consultation in the development of the proposed rule. The lack of Tribal consultation is in contradiction to the Department's Tribal Consultation Policy and we request that these regulations not be made effective until such Tribal consultation consistent with Department policy is conducted.

The proposed rule implementing sections 6041, 6042, and 6043 of the Deficit Reduction Act of 2005 (DRA) and Health Care Act of 2006 (TRHCA). These sections amend the Social Security Act (SSA) by adding a new section 1916A to provide State Medicaid agencies with increased flexibility to impose premium and cost sharing requirements on certain Medicaid recipients. We have serious concerns for the following reasons:

- We are concerned about that Tribal Consultation did not happen on the proposed rule despite the fact that CMS has adopted the TTAG to provide advice and guidance on program issues affecting AI/AN served by Titles XVIII, XIX, and XXI of the Social Security Act (SSA). This is inconsistent with the Department's Tribal Consultation Policy.
- The proposed rule does not honor treaty obligations for health services that are consonant with and required by the Federal Government's unique legal relationship with Tribal governments.
- Proposed cost sharing raises serious and unique barriers to access to Medicaid for AI/AN people, exemptions are required for Indians cost sharing requirements.
- Consistent with CMS policy requiring that States consult with Tribes in the development of waiver proposals, CMS should make this same requirement in the development of premium and cost-sharing proposals.

The CMS TTAG was established in October 2004 to provide advice and input to the CMS on policy and program issues affecting AI/AN people. For the last four years the TTAG has carried out its responsibilities as an effective advisory group by holding monthly conference calls and three face to face meetings each year. The TTAG has full participation of its fifteen members, one representative from each of the twelve geographic areas of the Indian Health Service (IHS) and one representative from three

[1] As defined in the Indian Self-Determination and Education Assistance Act, P.L. 93-638, 25 U.S.C., Section 450(b) a Tribal organization is a legally established governing body of any Indian tribe(s) that is controlled, sanctioned, or chartered by such Indian Tribe(s) and designated to act on their behalf.

national Indian organizations, National Indian Health Board, National Congress of American Indians, and Tribal Self-Governance Advisory Group.

Background:

As explained above, the CMS TTAG was established to provide advice and guidance to CMS in the development of policy that could impact AI/AN access to Medicaid services and the IHS and tribal programs that participate as providers of Medicaid services pursuant to section 1911 of the SSA. In 1976, Congress amended the SSA to provide Medicaid participation and reimbursement authority for Medicaid services provided in IHS and tribal facilities so that Indian people could access Medicaid services entitled to them as citizens of the State where they reside. The IHS estimates that nationwide approximately 35% of the 1.5 million IHS active users are eligible for or are Medicaid beneficiaries - in some locations, for instance with 70% unemployment, this percentage is higher. Over 500 health care facilities operated by the IHS, tribes, and tribal organizations, pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), are Medicaid participating providers.

In 2007, the CMS TTAG established a Policy Subcommittee to specifically provide a forum for tribal input in the development of policy guidance and regulations for having potential impact on AI/AN Medicaid beneficiaries and IHS and tribal provider of Medicaid services. The CMS TTAG Policy Subcommittee is not a substitute for tribal consultation but consists of tribal representatives with particular knowledge and expertise in Medicaid.

Department Tribal Consultation Policy:

The Department's Tribal Consultation Policy, revised on February 1, 2008, requires each HHS Operating and Staff Division (Division) to establish a process to ensure meaningful and timely input by Tribal officials in the development of policies that have Tribal implications. The consultation policy, at Section 4 (B), also requires that HHS Divisions, such as CMS, not promulgate regulations that have tribal implications or impose substantial direct compliance costs on Indian Tribes unless:

1. Funds necessary to pay the direct costs incurred by the Indian Tribe in complying with the regulations are provided by the Federal Government; or
2. The Division, prior to the formal promulgation of the regulation,
    a. Consulted with Tribal officials early and throughout the process of developing the proposed regulation;
    b. 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 the Division's prior consultation with Tribal officials, a summary of the nature of their concerns and the Division'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
    c. Made available to the Secretary any written communications submitted to the Division by Tribal officials.

Tribal consultation required per the HHS consultation policy:

1. Proposed rules have tribal implications:
   The proposed regulations have tribal implications because a substantial number of AI/AN Medicaid beneficiaries will be subject to new cost sharing requirements. Like other low-income groups, cost sharing requirements serve as a substantial barrier to AI/AN enrollment in the Medicaid program. Imposition of cost sharing requirements on AI/ANs undermines

Congressional intent of ensuring AI/AN access to Medicaid services in IHS and tribal health care facilities located in some of the most poor, remote and isolated areas of this country. Because of the Federal government's trust responsibility to provide health care to AI/ANs, cost sharing requirements have specific tribal implications that have not been addressed in the proposed rules. Because the impact of these proposed rules on AI/AN participation in State Medicaid programs will vary depending on locality, tribal consultation with all 561 Indian Tribes is needed to address specific tribal concerns.

2. Proposed rules could result in compliance costs on Indian Tribes:
The imposition of cost sharing requirements could result in direct costs by Indian Tribes. Because of the Federal government's trust responsibility to provide health care to AI/ANs, the IHS and tribal programs could incur costs in paying premiums on behalf of the IHS eligible beneficiaries. Payment of cost sharing requirements by the IHS and tribal programs will result in additional expenditures of IHS appropriated funds. While CMS estimates that the proposed rules will result in cost savings to the Medicaid program, the proposed rules will shift costs to the IHS - an agency that is currently under funded.

3. Lack of Tribal consultation in development & promulgation of proposed rule:
Contrary to the HHS Tribal Consultation Policy, the CMS did not consult with Tribes in the development of these regulations before they were promulgated. The CMS did not obtain advice and input from the CMS TTAG even though the TTAG meets on a monthly basis via conference calls and holds quarterly face to face meetings in Washington, D.C. The CMS did not utilize the CMS TTAG Policy Subcommittee which was specifically established by CMS for the very purpose of obtaining advice and input in the development of policy guidance and regulations.

   Contrary to the Department's consultation policy, the proposed rule does not contain a Tribal summary impact statement describing the extent of the tribal consultation or lack thereof, nor an explanation of how the concerns of Tribal officials have been met.

4. Regulations should not be effective until Tribal consultation is held:
Because CMS failed to comply with the HHS Tribal Consultation requirements in the promulgations of proposed rule, CMS-2244-P, the CMS TTAG requests that the proposed rule not be made applicable to AI/AN Medicaid beneficiaries until such time as CMS consults with Indian Tribes regarding the impact of these proposed rules on their tribal members.

   In the event, CMS proceeds to make these regulations effective on Indian tribes, the CMS TTAG recommends that the proposed rules be modified to require State Medicaid programs to consult with Indian Tribes prior to the consideration of and development of any imposition of premium or cost sharing requirements on AI/ANs.

Conclusion:

While our organization is one letter, it represents the health care views and interests of 43 Tribal governments. As indicated earlier, we are seriously concerned about the lack of Tribal consultation in the development of these and future proposed regulations. The development of these regulations is inconsistent with Presidential Executive Order 13175 and 13336 that have been affirmed by this Administration. The Department adopted a Tribal Consultation Policy on January 14, 2005. Under the HHS Consultation Policy every operating unit of HHS shares in the Department's responsibility to coordinate communicate and consult with Indian tribes on issues that affect these governments and their citizens. All operating Divisions, including CMS, are responsible for conducting tribal consultation on policies, including the promulgation of regulations that have impact on Indian tribes.

CMS did not consult with Tribes regarding proposed rule CMS-2232-P, [State Flexibility for Medicaid Benefit Packages], and the TTAG will be submitting comments to these rules as well. A 30 day comment period for Tribes to comment on Medicaid regulations, that are comprehensive and have a potentially significant impact on Tribal communities, is not sufficient. Per the HHS policy, the CMS is required to consult with Tribes in the early stages and throughout the development of any regulations with Tribal implications.

Thank you for consideration of our request to make the proposed rules, CMS-2244-P, not effective until Tribal consultation is held. We request CMS to engage the TTAG to review these proposed rules, as well as proposed rules currently under development and rules developed in the future.

Sincerely,

Linda Holt, NPAIHB Chairperson
Suquamish Tribal Council Member

cc: Secretary Michael Leavitt
Dennis Smith, Director, Center for Medicaid Services
Dorothy Dupree, Director, Tribal Affairs Group
Robert McSwain, Acting Director, IHS
CMS TTAG members

March 24, 2008

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Suislaw, & Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispell Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshoni Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

527 S.W. Hall
Suite 300
Portland, OR 97201
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Kerry Weems, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2237-IFC
MS C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Proposed Rule CMS - 2232 – P: Medicaid Program; State Flexibility for Medicaid Benefit Packages

Dear Mr. Weems:

The Northwest Portland Area Indian Health Board (NPAIHB) is a P.L. 93-638 Tribal organization[1] that represents the health care issues of the forty-three federally-recognized Tribes in the states of Idaho, Oregon, and Washington. On behalf of our Tribes, we reviewed the interim final rule (CMS-2232-P) and are seriously concerned about the impact on Tribal programs and American Indian and Alaska Native (AI/AN) access to Medicaid services. The following provide the basis of our concerns and we respectfully request that CMS withhold implementation of the rules until they are addressed through the CMS Tribal Technical Advisory Group (TTAG):

- We are seriously concerned about that Tribal Consultation did not happen on the proposed rule despite the fact that CMS has adopted the TTAG to provide advice and guidance on program issues affecting AI/AN served by Titles XVIII, XIX, and XXI of the Social Security Act.
- The proposed rule does not honor treaty obligations for health services that are consonant with and required by the Federal Government's unique legal relationship with Tribal governments.
- A basic tenet of this responsibility is that AI/ANs need access to Indian health programs for culturally appropriate care—something the rule may not provide.
- Proposed cost sharing under benchmark or benchmark-equivalent plans raises serious and unique barriers to access to Medicaid for AI/AN people, exemptions are required for Indians from benchmark plans and cost sharing.
- Consistent with CMS policy requiring that States consult with Tribes in the development of waiver proposals, CMS should make this same requirement in the development of benchmark or benchmark-equivalent plans

In our discussions with our state partners and others concerning these regulations, we believe these proposed rules go far beyond what was required by the Deficit Reduction Act (DRA). Because of the diversity and complexity of State Medicaid programs these rules appear to be poorly thought out and will likely create more confusion than clarity.

[1] As defined in the Indian Self-Determination and Education Assistance Act, P.L. 93-638, 25 U.S.C., Section 450(b) a Tribal organization is a legally established governing body of any Indian tribe(s) that is controlled, sanctioned, or chartered by such Indian Tribe(s) and designated to act on their behalf.

We believe, at a minimum, these rules will have multiple negative results for the following Tribal issues:

- Inability of AI/ANs to access culturally competent health services
- Inability of AI/ANs to access health services due to lack of transportation.

Thank you for the opportunity to review and comment on the proposed State Flexibility for Medicaid Benefit Packages. First we would like to define a continuing problem with the development of proposed rules. The lack of initial consultation on development of rules often results in an unyielding environment to accept change of proposed policy. The current procedure of developing proposed rules includes the state Medicaid directors, but does not afford the same government-to-government responsibility to federally recognized Indian tribes. While one could argue that not all of the proposed rules would have a specific or obvious impact on American Indians and Alaska Natives, it remain a responsibility of tribal governments to be responsive to their members in all aspects of Medicaid because of their dual citizenship.

The commitment of the United States government to consultation with Indian tribes has been affirmed in Presidential Memoranda in 1994 and 2004, in Executive Orders issued by the President in 1998 and 2000, directives from the White House Domestic Policy Council Working Group on Indian Affairs, and in recommendations from the Department of Health and Human Services (HHS) Working Group on Consultations with American Indians and Alaska Natives.

The Department of Health and Human Services (HHS) adopted a Tribal Consultation Policy on January 14, 2005. Under the HHS Consultation Policy every operating unit of HHS shares in the Department-wide responsibility to coordinate communicate and consult with Indian tribes on issues that affect these governments and their citizens. All operating Divisions, including CMS, are responsible for conducting tribal consultation on policies, including the promulgation of regulations that have impact on Indian tribes.

Medicaid Program

The CMS and Indian tribes share the goals of eliminating health disparities of American Indians and Alaska Natives (AI/AN) and ensuring that access to Medicare, Medicaid, and State Children's Health Insurance programs (SCHIP) is maximized. To achieve these goals, and to the extent practicable and not prohibited by law, it is essential that federally recognized Indian tribes and CMS engage in open, continuous, and meaningful consultation. Effective consultation leads to information exchange, mutual understanding, and informed decision-making.

It is understood that the *Deficit Reduction Act* of 2005, is specific to states, commonwealths, and territories and that there is no inclusion of government to government consideration for tribal governments. As a result this forces tribes to continue to work through a pseudo "middleman" the states, to access their federal funding. In fact American Indians and Alaska Natives (AI/AN) have prepaid for their health services by ceding more than 400 million acres of land in exchange for promises for health services.

Under – II. Provision of the Proposed Rule

P. 9714: the Deficit Reduction Act of 2005, Pub. L. 109–171, which amends the Social Security Act by adding a new section 1937 related to the coverage of medical assistance under approved State plans. Under this new section, States have increased flexibility under an approved State plan to define the scope of covered medical assistance by offering coverage of benchmark or benchmark-equivalent benefit packages to certain Medicaid recipients.

Comments:

1. There must be specific language added that requires the states to consult with federally recognized Indian tribes with service areas in a state, before the state is allowed to amend their respective State Medicaid Plan.
2. Since Medicaid services are reimbursed at 100% FMAP, the final rule should allow AI/ANs to be exempt from benchmark plans if services provided to AI/AN Medicaid beneficiaries are less in amount, duration, or scope than the benefits currently received; or are less than benefit packages offered to any other group of Medicaid beneficiaries anywhere in the state. This standard should apply with respect to all AI/AN Medicaid beneficiaries, regardless of whether they live on or near a reservation.
3. AI/AN beneficiaries should be exempt from payment of premiums for benchmark plans or benchmark-equivalent coverage.

Reasoning: As suggested in the Proposed Rules, changes to state plans could be counter productive in achieving the intent of Congress to develop plans that are person centered to maximize health outcomes for individuals.

P. 9715: Under section 1937 of the Act, a State may require that medical assistance to individuals, within one or more groups of individuals specified by the State, be provided through enrollment in a benchmark or benchmark equivalent benefit coverage package. A State has the option to amend its State plan to provide benchmark or benchmark equivalent coverage without regard to comparability, state wideness, freedom of choice, the assurance of transportation to medically necessary services and other requirements in order to tailor and provide the coverage to the individuals.

Comment:

1. The benchmark or benchmark equivalent packages that are offered in rural areas of states, must include coverage for transportation for medically necessary services.
2. Since Medicaid services are reimbursed at 100% FMAP, the final rule should allow AI/ANs to be exempt from benchmark plans if services provided to AI/AN Medicaid beneficiaries are less in amount, duration, or scope than the benefits currently received; or are less than benefit packages offered to any other group of Medicaid beneficiaries anywhere in the state. This standard should apply with respect to all AI/AN Medicaid beneficiaries, regardless of whether they live on or near a reservation.
3. AI/AN beneficiaries should be exempt from payment of premiums for benchmark plans or benchmark-equivalent coverage

Reasoning: Without this coverage the goals of numerous other federal agencies (e.g. HRSA, 100 percent of access to medical services) will never be achieved. Rural populations (including Indian reservations) are generally older, poorer, and frequently report inferior health status than non-rural populations. Thus they often have disproportionate health needs. Medical needs across age groups can be exacerbated by co-morbid conditions for which there are significant access barriers in rural communities, e.g., behavioral health services for mental illness, alcoholism, other substance abuse, as well as to oral health care. These circumstances when combined with a higher percentage of Medicaid eligibility in rural areas make the Medicaid program disproportionately critical to rural residents and disproportionately costly to governmental payers.

Attempts to vary benefit packages by waiving "state-wideness" must be carefully analyzed and viewed with great caution. Benefits available to rural Medicaid populations should not be less than those available to urban beneficiaries. In rural areas, patients who require specialty care must often travel

hundreds of miles to access services. The current system is poor and results in inadequacies in rural transportation systems that are creating additional mental and financial hardships for patients and their families. The transportation issue can be insurmountable for patients and results in decreasing quality of life as well as leading to higher long-term costs, including termination of life.

P. 9718: Under Subpart C—Benchmark Packages: General Provisions at Sections 440.300, 440.305, and 440.310 dealing with Basis, Scope, and Applicability would reflect the new statutory authority for States to provide medical assistance to recipients, within one or more groups of Medicaid eligible recipients specified by the State, through enrollment in benchmark coverage or benchmark equivalent coverage.

Comment: Proposed § 440.315 provides for limitation on enrollment of specified categories of individuals in a benchmark or benchmark-equivalent benefit plan. This limitation should be extended to AI/AN people that receive services from the Indian Health Service or Tribally operated health programs.

Reasoning:

Requiring AI/AN to participate in benchmark or benchmark-equivalent plans will have adverse consequences for AI/AN participation in Medicaid. AI/ANs may not participate in the Medicaid program if they are required to receive services from any other provider than health program operated by IHS or a Tribe. There are many reasons for this. Some of these reasons have to do with the costs of travel and the distinctive needs of Indian people receiving health care. Requiring AI/AN beneficiaries might mean travel to see a provider that would result in increased costs to the Medicaid program. Many AI/.AN people that are enrolled in Medicaid prefer to receive services from and IHS or Tribal provider for cultural reasons and long-standing relationships they have developed with providers. Disrupting this service would result in AI/AN people not seeking care or enrolling in Medicaid. Imposing such barriers to Medicaid participation on Indian beneficiaries and Indian health programs violates the Federal government's trust responsibility to provide health care to AI/ANs

Under – V. Regulatory Impact Analysis

P. 9723: Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditures in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million, updated annually for inflation. That threshold level is currently approximately $127 million. Because this rule does not mandate State participation in using these benchmark plans, there is no obligation for the State to make any change to their Medicaid program. Therefore, there is no mandate for the State. We believe this proposed rule would not mandate expenditures in that amount.

Comment: It appears that as the Proposed Rules are written, that in fact there will be additional administrative effort needed to participate in the Medicaid program.

Reasoning: The addition of regulations and introduction of new Medicaid plans is laden with legal requirements, additional analysis, and policy and procedure additions. The additional administrative cost of design, development, monitoring and surveillance are costs that could be saved and to apply to provision of direct services.

On behalf of our 43 member Tribes, the Northwest Portland Area Indian Health Board remains concerned about the lack of Tribal consultation in the development of other and future proposed regulations. The CMS did not consult with Tribes regarding this proposed rule as well as CMS-2244P-P, Medicaid

Program: Premiums and Cost Sharing, in which NPAIHB will be submitting comments as well. A 30 day comment period for Tribes to comment on Medicaid regulations, that are comprehensive and have a potentially significant impact on Tribal communities, is not sufficient or consistent with the requirement of Tribal consultation. Per the HHS policy, the CMS is required to consult with Tribes in the early stages and throughout the development of any regulations with Tribal implications.

We respectfully request that CMS refrain from implementing these new rules until such Tribal consultation is conducted.

Sincerely,

Linda Holt

Linda Holt, NPAIHB Chairperson
Suquamish Tribal Council Member

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April 4, 2008

General Memorandum 08-043

IHS Announces the Availability of FY 2008 Tribal Self-Governance Program Planning Cooperative Agreements

The Indian Health Service (IHS) announced in the attached March 31, 2008, FEDERAL REGISTER notice the availability of planning cooperative agreements under the Tribal Self-Governance Program (TSGP). This competitive grant program is authorized by Title V, Tribal Self-Governance Amendments of 2000, of the Indian Self-Determination and Education Assistance Act, PL 93-638, as amended. The TSGP is designed to promote self-determination by allowing tribes to assume more control of IHS programs and services through compacts negotiated with the IHS.

Applications are due **April 28, 2008**, and the IHS prefers that they be submitted electronically. The earliest anticipated project start date for recipients of the cooperative agreements is June 1, 2008. Detailed application criteria and contact information are contained in the attached notice.

The purpose of the program is to award cooperative agreements that provide planning resources to tribes interested in participating in the TSGP. These cooperative agreements allow tribes to gather information that leads to a greater understanding of IHS programs, services, functions, and activities; to determine funding available at the Service Unit, Area, and Headquarters levels; and to identify programmatic alternatives that will better meet the needs of tribal members.

To be eligible for a planning cooperative agreement, the applicant tribe must be a federally recognized tribe, request participation in the TSGP through a resolution from its governing body, demonstrate financial stability and management capability by having had no significant and material audit exceptions for three previous fiscal years, and submit copies of audits for the three previous fiscal years. However, Alaska Native Villages or Village Corporations are not eligible if they are located within an area served by an Alaska Native regional health entity already participating in Indian Self-Determination Act compacting.

There is $600,000 available to fund up to 12 tribes to enter the TSGP planning process for compacts. Accepted tribes would be awarded $50,000 for a 12-month project period.

Please contact us if we may provide further information or assistance regarding the IHS FY 2008 Tribal Self-Governance Program planning cooperative agreements.

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Inquiries may be directed to:
Geoffrey D. Strommer
(503-242-1745 or gstrommer@hsdwor.com)

to identify programs and associated funding which could be incorporated into their current programs.

• Determining the Tribe's share of each PSFA and evaluating the current level of health care services being provided to make an informed decision on new program assumption(s).

III. Eligibility Information

1. Eligible Applicants

To be eligible for a Planning Cooperative Agreement under this announcement, an applicant must meet all of the following criteria:

A. Be a Federally-recognized Tribe as defined in Title V, Public Law 106 260, Tribal Self-Governance Amendments of 2000, of the Indian Self-Determination and Education Assistance Act (the Act), Public Law 93–638, as amended. However, Alaska Native Villages or Alaska Native Village Corporations are not eligible if they are located within the area served by an Alaska Native regional health entity already participating in compact status (25 U.S.C. 458aaa–2(e)). Those Tribes not represented by a self-governance Tribal consortium compact, within their area, may still be considered to participate in the TSGP.

2. Cost Sharing or Matching

The Tribal Self-Governance Planning Cooperative Agreement announcement does not require matching funds or cost sharing to participate in the competitive grant process.

3. Other Requirements

The following documentation is required (if applicable):

A. This program is described at 93.210 in the CFDA.

B. Tribal Resolution—Submit a Tribal resolution from the governing body authorizing the submission of the application for the Tribal Self-Governance Planning Cooperative Agreement. Tribal Consortia applying for a Tribal Self-Governance Planning Cooperative Agreement shall submit Tribal Council Resolutions from each Tribe in the consortium. Draft resolutions, submitted with the application, are acceptable in lieu of an official signed resolution. However, an official signed Tribal resolution must be received by the Division of Grants Operations (DGO), Attn: John Hoffman, 801 Thompson Avenue, TMP 360, Rockville, MD 20852, by Friday, April 25, 2008. If an official signed resolution is not received by April 25, 2008, the application will be considered incomplete and will be returned without consideration.

C. Demonstrate, for three fiscal years, financial stability and financial management capability, which is defined as no uncorrected significant and/or material audit exceptions in the required annual audit of the Indian Tribe's self-determination contracts or self governance funding agreements with any Federal agency. Applicants are required to submit a current version of the organization's audit report. The applicants may scan the documents and attach them to the electronic application. If the applicant determines that the audit reports are too lengthy, the applicants may submit them separately via regular mail by the due date, April 28, 2008. Applicants, sending in audits via regular mail, must submit two copies of the audits for three previous fiscal years under separate cover directly to the Division of Grants Operations, Attn: John Hoffman, 801 Thompson Avenue, TMP 360, Rockville, MD 20852, referencing the Funding Opportunity Number, HHS–2008–IHS–TSGP–0001, as prescribed by Public Law 98–502, the Single Audit Act, as amended (see OMB Circular A–133, revised June 24, 1997, Audits of States, Local Governments, and Non-Profit Organizations), for the three previous fiscal years. If this documentation is not received by April 28, 2008, the application will be considered as incomplete and will be returned to the applicant without further consideration.

D. If application budgets exceed the stated dollar amount that is outlined within this announcement, the application will be returned to the applicant without further consideration.

IV. Application and Submission Information

1. Applicant package and detailed instructions for this announcement may be found in Grants.gov *(www.grants.gov)* or at: *http://www.ihs.gov/NonMedicalPrograms/gogp/gogp_funding.asp.*

Information regarding the electronic application process may be directed to Michelle G. Bulls, at (301) 443–6290.

Information regarding this announcement may also be found on the Office of Tribal Self-Governance Web site at: *http://www.ihs.gov/NonMedicalPrograms/SelfGovernance/index.cfm?module=planning_negotiation.*

2. Content and Form of Application Submission:

• Be single spaced.

• Be typewritten.

• Have consecutively numbered pages.

• Use black type not smaller than 12 characters per one inch.

• Be printed on one side only of standard size 8½″ x 11″ paper.

• Contain a narrative that does not exceed seven typed pages that includes the other submission requirements below. The seven page narrative does not include the work plan, standard forms, Tribal resolutions or letters of support (if necessary), table of contents, budget, budget justifications, narratives, and/or other appendix items.

Public Policy Requirements: All Federal-wide public policies apply to IHS grants with exception of the Lobbying and Discrimination public policy.—Include Letter of Intent requirements under Public Policy Requirements.

3. Submission Dates and Times:

Applications must be submitted electronically through Grants.gov by 12 midnight Eastern Standard Time (EST). If technical challenges arise and the applicant is unable to successfully complete the electronic application process, the applicant should contact Michelle G. Bulls, Grants Policy Staff (GPS), fifteen days prior to the application deadline and advise of the difficulties that your organization is experiencing. The grantee must obtain prior approval, in writing (e-mails are acceptable) allowing the paper submission. If submission of a paper application is requested and approved, the original and two copies may be sent to the appropriate grants contact that is listed in Section IV.1. above. Applications not submitted through Grants.gov, without an approved waiver, may be returned to the applicant without review or consideration. Late applications will not be accepted for processing, will be returned to the applicant, and will not be considered for funding.

4. Intergovernmental Review:

Executive Order 12372 requiring intergovernmental review is not applicable to this program.

5. Funding Restrictions:

A. Tribes are only eligible to be awarded one Tribal Self-Governance Planning Cooperative Agreement award.

B. Each planning cooperative agreement shall not exceed $50,000. The available funds are inclusive of direct and appropriate indirect costs.

C. The available funds are inclusive of direct and indirect costs.

D. IHS will not acknowledge receipt of applications.

6. Other Submission Requirements:

The application must comply with the following:

A. Table of Contents.

B. Abstract (one page)—Summarizes the project.

C. Narrative (no more than 7 pages) and should include the following:

resumes and scope of work for consultants that demonstrate experience and expertise relevant to the project.

E. Budget and Budget Justification (15 points)

Submit a line-item budget with a narrative justification for all expenditures identifying reasonable and allowable costs necessary to accomplish the goals and objectives as outlined in the project narrative.

2. Review and Selection Process

In addition to the above criteria/requirements, applications are considered according to the following:

A. Application Submission:

(1) The applicant and proposed project type is eligible in accordance with this cooperative agreement announcement.

(2) The applicant has not previously received a Tribal Self Governance Planning Cooperative Agreement award.

(3) Abstract, narrative, budget, required forms, appendices and other material submitted meet the requirements of the announcement allowing the review panel to undertake an in-depth evaluation.

B. Competitive Review of Eligible Applications:

Applications meeting eligibility requirements that are complete, responsive, and conform to this program announcement will be reviewed for merit by the Objective Review Committee (ORC) appointed by the IHS to review and make recommendations on these applications. The review will be conducted in accordance with the IHS Objective Review Guidelines. The technical review process ensures selection of quality projects in a national competition for limited funding. Applications will be evaluated and rated on the basis of the evaluation criteria listed in Section V.1. The criteria are used to evaluate the quality of a proposed project, determine the likelihood of success, and assign a numerical score to each application. The scoring of approved applications will assist the IHS in determining which proposals will be funded if the amount of TSGP funding is not sufficient to support all approved applications. Applications recommended for approval, having a score of 60 or above by the ORC are forwarded to the DGO for cost analysis and further recommendation. The program official forwards the recommended approval list to the IHS Director for final review and approval. Applications scoring below 60 points will be disapproved.

Note: In making final selections, the IHS Director will consider the ranking factor and the status of the applicant's three previous years' single audit reports. The comments from the ORC will be advisory only. The IHS Director will make the final decision on awards.

VI. Award Administration Information

1. Award Notices:

The Notice of Award (NOA) will be initiated by the DGO and will be mailed via postal mail to each entity that is approved for funding under this announcement. The NOA will be signed by the Grants Management Officer and this is the authorizing document for which funds are dispersed to the approved entities. The NOA will serve as the official notification of the grant award and will reflect the amount of Federal funds awarded, the purpose of the grant, the terms and conditions of the award, the effective date of the award, and the budget/project period. The NOA is the legally binding document. Applicants who are approved but unfunded or disapproved based on their Objective Review score will receive a copy of the Final Executive Summary which identifies the weaknesses and strengths of the application submitted.

2. Administrative Requirements:

Grants are administrated in accordance with the following documents:

- This Program Announcement.
- 45 CFR Part 92, "Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local and Tribal Governments," or 45 CFR Part 74, "Uniform Administrative Requirements for Awards to Institutions of Higher Education, Hospitals, Other Non-Profit Organizations, and Commercial Organizations."
- Grants Policy Guidance: HHS Grants Policy Statement, January 2007.
- Cost Principles: OMB Circular A–87, "Cost Principles for State, Local, and Indian Tribal Governments" (Title 2 Part 225).
- Administrative Requirements: OMB Circular A–122, "Non-profit Organizations" (Title 2 Part 230).
- Audit Requirements: OMB Circular A–133, "Audits of States, Local Governments, and Non-profit Organizations."

3. Indirect Costs:

This section applies to all grant recipients that request reimbursement of indirect costs in their grant application. In accordance with HHS Grants Policy Statement, Part II–27, IHS requires applicants to have a current indirect cost rate agreement in place prior to award. The rate agreement must be prepared in accordance with the applicable cost principles and guidance as provided by the cognizant agency or office. A current rate means the rate covering the applicable activities and the award budget period. If the current rate is not on file with the DGO at the time of award, the indirect cost portion of the budget will be restricted and not available to the recipient until the current rate is provided to DGO.

Generally, indirect costs rates for IHS grantees are negotiated with the Division of Cost Allocation (DCA) *http://rates.psc.gov/* and the Department of Interior (National Business Center) *http://www.nbc.gov/acquisition/ics/icshome.html.* If your organization has questions regarding the indirect cost policy, please contact the DGO at 301–443–5204.

4. Reporting:

A. Progress Report. Program progress reports are required semiannually. These reports must be submitted within 30 days of the end of the half year and will include a brief comparison of actual accomplishments to the goals established for the period, or, if applicable, provide sound justification for the lack of progress, and other pertinent information as required. A final report must be submitted within 90 days of expiration of the budget/project period.

B. Financial Status Report. Semi-annual financial status reports must be submitted within 30 days of the end of the half year. Final financial status reports are due within 90 days of expiration of the budget/project period. Standard Form 269 (long form) will be used for financial reporting. The final SF–269 must be verified from the grantee's records on how the value was derived. Grantees must submit reports in a reasonable period of time.

Failure to submit required reports within the time allowed may result in suspension or termination of an active grant, withholding of additional awards for the project, or other enforcement actions such as withholding of payments or converting to the reimbursement method of payment. Continued failure to submit required reports may result in one or both of the following: (1) The imposition of special award provisions; and (2) the non-funding or non-award of other eligible projects or activities. This applies whether the delinquency is attributable to the failure of the grantee organization or the individual responsible for preparation of the reports.

5. Telecommunication for the hearing impaired is available at: TTY 301–443–6394.

VII. Agency Contact(s)

1. Questions on the programmatic issues may be directed to: Matt Johnson,

HOBBS STRAUS DEAN & WALKER, LLP
Law Offices
2120 L Street, N.W., Washington, D.C. 20037
Tel. (202) 822-8282 Fax (202) 296-8834
(www.hsdwlaw.com)

April 4, 2008

General Memorandum 08-044

IHS Announces the Availability of FY 2008 Tribal Self-Governance Program Negotiation Cooperative Agreements

The Indian Health Service (IHS) announced in the attached March 31, 2008, FEDERAL REGISTER notice the availability of negotiation cooperative agreements under the Tribal Self-Governance Program (TSGP). This competitive grant program is authorized by Title V, Tribal Self-Governance Amendments of 2000, of the Indian Self-Determination and Education Assistance Act, PL 93-638, as amended. The TSGP is designed to promote self-determination by allowing tribes to assume more control of IHS programs and services through compacts negotiated with the IHS.

Applications are due **April 28, 2008**, and the IHS prefers that they be submitted electronically. The earliest anticipated project start date for recipients of the cooperative agreements is June 1, 2008. Detailed application criteria and contact information are contained in the attached notice.

The purpose of the program is to award cooperative agreements that provide negotiation resources to tribes interested in participating in the TSGP. The award is intended to aid in covering the costs associated with negotiating with the IHS and preparing for the compacts and funding agreements.

To be eligible for a negotiation cooperative agreement, the applicant must be a federally recognized tribe, request participation in the TSGP through a resolution from its governing body, demonstrate financial stability and management capability by having had no significant and material audit exceptions for three previous fiscal years, and submit copies of audits for the three previous fiscal years. However, Alaska Native Villages or Village Corporations are not eligible if they are located within an area served by an Alaska Native regional health entity already participating in Indian Self-Determination Act compacting.

There is $240,000 available to fund up to 12 tribes to enter the TSGP negotiation process for compacts. Accepted tribes would be awarded $20,000 for a 12-month project period.

Please contact us if we may provide further information or assistance regarding the IHS FY 2008 Tribal Self-Governance Program negotiation cooperative agreements.

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Inquiries may be directed to:
Geoffrey D. Strommer
(503-242-1745 or gstrommer@hsdwor.com)

806 SW BROADWAY • SUITE 900 • PORTLAND, OR 97205 • TEL 503.242.1745 • FAX 503.242.1072
117 PARK AVENUE • SECOND FLOOR • OKLAHOMA CITY, OK 73102 • TEL 405.602.9425 • FAX 405.602.9426
400 CAPITOL MALL • 11TH FLOOR • SACRAMENTO, CA 95814 • TEL 916.442.9444 • FAX 916.442.8344

371954, Pittsburgh, PA 15250–7945, (202) 512–1800. You may also access this information at the following Web site; *http://www.healthypeople.gov/Publications.*

The IHS is focusing efforts on three Health Initiatives that, linked together, have the potential to achieve positive improvements in the health of AI/AN people. These three initiatives are Health Promotion/Disease Prevention, Management of Chronic Disease, and Behavioral Health. Further information is available at the Health Initiatives Web site: *http://www.ihs.gov/NonMedicalPrograms/DirInitiatives/index.cfm.*

Dated: March 24, 2008.

Robert G. McSwain,

Acting Director, Indian Health Service.

[FR Doc. E8–6409 Filed 3–28–08; 8:45 am]

BILLING CODE 4165–16–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

RIN 0917–ZA22

Reimbursement Rates for Calendar Year 2008

AGENCY: Indian Health Service, HHS.

ACTION: Notice.

SUMMARY: Notice is given that the Director of Indian Health Service (IHS), under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Public Law 83–568 (42 U.S.C. 2001 (a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 *et seq.*), has approved the following rates for inpatient and outpatient medical care provided by IHS facilities for Calendar Year 2008 for Medicare and Medicaid beneficiaries and beneficiaries of other Federal programs. The Medicare Part A inpatient rates are excluded from the table below as they are paid based on the prospective payment system. Since the inpatient rates set forth below do not include all physician services and practitioner services, additional payment may be available to the extent that those services meet applicable requirements. Public Law 106–554, section 432, dated December 21, 2000, authorized IHS facilities to file Medicare Part B claims with the carrier for payment for physician and certain other practitioner services provided on or after July 1, 2001.

INPATIENT HOSPITAL PER DIEM RATE (EXCLUDES PHYSICIAN/PRACTITIONER SERVICES)

[Calendar Year 2008]

Lower 48 States	$1,811
Alaska	2,255
Outpatient per Visit Rate (Excluding Medicare)	
Lower 48 States	$253
Alaska	423
Outpatient per Visit Rate (Medicare)	
Lower 48 States	$215
Alaska	365
Medicare Part B Inpatient Ancillary per Diem Rate	
Lower 48 States	$373
Alaska	650
Outpatient Surgery Rate (Medicare)	
Established Medicare rates for freestanding Ambulatory Surgery Centers	

Effective Date for Calendar Year 2008 Rates

Consistent with previous annual rate revisions, the Calendar Year 2008 rates will be effective for services provided on/or after January 1, 2008 to the extent consistent with payment authorities including the applicable Medicaid State plan.

Dated: November 29, 2007.

Robert G. McSwain,

Acting Director, Indian Health Service.

Editorial Note: This document was received at the Office of the Federal Register on March 25, 2008.

[FR Doc. E8–6431 Filed 3–28–08; 8:45 am]

BILLING CODE 4165–16–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Tribal Self-Governance Program; Negotiation Cooperative Agreement

Announcement Type: New.

Funding Announcement Number: HHS–2008–IHS–TSGP–0001.

Catalog of Federal Domestic Assistance Numbers(s): 93.210.

Key Dates: Application Deadline Date: April 28, 2008.

Review Date: May 8–9, 2008.

Earliest Anticipated Start Date: June 1, 2008.

I. Funding Opportunity Description

The purpose of the program is to award cooperative agreements that provide negotiation resources to Tribes interested in participating in the Tribal Self-Governance Program (TSGP) as authorized by Title V, Tribal Self-Governance Amendments of 2000 of the Indian Self-Determination and Education Assistance Act of Public Law (Pub. L.) 93–638, as amended. There is limited competition under this announcement because the authorizing legislation, Public Law 106–260, Title V, restricts eligibility to Tribes that meet specific criteria (Refer to Section III.1.A., ELIGIBLE APPLICANTS in this announcement). The TSGP is designed to promote self-determination by allowing Tribes to assume more control of Indian Health Service (IHS) programs and services through compacts negotiated with the IHS. The Negotiation Cooperative Agreement provides Tribes with funds to help cover the expenses involved in preparing for and negotiating with the IHS and assists eligible Indian Tribes to prepare Compacts and Funding Agreements (FAs). This program is described at 93.210 in the Catalog of Federal Domestic Assistance (CFDA).

The Negotiation Cooperative Agreement provides resources to assist Indian Tribes to conduct negotiation activities that include but are not limited to:

1. Determine what programs, services, functions, and activities (PSFAs) will be negotiated.
2. Identification of Tribal shares that will be included in the FA.
3. Development of the terms and conditions that will be set forth in the FA.

The award of a Negotiation Cooperative Agreement is not required as a prerequisite to enter the TSGP. Indian Tribes that have completed comparable health planning activities in previous years using Tribal resources but have not received a Tribal self-governance planning award are also eligible to apply.

II. Award Information

Type of Awards: Cooperative Agreement.

Estimated Funds Available: The total amount identified for Fiscal Year (FY) 2008 is $240,000 for approximately twelve (12) Tribes. Awards under this announcement are subject to the availability of funds.

Anticipated Number of Awards: The estimated number of awards under the program to be funded is approximately 12.

Project Period: 12 months.

Award Amount: $20,000 per year.

Programmatic Involvement: IHS TSGP funds will be awarded as cooperative agreements and will have substantial programmatic involvement to establish a process through which Tribes can effectively approach the IHS to identify PSFAs and associated funding that could be incorporated into their programs.

The IHS roles and responsibilities will include:

Providing a description of PSFAs and associated funding at all levels, including funding formulas and methodologies related to determining Tribal shares.

Identification of IHS staff that will consult with applicants on methods currently used to manage and deliver health care.

Provide applicants with statutes, regulations, and policies that provide authority for administering IHS programs, including contract support costs criteria for new or expanded programs.

The Grantee's roles and responsibilities are essential to the overall success of the project.

Therefore the grantee must:

Determine the PSFAs and associated funding the Tribe may elect to assume.

Prepare to discuss each PSFA in comparison to the current level of services provided, so that an informed decision can be made on new program assumption.

Develop a compact and FA to submit to the Agency Lead Negotiator prior to negotiations.

III. Eligibility Information

1. Eligible Applicants

To be eligible for a negotiation cooperative agreement under this announcement, an applicant must meet all of the following criteria:

A. Be a Federally-recognized Tribe as defined in Title V, Public Law 106–260, Tribal Self-Governance Amendments of 2000, of the Indian Self-Determination and Education Assistance Act (ISDA), Public Law 93–638, as amended. However, Alaska Native Villages or Alaska Native Village Corporations are not eligible if they are located within the area served by an Alaska Native regional health entity already participating in ISDA compacting (25 U.S.C. 458aaa–2(e)). Those Tribes not represented by a self-governance Tribal consortium compact, within their area, may still be considered to participate in the TSGP.

2. Cost Sharing or Matching

The Self-Governance Negotiation Cooperative Agreement does not require matching funds or cost sharing to participate in the competitive grant process.

3. Other Requirements

The following documentation is required (if applicable):

A. This program is described at 93.210 in the CFDA.

B. Request participation in self-governance by resolution from the governing body of the Indian Tribe. An Indian Tribe that is proposing a Cooperative Agreement affecting another Indian Tribe must include resolutions from all affected Tribes to be served.

C. Tribal Resolution—A resolution of the Indian Tribe served by the project must accompany the application submission. For Tribal Consortia applying for a Negotiation Cooperative Agreement, individual Tribal Council Resolutions from all individual Tribes whose PSFAs will be compacted must be submitted. Draft resolutions are acceptable in lieu of an official resolution to submit with the application. However, an official signed Tribal resolution must be received by the Division of Grants Operations (DGO), Attn: John Hoffman, 801 Thompson Avenue, TMP 360, Rockville, MD 20852, by Friday, April 25, 2008. If an official signed resolution is not submitted by April 25, 2008 the application will be considered incomplete and will be returned to the applicant without further consideration.

* It is highly recommended that the Tribal resolution be sent by Federal Express for proof of receipt.

D. Demonstrate, for three FYs, financial stability and financial management capability, which is defined as no uncorrected significant and material audit exceptions in the required annual audit of the Indian Tribe's self-determination contracts or self-governance funding agreements with any Federal agency.

E. Grantees are required to submit a current version of the organization's audit report. Audit reports can be lengthy; therefore, the applicants may submit them separately via regular mail by the due date, April 28, 2008. If the grantee determines that the audit reports are not lengthy, the applicants may scan the documents and attach them to the electronic application. While all of the other components of the application will be submitted through *www.Grants.gov* (Grants.gov), the applicants must submit two copies of the audits that reflect three previous fiscal years under separate cover directly to the Division of Grants Operations, Attn: John Hoffman, 801 Thompson Avenue, TMP 360, Rockville, MD 20852, referencing the Funding Opportunity Number, HHS–2008–IHS–TSGP–0002, as prescribed by Public Law 98–502, the Single Audit Act, as amended (see 0MB Circular A–133, revised June 24, 1997, Audits of States, Local Governments, and Non-Profit Organizations). If this documentation is not submitted with the application by the application receipt date, April 28, 2008, the application will be considered as incomplete and be returned to the applicant without further consideration. Applicants must include the grant tracking number assigned to their electronic submission by Grants.gov and the date submitted via Grants.gov in their cover letter transmitting the required audits for the previous three fiscal years.

If the application budget exceeds the stated dollar amount that is outlined within this announcement, the application will be returned to the applicant without further consideration.

IV. Application and Submission Information

1. Applicant package may be found in Grants.gov or at: *http://www.ihs.gov/NonMedicalPrograms/gogp/gogp_funding.asp*. Information regarding the electronic application process may be directed to Michelle G. Bulls at (301) 443–6528.

The entire application package is available at: *http://www.ihs.gov/NonMedicalPrograms/SelfGovernance/index.cfm?module=planning_negotiation*.

Detailed application instructions for this announcement are downloadable on Grants.gov.

2. Content and Form of Application Submission:

Be single spaced.

Be typewritten.

Have consecutively numbered pages.

Use black type not smaller than 12 characters per one inch.

Be printed on one side only of standard size 8½″ x 11″ paper.

Contain a narrative that does not exceed seven typed pages that includes the other submission requirements below. The seven page narrative does not include the work plan, standard forms, Tribal resolutions or letters of support (if necessary), table of contents, budget, budget justifications, narratives, and/or other appendix items.

Public Policy Requirements: All Federal-wide public policies apply to IHS grants with the exception of the

Lobbying and Discrimination public policy.

3. Submission Dates and Times:

Applications must be submitted electronically through Grants.gov by 12 midnight Eastern Standard Time (EST). If technical challenges arise and the applicant is unable to successfully complete the electronic application process, the applicant should contact Michelle G. Bulls, Grants Policy Staff (GPS), at least fifteen days prior to the application deadline and advise of the difficulties. The grantee must obtain prior approval, in writing (e-mails are acceptable) allowing the paper submission. If submission of a paper application is requested and approved, the original and two copies may be sent to the appropriate grants contact that is listed in Section IV.1. above. Applications not submitted through Grants.gov, without an approved waiver, may be returned to the applicant without review or consideration. Late applications will not be accepted for processing, will be returned to the applicant, and will not be considered for funding.

4. Intergovernmental Review:

Executive Order 12372 requiring intergovernmental review is not applicable to this program.

5. Funding Restrictions:

A. Only one negotiation cooperative agreement will be awarded per applicant.

B. Each negotiation cooperative agreement shall not exceed $20,000.

C. The available funds are inclusive of direct and appropriate indirect costs.

D. IHS will not acknowledge receipt of applications.

6. Other Submission Requirements:

A. Table of Contents.

B. Abstract (one page)—Summarizes the project.

C. Narrative (no more than 7 pages) and should include the following:

(1) Background information on the Tribe.

(2) Proposed scope of work, objectives, and activities that provide a description of what will be accomplished including a one-page Time Frame Chart.

D. Budget narrative and justification.

E. Tribal Resolution.

F. Appendices to include:

(1) Resumes or position descriptions of key staff.

(2) Contractors/Consultants resumes or qualifications and scope of work.

(3) Current Indirect Cost Agreement.

(4) Organizational Chart (Optional) Abstract (one page)—Summarizes the project.

Electronic Submission—The preferred method for receipt of applications is electronic submission through Grants.gov. However, should any technical challenges arise regarding the submission, please contact Grants.gov Customer Support at 1–800–518–4726 or *support@grants.gov*. The Contact Center hours of operation are Monday–Friday from 7 a.m. to 9 p.m. EST. If you require additional assistance please call (301) 443–6290 and identify the need for assistance regarding your Grants.gov application. Your call will be transferred to the appropriate grants staff member. The applicant must seek assistance at least fifteen days prior to the application deadline. Applicants that do not adhere to the timelines for Central Contractor Registry (CCR) and/or Grants.gov registration and/or requesting timely assistance with technical issues will not be a candidate for paper applications.

To submit an application electronically, please use *http://www.Grants.gov* and select "Apply for Grants" link on the home page. Download a copy of the application package on the Grants.gov Web site, complete it offline, and then upload and submit the application via the Grants.gov site. You may not e-mail an electronic copy of a grant application to IHS.

Please be reminded of the following:

Under the new IHS application submission requirements, paper applications are not the preferred method. However, if you have technical problems submitting your application on-line, please directly contact Grants.gov Customer Support at: *http://www.grants.gov/CustomerSupport.*

Upon contacting Grants.gov obtain a tracking number as proof of contact. The tracking number is helpful if there are technical issues that cannot be resolved and a waiver request from GPS must be obtained.

If it is determined that a formal waiver is necessary, the applicant must submit a request, in writing (e-mails are acceptable), to *Michelle.Bulls@ihs.gov* that includes a justification for the need to deviate from the standard electronic submission process. Upon receipt of approval, a hard-copy application package must be downloaded by the applicant from Grants.gov, and sent directly to the Division of Grants Operations (DGO), 801 Thompson Avenue, TMP 360, Rockville, MD 20852 by the due date, April 28, 2008.

Upon entering the Grants.gov site, there are application instructions available to applicants under this announcement that outline the requirements of the Grants.gov submission process, as well as the hours of operation. We strongly encourage all applicants not to wait until the deadline date to begin the application process through Grants.gov as the registration process for CCR and Grants.gov could take up to fifteen working days.

To use Grants.gov, you, as the applicant, must have a DUNS Number and register in the CCR. You should allow a minimum of ten days working days to complete CCR registration. See below on how to apply.

You must submit all documents electronically, including all information typically included on the SF–424 and all necessary assurances and certifications.

Please use the optional attachment feature in Grants.gov to attach additional documentation that may be requested by IHS.

Your application must comply with any page limitation requirements described in the program announcement.

After you electronically submit your application, you will receive an automatic acknowledgment from Grants.gov that contains a Grants.gov tracking number. The Indian Health Service, DGO will retrieve your application from Grants.gov. DGO will not notify applicants that the application has been received.

You may access the electronic application for this program on *http://www.Grants.gov.*

You may search for the downloadable application package either by the CFDA number or the Funding Opportunity Number. Both numbers are identified in the heading of this announcement.

The applicant must provide the Funding Opportunity Number: HHS–2008–IHS–TSGP–0001.

E-mail applications will not be accepted under this announcement.

DUNS Number

Applicants are required to obtain a DUNS number from Dun and Bradstreet to apply for a grant or cooperative agreement from the Federal Government. The DUNS number is a nine-digit identification number, which uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access *http://www.dunandbradstreet.com* or call 1–866–705–5711. Interested parties may wish to obtain their DUNS number by phone to expedite the process.

Applications submitted electronically must also be registered with the CCR. A DUNS number is required before CCR registration can be completed. Many organizations may already have a DUNS number. Please use the number listed above to investigate whether or not your

organization has a DUNS number. Registration with the CCR is free of charge.

Applicants may register by calling 1–888–227–2423. Please review and complete the CCR Registration Worksheet located on *http://www.grants.gov/CCRRegister.*

More detailed information regarding these registration processes can be found at *http://www.grants.gov.*

V. Application Review Information

The instructions for preparing the application narrative also constitute the evaluation criteria for reviewing and scoring the application. Weights assigned to each section are noted in parentheses.

1. Criteria

Demonstration of Previous Planning Activities (30 points)

Has the Indian Tribe determined the PSFAs to be assumed? Has the Indian Tribe determined it has the administrative infrastructure to support the assumption of the PSFAs? Are the results of what was learned or is being learned during the planning process clearly stated?

Thoroughness of Approach (25 points)

Is a specific narrative provided regarding the direction the Indian Tribe plans to take in the TSGP? How will the Tribe demonstrate improved health and services to the community it serves? Are proposed time lines for negotiations indicated?

Project Outcome (25 points)

What beneficial contributions are expected or anticipated for the Tribe? Is information provided on the services that will be assumed? What improvements will be made to manage the health care system? Are Tribal needs discussed in relation to the proposed programmatic alternatives and outcomes which will serve the Tribal community?

Administrative Capabilities (20 points)

Does the Indian Tribe clearly demonstrate knowledge and experience in the operation and management of health programs? Is the internal management and administrative infrastructure of the applicant described?

Appendix Items

Work plan for proposed objectives. Position descriptions for key staff. Resumes of key staff that reflect current duties. Consultant proposed scope of work (if applicable). Indirect Cost Agreement. Organizational chart (optional). Audits.

2. Review and Selection Process

In addition to the above criteria/requirements, applications are considered according to the following:

A. Application Submission (Application Deadline: April 28, 2008). Applications submitted in advance of or by the deadline and verified by the tracking number will undergo a preliminary review to determine that:

The applicant and proposed project type is eligible in accordance with this cooperative agreement announcement.

The application is not a duplication of a previously funded project.

The application narrative, forms, and materials submitted meet the requirements of the announcement allowing the review panel to undertake an in-depth evaluation; otherwise, it may be returned.

B. Competitive Review of Eligible Applications (Objective Review: May 8–9, 2008). Applications meeting eligibility requirements that are complete, responsive, and conform to this program announcement will be reviewed for merit by the Objective Review Committee (ORC) appointed by the IHS to review and make recommendations on these applications. The review will be conducted in accordance with the IHS Objective Review Guidelines. The technical review process ensures selection of quality projects in a national competition for limited funding. Applications will be evaluated and rated on the basis of the evaluation criteria listed in Section V.1. The criteria are used to evaluate the quality of a proposed project, determine the likelihood of success, and assign a numerical score to each application. The scoring of approved applications will assist the IHS in determining which proposals will be funded if the amount of TSGP funding is not sufficient to support all approved applications. Applications recommended for approval, having a score of 60 or above by the ORC are forwarded to the DGO for cost analysis and further recommendation. The program official forwards the approval list to the IHS Director for final review and approval. Applications scoring below 60 points will be disapproved.

Note: In making final selections, the IHS Director will consider the ranking factors and the status of the applicant's single audit reports. The comments from the ORC will be advisory only. The IHS Director will make the final decision on awards.

VI. Award Administration Information

1. Award Notices.

The Notice of Award (NoA) will be initiated by the DGO and will be mailed via postal mail to each entity that is approved for funding under this announcement. The NoA will be signed by the Grants Management Officer and this is the authorizing document under which funds are dispersed to the approved entities. The NoA will serve as the official notification of the grant award and will reflect the amount of Federal funds awarded the purpose of the grant, the terms and conditions of the award, the effective date of the award, and the budget/project period. The NoA is the legally binding document. Applicants who are approved but unfunded or disapproved based on their Objective Review score will receive a copy of the Final Executive Summary which identifies the weaknesses and strengths of the application submitted. Any other correspondence announcing to the Project Director that an application was selected is not an authorization to begin performance.

2. Administrative Requirements.

Cooperative Agreements are administered in accordance with the following documents:

This Program Announcement.

Program Regulations, 42 CFR Part 136.101 et seq., 45 CFR Part 92, "Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local and Tribal Governments," or 45 CFR Part 74, "Uniform Administrative Requirements for Awards to Institutions of Higher Education, Hospitals, Other Non-Profit Organizations, and Commercial Organizations."

Grants Policy Guidance: HHS Grants Policy Statement, January 2007.

Cost Principles: 0MB Circular A–87, "Cost Principles for State, Local, and Indian Tribal Governments" (Title 2 Part 225).

Administrative Requirements: 0MB Circular A–122, "Non-Profit Organizations" (Title 2 Part 230).

Audit Requirements: 0MB Circular A–133, "Audits of States, Local Governments, and Non-Profit Organizations."

3. Indirect Costs.

This section applies to all grant recipients that request reimbursement of indirect costs in their grant application. In accordance with HHS Grants Policy Statement, Part II–27, IHS requires applicants to have a current indirect cost rate agreement in place prior to award. The rate agreement must be prepared in accordance with the applicable cost principles and guidance as provided by the cognizant agency or office. A current rate means the rate covering the applicable activities and the award budget period. If the current

rate is not on file with the Division of Grants Operations at the time of award, the indirect cost portion of the budget will be restricted and not available to the recipient until the current rate is provided to DGO.

Generally, indirect costs rates for IHS grantees are negotiated with the Division of Cost Allocation (DCA) *http://rates.psc.gov/* and the Department of Interior (National Business Center) *http://www.nbc.gov/acquisition/ics/icshome.htrnl.* If your organization has questions regarding the indirect cost policy, please contact the DGO at 301–443–5204 or Grants Policy Staff at 301–443–6290.

4. Reporting.

A. *Progress Report.* Program progress reports are required semi-annually. These reports must be submitted within 30 days of the end of the half year and will include a brief comparison of actual accomplishments to the goals established for the period, or, if applicable, provide sound justification for the lack of progress, and other pertinent information as required. A final report must be submitted within 90 days of expiration of the budget/project period.

B. *Financial Status Report.* Semi-annual financial status reports must be submitted within 30 days of the end of the half year. Final financial status reports are due within 90 days of expiration of the budget/project period. Standard Form 269 (long form) will be used for financial reporting. The final SF–269 must be verified from the grantee's records on how the value was derived. Grantees must submit reports in a reasonable period of time.

Failure to submit required reports within the time allowed may result in suspension or termination of an active cooperative agreement, withholding of additional awards for the project, or other enforcement actions such as withholding of payments or converting to the reimbursement method of payment. Continued failure to submit required reports may result in one or both of the following: (1) The imposition of special award provisions; and (2) the non-funding or non-award of other eligible projects or activities. This applies whether the delinquency is attributable to the failure of the grantee organization or the individual responsible for preparation of the reports.

5. Telecommunication for the hearing impaired is available at: TTY 301–443–6394.

VII. Agency Contact(s)

1. Questions on the programmatic issues may be directed to: Matt Johnson, Policy Analyst Office of Tribal Self-Governance Telephone No.: 301–443–7821 Fax No.: 301–443–1050 E-mail: *matthew.johnson@ihs,gov.*

2. Questions on grants management and fiscal matters may be directed to: John Hoffman, Grants Management Specialist Division of Grants Operations Telephone No.: 301–443–5204 Fax No.: 301–443–9602 E-mail: *john.hoffman2@ihs.gov.*

VIII. Other Information

The Public Health Service (PHS) strongly encourages all cooperative agreement and contract recipients to provide a smoke-free workplace and promote the non use of all tobacco products. In addition, Public Law 103–227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of the facility) in which regular or routine education, library, day care, health care or early childhood development services are provided to children. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Dated: March 24, 2008.

Robert G. McSwain,

Acting Director, Indian Health Service.

[FR Doc. E8–6428 Filed 3–28–08; 8:45 am]

BILLING CODE 4165–16–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Tribal Self-Governance Program Planning Cooperative Agreement

Announcement Type: New.

Funding Announcement Number: 1–[HS–2008–IHS–TS GP–0002.

Catalog of Federal Domestic Assistance Numbers(s): 93.210.

Key Dates: Application Deadline Date: April 28, 2008.

Review Date: May 8–9, 2008.

Earliest Anticipated Start Date: June 1, 2008.

I. Funding Opportunity Description

The purpose of the program is to award cooperative agreements that provide planning resources to Tribes interested in participating in the Tribal Self-Governance Program (TSGP) as authorized by Title V, Tribal Self-Governance Amendments of 2000 of the Indian Self-Determination and Education Assistance Act of Public Law (Pub. L.) 93–638, as amended. There is limited competition under this announcement because the authorizing legislation restricts eligibility to Tribes that meet specific criteria (Refer to Section 111.1.A., ELIGIBLE APPLICANTS in this announcement). The TSGP is designed to promote self-determination by allowing Tribes to assume more control of Indian Health Service (IHS) programs and services through compacts negotiated with the IRS. The Planning Cooperative Agreement allows a Tribe to gather information to determine the current types of Programs, Services, Functions, and Activities (PSFAs), and related funding available at the Service Unit, Area, and Headquarters levels and provide the opportunity to improve and enhance the healthcare delivery system to better meet the needs of the Tribal community. This program is described at 93.210 in the Catalog of Federal Domestic Assistance (CFDA).

II. Award Information

Type of Awards: Cooperative Agreement.

Estimated Funds Available: The total amount identified for Fiscal Year (FY) 2008 is $600,000 for approximately twelve (12) Tribes. Awards under this announcement are subject to the availability of funds.

Anticipated Number of Awards: The estimated number of awards to be funded is approximately 12.

Project Period: 12 months.

Award Amount: $50,000 per year.

Programmatic Involvement: TSGP funds will be awarded as cooperative agreements and will have substantial IHS programmatic involvement to establish a basic understanding of PSFAs and associated funding at the Service Unit, Area, and Headquarters levels.

The IHS roles and responsibilities will include:

- Providing a description of PSFAs and associated funding at all levels, including funding formulas and methodologies related to determining Tribal shares.
- Identifying IHS staff who will consult with applicants on methods currently used to manage and deliver health care.
- Providing applicants with statutes, regulations and policies that provide authority for administering IHS programs.

The grantee roles and responsibilities are critical to the success of the program and will include:

- Researching and analyzing the complex IHS budget, to gain a thorough understanding of funding distribution at all levels to determine which PSFAs the Tribe may elect to assume.
- Establishing a process by which Tribes can effectively approach the IHS

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April 4, 2008

General Memorandum 08-045

Indian Health Service Tribal Management Grants

The Indian Health Service has announced in the attached April 1, 2008, FEDERAL REGISTER notice the availability of $2,529,000 in expected FY 2009 funds for Tribal Management Grants. The IHS expects to make 20-25 new and continuation awards.

The Tribal Management Grant program provides funding to federally-recognized tribes and tribally-sanctioned tribal organizations to assume all or part of existing IHS programs, services, and functions and activities under the authority of the Indian Self-Determination Act. Grants may also be used under the authority of section 103(e) of the Self-Determination Act for obtaining technical assistance and planning.

The IHS will fund applications according to a priority system, beginning with the Priority I applications. Priority I applications are those from tribes who have received federal recognition within the past five years. Priority II applications are those from all other eligible federally recognized tribes or tribal organizations whose applications are for the sole purpose of addressing audit material weaknesses. Priority III applications are those from all other eligible tribes and tribal organizations submitting a competing continuation application or a new application. The funding of approved Priority I applicants will occur before the funding of approved Priority II applicants, and approved Priority II applicants will occur before the funding of approved Priority III applicants.

Applications must be for one of the following four projects: 1) feasibility studies, 2) planning, 3) evaluation studies, and 4) health management structure.

The deadline for the submission of applications is August 1, 2008. An application kit is available online at: www.ihs.gov/NonMedicalPrograms/tmg.

The IHS will hold training sessions to assist potential applicants in preparing their applications. The meetings will be held on the following dates and at the listed locations:

- April 30-May 1, 2008 - Minneapolis (limit 25 people)
- May 14-15, 2008 – Rapid City (limit 25 people)
- June 11-12, 2008 – Albuquerque (limit 25 people)
- June 23-24, 2008 – Albuquerque (limit 25 people; GCIT Grantsmanship Training)

The attached notice contains additional information regarding the training sessions.

Please contact us if we may provide further information or assistance regarding the IHS Tribal Management Grant Program.

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

806 SW BROADWAY • SUITE 900 • PORTLAND, OR 97205 • TEL 503.242.1745 • FAX 503.242.1072
117 PARK AVENUE • SECOND FLOOR • OKLAHOMA CITY, OK 73102 • TEL 405.602.9425 • FAX 405.602.9426
400 CAPITOL MALL • 11TH FLOOR • SACRAMENTO, CA 95814 • TEL 916.442.9444 • FAX 916.442.8344

Dates: The seminars are planned for the following dates:

1. April 8 and 9, 2008, in Rosemont, IL 60018. Details about dates are posted on AdvaMed's Web site at: *www.Advamedmtli.org/Chicago.*[1]

2. May 13 and 14, 2008, Bethesda, MD 20852. Details about dates are posted on AdvaMed's Web site at *www.Advamedmtli.org/Bethesda.*

3. June 17 and 18, 2008, Queens, NY. Details about dates are posted on AdvaMed's Web site at: *www.Advamedmtli.org/New York.*

Locations: The seminars are planned for the following locations:

1. April 8 and 9, 2008, Westin O'Hare, 6100 North River Rd., Rosemont, IL 60018. Details about location sites are posted on AdvaMed's Web site at: *www.Advamedmtli.org/Chicago.*

2. May 13 and 14, 2008, Marriott Bethesda North Conference Center, White Flint Auditorium, 5101 Marinelli Rd., North Bethesda, MD 20852. Details about location sites are posted on AdvaMed's Web site at: *www.advamedmtli.org/Bethesda.*

3. June 17 and 18, 2008, Crowne Plaza New York-LaGuardia, 104–04–Ditmars Blvd., East Elmhurst, NY 11369. Details about location sites are posted on AdvaMed's Web site at: *www.advamedmtli.org/NewYork.*

Contact: For FDA: William Sutton, Division of Small Manufacturers, International and Consumer Assistance, Center for Devices and Radiological Health (HFZ–220), 1350 Piccard Dr., Rockville, MD 20850, 800–638–2041, ext. 125, FAX: 240–276–3151, e-mail: *William.sutton@fda.hhs.gov.*

For AdvaMed: Veronica Allen, 202–434–7231, FAX: 202–783–8750, e-mail: *VAllen@AdvaMed.org.*

Registration: The registration fee for a limited number of FDA employees is waived. Send registration information (including name, title, firm name, address, telephone, and fax number) and the registration fee of $525 per person to AdvaMed, contact Veronica Allen, 202–434–7231, FAX: 202–783–8750. Payment forms accepted are major credit card (MasterCard, Visa, or American Express) or company check. If you wish to pay by check, contact Veronica Allen at *VAllen@Advamed.org.*

To register via the Internet, go to *www.AdvaMed.org.* The latest information on dates/venue sites will be posted on this Web site at: *www.advamedmtli.org/Chicago, www.admedmtli.org/Bethesda*, and *www.advamedmtli.org/NewYork* (FDA has verified the Web site addresses, but is not responsible for changes to the Web sites after this document publishes in the **Federal Register**).

For more information on the meeting, or for questions on registration, contact Veronica Allen (see *Contact*).

Attendees are responsible for their own accommodations. For further hotel information and driving directions, go to the registration Web site.

The registration fee will be used to offset the expenses of hosting the conference, including meals (breakfast and a lunch), refreshments, meeting rooms, and training materials. It also includes a networking reception on the evening of the first day of each seminar.

Space is limited; therefore, interested parties are encouraged to register early. There will be no onsite registration.

If you need special accommodations due to a disability, please contact Veronica Allen (see *Contact*) at AdvaMed as soon as possible.

SUPPLEMENTARY INFORMATION: The "Essentials of FDA Medical Device Regulations: A Primer for Manufacturers and Suppliers" seminar helps fulfill the Department of Health and Human Services' and FDA's important mission to protect the public health by educating new entrepreneurs on the essentials of FDA device regulations. FDA has made education of the medical device community a high priority to assure the quality of products reaching the marketplace and to increase the rate of voluntary industry compliance with regulations.

The seminar helps to implement the objectives of section 903 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 393) and the FDA Plan for Statutory Compliance, which includes working more closely with stakeholders and ensuring access to needed scientific and technical expertise. The seminar also furthers the goals of the Small Business Regulatory Enforcement Fairness Act (Public Law 104–121) by providing outreach activities by Government agencies directed at small businesses.

The following topics, as well as others, will be discussed at the seminar:

- Doing business in a regulated industry;
- Organizational structure of FDA;
- Overview of the quality system regulation;
- Design controls;
- Documents, records, and change control;
- Purchasing controls and acceptance activities;
- Production and process control;
- Corrective and preventive actions;
- Complaints, medical device reports, corrections, and recalls;
- Compliance issues;
- Management responsibility;
- Interacting with FDA—Where do you go for assistance?
- General question and answer session;
- Manufacturers and suppliers—the chain regulatory responsibility;
- Reimbursement of medical technology;
- The AdvaMed code of ethics; and
- Fraud and abuse.

Dated: March 27, 2008.

Jeffrey Shuren,

Associate Commissioner for Policy and Planning.

[FR Doc. 08–1085 Filed 3–28–08; 11:48 am]

BILLING CODE 4160–01–S

[1] FDA has verified the Web site addresses, but FDA is not responsible for any subsequent changes to the Web sites after this document publishes in the **Federal Register**.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Tribal Management Grant Program

Announcement Type: New and Competing Continuation Discretionary Funding Cycle for Fiscal Year 2009.

Funding Announcement Number: HHS–2009–IHS–TMD–0001.

Catalog of Federal Domestic Assistance Numbers(s): 93.228.

Key Dates: Training: Application Requirements Session: April 30–May 1, May 14–15, and June 11–12, 2008.

Grant Writing Session: June 23–27, 2008.

Application Deadline Date: August 1, 2008.

Receipt Date for Final Tribal Resolution: October 3, 2008.

Review Date: October 6–10, 2008.

Application Notification Date: November 12, 2008.

Earliest Anticipated Start Date: January 1, 2009.

I. Funding Opportunity Description

The Indian Health Service (IHS) announces competitive grant applications for the Tribal Management Grant (TMG) Program. This program is authorized under Section 103(b)(2) and Section 103(e) of the Indian Self-Determination and Education Assistance Act, Public Law 93–638, as amended. This program is described at 93.228 in the Catalog of Federal Domestic Assistance (CFDA).

The TMG Program is a national competitive discretionary grant program pursuant to 45 CFR part 75 and 45 CFR part 92 established to assist Federally-recognized Tribes and Tribally-

sanctioned Tribal organizations in assuming all or part of existing IHS programs, services, functions, and activities (PSFA) through a Title I contract and to assist established Title I contractors and Title V compactors to further develop and improve their management capability. In addition, TMGs are available to Tribes/Tribal organizations under the authority of Public Law (Pub. L.) 93–638 section 103(e) for (1) obtaining technical assistance from providers designated by the Tribe/Tribal organization (including Tribes/Tribal organizations that operate mature contracts) for the purposes of program planning and evaluation, including the development of any management systems necessary for contract management and the development of cost allocation plans for indirect cost rates; and (2) planning, designing and evaluating Federal health programs serving the Tribe/Tribal organization, including Federal administrative functions.

Funding Priorities: The IHS has established the following funding priorities for TMG awards.

- *Priority I*—Any Indian Tribe that has received Federal recognition (restored, un-terminated, funded, or unfunded) within the past five years, specifically received during or after March 2003.
- *Priority II*—All other eligible Federally-recognized Indian Tribes or Tribally sanctioned Tribal organizations submitting a competing continuation application or a new application for the sole purpose of addressing audit material weaknesses. The audit material weaknesses are identified in Attachment A (Summary of Findings and Recommendations) and other attachments, if any, of the transmittal letter received from the Office of the Inspector General (OIG), National External Audit Review Center (NEARC), Department of Health and Human Services (HHS). Please identify the weakness to be addressed by underlining the item on Attachment A. Please refer to Section 111.3, "Other Requirements," for more information regarding Priority II participation.

Federally-recognized Indian Tribes or Tribally-sanctioned Tribal organizations not subject to Single Audit Act requirements must provide a financial statement identifying the Federal dollars received in the footnotes. The financial statement must also identify specific weaknesses/recommendations that will be addressed in the TMG proposal and are related to 25 Code of Federal Regulations (CFR) Part 900, "Indian Self-Determination and Education Assistance Act Amendments," Subpart F—"Standards for Tribes and Tribal Organizations."

Priority II participation is only applicable to the Health Management Structure project type. For more information see Section H ELIGIBLE PROJECT TYPES, MAXIMUM FUNDING AND PROJECT PERIODS.

- *Priority III*—All other eligible Federally-recognized Indian Tribes or Tribal organizations submitting a competing continuation application or a new application.

The funding of approved Priority I applicants will occur before the funding of approved Priority II applicants. Priority H applicants will be funded before approved Priority if applicants. Funds will be distributed until depleted.

II. Award Information

Type of Awards: Grant.

Estimated Funds Available: Subject to the availability of funds, the estimated amount available is $2,529,000 in fiscal year (FY) 2009. There will be only one funding cycle in FY 2009. Awards under this announcement are subject to the availability of funds.

Anticipated Number of Awards: An estimated 20–25 awards will be made under the program.

Project Periods: Varies from 12 months to 36 months. Please refer to "ELIGIBLE PROJECT TYPES, MAXIMUM FUNDING AND PROJECT PERIODS" under this section for more detailed information.

Estimated Award Amount: $50,000/year–$100,000/year. Please refer to "ELIGIBLE PROJECT TYPES, MAXIMUM FUNDING AND PROJECT PERIODS" below for more detailed information.

Eligible Project Types, Maximum Funding and Project Periods

Applications may only be submitted for one project type. Applicants must state the project type selected. The TMG Program consists of four project types: (1) Feasibility study; (2) planning; (3) evaluation study; and (4) health management structure. Applications that address more than one project type will be considered ineligible and will be returned to the applicant. The maximum funding levels noted include both direct and indirect costs. Applicant budgets may not exceed the maximum funding level or project period identified for a project type. Applicants whose budget or project period exceed the maximum funding level or project period will be considered ineligible and will not be reviewed. Please refer to Section IV.6. "Funding Restrictions" for further information regarding ineligible activities.

1. *Feasibility Study (Maximum funding/project period:* $70,000/12 months) A study of a specific IHS program or segment of a program to determine if Tribal management of the program is possible. The study shall present the planned approach, training and resources required to assume Tribal management of the program. The study must include the following four components:

- Health needs and health care services assessments that identify existing health care services and delivery system, program divisibility issues, health status indicators, unmet needs, volume projections and demand analysis.
- Management analysis of existing management structures, proposed management structures, implementation plans and requirements, and personnel staffing requirements and recruitment barriers.
- Financial analysis of historical trends data, financial projections and new resource requirements for program management costs and analysis of potential revenues from Federal/non-Federal sources.
- Decision statement/report that incorporates findings, conclusions and recommendations; the presentation of the study and recommendations to the governing body for Tribal determination regarding whether Tribal assumption of program(s) is desirable or warranted.

2. *Planning (Maximum funding/project period:* $50,000/12 months) A collection of data to establish goals and performance measures for the operation of current health programs or anticipated PSFAs under a Title I contract. Planning will specify the design of health programs and the management systems (including appropriate policies and procedures) to accomplish the health priorities of the Tribe/Tribal organization. For example, planning could include the development of a Tribal Specific Health Plan or a Strategic Health Plan, etc. Please note: The Public Health Service urges applicants submitting strategic health plans to address specific objectives of Healthy People 2010. Interested applicants may purchase a copy of Healthy People 2010 (Summary Report in print; Stock No. 017–001–00547–9) or CD–ROM (Stock No. 107–001–00549–5) through the Superintendent of Documents, Government Printing Office, P.O. Box 371954, Pittsburgh, Pennsylvania, 15250–7945, or (202) 512–1800. This information is available in electronic form at the following Web site: *http://*

www.health.gov/healthypeople/publications.

3. *Evaluation Study (Maximum funding/project period:* $50,000/12 months) A systematic collection, analysis, and interpretation of data for the purpose of determining the value of a program. The extent of the evaluation study could relate to the goals and objectives, policies and procedures, or programs regarding targeted groups. The evaluation study could also be used to determine the effectiveness and efficiency of a Tribal program operation (i.e. direct services, financial management, personnel, data collection and analysis, third-party billing, etc.) as well as determine the appropriateness of new components to a Tribal program operation that will assist Tribal efforts to improve the health care delivery systems.

4. *Health Management Structure (Average funding/project period:* $100,000/12 months; maximum funding/project period: $300,000/36 months) The first year maximum is limited to $150,000 for multi-year projects. Health Management Structure allows for implementation of systems to manage or organize PSFAs. Management structures include health department organizations, health boards, and financial management systems including systems for accounting, personnel, third-party billing, medical records, management information systems, etc. This includes the design, improvements and correction of management systems that address weaknesses identified through quality control measures, internal control reviews and audit report findings under the Office of Management and Budget (OMB) Circular No. A–133—Revised June 27, 2003, "Audits of States, Local Governments, and Non-Profit Organizations." OMB Circular A–133, Audits of States, Local Governments and Non-Profit Organizations can be found at the following Web site: *http://www.whitehouse.gov/omb/circulars/a133/a133.htmlT.*

The 25 Code of Federal Regulations (CFR) Part 900, "Indian Self-Determination and Education Assistance Act Amendments," Subpart F—"Standards for Tribal or Tribal Organization Management Systems" sections (900.35—900.60) is available at the following Web site locations: *http://www.access.gpo.gov/nara/cfr/waisidx_04/25cfr900_04.html, http://www.ihs.gov/NonMedicalPrograms/TMG/Forms.asp.*

4. Please see Section IV "Application and Submission Information" for directions about how to request a copy of the TMG application package.

III. Eligibility Information

1. Indian Tribe or Tribal organization as defined by Public Law 93–638, Indian Self Determination and Education Assistance Act, as amended. Eligible applicants include Tribal organizations that operate mature contracts that are designated by a Tribe to provide technical assistance and/or training. Only one application per Tribe or Tribal organization is allowed. This paragraph should be cross-referenced with Section IV. (Application and Submission Information/Subsection 3. Content and Form of Narrative Submission).

2. Cost Sharing or Matching—The TMG Program does not require matching funds or cost sharing. However, in accordance with Public Law 93–638 section 103(c), the TMG funds may be used as matching shares for any other Federal grant programs that develop Tribal capabilities to contract for the administration and operation of health programs.

3. Other Requirements

The following documentation is required:

A. Tribal Resolution—A resolution of the Indian Tribe served by the project must accompany the application submission. The IHS will accept the following as proper documentation:

- If an official signed (passed) Tribal resolution encompassing the scope of this grant application is not available for electronic submission with the application on Grants.gov by the deadline, a draft resolution must be submitted as a place holder and as evidence of the intent of the entity. However, the draft resolution must be followed up with the submission of a faxed, fedexed or e-mailed pdf version of the final official signed Tribal resolution. The final signed resolution must be received by the Division of Grants Operations (DGO) by October 3, 2008. Otherwise, the application will be considered incomplete, ineligible for review, and returned to the applicant without consideration. It is recommended that applicants submitting the signed final resolution should ensure the information was received by the IHS by retaining documentation confirming delivery or receipt (i.e. fax transmittal receipt, FedEx tracking, postal return receipt, e-mail receipt, etc.).
- An Indian Tribe that is proposing a project affecting another Indian Tribe must include resolutions from all affected Tribes to be served.
- Applications by Tribal organizations will not require a specific Tribal resolution if the current Tribal resolution(s) under which they operate would encompass the proposed grant activities. A copy of that resolution must be provided for review.
- Tribal organizations applying for technical assistance and/or training grants must submit documentation that the tribal organization is applying upon the request of the Indian Tribe/Tribes it intends to serve.

B. Documentation for Priority I Participation—A copy of the **Federal Register** notice or letter from the Bureau of Indian Affairs (BIA) verifying establishment of Federal Tribal status within the last five years. Date must reflect that Federal recognition was received during or after March 2003.

C. Documentation for Priority II Participation—A copy of the transmittal letter and Attachment A from the Office of Inspector General, National External Audit Review Center (NEARC), HHS. See "FUNDING PRIORITIES" in Section I for more information. If an applicant is unable to locate a copy of their most recent transmittal letter or needs assistance with audit issues, information or technical assistance may be obtained by contacting the IHS Division of Audit Resolution (DAR) at (301) 443–7301, or the NEARC help line at (816) 374–6714 ext. 108. The auditor may also have the information/documentation required.

Federally-recognized Indian Tribes or Tribally-sanctioned Tribal organizations not subject to Single Audit Act requirements must provide a financial statement identifying the Federal dollars in the footnotes. The financial statement must also identify specific weaknesses/recommendations that will be addressed in the TMG proposal and are related to 25 CFR Part 900, "Indian Self-Determination and Education Assistance Act Amendments," Subpart F—"Standards for Tribes and Tribal Organizations."

- Documentation of Consortium Participation—If an Indian Tribe submitting an application is a member of a consortium, the Tribe must:

—Identify the consortium.
—Indicate if the consortium intends to submit a TMG application.
—Demonstrate that the Tribe's application does not duplicate or overlap any objectives of the consortium's application.

- Identify all of the consortium member Tribes.
- Identify if any of the member Tribes intend to submit a TMG application of their own.
- Demonstrate that the consortium's application does not duplicate or overlap any objectives of the other

consortium members who may be submitting their own TMG application.

Please refer to Section IV. Application and Submission Information, particularly Item 6 "Funding Restrictions" and Section V. "Application Review Information" for more information regarding other application submission information and/or requirements.

IV. Application and Submission Information

1. The Application package may be found in Grants.gov (*www.grants.gov*) or at: *http://www.ihs.gov/NonMedicalPrograms/gogp*. The entire grant application package is available at: *http://www.ihs.gov/NonMedicalPrograms/tmg*. Detailed application instructions for this announcement are downloadable on Grants.gov.

2. IHS Contacts:

Programmatic Concerns: Ms. Patricia Spotted Horse, Program Analyst, Office of Tribal Programs, Indian Health Service, 801 Thompson Avenue, Suite 220, Rockville, Maryland 20852, (301) 443–1104 (Telephone), (301) 443–4666 (Fax).

E-Mail Address: *Patricia.SpottedHorse@IHS.GOV*.

Business Concerns: Mr. Pallop Chareonvootitam, Grants Management Specialist, Division of Grants Operations, Indian Health Service, 801 Thompson Avenue, TMP 360 Rockville, Maryland 20852, (301) 443–5204 (Telephone), (301) 443–9602 (Fax).

E-Mail Address: *Pallop.Chareonvootitam@IHS.GOV*.

GRANTS.GOV Contact for HIS:

Information regarding the electronic grants.gov process, issues, and waivers waiving the electronic process may be obtained from the following person: Ms. Michelle G. Bulls, Chief Grants Management Officer, Director, Division of Grants Policy, Indian Health Service, 801 Thompson Avenue, TMP 625, Rockville, Maryland 20852, (301) 443–6528 (Telephone), E-Mail Address: *Michelle.Bulls@IHS.gov*.

3. Content and Form of Narrative Submission:

- Abstract (one page) summarizing the project.
- Introduction and Need for Assistance.
- Project Objective(s), Approach and Results and Benefits.
- Project Evaluation.
- Organizational Capabilities and Qualifications.
- Be typewritten and single spaced.
- Use black type not smaller than 12 characters per one inch.
- Margins must not be less than one inch.
- Have consecutively numbered pages.
- Contain a narrative that does not exceed 14 typed pages that includes the other submission requirements below. The 14-page narrative does not include the abstract, the work plan, standard forms, Tribal resolution(s), table of contents, budget, budget justifications, multi-year narratives, multi-year budget, multi-year budget justification, and/or other appendix items.

Public Policy Requirements: All Federal-wide public policies apply to IHS grants with exception of Lobbying and Discrimination policy.

4. Submission Dates and Times:

Applications must be submitted electronically through Grants.gov by 12 midnight Eastern Standard Time (EST) on Friday, August 1, 2008. If technical challenges arise and the applicant is unable to successfully complete the electronic application process, the applicant must contact Michelle G. Bulls, Division of Grants Policy, fifteen days prior to the application deadline and advise of the difficulties that your organization is experiencing. The grantee must obtain prior approval, in writing (e-mails are acceptable) allowing the paper submission. If submission of a paper application is requested and approved, the manually signed original and two copies of the application must be sent to the appropriate grants contact that is listed in Section IV.2. above. Applications not submitted through Grants.gov, without an approved waiver, will be returned to the applicant without review or consideration. Late applications will not be accepted for processing, will be returned to the applicant, and will not be considered for funding.

5. Intergovernmental Review:

Executive Order 12372 requiring intergovernmental review is not applicable to this program.

6. Funding Restrictions:

- Pre-award costs are not allowable.
- The available funds are inclusive of direct and indirect costs.
- Only one grant will be awarded per applicant.
- Ineligible Project Activities

The TMG may not be used to support recurring operational programs or to replace existing public and private resources. **Note:** The inclusion of the following projects or activities in an application will render the application ineligible and the application will be returned to the applicant:

—Planning and negotiating activities associated with the intent of a Tribe to enter the IHS Self-Governance Project. A separate grant program is administered by the IHS for this purpose. Prospective applicants interested in this program should contact Mr. Matt Johnson, Office of Tribal Self-Governance, Indian Health Service, Reyes Building, 801 Thompson Avenue, Suite 240, Rockville, Maryland 20852, (301) 443–7821, and request information concerning the "Tribal Self-Governance Program Planning Cooperative Agreement Announcement" or the "Negotiation Cooperative Agreement Announcement."

—Projects related to water, sanitation, and waste management.

—Projects that include direct patient care and/or equipment to provide those medical services to be used to establish or augment or continue direct patient clinical care are not allowable. Medical equipment that is allowable under the Special Diabetes Grant Program is not allowable under the TMG Program.

—Projects that include long-term care or provision of any direct services.

—Projects that include tuition, fees, or stipends for certification or training of staff to provide direct services.

—Projects that include pre-planning, design, and planning of construction for facilities, including activities relating to program justification documents.

—Projects that propose more than one project type. Please see Section H, "Award Information," specifically "ELIGIBLE PROJECT TYPES, MAXIMUM FUNDING AND PROJECT PERIODS" for more information. An example of a proposal with more than one project type that would be considered ineligible may include the creation of a strategic health plan (defined by TMG as a planning project type) and improving third-party billing structures (defined by TMG as a health management structure project type).

- Other Limitations—A current TMG recipient cannot be awarded a new, renewal, or competing continuation grant for any of the following reasons:

—A grantee may not administer two TMGs at the same time or have overlapping project/budget periods;

—The current project is not progressing in a satisfactory manner; or

—The current project is not in compliance with program and financial reporting requirements.

—Delinquent Federal Debts: No award shall be made to an applicant who has an outstanding delinquent Federal debt until either:

—The delinquent account is paid in full; or

—A negotiated repayment schedule is established and at least one payment is received.

7. Other Submission Requirements

Electronic Submission—The preferred method for receipt of applications is electronic submission through Grants.gov. However, should any technical challenges arise regarding the submission, please contact Grants.gov Customer Support at 1–800–518–4726 or *support@grants.gov*. The Contact Center hours of operation are Monday–Friday from 7 a.m. to 9 p.m. EST. If you require additional assistance, please call (301) 443–6290 and identify the need for assistance regarding your Grants.gov application. Your call will be transferred to the appropriate grants staff member. The applicant must seek assistance at least fifteen days prior to the application deadline. Applicants that do not adhere to the timelines for Central Contractor Registry (CCR) and/or Grants.gov registration and/or requesting timely assistance with technical issues will not be candidates for paper applications.

To submit an application electronically, please use the *www.Grants.gov* apply site. Download a copy of the application package, on the Grants.gov Web site, complete it offline and then upload and submit the application via the Grants.gov site. You may not e-mail an electronic copy of a grant application to IHS.

Please be reminded of the following:

- Under the new IHS application submission requirements, paper applications are not the preferred method. However, if you have technical problems submitting your application on-line, please contact directly Grants.gov Customer Support at: *http://www.Grants.gov/CustomerSupport*.
- Upon contacting Grants.gov, obtain a tracking number as proof of contact. The tracking number is helpful if there are technical issues that cannot be resolved and a waiver request from Grants Policy must be obtained.
- If it is determined that a formal waiver is necessary, the applicant must submit a request, in writing (e-mails are acceptable), to *Michelle.Bulls@ihs.gov* that includes a justification for the need to deviate from the standard electronic submission process. Upon receipt of approval, a hard-copy application package must be downloaded by the applicant from Grants.gov, and completed with appropriate manual signatures. An original and two copies of the application must be sent directly to the DGO, 801 Thompson Avenue, TMP 360, Rockville, MD 20852 by the due date, August 1, 2008.
- Upon entering the Grants.gov site, there is information available outlining the requirements to the applicant regarding electronic submission of an application through Grants.gov, as well as the hours of operation. We strongly encourage all applicants not to wait until the deadline date to begin the application process through Grants.gov as the registration process for CCR and Grants.gov could take up to fifteen working days.
- To use Grants.gov, you, as the applicant, must have a Data Universal Numbering System (DUNS) Number and must register in the CCR. You should allow a minimum of ten working days to complete CCR registration. See below on how to apply.
- You must submit all documents electronically, including all information typically included on the SF–424, Application for Federal Assistance, and all necessary assurances and certifications.
- Please use the optional attachment feature in Grants.gov to attach additional documentation that may be requested by IHS.
- Final signed Tribal resolutions are required no later than October 3, 2008, if a draft resolution was submitted with the initial electronic or paper application.
- Your application cannot exceed the 14-page limitation requirements described in the program announcement.
- After you electronically submit your application, you will receive an automatic acknowledgment from Grants.gov that contains a Grants.gov tracking number. The IHS DGO will retrieve your application from Grants.gov. DGO will not notify applicants that the application has been received.
- You may access the electronic application for this program on www.Grants.gov.
- You may search for the downloadable application package by either the CFDA number or the Funding Opportunity Number. Both numbers are identified in the heading of this announcement.
- The applicant must provide the Funding Opportunity Number: HHS–2009–IHS–TMD–0001.

E-mail applications will not be accepted under this announcement.

DUNS Number

Applicants are required to obtain a DUNS number from Dun and Bradstreet to apply for a grant or cooperative agreement from the Federal Government. The DUNS number is a nine-digit identification number, which uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access *http://www.dunandbradstreet.com* or call 1–866–705–5711. Interested parties may wish to obtain their DUNS number by phone to expedite the process.

Applications submitted electronically must also be registered with the CCR. A DUNS number is required before CCR registration can be completed. Many organizations may already have a DUNS number. Please use the number listed above to investigate whether or not your organization has a DUNS number. Registration with the CCR is free of charge.

Applicants may register by calling 1–888–227–2423. Please review and complete the CCR Registration Worksheet located on *http://www.Grants.gov/CCRRegister*.

More detailed information regarding these registration processes can be found *www.Grants.gov*.

V. Application Review Information

The instructions for preparing the application narrative also constitute the evaluation criteria for reviewing and scoring the application. Weights assigned to each section are noted in parentheses. The 14-page narrative should include only the first year of activities; information for multi-year projects should be included as an appendix. See "MULTI-YEAR PROJECT REQUIREMENTS" at the end of this section for more information.

1. Abstract—one page summary.

A. Criteria

Introduction and Need for Assistance (20 points)

(1) Describe the Tribe's/Tribal organization's current health operation. Include what programs and services are currently provided (i.e., Federally funded, State funded, etc.), information regarding technologies currently used (i.e., hardware, software, services, etc.), and identify the source(s) of technical support for those technologies (i.e., Tribal staff, Area Office, vendor, etc.). Include information regarding whether the Tribe/Tribal organization has a health department and/or health board and how long it has been operating.

(2) Describe the population to be served by the proposed project. Include a description of the number of IHS eligible beneficiaries who currently use services.

(3) Describe the geographic location of the proposed project including any geographic barriers to the health care users in the area to be served.

(4) Identify all TMGs received since FY 2003, dates of funding and summary

of project accomplishments. State how previous TMG funds facilitated the progression of health development relative to the current proposed project. (Copies of reports will not be accepted.)

(5) Identify the eligible project type and priority group of the applicant.

(6) Explain the reason for your proposed project by identifying specific gaps or weaknesses in services or infrastructure that will be addressed by the proposed project. Explain how these gaps/weaknesses were discovered. If proposed project includes information technology (i.e., hardware, software, etc.), provide further information regarding measures taken or to be taken that ensure the proposed project will not create other gaps in services or infrastructure (i.e., IHS interface capability, Government Performance and Results Act reporting requirements, contract reporting requirements, Information Technology (IT) compatibility, etc.).

(7) Describe the effect of the proposed project on current programs (i.e., Federally funded, State funded, etc.) and, if applicable, on current equipment (i.e., hardware, software, services, etc.). Include the effect of the proposed project on planned/anticipated programs and/or equipment.

(8) Address how the proposed project relates to the purpose of the TMG Program by addressing the appropriate description that follows:

- Identify if the Tribe/Tribal organization is an IRS Title I contractor. Address if the self-determination contract is a master contract of several programs or if individual contracts are used for each program. Include information regarding whether or not the Tribe participates in a consortium contract (i.e., more than one Tribe participating in a contract). Address what programs are currently provided through those contracts and how the proposed project will enhance the organization's capacity to manage the contracts currently in place.
- Identify if the Tribe/Tribal organization is an IHS Title V compactor. Address when the Tribe/Tribal organization entered into the compact and how the proposed project will further enhance the organization's management capabilities.
- Identify if the Tribe/Tribal organization is not a Title I or Title V organization. Address how the proposed project will enhance the organization's management capabilities, what programs and services the organization is currently seeking to contract and an anticipated date for contract.

Project Objective(S), Workplan and Consultants (40 points)

A. Identify the proposed project objective(s) addressing the following:

- Measurable and (if applicable) quantifiable.
- Results oriented.
- Time-limited.

Example: By installing new software, the Tribe will increase the number of bills processed by 15 percent at the end of 12 months.

B. Address how the proposed project will result in change or improvement in program operations or processes for each proposed project objective. Also address what tangible products are expected from the project (i.e. policies and procedures manual, health plan, etc.).

C. Address the extent to which the proposed project will build the local capacity to provide, improve, or expand services that address the need(s) of the target population.

D. Submit a workplan in the appendix which includes the following information:

- Provide the action steps on a timeline for accomplishing the proposed project objective(s).
- Identify who will perform the action steps.
- Identify who will supervise the action steps taken.
- Identify who will accept and/or approve work products at the end of the proposed project.
- Include any training that will take place during the proposed project and who will be attending the training.
- Include evaluation activities planned.

E. If consultants or contractors will be used during the proposed project, please include the following information in their scope of work (or note if consultants/contractors will not be used):

- Educational requirements.
- Desired qualifications and work experience.
- Expected work products to be delivered on a timeline.

If a potential consultant/contractor has already been identified, please include a resume in the Appendix.

F. Describe what updates (i.e., revision of policies/procedures, upgrades, technical support, etc.) will be required for the continued success of the proposed project. Include when these updates are anticipated and where funds will come from to conduct the update and/or maintenance.

Project Evaluation (15 Points)

Describe the proposed plan to evaluate both outcomes and process. Outcome evaluation relates to the results identified in the objectives, and process evaluation relates to the workplan and activities of the project.

A. For outcome evaluation, describe:

- What the criteria will be for determining success of each objective.
- What data will be collected to determine whether the objective was met?
- At what intervals will data be collected?
- Who will collect the data and their qualifications?
- How the data will be analyzed.
- How the results will be used.

B. For process evaluation, describe:

- How the project will be monitored and assessed for potential problems and needed quality improvements.
- Who will be responsible for monitoring and managing project improvements based on results of ongoing process improvements and their qualifications?
- How ongoing monitoring will be used to improve the project.
- Any products, such as manuals or policies, that might be developed and how they might lend themselves to replication by others.
- How the project will document what is learned throughout the project period.

C. Describe any evaluation efforts that are planned to occur after the grant period ends.

D. Describe the ultimate benefit to the Tribe that is expected to result from this project. An example of this might be the ability of the Tribe to expand preventive health services because of increased billing and third party payments.

Organizational Capabilities and Qualifications (15 Points)

A. Describe the organizational structure of the Tribe/Tribal organization beyond health care activities.

B. Provide information regarding plans to obtain management systems if the Tribe/Tribal organization does not have an established management system currently in place that complies with 25 CFR Part 900, Subpart F, and "Standards for Tribal Management Systems." If management systems are already in place, simply state it.

C. Describe the ability of the organization to manage the proposed project. Include information regarding similarly sized projects in scope and financial assistance as well as other grants and projects successfully completed.

D. Describe what equipment (i.e., fax machine, phone, computer, etc.) and facility space (i.e., office space) will be available for use during the proposed

project. Include information about any equipment not currently available that will be purchased through the grant.

F. List key personnel who will work on the project. Include title used in the workplan. In the appendix, include position descriptions and resumes for all key personnel. Position descriptions should clearly describe each position and duties, indicating desired qualifications and experience requirements related to the proposed project. Resumes must indicate that the proposed staff member is qualified to carry out the proposed project activities. If a position is to be filled, indicate that information on the proposed position description.

F. If the project requires additional personnel (i.e., IT support, etc.), address how the Tribe/Tribal organization will sustain the position(s) after the grant expires. (If there is no need for additional personnel, simply note it.)

Categorical Budget and Budget Justification (10 points).

A. Provide a categorical budget for each of the 12-month budget periods requested.

B. If indirect costs are claimed, indicate and apply the current negotiated rate to the budget. Include a copy of the rate agreement in the appendix.

C. Provide a narrative justification explaining why each line item is necessary/relevant to the proposed project. Include sufficient cost and other details to facilitate the determination of cost allowability (i.e., equipment specifications, etc.)

Multi-Year Project Requirements

Projects requiring a second and/or third year must include a narrative addressing the second and/or third year's project objectives, evaluation components, work plan, categorical budget and budget justification. The same weights and criteria as noted in Section V. Application Review Information that is used to evaluate a one-year project or the first year of a multi-year project will be applied when evaluating the second and third years of a multi-year application. A weak second and/or third year submission could negatively impact the overall score of an application.

Appendix Items

A. Work plan for proposed objectives.

B. Position descriptions for key staff.

C. Resumes of key staff that reflect current duties.

D. Consultant proposed scope of work (if applicable).

E. Indirect Cost Rate Agreement.

F. Organizational chart (optional).

G. Multi-Year Project Requirements (if applicable).

2. Review and Selection Process

In addition to the above criteria/requirements, applications are considered according to the following:

A. Application Submission (Application Deadline: August 1, 2008). Applications received in advance of or by the deadline and verified by the tracking number will undergo a preliminary review to determine that:

- The applicant and proposed project type is eligible in accordance with this grant announcement;
- The application is not a duplication of a previously funded project; and
- The application narrative, forms, and materials submitted meet the requirements of the announcement allowing the review panel to undertake an in-depth evaluation; otherwise the application may be returned.

B. Competitive Review of Eligible Applications (Objective Review: October 6–10, 2008).

Applications meeting eligibility requirements that are complete, responsive and conform to this program announcement will be reviewed for merit by the Ad Hoc Objective Review Committee (ORC) appointed by the IHS to review and make recommendations on these applications. The review will be conducted in accordance with the IHS Objective Review Guidelines. The technical review process ensures selection of quality projects in a national competition for limited funding. Applications will be evaluated and rated on the basis of the evaluation criteria listed in Section V.1. The criteria are used to evaluate the quality of a proposed project, determine the likelihood of success and to assign a numerical score to each application. The scoring of approved applications will assist the IHS in determining which proposals will be funded if the amount of TMG funding is not sufficient to support all approved applications. Applications recommended for approval, having a score of 60 or above by the ORC and scored high enough to be considered for funding will be reviewed by the DGO for cost analysis and further recommendation. The program official accepts the DGO recommendations for consideration when funding applications. The program official forwards the final approved list to the Director, Office of Tribal Programs (OTP), for final review and approval. Applications scoring below 60 points will be disapproved. Applications that are approved but not funded will not be carried over into the next cycle for funding consideration.

3. Anticipated Announcement and Award Dates. The IEIS anticipates the earliest award start date will be January 1, 2009.

VI. Award Administration Information

1. Award Notices

ORC Results Notification: November 12, 2008.

The Director, OTP, or program official, will notify the contact person identified on each proposal of the results in writing via postal mail. Applicants whose applications are declared ineligible will receive written notification of the ineligibility determination and their grant application via postal mail. The ineligible notification will include information regarding the rationale for the ineligible decision citing specific information from the original grant application. Applicants who are approved but unfunded and disapproved will receive a copy of the Executive Summary which identifies the weaknesses and strengths of the application submitted. Applicants who are approved and funded will be notified through the official Notice of Award (NoA) document. The NoA will be signed by the Grants Management Officer and is the authorizing document for notifying grant recipients of funding.

The NoA serves as the official notification of a grant award and will state the amount of Federal funds awarded, the purpose of the grant, the terms and conditions of the grant award, the effective date of the award, the project period, and the budget period. Any other correspondence announcing to the Applicant's Project Director that an application was recommended for approval is not an authorization to begin performance. Pre-award costs are not allowable charges under this program grant.

2. Administrative Requirements

Grants are administrated in accordance with the following documents:

- This grant announcement.
- Health and Human Services regulations governing Public Law 93–638 grants at 42 CFR 36.101 *et seq.*
- 45 CFR part 92, "Department of Health and Human Services, Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments Including Indian Tribes," or 45 CFR part 74, "Administration of Grants to Non-Profit Recipients."
- Public Health Service Grants Policy Statement.
- Appropriate Cost Principles: OMB Circular A–87, "State and Local

Governments," or OMB Circular A–122, "Non profit Organizations."

• OMB Circular A–133, "Audits of States, Local Governments and Non Profit Organizations."

• Other Applicable OMB Circulars.

3. Indirect Costs

This section applies to all grant recipients that request indirect cost in their application. In accordance with HHS Grants Policy Statement, Part II–27, IHS requires applicants to have a current indirect cost rate agreement in place prior to award. The rate agreement must be prepared in accordance with the applicable cost principles and guidance as provided by the cognizant agency or office. A current rate means the rate covering the applicable activities and the award budget period. If the current rate is not on file with the awarding office, the award shall include funds for reimbursement of indirect costs. However, the indirect cost portion will remain restricted until the current rate is provided to the DGO.

• Generally, indirect costs rates for IRS Tribal organization grantees are negotiated with the Division of Cost Allocation (DCA) *http://rates.psc.gov/* and indirect cost rates that are for IHS funded Federally recognized Tribes are negotiated with the Department of the Interior. If your organization has questions regarding the indirect cost policy, please contact the DGO at 301–443–5204. Additional information may be obtained at the following Web site for the National Business Center

[Department of the Interior]: National Business Center (NBC).

http://www.nbc/gov/acquisition/ics/icsprep.html.

http://www.nbc.gov/searchdata1.cfm.

Preparing and Submitting Indirect Cost Proposals

4. Reporting

A. Progress Report. Program progress reports are required either semi annually or annually. [Semi-annual] program progress reports must be submitted within 30 days at the end of the half year. These reports will include a brief comparison of actual accomplishments to the goals established for the period, reasons for slippage (if applicable), and other pertinent information as required. A final report must be submitted within 90 days of expiration of the budget/project period.

B. Financial Status Reports. Financial status reports are required either semi annually or annually. [Semi-annual] financial status reports must be submitted within 30 days of the end of the half year. Final financial status reports are due within 90 days of expiration of the budget/project period. Standard Form 269 (long form) will be used for financial reporting.

C. Reports. Grantees are responsible and accountable for accurate reporting of the Progress Reports and Financial Status Reports which are generally due semi-annually. Financial Status Reports (SF–269) are due 90 days after each budget period and the final SF–269 must be verified from the grantee records on how the value was derived. Grantees must submit reports in a reasonable period of time.

Failure to submit required reports within the time allowed may result in suspension or termination of an active grant, withholding of additional awards for the project, or other enforcement actions such as withholding of payments or converting to the reimbursement method of payment. Continued failure to submit required reports may result in one or both of the following: (1) The imposition of special award provisions; and (2) the non-funding or non-award of other eligible projects or activities. This applies whether the delinquency is attributable to the failure of the grantee organization or the individual responsible for preparation of the reports.

VII. Agency Contact(s)

Interested parties may obtain TMG programmatic information from the TMG Program Coordinator listed under Section IV of this program announcement, Grant-related and business management information may be obtained from the Grants Management Specialist listed under Section IV of this program announcement. Grants.gov concerns submission, and waiver requests may be addressed by Ms. Michelle Bulls, Division of Grants Policy. Contact information is noted under Section IV of this program announcement. Please note that the telephone numbers provided are not toll-free.

VIII. Other Information

Training:

The IHS will conduct three training sessions to assist applicants in preparing their FY 2009 TMG applications. There will be three 2-day training sessions. In addition, there will be one 5-day training session on Gamesmanship. The 5-day training session will provide participants with basic grant writing skills, information regarding where to search for funding opportunities, and the opportunity to begin writing a TMG grant proposal or to finalize a draft proposal. The 2-day training sessions will focus specifically on the TMG requirements providing participants with information contained in this announcement, clarifying any issues/questions applicants may have and critiquing project ideas. In an effort to make the training sessions productive, participants are expected to bring draft proposals to these sessions.

Priority will be given to groups eligible to apply for the TMG Program. Participation is limited to two personnel from each Tribe or Tribal organization. All sessions are first come—first serve with the above limitations noted. All participants are responsible for making and paying for their own travel arrangements. Interested parties should register with the TMG staff prior to making travel arrangements to ensure space is available in selected sessions. There is no registration fee to attend the training session(s). The registration form may be obtained from the TMG Web site at: *http://www.ihs.gov/NonMedicalPrograms/tmg.* The registration form may be faxed to (301) 443–4666. **Note:** A minimum of 10 attendees is required for the IHS to conduct the training sessions. The anticipated training dates and locations are listed below in chronological order:

• April 30–May 1, 2008—Minneapolis, Minnesota (Limit 25) (TMG Training).

• May 14–15, 2008—Rapid City, South Dakota (Limit 25) (TMG Training).

• June 11–12, 2008—Albuquerque, New Mexico (Limit 25) (TMG Training).

• June 23–27, 2008—Albuquerque, New Mexico (Limit 25) (The Grantsmanship Center Institute Training).

IHS Checklist

The following IHS Checklist is included to assist applicants in proposal preparation and follow-up. Applicants are highly encouraged to employ this checklist for their benefit and to submit it as part of their proposal as an attachment in Grants.gov to allow for verification of receipt. This checklist will be utilized by the DGO during their initial screening for eligibility and will be utilized by the OTP during their programmatic review for content of the application to ensure required items requested are submitted and the application is eligible for further review via the ORC. This checklist is available on the TMG Web site at *http://www.ihs.gov/nonmedicalprograms/tmg.*

IHS FY 2009 Tribal Management Grant Application Checklist

Applicant Name: _____

Application Tracking Number: _____

Electronic Submission: ____ Signed Paper Submission: ____ Waiver Obtained: ____

Title I: ____ Title V: ____ Project Type: _____

	Item	Applicant	Grants	Programs
1	IHS FY 2009 TMG Checklist	_____	_____	_____
2	Eligibility: (circle) Tribe Tribal Organization	_____	_____	_____
3	501c(3) Non-Profit Organization	_____	_____	_____
4	Tribal Resolution			
	a. Final signed resolution is due on or before October 3, 2008	_____	_____	_____
	b. Draft unsigned resolution is due August 1, 2008 (if applicable)	_____	_____	_____
5	Priority I Documentation (if applicable)	_____	_____	_____
6	Priority II Documentation (if applicable)	_____	_____	_____
7	Consortium Participation Documentation (if applic.)	_____	_____	_____
8	SF 424 Application for Federal Assistance	_____	_____	_____
9	SF 424A Budget – Non Construction	_____	_____	_____
10	SF 424B Assurances	_____	_____	_____
11	Disclosure of Lobbying Activities	_____	_____	_____
12	Abstract	_____	_____	_____
13	Project Narrative (14 pages maximum)			
	a. Introduction and Need for Assistance	_____	_____	_____
	b. Project Objective(s), Workplan & Consultants	_____	_____	_____
	c. Project Evaluation	_____	_____	_____
	d. Organizational Capabilities and Qualifications	_____	_____	_____
14	Categorical Budget & Budget Justification	_____	_____	_____
15	Multi-year Summary & Budget Justification			
16	APPENDIX ITEMS			
	a. Work plan for proposed objectives.	_____		

b. Position descriptions for key staff.	____	____	____
c. Resumes of key staff that reflect current duties.	____	____	____
d. Consultant proposed scope of work (if applicable).	____	____	____
e. Indirect Cost Rate Agreement.	____	____	____
f. Organizational chart (optional).	____	____	____
g. Multi-Year Project Requirements (if applicable).	____	____	____

Applicant Signature / Date: _____

IHS Grants Management Signature / Date: _____

IHS Program Office Signature / Date: _____

The Public Health Service (PHS) strongly encourages all grant and contract recipients to provide a smoke-free workplace and promote the non-use of all tobacco products. In addition, Pub. L. 103-227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of the facility) in which regular or routine education, library, day care, health care or early childhood development services are provided to children. This is consistent with the HHS mission to protect and advance the physical and mental health of the American people.

Date: 3/24/08

Robert G. McSwain
Acting Director
Indian Health Service

[FR Doc. E8–6429 Filed 3–31–08; 8:45 am]
BILLING CODE 4165–16–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Submission for OMB Review; Comment Request

Periodically, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish a summary of information collection requests under OMB review, in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these documents, call the SAMHSA Reports Clearance Officer on (240) 276–1243.

Project: National Evaluation of the Addiction Technology Transfer Centers (ATTC)—NEW

In recognition that systematic evaluation of this and other government programs are part of good management and accountability and will inform program improvement efforts, the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (CSAT) will conduct an independent evaluation of the ATTC Program. The purpose of the ATTC Program is to develop and strengthen the workforce that provides addictions treatment services to 23 million Americans age 12 and older who need treatment for alcohol or illicit drug problems. In partnership with Single State Authorities (SSAs), treatment provider associations, addictions counselors, multidisciplinary professionals, faith and recovery community leaders, addiction educators, and other stakeholders, the ATTCs assess the training and development needs of the substance use disorders workforce, and develop and conduct training and technology transfer activities to meet these needs. Particular emphasis is on raising awareness of and improving skills in using evidence-based and promising treatment/recovery practices in recovery-oriented systems of care.

The goals of the evaluation are to: (1) Identify the successes of technology transfer efforts and build upon them in the future; (2) share lessons learned across ATTC regions for the enhancement of all regions' activities; and (3) identify region-specific and cross-regional processes and outcomes. The evaluation will consist of three studies. The Planning and Partnering Study will collect data on the processes and procedures related to the planning, partnering, and provision of ATTC services/activities. The Customer Satisfaction and Benefit Study will collect data on the extent to which ATTC services/activities are satisfactory and to meet the needs of identified partners and other program stakeholders. The Change in Practice Study will collect data to determine the extent to which ATTCs have enhanced the competencies, including cultural competencies, of specialty addictions treatment practitioners, paraprofessionals, and multidisciplinary professionals to strengthen the workforce and whether the ATTCs have provided these individuals with new skills that have led to changes in treatment practice.

This will be the first independent, national evaluation of the ATTC Program since the program was first funded by SAMHSA in 1993. The evaluation approach will be formative and participatory, and the national evaluation team will collaborate with the ATTCs, CSAT, and other program stakeholders to implement the planned data collection activities. Surveys, interviews, and focus groups will be conducted over a three-year period with eight (8) main stakeholder groups who use or are among the target audiences for the ATTCs' services or are otherwise associated with the ATTC program (e.g., as ATTC partners): ATTC directors and staff; customers/recipients of ATTC services/activities; ATTC Advisory Board members; partners who collaborate with ATTCs in planning and delivering ATTC services/activities; directors of state substance abuse agencies; directors of treatment provider and recovery organizations and directors of provider associations; addiction educators; and cultural leaders involved in addictions treatment. The data collection instruments have been constructed to include information related to each stakeholder group, as identified above, and are expected to yield diverse perspectives related to the processes and outcomes of the ATTC Program. As a condition of their grant, each ATTC was required to budget .25 FTE to participate in data collection for the national evaluation.

The evaluation will collect new data that is necessary for the evaluation and will also use data and information collected under existing program requirements. (Each ATTC is required to submit GPRA data at the end of each ATTC training and technical assistance event and meeting/conference and 30 days after each event; each ATTC will conduct a workforce survey; and each ATTC also submits an annual report. None of the new data collection activities will be redundant with these existing reporting requirements.) CSAT plans the following new data collection activities:

(1) Semi-structured interviews with ATTC directors and other ATTC staff (e.g., co-directors, ATTC technology transfer specialists, ATTC evaluator) that are conducted during site visits to each ATTC. The purpose of the interviews will be to collect information on:

a. Goals and objectives of the ATTC.

b. Regional priorities and needs for technology transfer services.

c. Processes used to plan ATTC programs and services.

d. Collaborative relationships with organizations within and outside the ATTC region.

e. Organizational structure and staffing of the ATTC.

f. ATTC funding and leveraging of resources.

g. Efforts to coordinate services with other providers of training, technical assistance, or technology transfer services within the region.

h. Technology transfer strategies and services implemented by the ATTC to promote adoption of culturally appropriate, evidence-based, and promising practices.

i. Implementation and use of workforce surveys.

j. Participation in cross-regional and network-wide activities.

k. Background characteristics of the respondent.

(2) Focus groups with ATTC staff (including field staff who are assigned to work with specific states and may work in different locations throughout the ATTC region), to include information on:

a. Regional priorities and needs for technology transfer services.

b. Processes used to plan ATTC programs and services.

c. Efforts to coordinate services with other providers of technology transfer services within the region.

d. Technology transfer strategies and services implemented by the ATTC to promote adoption of culturally appropriate, evidence-based and promising practices.

e. Background characteristics of focus group participants.

(3) Telephone interviews with a sample of stakeholders of the ATTC program, including state substance abuse directors (SSAs), ATTC Advisory Board members, addiction educators, directors of treatment provider associations, cultural leaders, and leaders of recovery associations. The

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April 4, 2008

General Memorandum 08-047

IHS Grants for Elder Care Initiative

The Indian Health Service (IHS) is soliciting applications, via the attached notice from the March 31, 2008 FEDERAL REGISTER, for grants under its Elder Care Initiative Long Term Care Grant Program. Funds are for planning and designing long-term care services and for implementing service or a group of services to improve tribes' long-term care capacity. The services developed or supported by the grant must be those for which the IHS has the authority to provide, either directly or through agreements, and must be designed to serve the IHS beneficiaries.

Eligible applicants are tribes, tribal organizations, urban Indian organizations, or a consortium of these. The IHS has $600,000 in FY 2008 funds for the Elder Care Initiative, and expects to make 8-10 awards. Grants are in two categories:

- *Assessment and Planning.* The maximum grant is $50,000 per year, with a two-year award cycle.

- *Implementation.* The maximum grant is $75,000 per year, with a two-year award cycle.

A letter of intent to apply (not more than two pages in length) must be received by the IHS by May 2, 2008 (applications will not be reviewed unless a letter of intent was filed). The applications must be received by June 20, 2008 and submitted electronically through the grants.gov website. The attached notice contains further details and the IHS contact information regarding the application process.

If we may be of further assistance regarding the Elder Care Initiative Long Term Care Grant Program please contact us at the information below.

###

Inquiries may be directed to:
Karen Funk (kfunk@hsdwdc.com)
Adam Bailey (abailey@hsdwdc.com)

protein (acid-HP) and Asian-style sauces.

DATES: Submit written or electronic comments regarding the CPG at any time.

ADDRESSES: Submit written comments on the CPG to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. Submit electronic comments to: *http://www.regulations.gov.*

Submit written requests for single copies of CPG Sec. 500.500 Guidance Levels for 3–MCPD (3-chloro-1,2-propanediol) in Acid-Hydrolyzed Protein and Asian-Style Sauces to the Division of Compliance Policy (HFC–230), Office of Enforcement, Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 240–632–6860. Send two self-addressed adhesive labels to assist that office in processing your request, or fax your request to 240–632–6861. See the **SUPPLEMENTARY INFORMATION** section for electronic access to the document.

FOR FURTHER INFORMATION CONTACT: Judith L. Kidwell, Office of Food Additive Safety, Center for Food Safety and Applied Nutrition (HFS–265), Food and Drug Administration, 5100 Paint Branch Pkwy., College Park, MD, 20740–3835, 301–436–1071.

SUPPLEMENTARY INFORMATION:

I. Background

In the **Federal Register** of May 23, 2006 (71 FR 29651), FDA announced the availability of draft CPG Sec. 500.500 Guidance Levels for 3–MCPD (3-chloro-1,2-propanediol) in Acid-Hydrolyzed Protein and Asian-Style Sauces. FDA received one comment on the draft CPG. The International Hydrolyzed Protein Council (IHPC) offered clarification for the following sentence found in the **BACKGROUND** section of the draft CPG: "Since 1996, many countries * * * have recommended or required that industry take steps to ensure that 3–MCPD is not detectable in acid-HP or Asian-style sauces at levels ranging from 0.01 parts per million (ppm) to 1 ppm." IHPC suggested that we revise the sentence as follows: "Since 1996, many countries * * * have recommended or required that industry take steps to ensure that 3–MCPD in acid-HP or Asian-style sauces does not exceed levels ranging from 0.01 parts per million (ppm) to 1 ppm." IHPC explained that using the phrase "not detectable" and then listing allowable levels is confusing. We concur with the comment and have revised the final CPG accordingly. FDA also revised the **SPECIMEN CHARGES** section in the final CPG to provide operational guidance regarding reference to the United States Code (U.S.C.) when citing the violation charged in a domestic seizure and reference to the Federal Food, Drug, and Cosmetic Act when citing the violation charged in an import detention. We also have made other editorial changes to the CPG for clarification.

This CPG is being issued as level 1 guidance consistent with FDA's good guidance practices regulations (21 CFR 10.115). The CPG represents the agency's current thinking on 3–MCPD in acid-HP and Asian-style sauces. It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. An alternate approach may be used if such approach satisfies the requirements of the applicable statutes and regulations.

II. Comments

Interested persons may submit to the Division of Dockets Management (see **ADDRESSES**) written or electronic comments on the CPG at any time. Submit a single copy of electronic comments or two paper copies of any mailed comments, except that individuals may submit one paper copy. Comments are to be identified with the docket number found in brackets in the heading of this document. The CPG and received comments may be seen in the Division of Dockets Management between 9 a.m. and 4 p.m., Monday through Friday.

Please note that on January 15, 2008, the FDA Division of Dockets Management Web site transitioned to the Federal Dockets Management System (FDMS). FDMS is a Government-wide, electronic docket management system. Electronic comments or submissions will be accepted by FDA through FDMS only.

III. Electronic Access

Persons with access to the Internet may obtain the CPG from the Office of Regulatory Affairs home page at *http://www.fda.gov/ora* under "Compliance Reference."

Dated: March 14, 2008.

Margaret O'K. Glavin,

Associate Commissioner for Regulatory Affairs.

[FR Doc. E8–6504 Filed 3–28–08; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Office of Clinical and Preventive Services; Elder Care Initiative Long-Term Care Grant Program

Announcement Type: New.

Funding Announcement Number: HHS–2008–IHS–EHC–0001.

Catalog of Federal Domestic Assistance Numbers: 93.933.

Key Dates:

Letter of Intent Deadline: May 2, 2008.

Application Deadline Date: June 20, 2008.

Review Date: July 21–August 1, 2008.

Earliest Anticipated Start Date: September 1, 2008.

I. Funding Opportunity Description

The Indian Health Service (IHS) announces the availability of up to $600,000 for competitive grants through the Elder Care Initiative Long Term Care (ECILTC) Grant Program to support planning and implementation of sustainable long-term care services for American Indians and Alaska Native (AI/AN) elders. This program is authorized under the Snyder Act, Indian Health Care Improvement Act, as amended, 25 U.S.C. 1653(c), and Public Health Service Act, Section 301, as amended. This program is described at 93.933 in the Catalog of Federal Domestic Assistance (CFDA).

The AI/AN elder population is growing rapidly and the AI/AN population as a whole is aging. The prevalence of chronic disease in this population continues to increase, contributing to a frail elder population with increasing long-term care (LTC) needs.

LTC is best understood as an array of social and health care services that support an individual who has needs for assistance in activities of daily living over a prolonged period. LTC supports elders and their families with medical, personal, and social services delivered in a variety of settings to support quality of life, maximum function, and dignity. While families continue to be the backbone of LTC for AI/AN elders, there is well documented need to support this care with formal services. The way these services and systems of care are developed and implemented can have a profound impact on the cultural and spiritual health of the community.

Home and community-based services have the potential for meeting the needs of the vast majority of elders requiring LTC services, supporting the key roles of the family in the care of the elder and

the elder in the care of the family and community. A LTC system with a foundation in HCBS will also comply with the United States Supreme Court interpretation of the Americans with Disabilities Act in *Olmstead* v. *L.C.*, 527 U.S. 581 (1999). The 28 CFR 35.130(d) ruling obligates States and localities to provide care for persons with disability "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." An efficient and effective LTC system would make use of all available resources, integrating and coordinating services to assist families in the care of their elders.

The primary focus for planning and program development for AI/AN LTC is at the Tribal and urban community level. Tribes and communities have very different histories, capabilities, and resources with regard to LTC program development. Each Tribe or community will have different priorities in building LTC infrastructure. It is critical that the development of LTC services be well grounded in an assessment of need based on population demographics and rates of functional impairment. LTC services should be acceptable to elders and their families and consistent with community values in their implementation. The services should be a part of an overall vision and plan for a LTC system to support elders and their families.

There are a number of elements (Tribal sovereignty and the government-to government relationship, the unique funding structure of Indian health, and the importance of the cultural context) that distinguish AI/AN LTC. Tribes and AL/AN organizations have found it useful to look both inside and outside of the Indian Health system (IHS, Tribal, and urban Indian health programs) for LTC strategies and models.

The planning and design of LTC services must identify the revenue source(s) that will support the delivery of care. Finding resources for LTC services presents a formidable challenge. Funds appropriated through the IHS (whether direct service or Tribal) can provide healthcare services which are part of a LTC system, but do not provide for a comprehensive set of LTC services and cannot support housing or social services of a non-medical nature. Programs funded through the Administration on Aging American Indian, Alaska Native and Native Hawaiian Program (e.g. Title VI A and Title VI C Family Caregiver Support Program) have been key elements in the LTC infrastructure in AI/AN communities. Additional Older American Act resources may be available through State Units on Aging and Area Agencies on Aging. Other resources are available to provide LTC services on a reimbursable basis for eligible AI/AN elders. The majority of formal LTC services in this country are funded by reimbursements from state Medicaid and HCBS programs. The Veterans Administration may be a source of reimbursement for LTC services for eligible AI/AN veterans. Federal housing programs are a potential resource in developing the housing component of the LTC infrastructure. Each of these resources has unique eligibility requirements. Development of reimbursement-based LTC services often requires an ongoing investment of funds to support delivery of services during the initial period of client recruitment, start-up of services, and the receipt of reimbursement for those services.

This grant program is designed to provide support for the development of AI/AN LTC, with funding for either assessment and planning, or program implementation. LTC services developed with support of this grant program must be those which the IIHS has the authority to provide, either directly or through funding agreement, and must be designed to serve IRS beneficiaries. Most Tribes and urban communities are building toward their ideal LTC system incrementally, adding new or integrating existing services over time. The goal of this grant program is to support Tribes, Tribal Organizations, Tribal consortia, and Urban Indian health programs as they build LTC systems and services that meet the needs of their elders and that keep elders engaged and involved in the lives of their families and communities.

II. Award Information

Type of Awards: Grant.

Estimated Funds Available: The total amount identified for fiscal year (FY) 2008 is up to $600,000. The project period for the grants is 24 months in duration and each budget period is approximately 12 months. The award amounts are set at $50,000–$75,000 each year, depending on the project category. Continuation awards are subject to the availability of funds and satisfactory performance.

Anticipated Number of Awards: 8–10 awards will be made under this program announcement.

Project Period: Two Years (24 months).

Award Amount:

$50,000 per year for Category 1—Assessment and Planning Awards.

$75,000 per year for Category 2—Implementation Awards.

Category 1—Assessment and Planning awards will support the following activities:

a. Demographic assessment of the population and assessment of LTC needs on a population basis.

b. Evaluation of existing services and resources for LTC.

c. Evaluation of potential resources to fund LTC services.

d. Assessment of cultural and religious values regarding care of the elder for the population(s) served.

e. Assessment of elder preferences for type, structure, and setting of services.

f. Establishment of a comprehensive vision for LTC services with priorities for implementation.

g. Identification of potential funding sources for program development and for ongoing financing of service delivery.

h. The integration and incorporation of the above elements into a report or other document that guides LTC services/system implementation, including a plan for sustainability.

Category 2—Implementation awards will support the following activities: Implementation of a service or group of services that add capacity to the LTC system of the applicant's Tribe or organization. The implementation plan should be based on a comprehensive assessment and plan, including a business plan, The services should be designed to be self-sustaining at the end of the project period.

Applications must be for only one Project Type. Applications that address more than one Project Type will be considered ineligible and will be returned to the applicant. The maximum funding level includes both direct and indirect costs. Applications with budgets which exceed the maximum funding level or project period identified for a Project Type will not be reviewed.

III. Eligibility Information

1. The AI/AN applicant must be one of the following:

A. A Federally-recognized Indian Tribe; or

B. Tribal organization as defined by 25 U.S.C. 1603(e); or

C. Urban Indian organization as defined by 25 U.S.C. 1603(h); or

D. A consortium of eligible Tribes, Tribal organization or urban Indian health programs authorized by governing bodies to apply for and receive awards on their behalf under this program announcement.

Applicants must provide proof of non-profit status with the application.

2. Cost Sharing or Matching—The ECILTC Grant Program does not require matching funds or cost sharing.

3. Other Requirements:

A. A Letter of Intent (LOI) to apply is required and must be postmarked no later than May 2, 2008. The LOI is a mandatory but non-binding request for information that will assist in planning both the review and post award phase. There is no penalty for submitting a LOI and not proceeding with the grant application but a grant will not be reviewed if a LOI was not submitted. See Section IV.6.a for detailed instructions for submission of the LOI.

B. The following documentation (as applicable) is required for an application to be considered complete:

1. Tribal Resolution—A resolution of the Indian Tribe served by the project must accompany the application submission. An Indian Tribe that is proposing a project affecting another Indian Tribe must include resolutions from all affected Tribes to be served. Applications by Tribal organizations will not require a specific Tribal resolution if the current Tribal resolution(s) under which they operate would encompass the proposed grant activities. Draft resolutions are acceptable in lieu of an official resolution. However, an official signed Tribal resolution must be received by the Division of Grants Operations (DGO) prior to the beginning of the Objective Review, July 21, 2008. If an official signed resolution is not received by July 21, 2008, the application will be considered incomplete, ineligible for review, and returned to the applicant without consideration. Applicants submitting additional documentation after the initial application submission are required to ensure the information was received by the IBS by obtaining documentation confirming delivery (i.e. FedEx tracking, postal return receipt, etc.).

2. Tribal Consortium—If a consortium is submitting an application it must:

- Identify each of the consortium member Tribes.
- Identify if any of the member Tribes intend to submit a LTC grant application of their own.
- Demonstrate that Tribes, Tribal organizations, urban Indian health programs, or Tribal consortia's application does not duplicate or overlap any objectives of the other consortium members who may be submitting their own LTC grant application.

Any application received from a Consortium that does not meet the requirements above will be considered ineligible for review.

- Tribes, Tribal organizations, urban Indian health programs, or Tribal consortia's receiving Category I (Assessment and Planning funding) in the FY2006–2007 [ITIS Elder Care Initiative grant cycle will be considered ineligible for FY2008 Category I (Assessment and Planning) funding unless they can demonstrate that the current application serves a different population than the FY2006–2007 grant. (*e.g.* a consortium may target different Tribes).
- Tribes, Tribal organizations, urban Indian health programs, or Tribal consortias receiving Category II (Implementation) grants in the FY2006–2007 IHS Elder Health Care Initiative Grants cycle will be considered ineligible for FY2008 Category II (Implementation) funding unless they can demonstrate that they will be implementing an entirely new service or program (*e.g.* an applicant with current funding to implement an Adult Day Health Program may now apply for funding to implement a personal care program).

IV. Application and Submission Information

1. Applicant package may be found in Grants.gov (www.grants.gov) or at: *http://www.ihs.gov/NonMedicalPrograms/gogp/gogp_funding.asp*. Information regarding the electronic application process may be directed to Michelle G. Bulls, at (301) 443–6290.

Information regarding the Letter of Intent may be obtained from: Ms. Orlinda Platero, Office Clinical and Preventive Services, Indian Health Service, 801 Thompson Avenue, Suite 220, Rockville, Maryland 20852, (301) 443–2522, Fax: 301–594–6213.

The entire application package along with downloadable application instructions is available at: *http://www.grants.gov*. Details regarding the ECILTC Grant Program are available at: *http://www.ihs.gov/MedicalPrograms/ElderCare/*. Detailed application instructions for this announcement are downloadable on Grants.gov.

2. Content and Form of Application Submission:

- Be single spaced.
- Be typewritten.
- Have consecutively numbered pages.
- Use black type not smaller than 12 characters per one inch.
- Contain a narrative that does not exceed ten-typed pages. See Section V for instructions for the content of the narrative. The ten page narrative does not include the detailed work plan with timeline, standard forms, Tribal resolutions or letters of support (if necessary), table of contents, budget, budget justifications, budget narrative, and/or other appendix items.

Public Policy Requirements: All Federal-wide public policies apply to IRS grants with the exception of the discrimination public policy.

3. Submission Dates and Times:

Applications must be submitted electronically through Grants.gov by 12:00 midnight Eastern Standard Time (EST). If technical challenges arise and the applicant is unable to successfully complete the electronic application process, the applicant should contact Grants Policy Staff (UPS) at (301) 443–6290 at least fifteen days prior to the application deadline and advise of the difficulties that your organization is experiencing. The grantee must obtain prior approval, in writing (e-mails are acceptable) allowing the paper submission. If submission of a paper application is requested and approved, the original and two copies may be sent to the appropriate grants contact that is listed in Section P1.2., above. Applications not submitted through Grants.gov, without an approved waiver, may be returned to the applicant without review or consideration. Late applications will not be accepted for processing, will be returned to the applicant, and will not be considered for funding.

4. Intergovernmental Review:

Executive Order 12372 requiring intergovernmental review is not applicable to this program.

5. Funding Restrictions:

- Pre-award costs are allowable pending prior approval from the awarding agency. However, in accordance with 45 CFR Part 74, all pre-award costs are incurred at the recipient's risk. The awarding office is under no obligation to reimburse such costs if for any reason the applicant does not receive an award or if the award to the recipient is less than anticipated.
- The available funds are inclusive of direct and appropriate indirect costs.
- Only one grant will be awarded per applicant.
- IHS will not acknowledge receipt of applications.

6. Other Submission Requirements:

- If the applicant is unable to submit via Grants.gov and obtains a waiver from the standard application requirements, please use the following forms: SF–424, 424A, 424B, and certification forms, as appropriate. One original and two copies must be submitted to: attn: Norma Jean Dunne; Division of Grants Operations; 801 Thompson Avenue, Rockville, MD 20852. Copies of the forms may be found at: *http://www.ihs.gov/*

NonMedicalPrograms/gogp/index.cfm?module=forms. Applications are due by June 20, 2008.

• A LOI to apply is required and must be postmarked no later than May 2, 2008. The LOI is a mandatory but non-binding request for information that will assist in planning both the review and post award phase. There is no penalty for submitting a LOI and not proceeding with the grant application, but a grant will not be reviewed if a LOI was not submitted. Applicants will be notified by fax or e-mail that their LOI has been received, as it is received.

The LOI should be sent to Ms. Orlinda Platero at the following address: Ms. Orlinda Platero, Office Clinical and Preventive Services, Indian Health Service, 801 Thompson Avenue, Suite 326, Rockville, Maryland 20852, Telephone: (301) 443–2522, Fax: (301) 594–6213, E-mail: *Orlinda.Platero@ihs.gov.*

The LOI must contain:

• The name of the applying organization.

• The individual who is responsible for correspondence regarding the application, and contact information for that individual. Please indicate whether fax or e-mail notification of receipt of LOI is preferred, and provide e-mail address and/or fax number.

• The name of all member Tribes if the applicant is a Tribal Consortium and those Tribes involved in the proposal.

• Whether the intent is to apply for a Category I or Category II grant.

Electronic Submission—The preferred method for receipt of applications is electronic submission through Grants.gov. However, should any technical challenges arise regarding the submission, please contact Grants.gov Customer Support at 1–800–518–4726 or *support@grants.gov.* The Contact Center hours of operation are Monday–Friday from 7 a.m. to 9 p.m. EST. The applicant must seek assistance at least fifteen days prior to the application deadline. Applicants that don't adhere to the timelines for Central Contractor Registry (CCR) and/or Grants.gov registration and/or requesting timely assistance with technical issues will not be a candidate for paper applications.

To submit an application electronically, please use *http://www.Grants.gov* and select the "Apply for Grants" link on the home page. Download a copy of the application package on the Grants.gov Web site, complete it offline and then upload and submit the application via the Grants.gov site. You may not e-mail an electronic copy of a grant application to IHS.

Please be reminded of the following:

• Under the new IHS application submission requirements, paper applications are not the preferred method. However, if you have technical problems submitting your application on-line, please contact directly Grants.gov Customer Support at: *http://www.grants.gov/CustomerSupport.*

• Upon contacting Grants.gov, obtain a tracking number as proof of contact. The tracking number is helpful if there are technical issues that cannot be resolved and a waiver request from GPS must be obtained.

• If it is determined that a formal waiver is necessary, the applicant must submit a request, in writing (emails are acceptable), to *Michelle.Bulls@ihs.gov* that includes a justification for the need to deviate from the standard electronic submission process. Upon receipt of approval, a hard-copy application package must be downloaded by the applicant from: *http://www.ihs.gov/NonMedicalPrograms/gogp/index.cfm?rmodule=forms.* Please use the following forms for the standard application requirements: SF–424, 424A, 424B, and certification forms, as appropriate. One original and two copies must be submitted to: Attn: Norma Jean Dunne; Division of Grants Operations; 801 Thompson Avenue, TMP 360, Rockville, MD 20852 by the application due date of June 20, 2008.

• Upon entering the Grants.gov site, there is information available that outlines the requirements to the applicant regarding electronic submission of an application through Grants.gov, as well as the hours of operation. We strongly encourage all applicants not to wait until the deadline date to begin the application process through Grants.gov as the registration process for CCR and Grants.gov could take up to fifteen working days.

• To use Grants.gov, you, as the applicant, must have a Data Universal Numbering System (DUNS) number and register in the CCR. You should allow a minimum often days working days to complete CCR registration. See below on how to apply.

• You must submit all documents electronically, including all information typically included on the SF–424 and all necessary assurances and certifications.

• Please use the optional attachment feature in Grants.gov to attach additional documentation that may be requested by IHS.

• Your application must comply with any page limitation requirements described in the program announcement.

• After you electronically submit your application, you will receive an automatic acknowledgment from Grants.gov that contains a Grants.gov tracking number. The IRS, DGO will download your application from Grants.gov and provide necessary copies to the cognizant program office. DGO will not notify applicants that the application has been received.

• You may access the electronic application for this program on *http://www.Grants.gov.*

• You may search for the downloadable application package either by the CFDA number or the Funding Opportunity Number. Both numbers are identified in the heading of this announcement.

• The applicant must provide the Funding Opportunity Number: HHS–2008–IHS–EHC–0001. E-mail applications will not be accepted under this announcement.

DUNS Number

Applicants are required to have a DUNS number to apply for a grant or cooperative agreement from the Federal Government. The DUNS number is a nine-digit identification number, which uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access *http://www.dunandbradstreet.com* or call 1–866–705–5711. Interested parties may wish to obtain their DUNS number by phone to expedite the process.

Applications submitted electronically must also be registered with the CCR. A DUNS number is required before CCR registration can be completed. Many organizations may already have a DUNS number. Please use the number listed above to investigate whether or not your organization has a DUNS number. Registration with the CCR is free of charge.

Applicants may register by calling 1–888–227–2423. Please review and complete the CCR Registration Worksheet located on *http://www.grants.gov/CCRRegister.*

More detailed information regarding these registration processes can be found at *http://www.grants.gov.*

V. Application Review Information

Note: Only those programs or services which the IHS is authorized to provide, either directly or through funding agreement, can be supported by this grant program. UNLESS CONGRESS PROVIDES OTHERWISE, those services which are primarily housing or custodial in nature are not eligible for support (*e.g.* assisted living facility, board and care, or nursing home which is primarily custodial in nature). Supportive services delivered in those facilities, with the intent to promote the health and wellness of elders, are eligible for

funding. Programs and services developed with support of this grant program must be designed for the benefit of IHS beneficiaries.

The instructions for preparing the application narrative also constitute the evaluation criteria for reviewing and scoring the application. Weights assigned to each section are noted in parentheses. The narrative should include only the first year of activities; information for multi-year projects should be included as an appendix. See "Multi-year Project Requirements" at the end of this section for more information. The narrative section should be written in a manner that is clear to outside reviewers unfamiliar with prior related activities of the applicant. It should be well organized, succinct, and contain all information necessary for reviewers to understand the project fully.

1. Criteria

A. Category I (Assessment and Planning)

1. Introduction and Need for Assistance (35 Points)

Provide an understanding of the LTC needs of the elderly in the Tribe or service area and identify the additional information needed for planning. The number of elders that will be affected by the program will be considered a factor in the review as will the relationship of the amount of funding requested to the number of elders to be served. The applicant should use the best data available, understanding that, for most programs, many of these data elements will not be available or be poor in quality and that improved data for future planning will be an outcome of this grant-funded project. Data that is not available should be noted as such and addressed in the work plan (Section 2). Identify all information sources.

a. Currently available information for use in planning and service development:

i. Currently available information regarding population and need for services.

1. Demographics of the population and assessment of LTC needs on a population basis.

2. Geographic and social factors, including availability of caregivers.

3. Cultural and religious values regarding care of the elder for the population(s) to be served.

4. Elder preferences for type, structure, and setting of services.

ii. Currently available information regarding existing services and resources for LTC:

1. Availability and organization of existing aging and LTC services, including services available to Tribal or community members provided by non-Tribal/non-AI/AN organization programs.

2. Availability and organization of health services for the elderly, including Native healing systems.

3. Assessment of the capacity of available LTC services to support care provided "in the most integrated setting appropriate to the needs of qualified individuals with disabilities" (*Olmstead* v. *L.C*).

4. Assessment of caregiver workforce.

iii. Funding streams currently paying for LTC services.

iv. Current collaborations in program development or service delivery.

b. Current vision for LTC system/services and priorities for development.

c. Elder care assessment and planning activities within the past ten years:

i. Funding sources.

ii. Dates of funding.

iii. Summary of project accomplishments.

iv. Relationship to the current proposal. Copies of reports will not be accepted.

d. Unmet need for LTC services.

e. Information needed for planning and service implementation which is not currently available.

2. Work Plan (35 Points)

This section should demonstrate the soundness and effectiveness of the applicant's proposal. The work plan should be designed to produce as an end product the readiness to develop LTC service(s) and should include all information not already available. For an example of the information needed to demonstrate readiness to develop LTC service(s), see Section 1 Introduction and Need for Assistance in the Category II Implementation criteria.

Note that attendance and presentation at the AI/AN Long Term Care Conference and participation in periodic grantee teleconferences are a requirement of the grant and should be included as activities in the work plan.

a. State the proposed assessment or planning process.

b. List the objectives clearly.

i. Identify the data elements needed.

ii. Indicate the function of each data element in the plan.

c. Describe the approach to the project.

i. Tasks.

ii. Resources needed to implement and complete the project.

iii. Timeline.

iv. Specialized technical resources for data collection or analysis.

v. Training needs.

- Include in work plan attendance and presentation at the annual AI/AN Long Term Care Conference.

d. Identify the final product of the assessment/plan and the strategy for dissemination.

e. Submit a work plan in the appendix which includes the following information:

i. Action steps on a time line for implementation of the work plan.

ii. Identify who will perform the action steps.

iii. Identify who will supervise the action steps.

iv. Identify who will accept and/or approve work products at the end of the proposed project.

v. Include any additional training that will take place during the proposed project, who will conduct the training, and who will be attending the training.

vi. Include the following information if consultants or contractors will be used during the proposed project, their position description and scope of work (or note if consultants/contractors will not be used):

- Educational requirements.
- Desired qualifications and work experience.
- Expected work products.
- Contractor's supervisor.
- Include a resume and letter of commitment in the appendix for potential consultant/contractor.

3. Project Evaluation (10 Points)

This section should show how progress on this project will be assessed and how the success of this project will be judged.

a. Describe and list outcomes by which this project will be evaluated. Each proposed project objective and task of the work plan should be evaluated and the evaluation activities should appear on the work plan.

b. Identify the responsible person for the evaluation (need not be an outside evaluator).

4. Organizational Capabilities and Qualifications (10 Points)

This section outlines the broader capacity of the Tribe, Tribal organization, or urban health program to complete the project outlined in the work plan. It includes the identification of personnel responsible for completing tasks and chain of responsibility for successful completion of the project outlined in the work plan.

a. Describe the organizational structure of the Tribe/Tribal organization beyond health care activities.

b. Describe the ability of the organization to manage the proposed project. Include information regarding similarly sized projects in scope and financial assistance as well as other

grants and projects successfully completed.

c. Describe what equipment (i.e., fax machine, phone, computer, etc.) and facility space (*i.e.*, office space) will be available for use during the proposed project. Include information about any equipment not currently available that will be purchased through the grant.

d. List key personnel who will work on the project.

i. Identify existing personnel and new program staff to be hired.

ii. Include in the appendix, position descriptions and resumes for all key personnel. Position descriptions should clearly describe each position and duties, indicating desired qualifications experience, requirements related to the proposed project and how they will be supervised. Resumes must indicate that the proposed staff member is qualified to carry out the proposed project activities and who will determine if the work of a contractor is acceptable.

iii. Note who will be writing the progress reports.

iv. Indicate if a position is to be filled for a proposed position description.

v. Note and address how additional personnel beyond those covered by the grant funds, (i.e., IT support, volunteers, interviewers, etc.), will be filled and if funds are required, list the funding source.

vi. Indicate the percentage of time to be allocated to this project and identify the resources used to fund the remainder of the individual's salary if personnel are to be only partially funded by this grant.

5. Categorical Budget and Budget Justification (10 Points)

This section should provide a clear estimate of the project program costs and justification for expenses for the entire grant period. The budget and budget justification should be consistent with the tasks identified in the work plan.

a. Categorical budget (Form SF 424A, Budget Information Non Construction Programs) completing each of the budget periods requested.

b. Include a narrative justification for all costs, explaining why each line item is necessary or relevant to the proposed project. Include sufficient details to facilitate the determination of cost allowability.

c. Indicate any special start-up costs.

d. Include a brief program narrative budget justification for the second year.

e. If indirect costs are claimed, indicate and apply the current negotiated rate to the budget. Include a copy of the rate agreement in the appendix.

B. Category II (Program Implementation)

1. Introduction and Need for Assistance (35 points)

Provide an understanding of current need for and availability of LTC services for the elderly in the Tribe or service area. Identify the number of elders to be served. The number of elders that will be affected by the program will be considered a factor in the review as will the relationship of the amount of funding requested to the number of elders to be served. Demonstrate the necessary assessment and planning to successfully implement new service(s) and show that the services fit within a comprehensive vision or plan for elder care. If significant elements listed below are not available, programs should consider applying for Category I funding to support the assessment and planning activities necessary for successful program development.

a. Demographic assessment of the population and assessment of LTC needs on a population basis.

i. Population distribution. Number of elderly of different age and gender groups in the population.

ii. Rates of functional impairment and numbers of elders with need for assistance in activities in daily living with adequate detail to project need for services.

b. Geographic and social factors that affect access to services and availability of caregivers.

i. Rural vs. urban; population density.

ii. Family structure and organization.

c. Assessment of cultural and religious values regarding care of the elder for the population(s) to be served.

d. Assessment of elder preferences for type, structure, and setting of services.

e. Evaluation of existing services and resources for LTC.

i. Availability and organization of existing aging and LTC services. Include services available to Tribal or community members provided by programs or organizations that are not Tribal or AI/AN organizations.

ii. Availability and organization of health services for the elderly, including Native healing systems.

iii. Capacity of existing LTC services to support care provided "in the most integrated setting appropriate to the needs of qualified individuals with disabilities" (*Olmstead* v. *L.C*).

f. Assessment of caregiver workforce.

i. Availability of potential caregivers (formal and informal).

ii. Training resources for formal and informal caregivers.

g. Identification of potential resources for new LTC service.

i. Funding for program development.

ii. Funding for ongoing service delivery.

iii. Potential partners in program development.

h. Relevant Federal, 11-IS, Tribal and/or State standards, laws and regulations and codes and relevant licensure or certification requirements.

i. A comprehensive vision or plan for LTC systems/services which incorporates the information above and identifies priorities for implementation.

j. Unmet need for LTC services.

2. Work Plan (35 points)

This section should demonstrate the soundness and effectiveness of the applicant's proposal. This includes both the work plan for program implementation and the underlying plan or strategy for sustainability of the service(s) past the point of grant support. Note that attendance and presentation at the AI/AN LTC Conference and participation in periodic grantee teleconferences are a requirement of the grant and should be included as activities in the work plan.

a. Identify the LTC service(s) to be implemented and:

i. Show how it is consistent with the results of the assessment/planning process described above (Introduction and Need for Assistance).

ii. Integrates with existing LTC and health services.

b. Summarize the business plan or plan for self-sufficiency and sustainability, including:

i. Funding stream(s) to support ongoing services.

ii. Clearly indicate whether the program will be self-supporting (and if so, when) or not. If not self-supporting, what will be the source of additional revenue for services?

iii. Timeline with projections for client recruitment, expected revenue and shortfalls, resources for funds needed to bridge between onset of services and collection of reimbursement, etc.

iv. Licensure or certification requirements.

v. Indicate if Tribal revenue is expected to pay in part or in whole for services. A letter from the Tribal Council or administration indicating that these funds have been budgeted for this purpose should be included in the appendix.

c. Describe the approach to implementation.

i. Tasks.

ii. Resources needed to implement and complete the project.

iii. Timeline for implementation.

iv. Specialized technical resources.

v. Training needs.

• Include in work plan attendance and presentation at the annual AI/AN Long Term Care Conference.

vi. Consultation needs (if any).

d. Include a detailed work plan in the appendix, containing the following information:

i. Action steps on a time line for implementation of the work plan.

ii. Identify who will perform the action steps.

iii. Identify who will supervise the action steps.

iv. Identify who will accept and/or approve work products at the end of the proposed project.

v. Include any additional training that will take place during the proposed project,

vi. Include the following information if consultants or contractors will be used during the proposed project, their position description and scope of work (or note if consultants/contractors will not be used):

• Educational requirements.

• Desired qualifications and work experience.

• Expected work products.

• Contractor's supervisor.

• Include a resume and letter of commitment in the appendix for potential consultant/contractor.

e. Include a detailed business plan in the appendix, containing the following information:

i. Timeline with detailed expense and revenue projections.

ii. Timeline with client recruitment projections.

iii. Timeline with licensure or certification requirements and tasks.

iv. Identification of shortfall funding during implementation with documentation of the availability of budgeted funds to support the program until it is self-sustaining (if applicable).

3. Project Evaluation (10 Points)

This section should show how progress on this project will be assessed and how the success of this project will be judged.

a. Specifically list and describe the outcomes by which this project will be evaluated.

b. Identify the evaluator and/or the individual with responsibility for the evaluation (need not be an outside evaluator).

c. Each proposed project objective and task of the work plan should be able to be evaluated and the evaluation activities should appear on the work plan.

4. Organizational Capabilities and Qualifications (10 Points)

This section outlines the broader capacity of the Tribe, Tribal organization, or urban health program to complete the project outlined in the work plan. This includes the identification of personnel responsible for completing tasks and chain of responsibility for successful completion of the project outlined in the work plan.

a. Describe the organizational structure of the Tribe/Tribal organization beyond health care activities.

b. If management systems are already in place, simply note it.

c. Describe the ability of the organization to manage the proposed project. Include information regarding similarly sized projects in scope and financial assistance as well as other grants and projects successfully completed.

d. Describe what equipment (*i.e.*, fax machine, phone, computer, etc.) and facility space (*i.e.*, office space) will be available for use during the proposed project. Include information about any equipment not currently available that will be purchased through the grant.

e. List key personnel who will work on the project.

i. Identify existing personnel and new program staff to be hired.

ii. Include position descriptions and resumes for all key personnel in the appendix. Position descriptions should clearly describe each position and duties, indicating desired qualifications experience, requirements related to the proposed project and how they will be supervised. Resumes must indicate that the proposed staff member is qualified to carry out the proposed project activities and who will determine if the work of a contractor is acceptable.

iii. Note who will be writing the progress reports.

iv. Indicate if a position is to be filled for a proposed position description.

v. Note and address how additional personnel beyond those covered by the grant funds, (*i.e.*, IT support, volunteers, interviewers, etc.), will be filled and if funds are required, list the funding source.

vi. Indicate the percentage of time to be allocated to this project and identify the resources used to fund the remainder of the individual's salary if personnel are to be only partially funded by this grant.

5. Categorical Budget and Budget Justification (10 Points)

This section should provide a clear estimate of the project program costs and justification for expenses for the entire grant period. The budget and budget justification should be consistent with the tasks identified in the work plan.

a. Categorical budget (Form SF 424A, Budget Information Non-Construction Programs) completing each of the budget periods requested.

b. Include a narrative justification for all costs, explaining why each line item is necessary or relevant to the proposed project. Include sufficient details to facilitate the determination of cost allowability.

c. Indicate any special start-up costs.

d. Include a brief program narrative budget justification for the second year.

e. Indicate and apply the current negotiated rate to the budget if indirect costs are claimed. Include a copy of the rate agreement in the appendix.

2. Review and Selection Process

In addition to the above criteria/requirements, applications are considered according to the following:

a. Letter of Intent Submission (Deadline: May 2, 2008); and

b. Application Submission (Application Deadline: June 20, 2006). Applications submitted in advance of or by deadline and verified by the postmark will undergo a preliminary review to determine that:

• The applicant and proposed project type is eligible in accordance with this grant announcement.

• The application is not a duplication of a previously funded project.

• The application narrative, forms, and materials submitted meet the requirements of the announcement allowing the review panel to undertake an in-depth evaluation; otherwise, it may be returned.

c. Competitive Review of Eligible Applications (Objective Review: July 21–August 1, 2008).

Applications meeting eligibility requirements that are complete, responsive, and conform to this program announcement will be reviewed for merit by the Ad Hoc Objective Review Committee (ORC) appointed by the IHS to review and make recommendations on these applications. The review will be conducted in accordance with the IHS Objective Review Guidelines. The technical review process ensures selection of quality projects in a national competition for limited funding. Applications will be evaluated and rated on the basis of the evaluation criteria listed in Section V.1. and V.2. The criteria are used to evaluate the quality of a proposed project, determine the likelihood of success, and assign a numerical score to each application. The scoring of approved applications will assist the IHS in determining which proposals will be funded if the amount of funding is not sufficient to support all approved applications. Applications

recommended for approval, having a score of 60 or above by the ORC and scored high enough to be considered for funding, are ranked. Additional considerations in final ranking include: geographic diversity among funded programs, diversity in population size among Tribes and communities served by funded programs, and unique features with regard to type of program planned or population served. Applications scoring below 60 points will be disapproved and returned to the applicant. Applications that are approved but not funded will not be carried over into the next cycle for funding consideration.

3. Anticipated Announcement and Award Dates

Anticipated Award Notification: August 18, 2008.

Anticipated Award Start Date: September 1, 2008.

VI. Award Administration Information

1. Award Notices

The Notice of Award (NoA) will be initiated by DGO and will be mailed via postal mail to each entity that is approved for funding under this announcement. The NoA will be signed by the Grants Management Officer, and this is the authorizing document for which funds are dispersed to the approved entities. The NoA will serve as the official notification of the grant award and will reflect the amount of Federal funds awarded, the purpose of the grant, the terms and conditions of the award, the effective date of the award, and the budget/project period. The NoA is the legally binding document. Applicants who are approved but unfunded or disapproved based on their Objective Review score will receive a copy of the Executive Summary which identifies the weaknesses and strengths of the application submitted.

2. Administrative Requirements

Grants are administrated in accordance with the following documents:

- This Program Announcement.
- Administrative Requirements: 45 CFR Part 92, "Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local and Tribal Governments," or 45 CFR Part 74, "Uniform Administrative Requirements for Awards to Institutions of Higher Education, Hospitals, Other Non-Profit Organizations, and Commercial Organizations."
- Grants Policy Guidance: HHS Grants Policy Statement, January 2007.
- Cost Principles: OMB Circular A–87, "State, Local, and Indian" (Title 2 Part 225).
- Cost Principles: OMB Circular A–122, "Non-profit Organizations" (Title 2 Part 230).
- Audit Requirements: OMB Circular A–133, "Audits of States, Local Governments, and Non-profit Organizations."

3. *Indirect Costs:* This section applies to all grant recipients that request reimbursement of indirect costs in their grant application. In accordance with HHS Grants Policy Statement, Part 11–27, IHS requires applicants to have a current indirect cost rate agreement in place prior to award. The rate agreement must be prepared in accordance with the applicable cost principles and guidance as provided by the cognizant agency or office. A current rate means the rate covering the applicable activities and the award budget period. If the current rate is not on file with the DGO at the time of award, the indirect cost portion of the budget will be restricted and not available to the recipient until the current rate is provided to the DGO.

Generally, indirect costs rates for IFIS grantees are negotiated with the Division of Cost Allocation (DCA) *http://rates.psc.gov/* and the Department of Interior (National Business Center) *http://www.nbc.gov/acquisition/ics/icshome.html.* If your organization has questions regarding the indirect cost policy, please contact the DGO at (301) 443–5204.

4. Reporting

A. Progress Report. Program progress reports are required within 30 days of the completion of the semi annual report. These reports will include a brief comparison of actual accomplishments to the goals established for the period, or, if applicable, provide sound justification for the lack of progress, and other pertinent information as required. A final report must be submitted within 90 days of expiration of the budget/project period.

B. Financial Status Report. Semi-annual financial status reports must be submitted within 30 days of the end of the half year. Final financial status reports are due within 90 days of expiration of the budget/project period. Standard Form 269 (long form) will be used for financial reporting.

C. Reports. Grantees are responsible and accountable for accurate reporting of the Progress Reports and Financial Status Reports which are generally due semi-annually. Financial Status Reports (SF–269) are due 90 days after each budget period and the final SF–269 must be verified from the grantee records on how the value was derived. Grantees must submit reports in a reasonable period of time.

Failure to submit required reports within the time allowed may result in suspension or termination of an active grant, withholding of additional awards for the project, or other enforcement actions such as withholding of payments or converting to the reimbursement method of payment. Continued failure to submit required reports may result in one or both of the following: (1) the imposition of special award provisions; and (2) the non-funding or non-award of other eligible projects or activities. This applies whether the delinquency is attributable to the failure of the grantee organization or the individual responsible for preparation of the reports.

5. Telecommunication for the hearing impaired is available at: TTY (301) 443–6394.

VII. Agency Contact(s)

For program-related information regarding the IHS Elder Care Program: Bruce Finke, MD, Nashville Area Elder Health Consultant, 45 Vernon Street, Northampton, MA 01060, (413) 584–0790, *bruce.flnke@ihs.gov.*

For general information regarding this announcement: Ms. Orlinda Platero, Office Clinical and Preventive Services, Indian Health Service, 801 Thompson Avenue, Suite 326, Rockville, Maryland 20852, (301) 443–2522, Fax: (301) 594–6213.

For specific grant-related and business management information: Ms. Norma Jean Dunne, Division of Grant Operations, Indian Health Service, 801 Thompson Avenue, TMP 360–79, Rockville, Maryland 20852, (301) 443–5204, Fax: (301) 443–9602.

VIII. Other Information

The Department of Health and Human Services (HHS) is committed to achieving the health promotion and disease prevention objectives of Healthy People 2010, a HHS led activity for setting priority areas. This project will aid the accomplishment of Healthy People 2010 Focus Area 1—Access. Specifically, it will aid the accomplishment of objective 1–15, "Increase the proportion of persons with long-term care needs who have access to the continuum of long-term care services." Potential applicants may obtain a printed copy of Healthy People 2010, (Summary Report No, 017–001–00549–5) or CD-ROM, Stock No. 0 17–001–00549–5, through the Superintendent of Documents, Government Printing Office, P.O. Box

371954, Pittsburgh, PA 15250–7945, (202) 512–1800. You may also access this information at the following Web site; *http://www.healthypeople.gov/Publications.*

The IHS is focusing efforts on three Health Initiatives that, linked together, have the potential to achieve positive improvements in the health of AI/AN people. These three initiatives are Health Promotion/Disease Prevention, Management of Chronic Disease, and Behavioral Health. Further information is available at the Health Initiatives Web site: *http://www.ihs.gov/NonMedicalPrograms/DirInitiatives/index.cfm.*

Dated: March 24, 2008.

Robert G. McSwain,

Acting Director, Indian Health Service.

[FR Doc. E8–6409 Filed 3–28–08; 8:45 am]

BILLING CODE 4165–16–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

RIN 0917–ZA22

Reimbursement Rates for Calendar Year 2008

AGENCY: Indian Health Service, HHS.

ACTION: Notice.

SUMMARY: Notice is given that the Director of Indian Health Service (IHS), under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Public Law 83–568 (42 U.S.C. 2001 (a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 *et seq.*), has approved the following rates for inpatient and outpatient medical care provided by IHS facilities for Calendar Year 2008 for Medicare and Medicaid beneficiaries and beneficiaries of other Federal programs. The Medicare Part A inpatient rates are excluded from the table below as they are paid based on the prospective payment system. Since the inpatient rates set forth below do not include all physician services and practitioner services, additional payment may be available to the extent that those services meet applicable requirements. Public Law 106–554, section 432, dated December 21, 2000, authorized IHS facilities to file Medicare Part B claims with the carrier for payment for physician and certain other practitioner services provided on or after July 1, 2001.

INPATIENT HOSPITAL PER DIEM RATE (EXCLUDES PHYSICIAN/PRACTITIONER SERVICES)

[Calendar Year 2008]

Lower 48 States	$1,811
Alaska	2,255
Outpatient per Visit Rate (Excluding Medicare)	
Lower 48 States	$253
Alaska	423
Outpatient per Visit Rate (Medicare)	
Lower 48 States	$215
Alaska	365
Medicare Part B Inpatient Ancillary per Diem Rate	
Lower 48 States	$373
Alaska	650
Outpatient Surgery Rate (Medicare)	
Established Medicare rates for freestanding Ambulatory Surgery Centers	

Effective Date for Calendar Year 2008 Rates

Consistent with previous annual rate revisions, the Calendar Year 2008 rates will be effective for services provided on/or after January 1, 2008 to the extent consistent with payment authorities including the applicable Medicaid State plan.

Dated: November 29, 2007.

Robert G. McSwain,

Acting Director, Indian Health Service.

Editorial Note: This document was received at the Office of the Federal Register on March 25, 2008.

[FR Doc. E8–6431 Filed 3–28–08; 8:45 am]

BILLING CODE 4165–16–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Tribal Self-Governance Program; Negotiation Cooperative Agreement

Announcement Type: New.

Funding Announcement Number: HHS–2008–IHS–TSGP–0001.

Catalog of Federal Domestic Assistance Numbers(s): 93.210.

Key Dates: Application Deadline Date: April 28, 2008.

Review Date: May 8–9, 2008.

Earliest Anticipated Start Date: June 1, 2008.

I. Funding Opportunity Description

The purpose of the program is to award cooperative agreements that provide negotiation resources to Tribes interested in participating in the Tribal Self-Governance Program (TSGP) as authorized by Title V, Tribal Self-Governance Amendments of 2000 of the Indian Self-Determination and Education Assistance Act of Public Law (Pub. L.) 93–638, as amended. There is limited competition under this announcement because the authorizing legislation, Public Law 106–260, Title V, restricts eligibility to Tribes that meet specific criteria (Refer to Section III.1.A., ELIGIBLE APPLICANTS in this announcement). The TSGP is designed to promote self-determination by allowing Tribes to assume more control of Indian Health Service (IHS) programs and services through compacts negotiated with the IHS. The Negotiation Cooperative Agreement provides Tribes with funds to help cover the expenses involved in preparing for and negotiating with the IHS and assists eligible Indian Tribes to prepare Compacts and Funding Agreements (FAs). This program is described at 93.210 in the Catalog of Federal Domestic Assistance (CFDA).

The Negotiation Cooperative Agreement provides resources to assist Indian Tribes to conduct negotiation activities that include but are not limited to:

1. Determine what programs, services, functions, and activities (PSFAs) will be negotiated.
2. Identification of Tribal shares that will be included in the FA.
3. Development of the terms and conditions that will be set forth in the FA.

The award of a Negotiation Cooperative Agreement is not required as a prerequisite to enter the TSGP. Indian Tribes that have completed comparable health planning activities in previous years using Tribal resources but have not received a Tribal self-governance planning award are also eligible to apply.

II. Award Information

Type of Awards: Cooperative Agreement.

Estimated Funds Available: The total amount identified for Fiscal Year (FY) 2008 is $240,000 for approximately twelve (12) Tribes. Awards under this announcement are subject to the availability of funds.

Anticipated Number of Awards: The estimated number of awards under the program to be funded is approximately 12.

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April 9, 2008

General Memorandum 08-050

Senator Dorgan Solicits Input on IHS Contract Health Services

Senate Committee on Indian Affairs Chairman Dorgan is soliciting information and recommendations from tribal leaders and others regarding the Indian Health Service's (IHS) contract health services (CHS) program in preparation for a hearing on CHS. The hearing date has not yet been set.

Attached is the letter Senator Dorgan sent to tribal leaders requesting input for the hearing.

The CHS program provides funding to purchase health care for IHS beneficiaries from non-IHS providers. The person must meet the IHS medical priorities to be eligible to be served by the contract health services program. The IHS describes the situations in which CHS funds are used:

- There is no available IHS direct care facility
- The direct care facility cannot provide the required emergency or specialty services
- The direct care facility has an overflow of medical care workload

The CHS program funds always fall short of need. The FY 2008 CHS appropriation is $579 million and within that amount is $27 million for the Catastrophic Health Emergency Fund.

We urge you to take this opportunity to share your tribe's specific experiences with regard to the CHS program – i.e., its importance to your members, the portion of the year for which your CHS funds last, your ability to utilize the CHEF program, whether you have had any problems with the IHS medical criteria for the CHS program, how the Medicare-like rates may have made your CHS funds go farther, experiences with non-IHS providers when referring IHS beneficiaries to their facilities.

Please let us know if we may provide additional information or assistance in drafting a response to Senator Dorgan regarding IHS contract health services and/or the upcoming Senate Committee on Indian Affairs hearing on this important program.

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Inquiries may be directed to:
Bobo Dean (sdean@hsdwdc.com)
Geoff Strommer (gstrommer@hsdwor.com)

http://indian.senate.gov

United States Senate

COMMITTEE ON INDIAN AFFAIRS
WASHINGTON, DC 20510–6450

March 27, 2008

Dear Tribal Leader,

I am writing to seek your input on the current Indian health care system. As Chairman of the Senate Committee on Indian Affairs, improving the Indian health care system is one of my top priorities. During a recent hearing regarding the confirmation of Robert McSwain to be Director of the Indian Health Service, it was clear that there are significant problems in the overall functioning of the current system. With your help, I hope to make great improvements in the system during my Chairmanship.

As a part of this effort, I am working very hard to secure reauthorization of the Indian Health Care Improvement Act. In early 2007, I introduced the *Indian Health Care Improvement Act Amendments* (S. 1200), which was recently passed by the Senate in a resounding 83-10 vote. This bill both improves existing Indian health programs and authorizes vital new programs. The bill is now pending before the House of Representatives, and I will work with my colleagues in the House to get a bill to the President as soon as possible.

However, as you know, that bill is only a part of the solution to the problems faced by the current Indian health care system. More needs to be done.

In response to complaints and comments by tribal leaders, individual Indians and health care providers, I plan to hold a hearing soon on the Contract Health Services program. This program allows Indian health clinics and hospitals to obtain services from outside contractors when the clinics and hospitals cannot provide these services. However, the program is not working well, and many individual Indians are often faced with having to pay enormous bills that are supposed to be covered by the federal government.

In preparation for this hearing, I would greatly appreciate any input or comments you or your members can provide. Thoughts about how the current

Contract Health Services program is working and any problems that your community faces regarding health care will be beneficial.

Please send your suggestions to me by either:

- Fax: (202) 228-2589;
- Email: comments@indian.senate.gov; or
- In writing:

Senator Byron L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, D.C. 20510

I look forward to working with you to bring about meaningful reform in the area of Indian health.

Sincerely,

BYRON L. DORGAN

Idaho State Tribe Meeting

Evaluation Questions

Coeur d' Alene
Benewah Wellness Center

May 6, 2008

1. Have you accessed the meeting handout distribution that was posted on NPAIHB's website from the prior meeting? Yes___ No___

Six of eleven respondents indicated that they did access the web-posted hand outs.

2. If so, was this helpful? Yes___ No___
   Any suggestions for improvements?:

All six respondents referred to above indicated these web-posted hand outs were helpful.

3. On a scale of 1 to 4 (with 4 being the highest), to what extent has the Idaho State Tribe Meeting benefitted your program? 1 2 3 4
   Please elaborate:

The average rating is 3.6, indicating participants (State and Tribal) truly value these meeting and find benefit to their respective programs. One respondent indicated that this question was not applicable to him or her.

Participant comments:

- *Learn about new programs – Changes + get problems solved*
- *Updates*

4. How well did the Business Day agenda (May 5, 2008) meet your tribe's needs? (1=did not meet needs; 4=agenda fully met needs) 1 2 3 4

   What suggestions do you have to improve the development of the Business Day agenda?

Three respondents either did not respond or indicated that this question was not applicable to him/her. Of the eight others, the average for the responses came to 3.25. One constructive suggestion was provided: "Business agenda items need to be held in Boise so people [from the] State can attend to answer." No other comments or suggestions were provided.

5. How well did the regular Meeting Day agenda (May 6, 2008) meet your tribe's needs? (1=did not meet needs; 4=agenda fully met needs) 1 2 3 4
   What suggestions do you have to improve the development of the Meeting Day agenda?

Two respondents indicated that this was not applicable to him/her or did not respond. The average score for the remainder of the respondents is 3.56. No comments were submitted for this question.

6. Are the materials provided at the meetings useful? Yes___ No___
   Please elaborate.

All eleven respondents indicated that the handouts were useful. One comment was offered: "Power Point – don't have to write so much."

7. What additional services or resources would you like NPAIHB (Verné Boerner) to provide for you?

Three comments offered which indicated that at this time each had no recommendations on additional services or resources. Words of appreciation were offered to the planners and staff for these meetings.

8. What are the strengths of the Idaho State Tribes meeting?

Ten of the eleven individuals responded to this question:

- *National + State updates critical to keeping current with changes*
- *To hear other tribes' concerns + get answers or refer to next agenda*
- *Net-working w/ other tribes + resources*
- *Continued communication between the State of Idaho + tribes is very important*
- *Updated information + opportunity to network. More input from State offices when held in Boise.* [VFB note: this comment was offered by a separate individual than that of the individual commenting on the Business Day agenda, indicating that folks notice a different level of participation when meetings are held in Boise. In my discussions with Jim Roberts, he indicated that it was the design of this group to alter the meetings from tribal sites and Boise; returning to Boise every other meeting. This was designed to keep balance while maximizing State exposure to tribal issues and tribes' access to state employees/programs and information.]
- *Working together – communication*
  Staying abreast on what is happening
- *Networking*
- *See #3* [#3 comments were: Learn about new programs – Changes + get problems solved]
- *Keeping tribes in touch w/ what's going on w/ state + tribal programs*
- *Acts as a conduit between tribes & state*
  have facilitated advocacy by state staff

9. What topic would you like to most learn about at our next Idaho State Tribes meeting?

Seven respondents provided comments:

- *Need to develop options for changes to CHS programs*
- *Substance Abuse/meth – ATR access to tribes*
- *Where to go to when we have issues w/ a local Medicaid office*
- *At the next meeting the Division of Welfare can talk about the major changes (currently happening) in how applications for assistance are being processed*
  Susie Cummins
- *Will email*
  Good meeting
- *Topics to keep all the tribes attending*
- *638 tribes – Laws + Regs*