NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Funding Opportunities
JULY 2018

To: Idaho Delegates, Oregon Delegates, Washington Delegates, Tribal Chairs and Tribal Health Directors

Greetings! The NPAIHB - Funding Opportunity is provided on the basis that when there is pertinent announces we are made aware of, have received and/or researched for as part of our commitment to the health and well-being of our tribal members it is posted here for you. New posts will be available Friday/Monday **(unless there are no "New" grant announcements). Please see the "New" Funding Opportunity Information provided in this "color code".**

If you have a specific targeted goal or urgent community need and find yourself not knowing where to start "looking for a grant", our assistance is available anytime and we would be very excited to assist you. In addition, at the end of this announcement several funding organizations do not have deadlines and do accept proposals all year round.

SAMHSA - Center of Excellence for Eating Disorders

DEADLINE: Friday, August 17, 2018

AMOUNT: $750,000 X 5 YEARS

DESCRIPTION: The Substance Abuse and Mental Health Services Administration (SAMHSA), is accepting applications for fiscal year (FY) 2018 Center of Excellence (CoE) for Eating Disorders (Short Title: CoE-ED). The purpose of this program is to establish one National Center of Excellence to develop and disseminate training and technical assistance for healthcare practitioners on issues related to addressing eating disorders. It is expected that the grantee will facilitate the identification of model programs, develop and update materials related to eating disorders, and ensure that high-quality training is provided to health professionals.

WEBSITE/LINK: **https://www.samhsa.gov/grants/grant-announcements/sm-18-021**

Center of Excellence for Protected Health Information Related to Mental and Substance Use Disorders

DEADLINE: Friday, August 17, 2018

AMOUNT: Up to $1,000,000 per year – ONE AWARD X 5 YEARS.

DESCRIPTION: The Substance Abuse and Mental Health Services Administration (SAMHSA), is accepting applications for fiscal year (FY) 2018 Center of Excellence (CoE) for Protected Health Information Related to Mental and Substance Use Disorders. Short Title: CoE-PHI). The purpose of this program is to establish one National Center of Excellence to develop and disseminate training, technical assistance, and educational resources for healthcare practitioners, families, individuals, states, and communities on various privacy laws and regulations as they relate to information about mental and substance use disorders. These include: the Health Insurance Portability and Accountability Act (HIPAA)

and 42 CFR Part 2. The Center will also address the intersection of these laws and regulations with other privacy laws such as the Family Education Rights and Privacy Act (FERPA).

Although necessary for the protection of individuals, privacy regulations and laws are often complex and not easily interpreted. These regulations often create confusion for both practitioners and those seeking/receiving treatment. In many cases, these regulations are interpreted too stringently such that critical information from families, individuals or other healthcare practitioners is withheld leading to potential negative consequences. This project aims to address the complexity of these regulations through providing easily understood resources and training materials to simplify the interpretation and implementation of these regulations.

WEBSITE/LINK: **https://www.samhsa.gov/grants/grant-announcements/ti-18-021**

RWJF - Systems for Action: Systems and Services Research for a Culture of Health

DEADLINE: August 7, 2018 (1–2 p.m. ET) - Informational webinar for applicants. Registration required, here. September 12, 2018 (3 p.m. ET) - Deadline for receipt of one-page letter of intent (LOI) via email to **systemsforaction@uky.edu**. October 10, 2018 (3 p.m. ET) - Deadline for receipt of full proposals via RWJF online system. January 2019 - Applicant finalists notified of funding recommendations.

AMOUNT: This call will support studies that can be completed over a 24-month period with up to $250,000 each in total funding from RWJF. Up to six awards will be selected for funding under this solicitation.

DESCRIPTION: Systems for Action (S4A) is a signature research program of the Robert Wood Johnson Foundation (RWJF) that builds a Culture of Health by rigorously testing new ways of connecting the nation's fragmented medical, social, and public health systems. Studies conducted through the S4A program test innovative mechanisms for aligning the delivery and financing systems for medical, social, and public health services, with a focus on estimating their impact on health and health equity. S4A uses a wide research lens that includes and extends beyond medical care and public health to incorporate social service systems—such as housing; transportation; education; employment; food and nutrition assistance; child and family support; criminal and juvenile justice; and economic and community development.

WEBSITE/LINK: **https://www.rwjf.org/en/library/funding-opportunities/2018/systems-for-action--systems-and-services-research-to-build-a-cul.html?rid=0034400001rm5idAAA&et_cid=1307306**

Alcohol and Other Drug Interactions: Unintentional Injuries and Overdoses: Epidemiology and Prevention (R01 - Clinical Trial Optional) Synopsis 1 - HHS – NIH

DEADLINE: November 05, 2018

AMOUNT: Application budgets are not limited but need to reflect the actual needs of the proposed project. Award Project Period - The scope of the proposed project should determine the project period. The maximum project period is 5 years.

DESCRIPTION: The purpose of this funding announcement (FOA) issued by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) of the National Institutes of Health (NIH) is to encourage research grant applications that explore whether and how alcohol and other illicit drugs or illicitly used prescription drugs interact to contribute to

unintentional injuries and poisonings and how to prevent and/or reduce simultaneous use of alcohol or drugs singly or in combination.

WEBSITE/LINK **https://grants.nih.gov/grants/guide/pa-files/PA-18-863.html#toc-5**

Diet and Physical Activity Assessment Methodology (R01 Clinical Trial Not Allowed) - Department of Health and Human Services/National Institutes of Health

DEADLINE: November 05, 2018

AMOUNT: The number of awards is contingent upon NIH appropriations and the submission of a sufficient number of meritorious applications. Application budgets are not limited but need to reflect the actual needs of the proposed project. The total project period may not exceed five years.

DESCRIPTION: This Funding Opportunity Announcement (FOA) encourages innovative research to enhance the quality of measurements of dietary intake and physical activity. Applications submitted to this FOA may include development of: novel assessment approaches; better methods to evaluate instruments; assessment tools for culturally diverse populations or various age groups, including children and older adults; improved technology or applications of existing technology; statistical methods/modeling to improve assessment and/or to correct for measurement errors or biases; methods to investigate the multidimensionality of diet and physical activity behavior through pattern analysis; or integrated measurement of diet and physical activity along with the environmental context of such behaviors.

WEBSITE/LINK: **https://grants.nih.gov/grants/guide/pa-files/PA-18-856.html**

Notice of Intent to Publish: Tobacco Cessation Interventions Among People Living with HIV/AIDS (R01 Clinical Trial Optional) - Department of Health and Human Services/National Institutes of Health

DEADLINE: Oct 05, 2018

AMOUNT: $500,000

DESCRIPTION: The purpose of this Notice is to announce the NCI's intention to issue a Request for Applications (RFA) for research designed to optimize smoking cessation treatment among people living with HIV (PLWH) in the United States (U.S.). The goal of this RFA is to provide support for studies that employ rigorous designs that seek to systematically test existing evidence-based tobacco cessation interventions (e.g., combination of behavioral and pharmacological) and/or to develop and test adaptations of evidence-based tobacco cessation interventions for this population. The long-term goal is to reduce cigarette smoking rates among PLWH, and thus tobacco-related health disparities in this population. This Notice is being provided to allow potential applicants sufficient time to develop meaningful collaborations and responsive projects. The funding opportunity is expected to be published in the Summer of 2018 with expected application receipt date in Winter of 2018. This funding opportunity will utilize the R01 Research Project Grant mechanism, and is suitable for projects where proof-of-principle of the proposed methodology has already been established and supportive preliminary data are available. This Notice runs in parallel with a Notice of identical scientific scope, NOT - [KA([1] - CA-18-079, which uses the Exploratory/Developmental Grant (R21) mechanism.

WEBSITE/LINK: **https://www.grants.gov/web/grants/view-opportunity.html?oppId=306808**

Time-Sensitive Obesity Policy and Program Evaluation (R01 Clinical Trial Not Allowed) - Department of Health and Human Services/National Institutes of Health

DEADLINE: November 5, 2018

AMOUNT: Application budgets are not limited but need to reflect the actual needs of the proposed project. The scope of the proposed project should determine the project period. The maximum project period is 5 years.

DESCRIPTION: This Funding Opportunity Announcement (FOA) establishes an accelerated review/award process to support time-sensitive research to evaluate a new policy or program that is likely to influence obesity related behaviors (e.g., dietary intake, physical activity, or sedentary behavior) and/or weight outcomes in an effort to prevent or reduce obesity. This FOA is intended to support research where opportunities for empirical study are, by their very nature, only available through expedited review and funding. All applications to this FOA must demonstrate that the evaluation of an obesity related policy and /or program offers an uncommon and scientifically compelling research opportunity that will only be available if the research is initiated with minimum delay. For these reasons, applications in response to this time-sensitive FOA are not eligible for re-submission. It is intended that eligible applications selected for funding will be awarded within 4 months of the application due date. However, administrative requirements and other unforeseen circumstances may delay issuance dates beyond that timeline.

WEBSITE/LINK: https://grants.nih.gov/grants/guide/pa-files/PAR-18-854.html#toc-5

FORCASTED:

Native American Independent Living Demonstration Project

DEADLINE: FORCASTED

AMOUNT: $644,854

DESCRIPTION: As a capacity-building strategy, ILA proposes that the Native American Independent Living Demonstration Project will support Native American Independent Living (IL) Specialists who have similar responsibilities to the non- Native American IL Specialist counterpart in the center for independent living, but with a focus in Indian Country. The Project will provide the five independent living core services including: information and referral; skills training; peer counseling; individual and systems advocacy; and services that facilitate transition from nursing homes and other institutions to the community, assistance to individuals at risk of entering institutions and transition of youth to post-secondary life. In addition, the Native American IL Specialist will conduct activities such as: • Serve as an information and resource specialist about disabilities to the Tribes in their Area• Gather information about IL needs in Indian Country• Gather data and information about disabilities in Indian Country• Gather information about current tribal efforts at providing assistance to tribal members with disabilities• Serve as a liaison between State IL Programs, the Statewide Independent Living Councils (SILCs) and Indian Country• Establish inter-agency coalitions in Indian Country to focus on serving the unmet needs of tribal members with disabilities• Serve as an effective advocate and liaison between ACL programs and services and Indian Country.

WEBSITE/LINK: https://www.grants.gov/web/grants/view-opportunity.html?oppId=284788

AUGUST 2018

2018 Native Voices Rising (NVR)

DEADLINE: August 3, 2018

AMOUNT: $10,000

DESCRIPTION: The Common Counsel Foundation and Native Americans in Philanthropy are pleased to announce that the 2018 Native Voices Rising (NVR) grant pool is now open for both donors and potential grantees. NVR is now accepting grant applications. We encourage all Native-led groups that have a membership base in the community, work to develop leadership, and take collective action to win progressive social change to apply.

NVR grants provide general operating support of $10,000 to strengthen Native-led organizations in the United States that are improving the lives of their community members. Since created, a total of nearly $650,000 has been awarded to over 45 grassroots Native community organizations that are involved in organizing and advocacy. Previous grantees are collectively engaging thousands of community members across ten states. They focus on a wide range of critical issues, from human and civil rights, to reproductive justice, to environmental health, and sacred sites protection. Including specifically the protection of land, water, and the recognition of Native sovereignty.

Potential grantees can find application and eligibility guidelines here. More information on how to apply can be found at www.NativeVoicesRising.org**.**

WEBSITE/LINK: http://www.nativevoicesrising.org/media/

Retaining Employment and Talent After Injury/Illness Network (RETAIN) Demonstration Projects - Department of Labor/Office of Disability Employment Policy

DEADLINE: Aug 03, 2018 The closing date for receipt of applications under this announcement is August 3, 2018. Applications must be received no later than 4:00:00 p.m. Eastern Time.

AMOUNT: $2,500,000

DESCRIPTION: The Office of Disability Employment Policy (ODEP), in collaboration with the Employment and Training Administration (ETA), U.S. Department of Labor (DOL, the Department, or we), and the Social Security Administration (SSA) announce the availability of approximately $20,000,000 in funds authorized by Section 169, subsection (b)(5), of the Workforce Innovation and Opportunity Act (WIOA), Section 1110 of the Social Security Act, and Consolidated Appropriations Act of 2018 to plan and conduct pilot demonstration projects in Phase 1 of RETAIN – the Retaining Employment and Talent after Injury/Illness Network. A subset of Phase 1 RETAIN awardees will competitively receive Phase 2 RETAIN cooperative agreements and funds to implement projects at full scale. DOL will award all funds and administer all cooperative agreements in both phases of RETAIN.

The RETAIN Demonstration Projects will be funded in two (2) phases. This FOA covers Phase 1. The initial period of performance (Phase 1) is eighteen (18) months and includes planning and start-up activities, including the launch of a small pilot demonstration. The small pilot demonstration must begin within nine (9) months of the award or immediately after the Office of Management and Budget (OMB) provides Paperwork Reduction Act approval for the project's information collection, whichever occurs later. We expect to

provide approximately $2,500,000 each to up to eight (8) state workforce agencies in the form of cooperative agreements for Phase 1. The state workforce agencies must partner with the State Health Departments, or equivalent entities generally responsible for managing, regulating, or influencing the provision of health services; health care systems practicing coordinated care and population health management; and the State Workforce Development Board. Expenditures for planning activities are limited to $1,000,000, leaving a minimum of $1,500,000for pilot implementation.

At the conclusion of the initial period of performance, up to four (4) Phase 1 awardees will be awarded supplemental funding of up to$19,750,000 each to implement the demonstration projects during Phase 2 through a separate competition. Awardees will continue receiving support from the RETAIN Program TA Provider. If funds are available in future years, DOL may award additional Phase 2 cooperative agreements to Phase 1 awardees not initially selected for Phase 2. More information on the two-phased funding process is in Section II.A and II.B.

DOL will host a prospective applicant webinar for this competition. The date, time, and other logistical information will be posted on ODEP's website at **https://www.dol.gov/odep**

WEBSITE/LINK: https://www.grants.gov/web/grants/view-opportunity.html?oppId=305566

Lowe's Toolbox for Education® Grants

DEADLINE: August 6, 2018 – September 28, 2018

AMOUNT: $2,001 to $100,000.

DESCRIPTION: Through our support for public education, we're closing the funding gap facing many schools today. Each year, the Lowe's Toolbox for Education grants program contributes more than $5 million to fund improvements at public schools in the United States.

Projects should fall into one of the following categories: technology upgrades, tools for STEM programs, facility renovations and safety improvements. Projects should address a critical need and align with Lowe's company purpose; to help people love where they live. Toolbox grant requests can range from $2,000 to $100,000. Grants can only be applied for during the cycle dates. Please make sure that your school and grant request fall within the Giving Guidelines. The review process takes 90 days from the cycle close date and applicants will receive a status e-mail after review is completed.

WEBSITE/LINK: https://newsroom.lowes.com/apply-for-a-grant/

OVC FY 2018 Tribal Victim Services - Set-Aside Program

DEADLINE: Note: Phase 1 and Phase 2 each have separate deadlines.

The deadline for submitting Phase 1 application materials for this grant program is 9:00 p.m. eastern time on August 6, 2018. Applications submitted after that time will not be considered for funding. Applicants must register in the OJP Grants Management System (GMS) at https://grants.ojp.usdoj.gov/gmsexternal/ prior to submitting an application. All applicants must register, even those that have previously registered in GMS. Once registered, select the "Apply Online" button associated with the solicitation title.

Applicants that are approved in Phase 1 will be contacted on or before September 30, 2018, and invited to submit Phase 2 materials in GMS, and will be required to complete acceptance of the grant award offer and the process for release of funds. OVC anticipates that the deadline for submitting materials for Phase 2 will be January 4, 2019.

AMOUNT: OVC anticipates awarding up to $110 million through the Tribal Victims Services Set-Aside Program. Typically will not exceed $720,000 per applicant.

DESCRIPTION: OVC is seeking applications for the FY 2018 Tribal Victim Services Set-Aside Program solicitation. Under the solicitation, OVC will award eligible tribes, tribal consortia, and tribal designees grants to support a wide-range of services for victims of crime.

This year, as part of the 2018 Commerce, Justice, Science, and Related Agencies Appropriations Act, Congress specified that 3 percent of this year's Crime Victims Fund will be used to fund victim services in tribal communities. This is the first ever tribal set-aside for crime victims that the U.S. Department of Justice has been directed to administer.

WEBSITE/LINK: https://www.grants.gov/web/grants/view-opportunity.html?oppId=306472

Indian Education—Demonstration Grants for Indian Children

DEADLINE: August 10, 2018

AMOUNT: $750,000 per year x 26-40 awards

DESCRIPTION: Indian Education Discretionary Grants Programs--Demonstration Grants for Indian Children program-- Native Youth Community Projects (NYCP) Competition for fiscal year (FY) 2018.

The Office of Indian Education is soliciting applications for the FY 2018 Indian Education Discretionary Grants Programs--Demonstration Grants for Indian Children program--Native Youth Community Projects (NYCP) grant competition. The notice inviting applications was published on June 26, 2018 in the Federal Register.

WEBSITE/LINK: https://www2.ed.gov/programs/indiandemo/applicant.html

The Jobs Plus Initiative – HUD

DEADLINE: August 14, 2018

AMOUNT: $3,700,000 per project period

DESCRIPTION: The Jobs Plus program develops locally-based, job-driven approaches that increase earnings and advance employment outcomes through work readiness, employer linkages, job placement, educational advancement, technology skills, and financial literacy for residents of public housing. The place-based Jobs Plus program addresses poverty among public housing residents by incentivizing and enabling employment through earned income disregards for working residents and a set of services designed to support work including employer linkages, job placement and counseling, educational advancement, and financial counseling. Ideally, these incentives will saturate the target developments, building a culture of work and making working residents the norm.

The Jobs Plus program comprises these three core components (further described below):

- Employment-Related Services
- Financial Incentives – Jobs Plus Earned Income Disregard (JPEID)
- Community Supports for Work

Applicants are encouraged to develop key partnerships to connect participants with any other needed services to remove barriers to work. An Individualized Training and Services Plan (ITSP) should be developed for each participant to establish goals and service strategies, and to track progress.

Background

HUD, the Rockefeller Foundation, and MDRC, through a public-private partnership, designed and supported the Jobs Plus program model between 1998 and 2003. HUD has issued two separate evaluation reports on the demonstration, to identify and document the most promising approaches to increasing employment among families in public housing. Each evaluation showed ongoing positive effects for residents when the program was well-implemented and included the three core elements. More information on the findings can be found at http://www.mdrc.org/project/jobs-plus-community-revitalization-initiative-public-housing-families#overview.

WEBSITE/LINK:
https://www.hud.gov/program_offices/spm/gmomgmt/grantsinfo/fundingopps/fy18jobsplus

DHHS/Indian Health Service: Tribal Management Grant Program

DEADLINE: Aug 17, 2018

AMOUNT: $100,000 X 8 awards

DESCRIPTION: The purpose of this Indian Health Service (IHS) grant announcement is to announce the availability of the Tribal Management Grant (TMG) Program to enhance and develop health management infrastructure and assist federally recognized Indian Tribes and Tribal Organizations (T/TOs) in assuming all or part of existing IHS programs, functions, services and activities (PFSAs) through a Title I contract and assist established Title I contractors and Title V compactors to further develop and improve management capability. In addition, Tribal Management Grants are available to T/TOs under the authority of 25 U.S.C. Section 5322(e) for the following: (1) obtaining technical assistance from providers designated by the Tribe/Tribal Organization (including T/TOs 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, monitoring, and evaluating Federal programs serving T/TOs, including Federal administrative functions.

WEBSITE/LINK: https://www.grants.gov/web/grants/view-opportunity.html?oppId=300726

Tribal Opioid Response Grants – DHHS/SAMHSA

DEADLINE: Aug 20, 2018

AMOUNT: $50,000,000 X 263 AWARDS

DESCRIPTION: The Substance Abuse and Mental Health Services Administration (SAMHSA) is accepting applications for fiscal year (FY) 2018 Tribal Opioid Response grants (Short Title: TOR). The program aims to address the opioid crisis in tribal communities by increasing access to culturally appropriate and evidence-based treatment, including medication-assisted treatment (MAT) using one of the three FDA-approved medications for the treatment of opioid use disorder (OUD). The intent is to reduce unmet treatment need and opioid overdose related deaths through the provision of prevention, treatment and/or recovery activities for OUD.

The program supplements current activities focused on reducing the impact of opioids and will contribute to a comprehensive response to the opioid epidemic. Tribes will use the results of a current needs assessment if available to the tribe (or carry out a strategic planning process to conduct needs and capacity assessments) to identify gaps and resources from which to build prevention, treatment and/or community-based recovery support services. Grantees will be required to describe how they will expand access to treatment and recovery support services as well as advance substance misuse prevention in coordination with other federally-supported efforts. Grantees must use funding to supplement and not supplant existing opioid prevention, treatment, and/or recovery activities. Grantees are required to describe how they will improve retention in care, using a chronic care model or other innovative model that has been shown to improve retention in care.

WEBSITE/LINK: https://www.grants.gov/web/grants/view-opportunity.html?oppId=306430

Advancing Exceptional Research on HIV/AIDS and Substance Abuse (R01 Clinical Trial Optional)

DEADLINE: August 22, 2018

AMOUNT: Application budgets are not limited but need to reflect the actual needs of the proposed project. The scope proposed should determine the project period. The maximum project period is five years.

DESCRIPTION: This FOA supports highly innovative R01 applications on HIV/AIDS and drug abuse and complements the Avant-Garde Award Program for HIV/AIDS and Drug Use Research and the Avenir Award Program for Research on Substance Abuse and HIV/AIDS. The Avant-Garde award supports individuals who conduct high-risk, high-reward research and does not require a detailed research plan. The Avenir award is similar to the Avant-Garde award but focuses on support for early stage investigators. Applications submitted under this FOA are required to have a detailed research plan and preliminary data. This FOA focuses on innovative research projects that have the potential to open new areas of HIV/AIDS research and/or lead to new avenues for prevention and treatment of HIV/AIDS among substance abusers. The nexus with drug abuse should be clearly described. This FOA is open to both individual researchers and research teams and is not limited to any one area of research on HIV and substance use, but all studies must focus on NIH HIV/AIDS Research Priorities **https://grants.nih.gov/grants/guide/notice-files/NOT-OD-15-137.html**.

WEBSITE/LINK: https://www.grants.gov/web/grants/view-opportunity.html?oppId=301634

OJJDP FY 18 Gang Suppression Planning Grants Program - Department of Justice Office of Juvenile Justice Delinquency Prevention

DEADLINE: Aug 27, 2018

AMOUNT: $200,000 X 5 awards

DESCRIPTION: OJJDP FY 2018 Gang Suppression Planning Grants Program is part of the Project Safe Neighborhoods (PSN) Suite of programs, which is focused on reducing violent crime. The PSN Suite comprises PSN, Strategies for Policing Innovation, Innovative Prosecution Solutions, Crime Gun Intelligence Centers, National Public Safety Partnerships, Technology Innovation for Public Safety, Encouraging Innovation: Field Initiated Programs; Innovations in Community-Based Crime Reduction, and Community Based Violence Prevention Demonstration. These initiatives will coordinate proactively with the PSN team in the district of the respective United States Attorney Office (USAO) to enhance collaboration and strengthen commitment to reducing violent crime. Applicants must demonstrate this coordination with their USAO district PSN team in their submission.

WEBSITE/LINK: https://www.grants.gov/web/grants/view-opportunity.html?oppId=306679

Kent Richard Hofmann Accepting LOIs for Community-Based HIV/AIDS Efforts

DEADLINE: August 31, 2018 (Letters of Intent)

AMOUNT: Grant amounts will be determined on a project-by-project basis.

DESCRIPTION: The Kent Richard Hofmann Foundation is a private foundation dedicated to the fight against HIV and AIDS.

The foundation is accepting Letters of Intent from community-based organizations working in the areas of HIV/AIDS care and direct services, education, and research. Grants will be awarded in support of programs in development as well as established programs, with emphasis on their direct benefit to clients or target audiences. Requests from across the U.S. will be considered, with preference given to those focused on smaller communities and rural areas; for seed money for new projects, programs, or structures; and/or for innovative ideas designed to meet basic needs.

WEBSITE/LINK: http://www.krhofmann.org/

COMMUNITY

Coordinating Center to Support NIDA Rural Opioid HIV and Comorbidity Initiative (U24 - Clinical Trial Not Allowed) - Department of Health and Human Services, National Institutes of Health

DEADLINE: Aug 15, 2018

AMOUNT: $500,000

DESCRIPTION: The purpose of this FOA is to fund a single interdisciplinary Coordinating Center to formalize and centralize support of the rural opioid initiative administered by NIDA and co-funded by CDC, SAMHSA, and ARC. This initiative was funded under RFA-DA-

17-014 and RFA-DA-17-023. The Coordinating Center will provide scientific, technical, regulatory, ethical, and logistical support of data comparability, new data collection, and data integration; developing integrated rural opioid initiative datasets; assisting grantees with acquisition and analysis of local administrative and/or research datasets that enable evaluation of their implementation activities or augment their community assessments; conducting requested analyses that relate to the integrated rural opioid initiative datasets; developing and executing a rural opioid initiative publication and dissemination plan; and providing logistical support for in-person meetings, conference calls, and webinars that include the rural opioid initiative grantees and funders. The Coordinating Center will be represented on the rural opioid initiative executive steering committee, along with the funders and rural opioid initiative grantees.

WEBSITE/LINK: https://grants.nih.gov/grants/guide/rfa-files/RFA-DA-19-004.html

SEPTEMBER 2018

Project Athena Foundation Accepting Applications for Adventures for Women Survivors of Trauma

DEADLINE: Applications are reviewed on a quarterly basis in March, June, September, and December.

AMOUNT: (See the Project Athena Foundation website for complete program guidelines and application instructions.)

DESCRIPTION: The Project Athena Foundation is dedicated to helping women survivors of medical or other traumatic setbacks achieve their adventurous dreams. The foundation provides travel expenses, coaching, equipment, and the encouragement and inspiration needed to help these women make the life-affirming transition from survivor to athlete.

The foundation offers several yearly adventures that provide mental and physical challenges in a non-competitive environment. The goal is for the participant to have something to look forward to, a goal set to accomplish, and to be surrounded by like-minded people. In 2018-19, the foundation is offering the following adventures: San Diego Cove to Harbor Marathon Trek 2018, Florida Keys to Recovery 2018 (waitlist pending), San Diego Harbor to Harbor Trek April 2019, Grand Canyon Rim-2-Rim-2-Rim Trek August 2019, Grand Canyon Rim-2-Rim Trek August 2019, San Diego Cove to Harbor Marathon Trek 2019, and Florida Keys to Recovery 2019.

A medical or traumatic setback can be defined as, but is not limited to, cancer, congenital defects, neurological disorders, autoimmune disorders, amputations, and posttraumatic stress disorder.

WEBSITE/LINK: http://projectathena.org/apply-for-a-grant/

Fund for a Just Society – Unitarian Universalist Funding Program

DEADLINE: September 15, 2018

AMOUNT: $15,000

DESCRIPTION: The Fund for a Just Society, a program of the Unitarian Universalist Association, provides grants to nonprofit organizations in the U.S. and Canada that address issues of social and economic justice. The Fund supports organizations that use community organizing to bring about systemic change leading to a more just society; mobilize with

those who have been disenfranchised and excluded from resources, power, and the right to self-determination; and have an active focused campaign to create systemic change. Consideration is given to projects that are less likely to receive conventional funding because of the innovative or challenging nature of the work or the economic and social status of the constituency. The maximum grant amount is $15,000; however, most grants range between $6,000 and $8,000. Requests are reviewed two times per year; the next application deadline is September 15, 2018. Visit the Unitarian Universalist Association website to review the funding guidelines.

WEBSITE/LINK: https://www.uufunding.org/fund-for-a-just-society.html

DECEMBER 2018

Walmart Foundation Accepting Applications for Community Grant Program

DEADLINE: December 31, 2018. Applications will be accepted on a rolling basis until December 31.

AMOUNT: Through the annual program, grants of up to $5,000 will be awarded to support local nonprofit organizations within the service area of individual Walmart stores in the areas of hunger relief and healthy eating, sustainability, women's economic empowerment, and/or career opportunities.

DESCRIPTION: To be eligible, an organization must be tax-exempt status under Section 501(c)(3), (4), (6) or (19) of the Internal Revenue Code; be a recognized government entity (i.e., state, county, or city agency, including law enforcement or fire departments) that is requesting funds exclusively for public purposes; be a K-12 public or private school, charter school, community/junior college, state/private college or university; or be a church or other faith-based organization with a proposed project that benefits the community at large.

WEBSITE/LINK: http://giving.walmart.com/apply-for-grants/local-giving

NO DEADLINE – GRANT RESOURCE INFORMATION:

Elizabeth Taylor AIDS Foundation Seeks Applications for HIV/AIDS Programs

DEADLINE: Strategic Funding – Year round by invitation only. (To be eligible, applicant organizations must have at least three years' experience in delivering HIV/AIDS programs.)

AMOUNT: One-year grants of up to $25,000 will be awarded for domestic and international programs that offer direct care services to people living with HIV and AIDS. Online trainings, curriculum development, and website projects will be a secondary priority for funding considerations.

DESCRIPTION: The Elizabeth Taylor AIDS Foundation was established by Elizabeth Taylor in 1991 to provide grants to existing organizations for domestic and international programs that offer direct care services to people living with HIV and AIDS. Since its inception, the foundation has concentrated on supporting marginalized communities and has grown to also fund innovative HIV education and advocacy programs. To date, ETAF

has awarded grants to more than six hundred and seventy-five organizations in forty-four countries and forty-two states in the United States.

WEBSITE/LINK: **http://elizabethtayloraidsfoundation.org/apply/**

Kars4Kids Small Grant Program

DEADLINE: Online applications may be submitted throughout the year.

AMOUNT: Grants generally range from $500 to $2,000.

DESCRIPTION: The Kars4Kids Small Grant Program is dedicated to supporting educational initiatives around the country, helping us impact more children. Kars4Kids is a national Jewish nonprofit organization that is dedicated to helping children develop into productive members of communities throughout the United States. The Kars4Kids Small Grant Program provides support to nonprofit organizations that are working to make a difference in the areas of education and youth development.

WEBSITE/LINK: **http://www.kars4kidsgrants.org/**

Evidence for Action: Investigator-Initiated Research to Build a Culture of Health

DEADLINE:

Informational Web Conferences:

Lessons Learned from a Year of Evidence for Action Grant Reviews

February 18, 2016 from 1:30-2:30 p.m. ET (10:30-11:30 a.m. PT)

Registration is required.

Archived Web Conferences

Informational Web Conferences were scheduled for June 3, 2015 and July 22, 2015 Recordings for both events are now available.

June 3, 2015 web conference recording available here.

July 22, 2015 web conference recording available here.

Timing: Since applications are accepted on a rolling basis, there is no deadline for submission. Generally, applicants can expect to be notified within 6-8 weeks of their LOI submission. Applicants invited to the full proposal stage will have 2 months to submit their proposal once they receive notification. Full proposal funding decisions will generally be made within 6-8 weeks of the submission deadline.

AMOUNT: Approximately $2.2 million will be awarded annually. We expect to fund between five and 12 grants each year for periods of up to 30 months. We anticipate that this funding opportunity will remain open for at least a period of three years; however, decisions about modifications to the program and the duration of the program will be made by RWJF at its sole discretion.

DESCRIPTION: Evidence for Action: Investigator-Initiated Research to Build a Culture of Health is a national program of RWJF that supports the Foundation's commitment to building a Culture of Health in the United States. The program aims to provide individuals,

organizations, communities, policymakers, and researchers with the empirical evidence needed to address the key determinants of health encompassed in the Culture of Health Action Framework. In addition, Evidence for Action will also support efforts to assess outcomes and set priorities for action. It will do this by encouraging and supporting creative, rigorous research on the impact of innovative programs, policies and partnerships on health and well-being, and on novel approaches to measuring health determinants and outcomes.

WEBSITE: **http://www.rwjf.org/en/library/funding-opportunities/2015/evidence-for-action-investigator-initiated-research-to-build-a-culture-of-health.html?rid=3uOaFeLLcJROtLce2ecBeg&et_cid=469879**

Changes in Health Care Financing and Organization: Small Grants

DEADLINE: Grants are awarded on a rolling basis; proposals may be submitted at any time.

AMOUNT: This solicitation is for small grants of $100,000 or less.

DESCRIPTION: Changes in Health Care Financing and Organization (HCFO) supports research, policy analysis and evaluation projects that provide policy leaders timely information on health care policy, financing and organization issues. Supported projects include:

examining significant issues and interventions related to health care financing and organization and their effects on health care costs, quality and access; and

exploring or testing major new ways to finance and organize health care that have the potential to improve access to more affordable and higher quality health services.

Eligibility and Selection Criteria

Researchers, as well as practitioners and public and private policy-makers working with researchers, are eligible to submit proposals through their organizations. Projects may be initiated from within many disciplines, including health services research, economics, sociology, political science, public policy, public health, public administration, law and business administration. RWJF encourages proposals from organizations on behalf of researchers who are just beginning their careers, who can serve either individually as principal investigators or as part of a project team comprising researchers or other collaborators with more experience. Only organizations and government entities are eligible to receive funding under this program.

Preference will be given to applicants that are either public entities or nonprofit organizations that are tax-exempt under Section 501(c) (3) of the Internal Revenue Code and are not private foundations as defined under Section 509(a).

Complete selection criteria can be found in the Call for Proposals.

WEBSITE: **http://www.rwjf.org/en/grants/funding-opportunities/2011/changes-in-health-care-financing-and-organization--small-grants.html**

The National Children's Alliance

Deadline: **http://www.nationalchildrensalliance.org/**

Amount: See website

Description: The National Children's Alliance has a Request for proposals to help support the development of CACs and Multidisciplinary Teams. NACA encourages all tribal communities to apply. They can offer FREE technical support to help you with your application.

Common Wealth Fund

The Commonwealth Fund encourages and accepts unsolicited requests on an ongoing basis. The Fund strongly prefers grant applicants to submit letters of inquiry using the online application form. Applicants who choose to submit letters of inquiry by regular mail or fax should provide the information outlined in a two- to three-page document.

They fund:

- **Delivery System Innovation and Improvement**
- **Health Reform Policy**

Health System Performance Assessment and Tracking

http://www.commonwealthfund.org/Grants-and-Programs/Letter-of-Inquiry.aspx

Kaboom! Invites Grant Applications to Open Previously Unavailable Playgrounds

Deadline: KaBOOM! is inviting grant applications from communities anywhere in the United States working to establish joint use agreements to re-open playground and recreational facilities previously unavailable due to safety and upkeep concerns. (No specific deadline.)

Amount: Let's Play Land Use grants of $15,000 and $30,000 will support creation of joint-use agreements between local governments and school districts that address cost concerns related to safety, vandalism, maintenance, and liability issues to re-open previously unavailable playgrounds and recreational facilities.

The $15,000 grants will support the opening of at least four playgrounds in cities with populations of less than 100,000 people. The $30,000 grants will support the opening of at least eight playgrounds in larger communities.

Description: Grants can be used for training and technical assistance, utilities and other building related to the extra use of the facility, legal fees, contract security

services, and marketing campaigns related to the joint-use agreement. Grant recipients must commit to opening the playgrounds within twelve months of the grant decision.

Complete grant application guidelines are available on the KaBOOM! website:

http://kaboom.org/about_kaboom/programs/grants?utm_source=direct&utm_medium=surl

- **Meyer Memorial Trust**

Deadline: Monthly (Except January, April and August)

Amount: Range generally from $40,001 to $300,000 with grant periods from one to two (and occasionally three) years.

Description: Responsive Grants are awarded for a wide array of activities in the areas of human services, health, affordable housing, community development, conservation and environment, public affairs, arts and culture and education. There are two stages of consideration before Responsive Grants are awarded. Initial Inquires are accepted at any time through MMT's online grants application. Applicants that pass initial approval are invited to submit full proposals. The full two-step proposal investigation usually takes five to seven months. **http://www.mmt.org/program/responsive-grants**

- **Kellogg Foundation Invites Applications for Programs that Engage Youth and Communities in Learning Opportunities**

Deadline: No Deadline

Amount: No Amount Specified

Description: The W.K. Kellogg Foundation is accepting applications from nonprofit organizations working to promote new ideas about how to engage children and youth in learning and ways to bring together community-based systems that promote learning. The foundation will consider grants in four priority areas: Educated Kids; Healthy Kids; Secure Families; and Civic Engagement.

Educated Kids: To ensure that all children get the development and education they need as a basis for independence and success, the foundation seeks opportunities to invest in early child development (ages zero to eight) leading to reading proficiency by third grade, graduation from high school, and pathways to meaningful employment.

Healthy Kids: The foundation supports programs that work to ensure that all children grow and reach optimal well-being by having access to fresh, healthy food, physical activity, quality health care, and strong family supports.

Secure Families: The foundation supports programs that build economic security for vulnerable children and their families through sustained income and asset accumulation.

Civic Engagement: The foundation partners with organizations committed to inclusion, impact, and innovation in solving public problems and meeting the needs of children and families who are most vulnerable.

See the Kellogg Foundation Web site for eligibility and application guidelines. **http://foundationcenter.org/pnd/rfp/rfp_item.jhtml?id=411900024#sthash.8WbcfJRk.dpuf**

- **W.K. Kellogg Foundation**

Deadline: The Kellogg Foundation does not have any submission deadlines. Grant applications are accepted throughout the year and are reviewed at their headquarters in

Battle Creek, Michigan, or in our regional office in Mexico (for submissions focused within their region).

Amount: NO LIMIT (Please read restrictions/What they won't fund.)

Description: What to Expect Once they receive your completed online application, an automated response, which includes your WKKF reference number, will be sent to you acknowledging its receipt. Their goal is to review your application and email their initial response to you within 45 days. Your grant may be declined or it may be selected for further development.

As part of review process you may be asked to submit your organization's financial reports and/or IRS Form 990. While this information may be required, it is not intended to be the overall determining factor for any funding. You will not be asked to provide any financial reports or detailed budget information during this initial submission. They will only request this information later if needed as part of the proposal development.

If you would like to speak with someone personally, please contact the Central Proposal Processing department at (269) 969-2329. http://www.wkkf.org/

- **AHRQ Research and Other Activities Relevant to American Indians and Alaska Natives**

http://www.ahrq.gov/research/findings/factsheets/minority/amindbrf/index.html

Community Grant Program- WALMART

DEADLINE: The 2016 grant cycle begins Feb. 1, 2016 and the application deadline to apply is Dec. 31, 2016. **Application may be submitted at any time during this funding cycle. Please note that applications will only remain pending in our system for 90 days.**

AMOUNT: Awarded grants range from $250 to $2,500.

DESCRIPTION: Through the Community Grant Program, our associates are proud to support the needs of their communities by providing grants to local organizations.

WEBSITE: http://giving.walmart.com/apply-for-grants/local-giving

Community Facilities Direct Loan & Grant Program

DEADLINE: Applications for this program are accepted year round.

AMOUNT: (See website.)

DESCRIPTION: This program provides affordable funding to develop essential community facilities in rural areas. An essential community facility is defined as a facility that provides an essential service to the local community for the orderly development of the community in a primarily rural area, and does not include private, commercial or business undertakings. Who can answer questions? Contact your local RD office.

WEBSITE/LINK: https://www.rd.usda.gov/programs-services/community-facilities-direct-loan-grant-program

SCHOLARSHIP:

The Meyerhoff Adaptation Project -

The Meyerhoff Scholars Program is open to all high-achieving high school seniors who have an interest in pursuing doctoral study in the sciences or engineering, and who are interested in the advancement of minorities in the sciences and related fields. Students must be nominated for the program and are most typically nominated by their high school administrators, guidance counselors, and teachers. Awards range from $5,000 – $22,000 per year for four years.

The Meyerhoff Selection Committee considers students academic performance, standardized test scores, recommendation letters, and commitment to community service. Scholars are selected for their interests in the sciences, engineering, mathematics, or computer science, as well as their plans to pursue a Ph.D. or combined M.D./Ph.D. in the sciences or engineering. Reviewing the freshman class profile may provide an idea of the kinds of students who are admitted to UMBC and the Meyerhoff Scholars Program.

Applicants are expected to have completed a strong college preparatory program of study from an accredited high school. The minimum program of study should include:

English: four years

Social Science/History: three years

Mathematics*: three years

Science: three years

Language other than English: two years

*Students are strongly recommended to have completed four years of mathematics, including trigonometry, pre-calculus, and/or calculus.

Eligibility Criteria

To be considered for the Meyerhoff Scholars Program, prospective students must have at least a “B” average in high school science or math courses, and many applicants have completed a year or more of calculus. Preference is given to those who have taken advanced placement courses in math and science, have research experience, and have strong references from science or math instructors. In recent years, a strong preference has been given to those students interested in the Ph.D. or M.D./Ph.D. (over the M.D.).

Students must meet all eligibility requirements:

Minimum of 600 on the Math component of the SAT

Cumulative High School GPA of a 3.0 or above

Aspire to obtain a Ph.D. or M.D./Ph.D. in Math, Science, Computer Science, or Engineering

Display commitment to community service

Must be a citizen or permanent resident of the United States

WEBSITE:
http://meyerhoff.umbc.edu/how-to-apply/benefits-and-eligibility/

~ONLY FOR WASHINGTON STATE UNIVERSITY~

First Scholars – The Suder Foundation

DEADLINE:

AMOUNT: The goal of the First Scholars program is to help first-generation college students succeed in school, graduate, and have a life complete with self-awareness, success and significance. Scholars receive personalized support, including a four-year renewable scholarship of $5,000. The program is open to incoming first-time, full-time freshmen whose parents have no more than two years of education beyond high school and no post-secondary degree.

DESCRIPTION: The First Scholars™ Program is available to incoming first-time, full-time freshmen whose parents have no more than two years of education beyond high school and no post-secondary degree. Participation in First Scholars™ includes a four-year renewable scholarship, half disbursed in the fall semester and half disbursed in the spring semester. Students can receive the award depending on eligibility requirements for a total of 4 years if program requirements are met.

This scholarship is open to Washington residents who enroll at Washington State University - Pullman full-time during the 2016-2017 academic year. The program requires that the recipients live on campus in a specified residence hall for the 2016-2017 academic year, and outside of the family home the following three academic years in order to renew the scholarship.

First-generation students represent a cross-section of America and college campus demographics. First Scholars come from diverse cultural, socioeconomic, geographic and family backgrounds and experiences. First-gen students are found in all departments and colleges of virtually every major public university across the country. Our affiliate universities have an average 30-50% first-gen enrollment and the number keeps rising. However, the average national graduation rate for first-generation students is only 34%, compared with 55% for the general student population.

WEBSITE: http://firstscholars.wsu.edu/

Education Award Applications –The American College of Psychiatrists

DEADLINE: June 30

AMOUNT: (SEE WEBSITE)

DESCRIPTION: The Award for Creativity in Psychiatric Education is open to any creative/innovative program for psychiatric education that has been in operation for at least two years, and has been a part of a U.S. or Canadian approved psychiatric residency training program. Trainees may include: medical students, residents, other physicians, allied mental health professionals, or members of the community. The Committee selects an awardee in the fall; all applicants are notified of the Committee's decision by November 15.

WEBSITE: http://www.acpsych.org/awards/education-award-applications-deadline-december-1

(Internship Program/Scholarship Opportunities)

CDC Undergraduate Public Health Scholars Program (CUPS): A Public Health Experience to Expose Undergraduate and Graduate Students to Minority Health, Public Health and Health Professions/Department of Health and Human Services/Centers for Disease Control - OD

DEADLINE: Jun 19, 2017 Electronically submitted applications must be submitted no later than 5:00 p.m., ET, on the listed application due date.

AMOUNT: $850,000

DESCRIPTION: CDC seeks to fund organizations with the ability to reach undergraduate and graduate students, including sexual and gender, people with disabilities, low socioeconomic status (SES) and those from underrepresented racial and ethnic minority populations. The ultimate goal is to increase the diversity of the public health workforce, improve the representation of underrepresented populations in public health, and increase the quality of public health services nationally.

WEBSITE/LINK: http://www.cdc.gov/features/studentopportunities/index.html

DIRECTORS OF HEALTH PROMOTION AND EDUCATION (DHPE)-2017 SPRING HEALTH EQUITY INTERNSHIP

DEADLINE: & AMOUNT: For more information, contact Karen Probert at **internship@asphn.org**.

DESCRIPTION: DHPE has received supplemental funding to support the Health Equity Internship for an additional year. The funding is from the Centers of Disease Control and Prevention (CDC) Division for Heart Disease and Stroke Prevention (DHDSP). The mission of the CDC DHDSP is to provide public health leadership to improve cardiovascular health for all, reduce the burden, and eliminate disparities associated with heart disease and stroke. DHPE is working with the Association of State Public Health Nutritionists (ASPHN) to administer the Internship Program for the 2017 Spring cohort.

College students selected for these cohorts should be interested in an internship project and placement site that focuses on the following:

Cardiovascular Disease Risks Reduction;

Heart Disease Prevention and Education, including Hypertension and Stroke;

Nutrition and Healthy Eating;

Physical Activity and/or Obesity. Interested students should mention their proposed internship site within their application.

Preference will be given to undergraduate and graduate students who attend Minority-Serving Institutions (HBCUs, HSIs and Tribal Colleges), are from racial and ethnic populations, and/or have demonstrated interest in working to achieve health equity in minority and underserved communities.

WEBSITE/LINK: For more information, contact Karen Probert at **internship@asphn.org**.

Native Student Travel Scholarships: Connecting STEM and Justice

DEADLINE: Apply now for sponsorship to visit Philadelphia and attend the International Association of Chiefs of Police Conference (IACP) on October 21-24, 2017.

AMOUNT: Funding includes registration, airfare, lodging, ground transportation, baggage, meals, and incidental expenses. You would fly from your home airport to Philadelphia on October 20, 2017, and return on October 25, 2017. Decision notices will be sent to all applicants by August 30, 2017.

DESCRIPTION: Are you an American Indian or Alaska Native student in science, tech, engineering, or math (STEM)?

The National Institute of Justice is looking for five qualified undergrad or grad students to attend this conference, which brings together thousands of professionals from federal, state, local, and tribal organizations.

Attendance will aid you in exploring applications of your STEM training to issues of criminal justice and public safety. You will have the opportunity to interact with scientists and attend panel discussions on the most urgent issues facing communities and innovative, evidence-based solutions.

WEBSITE/LINK: **https://nij.gov/topics/tribal-justice/Pages/native-student-travel-scholarships.aspx?utm_source=eblast-govdelivery&utm_medium=email&utm_campaign=adhoc**

VETERANS

- **VFW Accepting Applications From Veterans for Emergency Financial Assistance**

DEADLINE: Open

AMOUNT: Grants of up to $5,000 will be awarded to active and discharged military service members who have been deployed in the last six years and have run into unexpected financial difficulties as a result of deployment or other military-related activity or natural disaster....

DESCRIPTION: As the nation's largest organization of combat veterans, we understand the challenges veterans, service members and military families can face and believe that experiencing financial difficulties should not be one of them. That's the premise behind the VFW's Unmet Needs program.

Unmet Needs is there to help America's service members who have been deployed in the last six years and have run into unexpected financial difficulties as a result of deployment or other military-related activity. The program provides financial aid of up to $5,000 to assist with basic life needs in the form of a grant -not a loan- so no repayment is required. To further ease the burden, we pay the creditor directly.

Since the program's inception, Unmet Needs has distributed over $5 million in assistance to qualified military families, with nearly half of those funds going directly toward basic housing needs.

The needs of our veterans, service members and their families should never go unmet. Let us offer you a hand up when you need it!

Please review the Unmet Needs eligibility criteria to see if you or someone you know qualifies for a grant through the Unmet Needs program.

WEBSITE:
http://www.vfw.org/UnmetNeeds/?gclid=CjwKEAiAhPCyBRCtwMDS5tzT03gSJADZ8VjRw5RxJw1br5NTowrY1NFzylowGtdvOagXa3LHyYK_PRoCB4Hw_wcB

RWJF: Submit a Pioneering Idea Brief Proposal - Throughout the year, we welcome Pioneering Ideas Brief Proposals that can help us anticipate the future and consider new and unconventional perspectives and approaches to building a Culture of Health.

DEADLINE: Open

AMOUNT: See site

DESCRIPTION: The goal of the Pioneering Ideas Brief Proposal funding opportunity is to explore; to look into the future and put health first as we design for changes in how we live, learn, work and play; to wade into uncharted territory in order to better understand what new trends, opportunities and breakthrough ideas can enable everyone in America to live the healthiest life possible.

While improving the status quo is vital to the health and well-being of millions of Americans now, the Pioneering Ideas Brief Proposal opportunity reaches beyond incremental changes to explore the ideas and trends that will influence the trajectory and future of health. Ultimately, we support work that will help us learn what a Culture of Health can look like—and how we can get there.

What is a Pioneering Idea?

Good question! We don't want to provide a checklist that limits your thinking—or ours. We do want to give you as clear a picture as we can about the kinds of proposals we hope to see, so you can best assess whether submitting an idea through our Pioneering Ideas Brief Proposal process is the right next step for you. Our application form allows you to introduce your idea; if it seems to be a fit for our portfolio we will reach out for more information.

We share some examples below of Pioneering Ideas we have funded in the past to give you a sense of where we've been. Keep in mind that ultimately, we need you to challenge us, and to tell us where we should be going and what ideas have the most potential to transform the way we think about health. As you review the examples below, you may notice some shared themes or characteristics which:

Challenge assumptions or long-held cultural practices.

Take an existing idea and give it a new spin—or a novel application.

Offer a new take or perspective on a long-running, perplexing problem.

Apply cutting-edge ideas from other fields to health.

Explore the potential for emerging trends to impact our ability to build a Culture of Health.

WEBSITE/LINK: http://www.rwjf.org/en/how-we-work/submit-a-proposal.html?rid=CR0RfoW1kVrIxFKudcSYjlL9Zh7yWU63VdhdaVE2UAc&et_cid=639126

IDAHO & WASHINGTON - ONLY

ASPCA Northern Tier Shelter Initiative Coalition Grants

DEADLINE: No Deadline

AMOUNT: Grant amounts will vary depending on project. A site visit may be required as part of the review process or as a condition of receiving the grant funds. Consultation services may be offered as part of a grant package.

DESCRIPTION: Priority will be given to coalitions working toward long-term, systemic, and sustainable community/regional improvements in animal welfare services. This may include (but not limited to) programs that:

Increase capacity to provide quality animal care and services by:

Improving protocols around vaccination on intake, disease spread prevention, decreased length of stay, physical and behavioral care of sheltered pets

Improving capacity to provide basic health services including spay/neuter and vaccines for animals at risk in the community.

Increase coalition live release rate via:

Fee-waived adoption programs and policies

High-volume adoption events

Foster programs

Relocation initiatives within the seven Northern Tier target states

Decrease shelter intake via:

Lost and found programs

Return to owner in the field

Pet retention assistance, such as safety net programs

Re-homing assistance

WEBSITE: http://aspcapro.org/grant/2016/05/06/aspca-northern-tier-shelter-initiative-coalition-grants

Healthy Native Babies Outreach Stipend Application

DEADLINE: Applications will be accepted on a rolling basis as funds are available.

AMOUNT: $1500

DESCRIPTION: The Healthy Native Babies Project, a project of the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), has created culturally

appropriate materials with safe infant sleep messages for American Indian and Alaska Native communities. These materials can be tailored for local communities by selecting various photos, graphic designs, and phrases in Native languages from the Healthy Native Babies Project Toolkit Disk. Outreach stipends are available for printing customized outreach materials to disseminate in your community. Recipients must be from one of the following Indian Health Service (IHS) Areas: Alaska, Bemidji, Billings, Great Plains, and Portland. Information on IHS Areas can be found at: **https://www.ihs.gov/locations/.**

WEBSITE/LINK: http://files.constantcontact.com/913a319f001/8e50ceae-d3be-462e-be3d-3216455225bc.pdf?ver=1470849886000

Good Sports Accepting Applications for Sports Equipment Program

DEADLINE: *ROLLING FUNDING*

AMOUNT: While the equipment, apparel, and footwear received through the program are free, recipients are expected to pay shipping and handling costs, which amount to roughly 10 percent of the donation value, with a maximum fee of $1,500.

DESCRIPTION: Good Sports helps lay the foundation for healthy, active lifestyles by providing athletic equipment, footwear, and apparel to disadvantaged young people nationwide. By working closely with teams, coaches, and community leaders across the United States, the organization is able to focus on the respective needs of each individual program and help offset the main factors causing the greatest challenges.

Good Sports is accepting applications from organizations and schools for equipment, apparel, and footwear for a wide range of sports. Organizations that are approved will have access to equipment, apparel, and footwear inventory for a two-year period. During that time, organizations can make up to six separate donation requests — as long as need is well documented, donations will be granted. There is no need to resubmit a full application again during the two-year period.

To be eligible, applicants must directly serve youth between the ages of 3 and 18; serve youth in an economically disadvantaged area; be located in North America (the U.S. and Canada); and operate an organized sport, recreational activity, or fitness program that offers consistent and structured opportunity for play to large groups of children. Schools must apply as a whole; applications for individual programs within a school will not be considered. Donation requests for short-term events such as sports camps and tournaments or to individual athletes will not be considered.

Applications are reviewed on a rolling basis. It is recommended, however, that organizations apply at least eight weeks prior to the start of their particular season or program to ensure the desired equipment can be accessed and shipped on time.

WEBSITE/LINK: https://www.goodsports.org/apply/

Good Sports Accepting Applications for Athletic Equipment Grants

DEADLINE: *ROLLING FUNDING*

AMOUNT: You will be required to sign a release form and pay a shipping and handling fee with each donation. This will always equal 10% of the total retail value of the items; for example, if the total value of your items equals $2,000, you will be asked to provide $200, etc.

DESCRIPTION: Good Sports in Quincy, Massachusetts, is a nonprofit whose mission is to increase youth participation in sports, recreation, and fitness activities.

To that end, the organization provides sports equipment, apparel, and footwear to youth organizations offering sports, fitness, and recreational programs to youth in need.

To be eligible, organizations must directly serve youth between the ages of 3 and 18 in an economically disadvantaged area; be located in North America (U.S. and Canada); and operate an organized sport, recreational activity, or fitness program that offers consistent and structured opportunity for play to large groups of children. Winning organizations may make up to six equipment requests within a two-year period. Winners will be responsible for operational costs, including equipment shipping, up to $1,500.

WEBSITE/LINK: http://www.goodsports.org/apply/

Voya Foundation Grants

DEADLINE: Grant requests are reviewed throughout the year. Grant applicants should check the online system for quarterly deadlines, which are subject to change.

AMOUNT: Value of grant requests must be a minimum of $2,500.

DESCRIPTION: The Voya Foundation, the philanthropic arm of Voya Financial, works to ensure that youth are equipped with science, technology, engineering, and math (STEM) expertise and financial knowledge necessary to compete in the twenty-first century workforce and make smart financial decisions that lead to a secure retirement.

To that end, Voya is accepting applications from organizations that provide innovative and experiential K-8 STEM learning opportunities that promote an early interest in STEM career fields and improve teachers' capabilities in STEM; or that provide financial education curriculum to grade 9-12 students focused on navigating major financial milestones such as student debt, credit, home ownership, financial products and services/financial capability, and family needs.

1) STEM Education: The foundation supports organizations that fund high-quality experiential STEM learning opportunities for children in grades K-8. Programs are evaluated based on improvements in covered STEM concepts and increased interest in STEM careers generated over the course of the program.

2) Financial Literacy: Voya's financial literacy grants support organizations that provide financial literacy curriculum to students in high school (grades 9-12). Programs must cover student debt, credit, home ownership, investing, and understanding of financial products and services (financial capability), and family financial planning.

To be eligible, applicants must be considered tax exempt under Section 501(c)(3) of the Internal Revenue Code.

WEBSITE/LINK: http://corporate.voya.com/corporate-responsibility/investing-communities/voya-foundation-grants

COMMUNITY

FY 2017 Economic Development Assistance Programs - Application submission and program requirements for EDA's Public Works and Economic Adjustment Assistance programs. Department of Commerce

DEADLINE: There are no submission deadlines under this opportunity. Proposals and applications will be accepted on an ongoing basis until the publication of a new EDAP NOFA.

AMOUNT: $3,000,000

DESCRIPTION: Under this NOFA, EDA solicits applications from applicants in rural and urban areas to provide investments that support construction, non-construction, technical assistance, and revolving loan fund projects under EDA's Public Works and EAA programs. Grants and cooperative agreements made under these programs are designed to leverage existing regional assets and support the implementation of economic development strategies that advance new ideas and creative approaches to advance economic prosperity in distressed communities, including communities and regions that have been impacted, or can reasonably demonstrate that they will be impacted, by coal mining or coal power plant employment loss, or employment loss in the supply chain industries of either. EDA provides strategic investments on a competitive- merit-basis to support economic development, foster job creation, and attract private investment in economically distressed areas of the United States. This EDAP NOFA supersedes the EDAP Federal Funding Opportunity dated December 23, 2016.

WEBSITE/LINK: https://www.grants.gov/web/grants/view-opportunity.html?oppId=294771

SEARCH—Special Evaluation Assistance for Rural Communities and Households

DEADLINE: Applications accepted on an ongoing basis

AMOUNT: (SEE WEBSITE.)

DESCRIPTION: SEARCH - Special Evaluation Assistance for Rural Communities and Households provides grants to eligible communities to fund predevelopment costs for proposed water and waste disposal projects, including:

Feasibility studies to support applications for funding water or waste disposal projects

Preliminary design and engineering analysis

Technical assistance for the development of an application for financial assistance

Eligible projects include planning costs to:

Construct, enlarge, extend, or improve rural water, sanitary sewage, solid waste disposal, and storm wastewater disposal facilities

Construct or relocate public buildings, roads, bridges, fences or utilities, and to make other public improvements necessary for the successful operation or protection of facilities

Relocate private buildings, roads, bridges, fences, or utilities, and other private improvements necessary for the successful operation or protection of facilities.

WEBSITE/LINK: https://www.rd.usda.gov/programs-services/search-special-evaluation-assistance-rural-communities-and-households

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

OFFICE OF FEDERAL
FINANCIAL MANAGEMENT

June 20, 2018

M-18-18

MEMORANDUM FOR CHIEF FINANCIAL OFFICERS AND HEADS OF SMALL EXECUTIVE AGENCIES

FROM: Tim Soltis
Deputy Controller, Office of Federal Financial Management

SUBJECT: Implementing Statutory Changes to the Micro-Purchase and the Simplified Acquisition Thresholds for Financial Assistance

In accordance with recent statutory changes set forth in the National Defense Authorization Acts (NDAA) for Fiscal Years 2017 and 2018, this memorandum raises the threshold for micro-purchases under Federal financial assistance awards to $10,000, and raises the threshold for simplified acquisitions to $250,000 for all recipients. Further, it implements an approval process for certain institutions that want to request micro-purchase thresholds higher than $10,000. Agencies are required to implement these changes in the terms and conditions of their awards, and recipients of existing Federal financial assistance awards may implement them in their internal controls.

Background

This memorandum applies to all Federal agencies, as defined at 5 U.S.C. § 551(1), that award grants or cooperative agreements. It implements changes to the micro-purchase and simplified acquisition thresholds for financial assistance under the NDAAs for Fiscal Year (FY) 2017 and FY2018. The micro-purchase threshold refers to purchases of supplies or services using simplified acquisition procedures, not to exceed an established amount pursuant to the Office of Management and Budget (OMB) Governmentwide Guidance for Grants and Agreements ("Uniform Guidance") at 2 C.F.R. § 200.67 (Micro-purchase). The simplified acquisition threshold refers to purchases of property or services using small purchase methods not to exceed an established amount pursuant to 2 C.F.R. § 200.88 (Simplified acquisition threshold). For Federal financial assistance awards, these purchases are acquired for use by a Federal program. The NDAA for FY2017 increased the micro-purchase threshold from $3,500 to $10,000 for institutions of higher education, or related or affiliated nonprofit entities, nonprofit research organizations or independent research institutes (41 U.S.C. § 1908). The NDAA for FY2018 increases the micro-purchase threshold to $10,000 for all recipients and also increases the simplified acquisition threshold from $100,000 to $250,000 for all recipients.

Implementing the NDAA for FY2017

Section 217(b) of the NDAA for FY2017 raises the micro-purchase threshold to $10,000 for procurements under grants and cooperative agreements for institutions of higher education, or related or affiliated nonprofit entities, nonprofit research organizations or independent research institutes.[1]

[1] Pub. L. No. 114-328 (codified at 41 U.S.C. § 1902(a)(2)).

The NDAA for FY2017 also establishes an interim uniform process by which these recipients can request and Federal agencies can approve requests to apply a higher micro-purchase threshold. Specifically, the 2017 NDAA allows a threshold above $10,000 if approved by the head of the relevant executive agency. For purposes of this approval, the institution's cognizant Federal agency for indirect cost rates will be the relevant executive agency as defined in 2 C.F.R. § 200.19 (Cognizant agency for indirect costs). To receive a higher threshold, the institution must either have "clean single audit findings" (*i.e.*, in accordance with 2 C.F.R. § 200.520 - Criteria for a low-risk auditee), have an acceptable internal institutional risk assessment, or the higher threshold must be consistent with State law for public institutions.

Agencies should reflect this change through policy or terms and conditions in awards for those institutions. The effective date for this change was when the NDAA for FY2017 was signed into law on December 23, 2016. OMB intends to revise the Uniform Guidance to conform with the law.[2]

Process for Requesting a Higher Threshold Under the NDAA for FY2017

Requests for approval should be submitted to the institution's cognizant Federal agency for indirect cost rates; however, institutions should contact the agency before sending the request to determine the correct point of contact. The cognizant Federal agency will assign review of the request to the appropriate office within the agency to determine whether to approve, and will maintain records and justification of all approvals. The request should include the threshold level being requested and the justification(s) for it based on the criteria above per Section 217(b) of the NDAA for FY2017.

Implementing the NDAA for FY2018

This memorandum also implements provisions of the NDAA for FY 2018, Pub. L. No. 115-91, which became law on December 12, 2017. Specifically, section 806 raised the micro-purchase threshold from $3,500 to $10,000, and section 805 raised the simplified acquisition threshold from $100,000 to $250,000. Pursuant to 2 C.F.R. § 200.67 (Micro-purchase) and 2 C.F.R. § 200.88 (Simplified acquisition threshold), these higher thresholds are not effective until implemented in the Federal Acquisition Regulation (FAR) at 48 C.F.R. Subpart 2.1 (Definitions).[3]

In order to allow maximum flexibility for grant recipients in light of the changes to the NDAA for FY2018, OMB is granting an exception allowing recipients to use the higher threshold of $10,000 for micro-purchases and $250,000 for simplified acquisitions in advance of revisions to the FAR at 48 C.F.R. Subpart 2.1 and the Uniform Guidance. Pursuant to 2 C.F.R. § 200.102 (Exceptions), OMB may allow exceptions to the Uniform Guidance when exceptions are not prohibited by statute. The exception takes effect upon the date of issuance of this memo. Agencies should apply this exception to all recipients. Recipients should document any change based on this exception in accordance with 2 C.F.R. § 200.318 (General procurement standards).

If you have any questions regarding this memorandum, please contact Mary Tutman at Mary.E.Tutman@omb.eop.gov or Gil Tran at Hai_M._Tran@omb.eop.gov.

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[2] The American Innovation and Competitiveness Act, Pub. L. No. 114-329, § 207(b) (2017) states that the Uniform Guidance shall be revised to conform with the requirements concerning the micro-purchase threshold.

[3] Codified at 41 U.S.C. § 1902(f).

Apply for funding to support crime victim services in your tribal community.

Deadline: August 6, 2018
Posted: June 22, 2018

OVC is seeking applications for the FY 2018 Tribal Victim Services Set-Aside Program solicitation. Under the solicitation, OVC will award eligible tribes, tribal consortia, and tribal designees grants to support a wide-range of services for victims of crime.

This year, as part of the 2018 Commerce, Justice, Science, and Related Agencies Appropriations Act, Congress specified that 3 percent of this year's Crime Victims Fund will be used to fund victim services in tribal communities. This is the first ever tribal set-aside for crime victims that the U.S. Department of Justice has been directed to administer. With this funding, **OVC anticipates awarding up to $110 million** through the Tribal Victims Services Set-Aside Program.

Phase 1 applications are due August 6, 2018.

Apply Now.

Pre-Application Webinar

On June 28, 2018, from 2:00 p.m. to 3:30 p.m. eastern time, OVC will conduct a webinar explaining the Phase 1 application process. OVC staff will review solicitation requirements and address questions. Register now.

Learn More

View all Solicitations

Your feedback makes us better!

Let us know how we might improve our communications to better serve you.

Take Quick Survey

Connect with us

OVC shares your mission and has a wide range of resources to help you accomplish it. Visit the National Criminal Justice Reference Service (NCJRS) online to register for services or to find out more.

HHS makes $350 million available to fight the opioid crisis in community health centers nationwide

Today, the Department of Health and Human Services (HHS) announced the availability of $350 million in new funding to expand access to substance use disorder and mental health services at community health centers across the nation. These funds will support health centers in implementing and advancing evidence-based strategies, including expanded medication-assisted treatment (MAT) services, and are expected to be awarded in September of this year by HHS's Health Resources and Services Administration (HRSA).

"Local communities have played a vital role in combating our country's opioid crisis," said HHS Secretary Alex Azar. "The contributions of HRSA-funded health centers in particular have been invaluable. These new grants, provided by the government funding bill President Trump signed earlier this year, will allow centers to expand their important work providing high quality substance abuse and mental health services."

The Expanding Access to Quality Substance Use Disorder and Mental Health Services funding opportunity supports HHS's Five-Point Opioid Strategy, launched in 2017 to empower local communities on the frontlines to combat the crisis. These funds will make a significant impact in furthering community-driven efforts to reduce opioid use and increase access to mental health services.

Primary care settings, like the community health centers supported by HRSA's Health Center Program, have increasingly become a gateway to integrated care for individuals with substance use disorder (SUD) and primary care needs. HRSA support enables community health centers to enhance access to primary care-based SUD services, including MAT services, as well as pain management and other prevention services. In 2017 alone, nearly 65,000 health center patients received MAT.

"HRSA's recent investments in substance use disorder and mental health services have significantly increased the capacity of health centers to provide critical care to their communities," said HRSA Administrator Dr. George Sigounas. "For example, the number of health center clinicians providing MAT increased by 75% between 2016 and 2017, from 1,700 to nearly 3,000 in 2017. This is just one way that health centers are in a unique position to make a significant impact in combatting the opioid crisis, and this new funding will further that impact."

The Expanding Access to Quality Substance Use Disorder and Mental Health Services funding opportunity invests in personnel and one-time infrastructure enhancements to enable health centers to address immediate barriers they have faced to implementing or expanding SUD and mental health services. It also builds on the $200 million investment made last year to 1,178 community health centers across the US to increase access to SUD and mental health services.

HRSA's Health Center Program provides grant funding to community-based health centers in underserved areas. Nearly 1,400 community health centers operate more than 11,000 sites, providing care to nearly 26 million people across the nation, in every state, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin.

Throughout the country, community health centers employ more than 200,000 people, and with this new funding opportunity, they will be able to increase personnel to help expand access to SUD and mental health services.

Applications for the Expanding Access to Quality Substance Use Disorder and Mental Health Services award are due July 16, 2018.

For more information about the SUD-MH funding opportunity, visit: https://bphc.hrsa.gov/programopportunities/fundingopportunities/sud-mh

For additional information on how HRSA is addressing the Opioid Crisis, visit HRSA's Opioid Crisis Webpage

To learn more about HRSA's Health Center Program, visit: http://bphc.hrsa.gov/about

To find a health center in your area, visit: http://findahealthcenter.hrsa.gov

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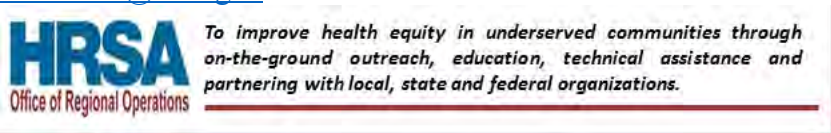

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MEMORANDUM

June 15, 2018

To: Tribal Health Clients

From: HOBBS, STRAUS, DEAN & WALKER, LLP

Re: *IHS Initiates Consultation on Changes to the Indian Health Manual, Part 2, Chapter 3 on Purchase/Referred Care*

On May 18, 2018, the Indian Health Service (IHS) circulated a Dear Tribal Leader Letter (DTLL) (attached)[1] initiating tribal consultation[2] on changes to its Indian Health Manual (the "Manual"), Part 2, Chapter 3 "Services to Indians and Others" (also known as "Purchased/Referred Care" or "PRC") (the "PRC Chapter"). The DTLL seeks input and recommendations from Tribes on proposed changes to the PRC Chapter. On May 23, the IHS held an in-person Tribal Listening Session during the National Indian Health Board 9th Annual National Tribal Public Health Summit. On May 25 and June 11, the IHS held All Tribes Conference Calls. The IHS has scheduled additional in-person Tribal consultations, as described in a June 8, 2018 DTLL (attached).

The IHS will accept written comments on the proposed "Draft PRC Chapter" through July 6, 2018. We have attached a sample comment letter, with a redline of the Draft PRC Chapter suggesting changes, for your consideration and use.

The current PRC Chapter is available here.[3] The Draft PRC Chapter is available here.[4] Although the Draft PRC Chapter states that it identifies all of the proposed changes in bolded text, it does not. We developed a redline comparison of the current PRC Chapter and the Draft PRC Chapter (attached) that identifies numerous changes proposed but not identified by the IHS. Our unofficial comparison is the type of document that all Tribal Representatives requested from the IHS on the May 25 call, but so far, the IHS has only produced the bolded Draft PRC Chapter. In response to an email inquiry, Terri Schmidt, R.N., Acting Director of Office of Resource Access and Partnerships of the IHS, stated that the bolded text version of the Draft PRC chapter was only to identify the "significant

[1] Relevant documents, including Manual Exhibits, are available at https://www.ihs.gov/newsroom/triballeaderletters/. On the May 25 call, Ms. Schmidt reported that these had been updated to match the Draft PRC Chapter; however, some of the documents appear to be the current policy.

[2] The IHS reclassified the initial Tribal Consultations as Tribal Listening Sessions.

[3] *Part 2 - Services To Indians And Others*, https://www.ihs.gov/IHM/pc/part-2/p2c3/#2-3.24 (last visited June 5, 2018).

[4] *Draft PRC Chapter of the IHM*, https://www.ihs.gov/prc/draft-prc-chapter-of-the-ihm/ (last visited June 5, 2018).

changes." As discussed below, there are changes in the draft that are significant that were not identified in bold by the IHS.

Background

IHS's legal authority for issuing the Manual is addressed in the eligibility regulation at 42 C.F.R. § 136.3, which provides that the IHS will periodically issue administrative instructions to its officers and employees that are primarily found in the Manual: "These instructions are operating instructions to assist IHS officers and employees in carrying out their responsibilities and are not regulations establishing program requirements which are binding upon members of the general public." Thus, the IHS cannot use the Manual to rewrite the PRC regulations at 42 C.F.R. Part 136, Subpart C and 42 C.F.R. § 136.61, which establishes the payor of last resort rule.

If the IHS wants to issue "substantive rules of general applicability adopted as authorized by law or statements of general policy or interpretations of general applicability," the IHS must publish them in the Federal Register in accordance with the Administrative Procedure Act (APA), 5 U.S.C. §§ 552(a) and 553 (notice and comment rulemaking). Thus, the IHS cannot use the Draft PRC Chapter to (1) redline/edit and paraphrase the actual language of the regulations as a means to change the regulations without going through APA procedures; (2) establish formal agency interpretations of statutes and regulations again without complying with the APA; or (3) declare, in certain instances, that the IHS will no longer adhere to specific requirements in the regulations.

Furthermore, as stated in 42 C.F.R. § 136.3 noted above, the Manual provides administrative instructions to IHS officers and employees carrying out PRC programs operated by the IHS. It is not binding on Indian tribes and tribal organizations carrying out contracted or compacted PRC programs under the Indian Self-Determination and Education Assistance Act (ISDEAA), unless a tribe or tribal organization expressly agrees in its contract, compact, or funding agreement to be bound by the Manual. 25 U.S.C. §§ 5329(c)(1) (model self-determination contract § 1(b)(11)), 5397(e).

The IHS's proposed revisions to the PRC Chapter in large part bring to the forefront issues that involve an ongoing dispute between tribes and the IHS regarding PRC and tribal self-insurance plans. As we have previously reported, the question of whether tribal self-insurance plans are alternate resources required to pay before the Catastrophic Health Emergency Fund (CHEF) and the underlying PRC program was resolved in favor of the tribal position in *Redding Rancheria v. Hargan*, No. 14-2035 (D.D.C. Nov. 7, 2017).[5] However, the *Redding* case is not yet final, as the court remanded to the IHS to reconsider the Rancheria's CHEF claims in light of the court's holding.

[5] We reported in more detail on the *Redding Rancheria* decision in our memorandum to tribal health clients dated November 8, 2017.

It is important to remember that in January 2016, while the *Redding* case was pending, the IHS published proposed regulations governing administration of the CHEF.[6] Those proposed regulations defined "alternate resources" to CHEF as specifically including tribal self-insurance plans. At the request of Tribes, the IHS agreed not to publish the final CHEF regulations until after the *Redding* litigation concludes, and thus the CHEF regulations are still on hold. In addition, during the May 25 and June 11 calls, IHS leadership communicated that, although they are putting the Draft PRC Chapter out for comment, any revisions to the policy will not be finalized until the litigation concludes and a final decision is issued, and until then, the current policy will remain effective.

All Tribes Call Update

During the May 25 and June 11 calls, IHS leadership identified and described some of the proposed PRC Chapter revisions. The Draft PRC Chapter was not available at the time of the May 25 call, so comments from Tribal Representatives were limited because they could not readily identify the proposed changes. Some of the comments from Tribal Representatives and answers from Ms. Schmidt are incorporated in the discussion of changes below.

On the May 25 call, Ms. Schmidt stated that the Draft PRC Chapter incorporates recommendations from the General Accountability Office (GAO) but that the IHS had not met with Tribal Workgroups or technical advisors yet to hear their recommendations. Tribal Representatives commented that the IHS should have consulted with Tribal Workgroups before issuing a DTLL and encouraged the IHS to do so for future matters. Several days after the call, Ms. Schmidt announced that the PRC Workgroup would be having a special meeting on June 6 to discuss the proposed changes. No discussion of this meeting was referenced during the June 11 call.

Substantive Issues Identified In The Draft PRC Chapter

The following is a brief summary of some of the major issues we have identified with IHS's proposed revisions to the PRC Chapter.

Definitions

Since the PRC Chapter cannot re-define terms already defined by statute or regulation, Section 2-3.1.5 should contain definitions as already prescribed by law. For example, Section 2-3.1(5)(25) deletes "former reservations in Oklahoma" from the definition of "Reservation," even through the phrase is in the definition of the term in 25

[6] 81 Fed. Reg. 4239 (Jan. 26, 2016). We reported in more detail on the Proposed Rule in our memorandum to tribal health clients dated October 25, 2016.

U.S.C § 1603(16) and 42 C.F.R. § 136.21(i). If clarification is necessary for IHS officers and employees to understand terms, the PRC Chapter should set off the legal definition in quotes to contrast it with the Agency's own explanation.

Problematically, the definition of "Tribally-Operated Program," which is defined in Section 2-3.1(5)(31) as "a program operated by a Tribe or Tribal organization that has contracted under Pub. L. 93-638 to provide a PRC program," is inconsistent with the court's ruling in the *Redding Rancheria* case.

The court in *Redding Rancheria* interpreted the following provision, codified by the Affordable Care Act (ACA) at 25 USC § 1623(b):

> Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act [IHCIA] (25 U.S.C. § 1603) shall be the payer of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary.

During litigation, the IHS took the position that this language referred to the definition of the term "tribal health program" in Section 4(25) of the IHCIA, 25 U.S.C. § 1603(25), which is defined as a program compacted or contracted with the IHS under the ISDEAA. The effect of the IHS's interpretation was to exclude tribal self-insured health plans and make them alternate resources. The court rejected this argument, determining that the parenthetical language—"(as those terms are defined in section 4 of the IHCIA)"—referred to how all of the entities listed (the IHS, tribes, tribal organizations, and urban Indian organizations) are defined in the IHCIA. The result of the court's holding was that "health programs operated by Indian tribes, tribal organizations" meant *any* health program operated by tribes and tribal organizations, including tribal self-insurance plans.

Therefore, we recommend that the term "Tribally-Operated Program" be removed from the PRC Chapter and that the IHS instead use the term "Tribal Health Program," which is defined in Section 1603(25) of the IHCIA, for references to tribally compacted or contracted programs, as appropriate.

Alternate Resources and Tribal Self-Insurance

In numerous places throughout the Draft PRC Chapter, the IHS defines and provides criteria for determining what it would consider an "alternate resource." The Definitions section includes programs under "the Social Security Act (*i.e.,* Medicaid, Medicare and Children's Health Insurance Program), other Federal healthcare programs,

State and local healthcare programs, [the] Veterans Health Administration, and private insurance," and does not identify any exceptions (Section 2-3.1(5)(1)). The payor of last resort rule section also adds Vocational Rehabilitation, Children's Rehabilitative Services and the Crime Victims Act. (Section 2-3.8(7)). Instead of multiple, inconsistent definitions, the Draft PRC Chapter should cite the current regulation at 42 C.F.R. § 136.21, referring to the definition of "alternate resources" at 42 C.F.R. § 136.61(c), for the definition. Furthermore, the Draft PRC Chapter should note that "local" does not mean "tribal," and "private health insurance" does not mean tribal self-insured health plans.

Tribal Self-Insurance. Section 2-3.8(9) would expressly exempt "tribally funded self-insurance plans"[7] from consideration as an alternate resource but "[a]ny portion of the plan that is reinsured will not be considered Tribal Self-Insurance." While the proposed language as drafted may be intended to only include the reinsurance itself as an alternate resource, that is not how it reads. The language as drafted states that the IHS would consider the entire reinsurance plan an alternate resource if a tribe has any reinsurance on it. While it may be appropriate for reinsurance to be considered an alternate resource when the reinsurance is paying, rather than the tribe, it is not appropriate for a Tribal Self-Insured plan to be considered an alternate resource simply because it is reinsured. Furthermore, the Draft PRC Chapter's exclusionary clause does not recognize that the IHS may bill tribal self-insurance if the tribe gives permission.[8] The PRC Chapter should not foreclose this option.

Sponsorship of Plans. In terms of other coverage provided by tribes, from the language of Section 2-3.8(10), it appears the IHS would consider insurance purchased by a tribe for its members (also known as "sponsorship" plans) as an alternate resource, unlike tribal self-insurance but separate from reinsurance. Section 402 of the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1642, authorizes Indian tribes, tribal organizations, and urban Indian organizations to use federal funds available to them under the ISDEAA, Social Security Act programs (such as Medicare, Medicaid, and Children's Health Insurance Plan reimbursements), or under other federal law, to purchase "health care benefits coverage" for IHS eligible beneficiaries. It is unclear what the IHS means by "sponsorship through indemnity" in Section 2-3.8(10) of the Draft PRC Chapter. This should be clarified to simply state "sponsorship of insurance plans."

Charity or Indigent Care Programs. In Sections 2-3.8(1)(3) and 2-3.8(1)(7) of the Draft PRC Chapter, the IHS states that a charity or indigent care program is not considered an "alternate resource" for purposes of the payor of last resort rule when the PRC provider absorbs the full cost of services provided. In other words, the IHS does not consider a non-Indian provider an available source of payment to himself or itself. One example of this

[7] We note that the phrase "tribally funded self-insurance plans" differs from the specifically defined term "Tribal Self-Insurance," and the defined term "Tribal Self-Insurance" should be used.
[8] *See* 25 U.S.C. § 1621e(f).

could be when a hospital charity program writes-off the cost of care for services provided to persons eligible for the charity program. However, such programs may still be "health care resources" under the IHS payor of last resort rule at 42 C.F.R. § 136.61, and we think it is reasonable to conclude under the statutory language at 25 U.S.C. § 1623(b) that a charitable source of coverage—including write-offs by providers under established charity or indigent care programs—should be accessed before a PRC program would have to be the payer for care. We thus suggest that the language on charitable programs in Section 2-3.8(1)(3) be removed and the language in Section 2-3.8(1)(7) be revised to clarify that available charity or indigent care programs are considered alternate resources for purposes of PRC if an individual is eligible for the program or would be eligible but for having PRC.

Student Grant Funds. As drafted, the provision requiring students to purchase health insurance with grant funds places a requirement on students that may be incompatible with the terms of a grant(s). Additionally, it is unclear whether "individuals" in the next sentence means to require *any* person receiving funds for health insurance to purchase it, or only students.

Failure to Follow Alternate Resource Procedures. As Section 2-3.8(4)(1) is structured in the Draft PRC Chapter, it is not clear what action the 10-day timeframe applies to. Is it for contacting facility staff for help, to complete an application, or both? Or, does it reference the issuance of a denial letter? As currently drafted, it is unlikely that providers would be able to understand the requirements of this provision. Furthermore, the current PRC Chapter provides for a 30-day timeframe, which the IHS changed to 10-days in the Draft PRC Chapter.

PRCDAs and the Process for Redesignation

In Section 2-3.3(1), the IHS takes the position that it may only provide services in Purchased/Referred Care Delivery Areas (PRCDAs) under the current regulations, stating that it would have to amend the regulations by notice and comment rulemaking in order to recognize new PRCDAs. While the IHS does not directly state it, they appear to be taking the position that new PRCDAs established by Congress cannot be implemented until the IHS changes its regulations. This position is contrary to current law because acts of Congress supersede conflicting agency regulations.

Another confusing change seems to expand the consultation requirement. Currently, the regulations only require consultation with tribes *within* a PRCDA;[9] but as we read the new provision in Section 2-3.4(3)(1) of the Draft PRC Chapter, an Area PRC Officer must consult with *any* tribe affected by a designation or redesignation of a PRCDA. The intent behind the provision could be to simply reiterate the consultation requirement

[9] *See* 42 C.F.R. § 136.22(b).

instead of creating a new one, but this is not clear from how the IHS phrased it.

In Section 2-3.4(3)(3), the IHS includes an ad hoc PRCDA Designation/Re-Designation Committee—a committee with which we are not familiar. It is unclear whether this Committee is new or if it is already existing practice that is just now being written down. As provided for in the Draft PRC Chapter, this Committee would review redesignation requests submitted to the Director of the Division of Contract Care (DCC) to determine if the information submitted meets the criteria set forth in Section 2-3.4(1). The Director of the DCC would then send the Committee's findings and recommendation to the Director of the IHS for a final determination. As drafted, the Committee's recommendation would replace that of the Director of the DCC. There is not much information about the Committee besides that its membership would include leadership from numerous offices within the IHS. Furthermore, stating that the PRCDA designation/redesignation cannot be appealed suggests that the IHS's decision cannot be appealed under the APA, which is incorrect.

Eligibility Requirements

The way in which both the current and Draft PRC Chapter outline the PRC eligibility requirements is different from how they are outlined in the PRC eligibility regulations, which creates significant confusion. In the attached sample comment letter, we suggest that this be fixed in the Draft PRC Policy at Section 2-3.6(2), in order to mirror the outline in the regulations as follows:

> To be eligible for PRC, an individual must be eligible for direct care as defined in 42 C.F.R. § 136.12; and either
>
> 1. reside within the U.S. on a Federally-recognized Indian reservation; or
>
> 2. reside within a PRCDA and;
>
>   a. be a member of the Tribe or Tribes located on that reservation; or
>
>   b. maintain close economic and social ties with that Tribe or Tribes.

Other changes in the eligibility section include: (1) a change to Section 2-3.6(3), which recognizes the ability of tribes to define who is eligible for PRC though close economic and social ties; and (2) the addition of "high school" students as full-time students eligible for care outside of their PRCDA (Section 2-3.6(4)). On the calls, Ms. Schmidt noted, in response to questions from Tribal Representatives, that this would include

students at advanced schools and at state-funded high schools, such as those in Alaska.

Additionally, the IHS includes a new provision about PRC for persons in custody. On the calls, Ms. Schmidt explained that the IHS is not responsible for the cost of care for eligible persons in custody at non-Indian law enforcement agencies. However, she said the IHS is responsible for persons in the custody of Indian law enforcement. The Draft PRC Chapter does not define what the IHS would consider "Indian law enforcement," but on the June 11 call, Ms. Schmidt said that it includes the BIA and tribal law enforcement. One Tribal Representative asked if this included those law enforcement agencies operating under a compact with a tribe to provide law enforcement, such as in the State of Oklahoma, and Ms. Schmidt said that the IHS would consider those persons as in the custody of Indian law enforcement for PRC purposes. The provision does not address persons in custody related to the Violence Against Women Act.

Tribal Appeals Process

We support the new provision at the end of Section 2-3.11(4), which is the tribal appeals process for contractors, because it recognizes that tribal contractors are not legally required to use the IHS appeals process for their PRC program. However, it appears to only discuss the Tribal Appeals Process in terms of retained authority but does not refer to the option to buy back the appeals process.

Additionally, Section 2-3.11(5)(1) states that the IHS will not use "Tribal criteria and interpretations" in the appeals process. This is not consistent with several other provisions: Section 2-3.6(3), which states that the IHS will recognize tribally defined criteria for PRC eligibility; Section 2-3.11(7) (following this provision) that recognizes that tribes may set different standards for PRC eligibility and medical priorities; and Section 2-3.20(6), recognizing tribal criteria for high cost cases. This provision should allow for a process that includes review by the aforementioned tribal standards, not those set by the IHS. As an aside, we support all of the provisions recognizing the authority of tribes to set their own criteria and standards.

Notification of a Claim

The definition of "Notification of a Claim" in Section 2-3.1(5)(22) is duplicative of Section 2-3.21(2)(1) and (2). As this term requires significant explanation, more in the form of requirements than a definition, we recommend to the IHS in the attached sample comment letter that Section 2-3.1(5)(22) be deleted.

Section 2-3.21(2)(1) is paraphrased from 42 C.F.R. § 136.24(b), and is not an accurate statement of the regulations. This provision should accurately reflect the law. Similarly, Section 2-3.21(2) prefaces all the requirements that follow with citations to statutes and the regulations. This could lead the reader to presume that those statutes and

regulations legally oblige the provider to meet the requirements. However, the three requirements in Section 2-3.21(2)(2) are not mandated by any law and are only provided for in policy.

Additionally, Section 2-3.21(2)(2)(1) appears to require information from a provider (whether a patient is eligible for care) that a provider would not have. It is the IHS's responsibility for determining whether a patient is eligible. It is unclear whether the IHS intends that this provision require sufficient information about the patient from the provider so that *the IHS* can identify a patient as eligible on its end. Similarly, the use of "IHS services" in this provision is unclear because it is an undefined term.

Contacts

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This document was prepared by Hobbs Straus Dean & Walker, LLP, to highlight the changes proposed by the Indian Health Service to the PRC Chapter and aid our clients in preparing comments. It compares the current PRC Chapter (Part 2, Chapter 3 of the Indian Health Manual) to the Draft PRC Chapter.

2-3.1 INTRODUCTION

A. Purpose. This revised chapter ~~consolidates~~publishes the policy, procedures, and guidance for the effective management of the Indian Health Service (IHS) ~~Contract Health Services (CHS~~Purchased/Referred Care (PRC) Program. The authority to manage the operation of the ~~CHS~~PRC Program is delegated to the greatest degree possible, within the limits of available funds, to Area Directors and Chief Executive Officers (CEO). In the event PRC funds are depleted, PRC payment for services must be denied or deferred and the CEO must notify the Area Director.

B. Authorities.

~~1. Geographic Composition of the Contract Health Service Delivery Areas (CHSDA) and Service Delivery Areas (SDA) of the Indian Health Service, Federal Register (FR): June 21, 2007 (Volume 72, Number 119) Pages 34262-34267~~

~~Persons to whom services will be provided. 42~~

(1) 25 U.S.C. 13 (Snyder Act)

(2) 42 U.S.C. 2001 et seq. (the Transfer Act of 1954)

~~2. 42~~ *Code of Federal Regulations* (CFR~~), Title 42, §)~~ 136~~.12~~

~~3. Definitions. 42 CFR §136.21~~

~~4. Establishment of contract health service delivery areas. 42 CFR §136.22~~

~~5. Redesignation of contract health service delivery areas. 42 CFR §136.22(b)~~

~~6. Persons to whom contract health services will be provided. 42 CFR §136.23~~

~~7. Priorities for contract health services. 42 CFR §136.23(e)~~

~~8. Payor of last resort. 42 CFR §136.61~~

~~9. Administrative Procedures Act, 5 United States Code (U.S.C.) 500, et seq.~~

~~10. Alaska Native Claims Settlement Act, 43 U.S.C., 1601 et seq.~~

~~(1)~~(3) ~~The Victims of Crime Act of 1984 42 U.S.~~ Subparts C~~. 112, §10601~~, D, I and G

~~11. Indian Civil Rights Act of 1968, 25 U.S.C. 1301, et seq.~~

~~12. Eligibility of California Indians, Rancheria Act of August 18, 1958, (72 Statutes at Large (STAT.) 619)~~

~~13. Social Security Amendments of 1972,~~ Public Law (Pub. L.) ~~92-603~~

~~14. Indian Self-Determination~~111-148, Patient Protection and ~~Education Assistance Act, P.L. 93-638, as amended~~

~~(2)~~(4) ~~Indian Health~~Affordable Care ~~Improvement Act, P.L. 94-437, as amended~~Act (March 23, 2010) – (Payer of Last Resort)

~~15. Electronic Signatures in Global and National Commerce Act, P.L. 106-229~~

~~16. Federal Managers' Financial Integrity Act of 1982, P.L. 97-255~~

~~17. The Fiscal Year (FY) 1987 Appropriations Act for the IHS, P.L. 99-591~~

~~18. Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, Section 17003~~

(5) Pub. L. 111-5 "The American Recovery and Reinvestment Act of 2009" – (Medicaid Cost Sharing)

(6) Pub. L. 108-173 "Medicare Prescription Drug Improvement and Modernization Act of 2003" – (PRC Rates for services furnished by

Medicare-Participating Hospitals)

C. Policy. It is IHS policy to ensure that ~~CHS~~PRC funds are used to supplement and complement other health care resources available to eligible American Indian and Alaska Native (AI/AN) people. ~~Contract Health Service~~ The funds are utilized in situations~~,~~ where:

(1) no IHS direct care facility exists;

(2) the ~~existing IHS~~ direct care element is incapable of providing required emergency and/or specialty care;

(3) ~~utilization in~~ the direct care element ~~exceeds existing staffing~~has an overflow of medical care workload; and

(4) supplementation of alternate resources (i.e., Medicare, Medicaid, ~~or~~ private insurance, Veterans Health Administration) is required to provide comprehensive health care to eligible AI/ANs.

D. Acronyms.

(1) AMA – Against Medical Advice
(2) ARRA – American Recovery and Reinvestment Act
(3) CY – Calendar Year
(4) CHEF – Catastrophic Health Emergency Fund
~~(1)~~(5) CEO - Chief Executive Officer
(6) CFR - *Code of Federal Regulations*
~~19. CHEF - Catastrophic Health Emergency Fund~~
~~20. CHS - Contract Health Services~~
~~21. CHSDA - Contract Health Service Delivery Area~~
(7) CHS/MIS - Contract Health Services/Management Information System
~~22. CHSO - Contract Health Service Officer~~
(8) CDSR - Core Data Set Requirement
(9) DCC - Division of Contract Care
(10) EHR – Electronic Health Record
(11) EPHI – Electronic Personal Health Information
(12) FMFIA – Federal Managers Financial Integrity Act
~~(12)~~(13) FMCRA - Federal Medical Care Recovery Act
~~(13)~~(14) ~~FMFIA -~~ FR – *Federal* ~~Managers' Financial Integrity Act~~*Register*
~~(14)~~(15) FI - Fiscal Intermediary
~~23. FR - Federal Register~~
(16) FY – Fiscal Year
(17) HITECH – Health Information Technology for Economic and Clinical Health Act
~~(15)~~(18) HIPAA – Health Insurance Portability and Accountability Act
~~(16)~~(19) IHCIA – Indian Health Care Improvement Act
(20) MMA – Medicare Modernization Act

(21) PHI – Protected Health Information
(22) PRC – Purchased/Referred Care
(23) PRCDA – Purchased/Referred Care Delivery Area
(24) PRCO – Purchased/Referred Care Officer
~~(17)~~(25) RCIS – Referred Care Information System
(26) RPMS – Resource and Patient Management System
(27) UFMS – Unified Financial Management System
(28) U.S.C. – *United States Code*
(29) VA – Veterans Health Administration

E. Definitions~~. (See also~~ (Also see 42 CFR ~~§~~136.21~~)~~).

(1) Alternate Resources. ~~Health care~~ Alternate resources ~~other than those~~are any Federal, State, local, or private source of coverage for which the ~~IHS. patient~~ is eligible. Such resources include health care providers~~,~~ and institutions~~, or~~ and health care programs for the payment of health services including~~,~~ but not limited to programs under ~~Titles XVIII and XIX of~~ the Social Security Act (i.e., Medicare and Medicaid, ~~State Children s~~Childrens Health Insurance Program), other Federal health care programs, State and local health care programs, Veterans Health Administration and private insurance.

(2) Appropriate Ordering Official. The person, with documented delegated procurement authority, who signs the purchase order~~s~~ authorizing the obligation of ~~CHS~~PRC funds.

(3) Area Director. The Director of an IHS Area Office designated for purposes of administration of IHS programs.

(4) Catastrophic Health Emergency Fund. The Catastrophic Health Emergency Fund (CHEF) is the fund ~~appropriated~~established by Congress to ~~partially cover the IHS portion of~~ reimburse extraordinary medical expenses incurred for catastrophic illnesses and ~~events that are~~ disasters covered by ~~IHS CHS~~a PRC program of the IHS, whether such program is carried out by IHS or an Indian Tribe or Tribal organization under the Indian Self-Determination and Education Assistance Act.

(5) Catastrophic Illness. Catastrophic illness is a medical ~~priorities. The IHS will pay, from the CHEF, for~~condition that is costly by virtue of the intensity and/or duration of its treatments. Examples of conditions that frequently require multiple hospital stays and extensive treatment are cancer, burns, premature births, cardiac disease, end-stage renal disease, strokes, trauma-related cases ~~that are covered by IHS CHS~~such as automobile accidents and gunshot wounds and some mental disorders.

(6) Medicare Approved Transplant Program. A facility or institution that has met or exceeded defined standards of care in which transplants of organs are performed. The transplant program is a component within a transplant hospital that provides transplantation of a particular type of organ.

~~(4)~~(7) CHEF Case. A CHEF case is an episode of acute medical ~~priorities. The IHS is not responsible to cover cases that are expensive but outside the CHS~~care for a condition from an illness or injury, requiring extensive treatment that incurs medical ~~priorities~~costs to the IHS in excess of the CHEF threshold.

(8) CHEF Threshold Cost. A designated amount above which incurred medical costs will be considered for CHEF reimbursement after a review of the authorized expenses and diagnosis.

~~(5)~~(9) Chief Executive Officer. The Chief Executive Officer (CEO ~~holds~~) is the ~~overall responsibility for and~~ Director of the ~~administration of health service~~IHS program ~~activities occurring~~ at the service unit level. ~~Program activities are categorized as administrative, clinical, or financial in nature~~ for the purposes of administration of the health service programs for that location.

~~Contract Health Service~~

(10) Medical Referral. A referral for health care services that is not authorized for payment by PRC.

~~(6)~~(11) Purchased/Referred Care Delivery Area. The Purchased/Referred Care Delivery Area (PRCDA) is the geographic area~~s~~ within which ~~CHS~~PRC will be made available by the IHS and Tribes.

~~Contract Health Services. Health services paid by the IHS that are~~

(12) Purchased/Referred Care. Purchased/Referred Care (PRC) is any health service that is:

a. delivered based on a referral by, or at the expense of, an Indian health program; and

~~a.~~b. provided ~~to eligible AI/ANs by non-IHS~~by a public or private ~~providers (e.g., dentists, physicians, hospitals).~~medical provider or hospital which is not a provider or hospital of the IHS or Tribal health program.

~~24. Contract Health Services Eligible Person. A person as defined in Section 2-3.6 of this chapter as being eligible for CHS.~~

~~Contract Health Services to~~

~~(7)~~(13) Purchased/Referred Care in Support of Direct Care. These are contracted specialty physician and non-physician specialty medical services provided within an IHS/Tribal facility when the patient is under direct supervision of an IHS physician or a contract physician practicing under the auspices (or authority) of ~~an~~the IHS facility.

~~(8)~~(14) ~~Contract Health Services~~ Core Data Set. The ~~CHS~~PRC Core Data Set consists of ~~data~~ required data for management of the ~~CHS~~PRC program that constitutes a subset of data collected in the IHS information system. The purpose of the data is to assist the IHS in its internal management and to satisfy Congressional and other mandatory reporting requirements.

(15) Deferred Services. Deferred services are services referred for PRC that do not meet immediate medical priority for payment guidelines for which the provision of treatment can be postponed or delayed and the service has not been provided.

(16) Descendent of a Tribal Member. An individual biologically descended from an enrolled member of the Tribe.

(17) E-SIGN. E-SIGN is the electronic equivalent of a hand-written signature requiring user authentication, such as a digital certificate, smart card or biometric method for verification.

~~(9)~~(18) Emergency. An emergency is any medical condition for which immediate medical attention is necessary to prevent the death or serious impairment of the health of an individual~~s health~~.

~~25. E-SIGN. The electronic equivalent of a hand-written signature requiring user authentication and verification, such as a digital certificate, smart card, or biometric methods. On June 30, 2000, Congress enacted the Electronic Signatures in Global and National Commerce Act, (E-SIGN) to expand the use of electronic records and signatures in interstate and foreign commerce and ensure the validity and legal effect of contracts entered into electronically. E-SIGN ensures that contracts and purchase orders entered into electronically will be legally effective and valid, and that consumers who enter into contracts electronically have the same protections they have when contracting in the "brick and mortar" world.~~

(19) Episode of Care. The period of consecutive days for a discrete health condition during which reasonable and necessary medical services related to the condition occur.

~~(10)~~(20) Fiscal Intermediary. The Fiscal Intermediary (FI) is the fiscal agent ~~is an organization~~ contracted by ~~the~~ IHS to ~~validate and pay CHS~~provide and implement a system to process PRC medical, dental and behavioral health claims~~.~~ for payment (42 U.S.C. 238m).

~~(11)~~(21) Indian Tribe. Any Indian Tribe, band, nation, group, pueblo, or community, including any Alaska Native village or Native group, which is Federally-recognized as eligible for the special programs and services provided by the United States (U.S.) to ~~AI/ANs~~Indians, because of the~~i~~~~s~~r status as Indians.

(22) Notification of a Claim. For the purposes of part 136, and also 25 U.SC. 1621s and 1646, the submission of a claim that meets the requirements of 42 CFR 136.24.

a. Such claims must be submitted within 72 hours after the beginning of treatment for the condition or after admission to a health care facility, notify the appropriate ordering official of the fact of the

determine the relative medical need for the services and the eligibility of the Indian for the services.

~~a.~~b. The information submitted with the claim must be sufficient to :

(i) Identify the patient as eligible for IHS services (e.g., name, address, home or referring service unit, Tribal affiliation),

(ii) Identify the medical care provided (e.g., the date(s) of service, description of services), and

(iii) Verify prior authorization by the IHS for services provided (e.g., IHS purchase order number or medical referral form) or exemption from prior authorization (e.g., copies of pertinent clinical information for emergency care that was not prior-authorized).

(23) PRC Rates. The PRC rates are the rates IHS adopted in 42 CFR 136 Subpart D and Subpart I for payment of services authorized for payment through a PRC program. These rates are commonly referred to as Medicare-like rates.

(24) PRC Referral. An authorization for medical care by the appropriate ordering official in accordance with 42 CFR part 136 subpart C.

~~(12)~~(25) Reservation. Any Federally-recognized Indian ~~Tribe s~~Tribes reservation, pueblo, colony, Indian allotments, or Rancheria, including ~~former reservations in Oklahoma, and~~ Alaska Native regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601~~,~~ *et seq*.~~) and Indian allotments.~~).

~~(13)~~(26) Residence. ~~Where~~ In general usage, a person "resides" where he or she lives and makes his or her home as evidenced by acceptable proof of residency or ~~acceptable proof~~ established by the ~~Service Unit~~IHS facility or PRC program.

~~(14)~~(27) Secretary. ~~The~~ Secretary of the Department of Health and Human Services (HHS).

~~(15)~~(28) Service. The Indian Health Service.

~~(16)~~(29) Tribal Health Director. The Director of a Tribally-operated program, or his/her designee, authorized to make decisions on payment of ~~CHS~~PRC funds pursuant to a Pub. L. 93-638 contract.

~~(17)~~(30) Tribal Member. A person who is an enrolled ~~descendent~~member of a ~~Federally Recognized~~ Tribe or is granted Tribal membership by some other criteria ~~in~~by the appropriate Tribal ~~constitution~~governing policy/document.

~~(18)~~(31) Tribally-Operated Program. A program operated by a Tribe or Tribal organization that has contracted under Pub. L. 93-638 to provide a ~~CHS~~PRC program.

~~(19)~~(32) Tribal Self-Insurance. A health plan that is funded solely by a Tribe or Tribal organization and for which the Tribe or Tribal organization assumes the burden of payment for health services covered under the plan either directly or through an administrator. Any portion of the plan ~~may~~that is reinsured will not be ~~re-insured, but the Tribe or~~considered Tribal ~~organization must bear some risk~~Self-Insurance.

(33) Unmet need - PRC. The IHS collects data on cases of unfunded PRC services — services for which funding was not available — from the individual federally and tribally-operated PRC programs. Counts of deferral and denial cases are recorded by the individual PRC programs, collected by the Area Offices, and submitted to HQ. The aggregate count of cases is multiplied by the average cost per PRC claim (weighted average of the costs for inpatient, outpatient and transportation paid PRC claims) provided by the FI to estimate PRC program resource unmet need.

(34) Urgent Care. The delivery of ambulatory care in a facility dedicated to the delivery of medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency department.

(35) Veterans Eligible for VA Resources. Eligibility for VA resources is dependent upon a number of variables, which may influence the final determination of services for which the veteran qualifies. These factors include the nature of a veterans discharge from the military service (e.g., honorable, other than honorable), length of service, VA adjudicated disabilities (commonly referred to as service connected disabilities), income level and available VA resources among others.

2-3.2 RESPONSIBILITIES

A. Director, Division of Contract Care. The Director, Division of Contract Care (DCC), IHS Headquarters (HQ) will:

(1) Establish general policies regarding the administration of the ~~CHS~~PRC program in the IHS.

(2) Establish standards of performance for Area, service unit~~,~~ and FI operations of ~~CHS~~PRC.

(3) Assess the performance of the ~~CHS~~PRC program at ~~the~~ Area, service unit and ~~Service Unit levels; and the~~ FI against established standards.

(4) Assess ~~the~~ long-term purpose and direction of the ~~CHS~~PRC program to ensure maximum effectiveness of the program in meeting the health needs of ~~Indian~~AI/AN people.

(5) ~~Formulate~~Develop long-term plans and objectives for the future development of the ~~CHS~~PRC program.

(6) Provide staff assistance to Area Offices in matters of general policies and procedures.

(7) Prepare budget justification for the total ~~CHS~~PRC program.

(8) Allocate funds through the Office of Finance and Accounting to Area Directors.

(9) Promptly and appropriately respond to ~~CHS appeal~~appeals of denials of PRC by IHS Area Offices.

(10) Provide guidance in the establishment of ~~Area~~ medical priorities.

(11) Provide project officer services for the FI contract and all FI evaluation projects.

(12) Respond to congressional questions and requests for information from the ~~CHS~~PRC program.

(13) Centrally manage the CHEF.

(14) Establish general guidelines and policies for applying ~~managed~~ coordination of care practices and ~~CHS~~PRC quality assurance activities in the Areas and service units.

(15) ~~Establish~~ Continue to operate and ~~implement~~refine a Management Control System for the ~~CHS~~PRC function that conforms to the requirements of the Federal Managers Financial Integrity Act (FMFIA), Section 2 ~~(~~[31 U.S.C. 3512 (b~~)),~~)] and IHS policies and procedures cited in Part 5, Chapter 16, "Management Control Systems~~,~~," *Indian Health Manual* (IHM).

B. Area Director. The Area Director administers the ~~Area Office CHS~~PRC program, ensuring ~~that~~ the program operates within regulations, policies, procedures~~,~~ and the budget. The Area Director ~~will~~through the respective Area PRC Officer shall:

(1) Develop and establish policies and methods for the direction, control, review~~,~~ and evaluation of the Area and service unit ~~CHS~~PRC programs.

(2) Establish ~~Area~~ medical priorities for the care of eligible AI/AN people that

will most effectively meet their needs within the funds available ~~that~~and are consistent with the National IHS medical priorities.

(3) Maintain records for planning and for controlling funds and furnish reports to ~~IHS Headquarters~~the Director, DCC, at HQ as required.

(4) Allocate an equitable share of funds among the ~~CHS Service Units~~ IHS/Tribal PRC programs based on established formulas agreed to by the Tribes.

~~1. Establish Contracts/Rates Quote Agreements in coordination with CEOs for needed services with hospitals, clinics, physicians, dentists, and others in accordance with the Area policies and established regulations, the CHS payment policy of June 30, 1986, and policy and procedures established in the Part 5, Chapter 5, Section 13, Acquisition of Health Care Services, IHM.~~

(5) Coordinate appropriate contract activities with the Area Contracting Officer.

~~2. Periodically review and evaluate the quality and effectiveness of services provided under contract. In carrying out this responsibility, Areas are encouraged to utilize the services of one or more Quality Improvement Organizations (QIO) originally known as Peer Review Organizations (PRO). The name was officially changed to QIO via regulations published in the May 24, 2002 FR.~~

(6) Act promptly and appropriately ~~respond to CHS appeal~~on appeals of service unit PRC denials ~~by Service Units~~.

(7) Act promptly and appropriately on appeals from Pub. L. 93-638 operated ~~CHS~~PRC programs if the program has elected to follow the IHS appeals process.

(8) Monitor the CHEF cases ~~submitted by the Service Units or P.L. 93-638 operated CHS programs~~.

(9) Establish general guidelines and policies for applying ~~managed~~ coordination of care practices and ~~CHS~~PRC quality assurance activities in the ~~Areas or Service Units~~IHS Area facilities.

(10) Be responsible for ~~the~~ internal controls related to the FMFIA.

2-3.~~3 CONTRACT HEALTH SERVICE~~2 PURCHASED/REFERRED CARE DELIVERY AREA

~~A. Contract Health Service~~ Purchased/Referred Care Delivery Area~~. All approved Contract Health Service Delivery Areas (CHSDA) are specified in~~ (PRCDA). Currently the IHS provides services under regulations in effect on September 15, 1987 republished at 42 CFR ~~§~~Part 136~~.22~~, Subparts A-C, and may be changed only in accordance with the Administrative Procedures Act (5 U.S.C. 553).

~~B. Established Contract Health Service Delivery Areas. Established CHSDA are~~ 42 CFR Part 136, Subpart C defines a PRCDA as the geographic area within which PRC will be made available to members of an identified ~~below:~~

~~1. The State of Alaska.~~
~~2. The State of Nevada.~~
~~3. The State of Oklahoma.~~
~~4. Chippewa, Mackinac, Luce, Alger, Schoolcraft, Delta, and Marquette counties in the State of Michigan.~~
~~5. Clark, Eau Claire, Jackson, Lacrosse, Monroe, Vernon, Crawford, Shawano, Marathon, Wood, Juneau, Adams, Columbia, and Sauk counties in the State of Wisconsin, and Houston County in the State of Minnesota.~~
~~6. The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura.~~
~~7. Aberdeen Area - Trenton (Turtle Mountain Chippewa), North Dakota.~~
~~8. Aberdeen Area - Northern Ponca, Nebraska.~~

A. ~~With respect to all other reservations, within the funded~~ Indian community who reside in the PRCDA. It should be clearly understood that residence within a PRCDA by a person who is within the scope of the Indian health program, as set forth in 42 CFR 136.12, creates no legal entitlement to PRC but only potential eligibility for services.

B. Services Needed But Not Available. Services needed but not available at an IHS or Tribal facility are provided under the PRC program depending on the availability of funds, the persons relative medical priority and the actual availability and accessibility of alternate resources in accordance with the regulations.

C. Established Purchased/Referred Care Delivery Areas. Established PRCDA are listed in the *Federal Register* (FR) Notices. The current PRCDA *Federal Register* Notice can be found on the IHS PRC Web site: http://www.ihs.gov/PRC/documents/PRCDA_FEDERAL_REGISTER_NOTICE_June_21_2007.doc~~the CHSDA~~

(1) A PRCDA typically consists of a county that includes all or part of a reservation, and any county or counties that have a common boundary with the reservation.

(2) ~~In addition,~~ Congress has statutorily create~~s~~d or re-~~designates the CHSDA~~designated a PRCDA through legislative enactments such as appropriations, restoration and/or recognition acts, public laws, etc. ~~This information is dissemenated to the public through Federal Register (FR) Notices, as necessary.~~

(3) Some Tribes and particularly many of the newly recognized Tribes do not have reservations. When congress has not legislatively designated counties to serve as a PRCDA for such a Tribe, the Director, IHS, exercises reasonable administrative discretion to designate a PRCDA to effectuate the intent of Congress for the Tribe.

(4) The Director, IHS, publishes a notice in the FR when there are revisions or updates to the list of PRCDAs, including the designation of a PRCDA for a newly recognized Tribe.

2-3.4 REDESIGNATION OF A PRC~~HS~~DA

A. Re-designation Request. The Tribal group(s) affected, or the IHS, (after ~~consultation~~working with the affected Tribal group(s~~))~~) may request for re-designation of a ~~CHSDA.~~ PRCDA. All requests for re-designation shall contain the following information:

(1) The estimated number of AI/AN people who will be included and/or excluded ~~regarding CHS~~for eligibility of PRC. Note: The re-designation of a PRCDA may not result in the exclusion of AI/AN people eligible under 42 CFR 136.23(a)(1), i.e., reservation residents.

(2) The Tribal governing body~~'~~s designation of the categories of AI/AN people to be included and/or excluded from ~~CHS~~ eligibility~~, e.g.,~~ for PRC; such as:

b. members of the Tribe who live near the reservation~~;~~ or

c. ~~American Indian/Alaska Native~~ AI/AN people~~,~~ who are not members of the Tribe~~,~~ but have close economic and social ties with the Tribe.

~~A. Re-designation Request Requirements.~~

~~1. The re-designation of a CHSDA may not result in the exclusion of Indian people eligible under 42 CFR §136.23(a)(1), i.e., reservation residents.~~

~~2. The estimated costs of including additional AI/AN people in the CHSDA are determined according to the IHS resource allocation guidelines currently in effect.~~

(3) The ~~effect~~impact of ~~changing~~ the ~~CHSDA~~change in the PRCDA on the level of ~~CHS funding~~PRC being provided to eligible AI/AN people in the ~~originally configured CHSDA~~original PRCDA.

(4) The justification for the ~~CHSDA~~ change in the PRCDA. The justification may include~~, but is not limited to,~~ criteria used in establishing the PRC~~HS~~DA for the States ~~of Oklahoma, Nevada, Michigan, and Minnesota as~~ outlined in 42 CFR §136.22, but are not limited to these criteria.

B. Submission of a ~~Request for~~ Proposed PRC~~HS~~DA Change. ~~All proposed CHSDA changes~~ Proposals for a change in a PRCDA must be submitted to the Director of the Area Office of the affected Tribe for review and forward~~inged~~ to ~~IHS Headquarters~~the Director, DCC, for appropriate action.

C. Requirements.

(1) The Area ~~CHS~~PRC Officer will analyze the ~~proposal outlining positive and negative features,~~ request and will recommend acceptance or rejection of the request to the Area Director. For tribally- managed programs, ~~the~~ analysis will be coordinated with the Area Tribal Project Officer for contracted programs or ~~the~~ Self-Governance Coordinator for compacted programs. If another Tribe(s) is affected by the PRCDA designation/re-designation there must be

consultation by the Area with the affected Tribe(s).

~~(1)~~(2) The Area Director will then forward~~s~~ the recommendation, in writing to the Director, DCC, for appropriate action on the proposal.

~~(2)~~(3) The Director, DCC, ~~reviews~~will review the ~~recommendation~~request for the re-designation of the PRC~~HS~~DA, and appl~~ies~~y the criteria outlined in Paragraph A ~~and B in this section~~above to the information submitted to support the ~~recommendation~~request. If the submittal from the Area is complete, the Director, DCC will convene a meeting of an ad hoc PRCDA Designation /Re-designation Committee to consider the request. The committee members consist of IHS HQ representatives from the DCC; Office of Finance and Accounting/Division of Budget Formulation; Office of Public Health Support/Division of Program Statistics; Office of Management Services/Division of Regulatory Affairs; Office of Tribal Self-Governance; and Office of Direct Service and Contracting Tribes. The Director, DCC will chair the committee meeting.

~~(3)~~(4) ~~After review,~~ The Director, DCC, shall prepare a report ~~finding~~containing the findings of the PRCDA Designation /Re-designation Committee as to whether the criteri~~on~~a have been met. The Director, DCC, will submit ~~his/her written~~the findings and recommendation to approve or deny the request via memorandum~~, as to whether the request for the re-designation should be granted,~~ to the Director, IHS. If approval is recommended, the Director, DCC will draft the PRCDA re-designation *Federal Register* notice.

(5) The Director, IHS will inform the Tribe requesting the PRCDA designation/re-designation and the corresponding Area Director of the decision. The decision is final and cannot be appealed.

D. Tribal Consultation. The regulations at 42 CFR §136.22(b) state that after ~~consultation with the Tribal governing body or bodies of those reservations~~ con
included in the PRC~~HS~~DA, the Secretary may from time to time, re-designate areas within the ~~United States~~U.S. for inclusion in or exclusion from a ~~CHSDA.~~ PRCDA. Consultation with the affected Tribe(s) occurs during the review of the request for re-designation, ~~and~~but the IHS publishes a notice ~~in the Federal Register (FR) requesting public~~with requests for comments as part of the consultation process. (See Manual Exhibit 2-3-~~M~~A for sample materials on re- designation of a PRC~~HS~~DA.)

~~(4)~~(1) ~~After determining~~If IHS determines that a re-designation of a ~~Tribe s CHSDA~~Tribes PRCDA should be made, the IHS shall publish a notice with ~~comment period~~ request for comments in the FR advising the public that the IHS proposes to re-designate a particular ~~Tribe s CHSDA~~Tribes PRCDA.

~~(5)~~(2) The ~~FR~~ notice with request for ~~public~~ comments shall include:

a. The proposed action and the background information sufficient to

provide the public an explanation for the Agency's decision.

b. A statement as to the date when comments must be received. There must be at least a 30-day "comment" period from the date of the notice's publication. of the notice.

b.c. Reference to the legal authority and the name and address of the public official to whom comments should be addressed.

D.E. Effective Date of PRCHSDA Change. After a review of any comments received by the IHS after the publication of its notice with the request for comments, and after determining that a Tribe s CHSDAthe Tribes PRCDA should still be re-designated, IHS publication of the public notice with a comment period, and review of any comments received, the IHS shall publish a final notice advising the public of the decision. Anythat the IHS is re-designating a particular Tribes PRCDA. The change toin the CHSDA isPRCDA will be effective on the date of publication of the final notice in the FR.

B. Additional Counties. Counties may be added to a Tribe s CHSDA by operation of the CHS regulations when:

F. Exception. Under certain circumstances, the notice and comment process described above, in paragraphs 2-3.4A-E, is not necessary in order to add counties to a Tribes PRCDA. Instead, a memorandum from the Director, IHS, is mailed to the respective Area Director regarding the action resulting in a correction to, expansion of, or the creation of the Tribes PRCDA with instructions to the Area Director to contact the Tribe with this information. Such circumstances include the following:

(1) the IHS inadvertently or mistakenly omitsted the county from the Tribe s CHSDATribes PRCDA list; or

(2) the Tribe sTribes reservation was expanded or created by a proclamation issued by the Secretary of Interior or by congressional statute, e.g., Federal recognition of a Tribe.

C.A. Exception. Under exceptional circumstances, the public notice and comment process described in paragraphs 2-3.4A-F is not necessary. Instead, a memorandum from the Director, IHS, is mailed to the respective Area Director regarding the action resulting in the creation, correction, or expansion of the Tribe s CHSDA, with instructions to the Area Director to contact the Tribe with this information.

2-3.5 PERSONS TO WHOM CHSPRC WILL BE PROVIDED

A. Authority. The CFR, Title 42 CFR Part 136.23 is the appropriate citation for all correspondence to providers and AI/AN patients. regarding eligibility for PRC. NOTE: This IHM chapter should not be cited as the authority for making decisions on eligibility or payment denials.

B. Funds Available. There is no authority to authorize payment for services under the CHSPRC program unless funds are in fact available.

C. Insufficient Funds. When funds are insufficient to provide the volume of purchased/referred care indicated as needed by the population residing in a PRCDA, priorities for service shall be determined on the basis of relative medical need. Manual Exhibit 2-3-B demonstrates the process for determining the disposition for a patient being considered for PRC funding. In the event that all PRC funds are depleted, referrals will be denied PRC payment or deferred. Medical referrals will still be made based on services needed by the patient. However, no payment or promise of payment can be made when there are no funds available. The Service Unit CEO will notify the Area Director when PRC funds are insufficient.

~~C.~~D. Services.

(1) Any expenditure of ~~CHS~~PRC funds is limited to services that are medically indicated ~~services.~~ . See ~~Manual Exhibit 2-3-D Contract Health Services~~the Medical ~~Priorities~~ Priority list for services that may be included and those specifically excluded. The listing for PRC Medical Priorities can be found at the PRC Web site: http://www.ihs.gov/PRC/index.cfm?module=PRC_requirements_priorities_of_care

(2) No ~~CHS~~PRC funds may be expended for services that are reasonably accessible and available at IHS facilities.

(3) The determination of whether an IHS ~~or tribally operated~~ facility is "reasonably accessible and available" is made by the CEO~~,~~ based on the following criteria:

a. Determination ~~by a qualified IHS Clinical health professional of the patient s~~of the actual medical condition ~~at admission~~of the patient, i.e., emergent, urgent, or routine.

b. The ~~capacity~~ability of the IHS ~~or Tribal facility~~ to provide the necessary service.

c. The level of funding available to provide ~~CHS~~PRC.

d. Distance from the IHS facility.

~~d.~~e. Inclement weather and/or ~~Tribal~~ unsafe travel conditions must be taken into consideration for time/distance to an IHS facility.

~~D.~~E. Guidelines. The following guidelines will be used in applying the above criteria:

(1) There must be a compelling reason to believe, upon review of the medical record and assessment of the patient's situation~~,~~ that without immediate medical treatment an ~~individual s~~individuals life or limb would have been endangered.

(2) Available ~~CHS~~PRC funds may be authorized for an emergency to the extent that the contract facility ~~is~~was the nearest available provider capable of providing the necessary services and the ~~patient s~~patients condition dictate~~s~~d that he/she be transported to ~~that facility~~the nearest hospital.

(3) ~~Medical and dental priorities (Manual Exhibits 2-3-D and E) include~~ A list of diagnostic categories that have been administratively determined to be emergencies~~.~~ is included. This list is not all inclusive and other conditions may be included as an emergency when so determined by ~~a~~ qualified IHS ~~clinical health professional.~~professionals. Medical and dental priorities may be found at the following: http://www.ihs.gov/PRC/index.cfm?module=PRC_requirements_priorities_of_care ~~The~~)

(4) Final decision as to classification of medical services as "emergency" will be based on review by ~~a qualified IHS~~an appropriate clinical health professional or by documented medical history.

(5) Services for an acute condition (urgent but not emergent) may be provided through ~~CHS~~PRC funds when the nature of the medical need of the patient, as determined by a ~~qualified IHS clinical health~~ professional, can best be met by using a ~~contract~~private facility and ~~when~~ sufficient ~~CHS~~PRC funds are available for this level of service.

(6) Routine health services (not ~~urgent or~~ emergent or urgent) should ordinarily be provided by IHS ~~or Tribal~~ staff and facilities. Routine health services may be provided through ~~the CHS Program~~PRC when the CEO has determined that sufficient ~~CHS~~PRC funds are available for this priority of medical service. As a general rule, routine health services will not be provided through ~~CHS~~PRC when an IHS ~~or Tribal~~ facility capable of providing these services is within 90 minutes one-way surface transportation time from the ~~patient s~~persons place of residence. Weather conditions at the time of the illness should be considered when estimating time to the facility.

(7) ~~Each Service Unit may develop policy or policies, with Tribal participation~~If a facility desires to change the criteria in 2-3.5E(6) for their patients, on the availability and accessibility of IHS facilities ~~if~~for routine health services they must request the Area Office to issue a supplement on the criteria to be used ~~are different than the previous guidance specified in this section. Contract Health Service policies~~for their facility. The new criteria should be developed with Tribal consultation and issued by the Area Office as stipulated in 1-1.2 IHM. This change will be posted ~~in a publicly accessible location~~ and published to maximize knowledge among the AI/AN population served. This can be done through posters in clinic and hospital waiting areas, local media, brochures and wallet size information cards.

~~(7)~~(8) ~~Contract Health Service~~ Purchased/Referred Care funds may be expended for

services to support direct care individuals ~~receiving direct care~~ treated in an IHS ~~or Tribal~~ facility to the extent that the individual is eligible for direct services. However, hospitals and clinics funds shall be used to support direct care whenever possible. Payment of costs for ~~services contracted~~"contract to support direct care" specialty services (e.g., prenatal, podiatry, or orthopedic ~~care~~clinics) provided within the facility are permitted when patients are under the direct supervision of an IHS ~~or Tribal~~ physician or a contract physician practicing under the auspices of ~~IHS or Tribal facility~~the medical staff rules ~~or~~and regulations~~. Most services in a non-~~ of the IHS ~~or non-tribally operated~~ facility. PRC funds are not ~~included unless the patient meets CHS eligibility criteria of Title 42 CFR §136.23, Persons to whom Contract Health Services will be provided.~~ to be used to support routine primary care that the facility is designed to provide. Manual Exhibit 2-3-C includes directives from IHS DCC, HQ on when PRC can be used in support of direct care. Expenditures must be consistent with the directives set forth therein.

2-3.6 ~~CONTRACT HEALTH SERVICE~~ ELIGIBILITY REQUIREMENTS

A. Documentation. An AI/AN claiming eligibility for ~~CHS~~PRC has the responsibility to furnish the CEO ~~or the Tribal program~~ with verifiable documentation to substantiate the claim. Each facility should establish a policy on documentation. Manual Exhibit 2-3-D lists examples of acceptable documentation and examples to clarify the concept of residency.

B. Eligibility. ~~The definition of eligibility for CHS~~ Eligibility for PRC is governed by 42 CFR 136.23. The PRC program is not an entitlement program and thus, when funds are insufficient to provide the volume of PRC needed, services shall be ~~consistent with Title 42 CFR §~~determined on the basis of relative medical need in accordance with established medical priorities [42CFR 136.23~~. If local rules and Title 42 CFR §136.23 conflict, Federal regulations prevail.~~ (e)]. To be eligible for ~~CHS~~PRC, an individual ~~must~~:

(1) must be eligible for direct care as defined in 42 CFR §136.12; and either

(2) reside within the U.S. on a Federally-recognized Indian reservation; or

(3) reside within a PRC~~HS~~DA and;

a. ~~Be a member~~ are members of the Tribe or Tribes located on that reservation; or

b. maintain close economic and social ties with that Tribe or Tribes.

C. Close Economic And Social Ties. The basis for determining ~~a person s~~ close economic and social ties is established by the Tribe(s) served and may include ~~the following~~criteria such as:

(1) ~~The person is employed by~~ employment with a Tribe whose reservation is

located within a PRC~~HS~~DA in which the ~~person~~applicant lives;

(2) ~~The person is married~~ marriage to ~~or is the child of (see 2-3.6K (2) below),~~ an eligible member of the Tribe; or

(3) ~~The Tribe~~ determination by the Tribe(s), including certification (a written decision by the legal governing body of a Tribe which has legal authority) from the Tribe(s) near where the ~~person resides determines and certifies~~individuals live that ~~the person has~~he/she have close economic and social ties with the Tribe whose reservation is located within the ~~CHSDA~~PRCDA in which the applicant resides.

D. Full-time Student. ~~Contract Health Services~~ PRC will be made available to ~~the following~~ students who would be eligible at the place of their permanent residence, but who are temporarily absent from their residence, as follows:

(1) Full ~~-~~time ~~students in~~student programs such as high school, college (undergraduate and graduate) vocational, technical, or other academic ~~institutions~~education, during their attendance and ~~established~~normal school breaks. The service unit where the student was eligible for ~~CHS~~PRC prior to leaving for school is responsible for the student. ~~The student remains~~ These students remain eligible ~~for CHS 180 days~~ after ~~completing~~ the completion of the courses of study up to 180 days. After 180 days has elapsed the student is no longer eligible for PRC.

(2) ~~Full time~~At all Bureau of Indian Affairs (BIA) Boarding ~~school students can receive CHS whether or not they resided in a CHSDA before attending the school. Contract Health Services are~~ Schools, PRC is provided for ~~them~~students during their full-time attendance, by the Area ~~in which~~where the boarding school is located. Included are BIA off-reservation schools such as:

a. Flandreau Indian School, Moody County, South Dakota;

~~a.~~b. Circle of Nation School Wahpeton ~~Indian School~~, Richland County, North Dakota;

~~b.~~c. Sherman Indian High School, Riverside County, California;

~~c.~~d. Riverside Indian School, Caddo County, Oklahoma; and

~~d.~~e. Chemawa Indian School, Marion County, Oregon.

Boarding school students can receive PRC whether or not they resided in a PRCDA before attending the school. While the ~~students are~~student is on a scheduled break or vacation, ~~their~~the students PRC permanent area of residence is responsible for payment of ~~CHS~~PRC services.

E. Transients. PRC eligible persons who are ~~traveling~~on travel or ~~who~~ are temporarily

employed, such as seasonal or migratory workers, ~~are~~remain eligible for ~~CHS~~PRC at their permanent residence during their temporary absence.

F. Persons in Custody. The cost of medical and related health services for eligible beneficiaries in custody of (non-Indian) law enforcement agencies is not the responsibility of the IHS, but is the responsibility of that particular agency. Persons in the custody of Indian law enforcement agencies will be considered eligible on the same basis as other beneficiaries of the Service. IHS does not provide the same health services in each area served and services provided will depend upon the facilities and services available (42 CFR 136.11(c)).

G. Persons outside the United States. Persons visiting a foreign country are eligible for PRC if the beneficiary is eligible for the PRC program and the purchase of care complies with the PRC regulations and the *Federal Acquisition Regulations* (FAR). See guidance in Manual Exhibit 2-3-E.

~~F.~~H. Other Persons outside the ~~CHSDA.~~ PRCDA. Persons, who leave the PRC~~HS~~DA in which they are eligible for ~~CHS~~PRC and ~~who~~ are neither students nor transients, will be eligible for ~~CHS~~PRC for a period not to exceed 180 days from such departure.

~~G.~~I. Other Eligibility Considerations. ~~To be eligible for CHS, an Indian~~ An AI/AN is not required to be a citizen of the U.S. ~~However, the Indian~~ to be eligible for PRC. The AI/AN (e.g., a citizen of Canada or Mexico) must reside in the U.S. and be a member of a Federally recognized Tribe whose traditional land is divided by the Canadian border (e.g., St. Regis Mohawk, Blackfeet) or Mexican border (e.g., Tohono ~~O Odham~~OOdham, Kickapoo).

~~H.~~J. California Indians. Section ~~809(b)~~1679a of the Indian Health Care Improvement Act~~,~~ (IHCIA~~) P.L. 94-437,~~), states that the following California Indians shall be eligible for ~~CHS~~health services provided by the Service:

(1) Any member of a Federally-recognized Indian Tribe;

(2) Any descendent of an Indian who was residing in California on June 1, 1852, but only if such descendent:

~~a. is living in California,~~

a. is a member ~~if~~of the ~~Indian~~AI/AN community served by a local program of the Service, and

b. is regarded as an Indian by the community in which ~~the descendent~~such descendant lives~~; or any Indian~~,

(3) Any AI/AN who holds trust interests in public domain, national forest, or ~~Indian~~AI/AN reservation allotments in California; and ~~any Indian~~

~~(3)~~(4) Any AI/AN in California who is listed on the plans for distribution of assets of California Rancherias and reservations under the Rancheria Act of August

18, 1958 (72 STAT. 619), and any descendent of such an Indian.

~~(4)~~(5) Section ~~809(c~~1679(b) of the IHCIA states that nothing in this Section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

~~I.~~K. ~~American Indian/Alaska Native Children Adopted by Non-Indian Parents.~~ Indians Adopted By Non-~~Indian~~AI/AN Parents. Indians adopted by non-AI/AN parents must meet all ~~CHS~~PRC requirements to be eligible for care (e.g., reside within a PRC~~HS~~DA).

L. Foster Children. American Indian/Alaska Native children who are placed in foster care outside a PRC~~HS~~DA by order of a court of competent jurisdiction and who were eligible for ~~CHS~~PRC at the time of the court order shall continue to be eligible for ~~CHS~~PRC while in foster care. Section ~~813~~1680c(a~~)(1~~) of the IHCIA, states in part:

"(a)(1) Any individual who ~~(A~~ (1) has not attained 19 years of age, (~~B~~2) is the natural or adopted child, step-child, foster-child, legal ward, or orphan of an eligible Indian, and (~~C~~3) is not otherwise eligible for the health services provided by the Service, shall be eligible for all health services provided by the service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age~~.~~ ..... If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for services until 1year after the date of a determination of competency."

M. Non-~~Indian~~AI/AN Pregnant Woman. A non-~~American Indian/Alaska Native~~ AI/AN woman pregnant with an eligible AI/~~AN s~~ANs child who resides within a PRC~~HS~~DA is eligible for ~~CHS~~PRC during pregnancy through post-partum (usually 6 weeks). If unmarried, the non-AI/AN pregnant woman is eligible for ~~CHS~~PRC if the eligible AI/AN male states in writing that he is the father of the unborn child or ~~if~~ such are determined by order of a court of competent jurisdiction ~~determines the eligible AI/AN male is the father.~~ . This will ensure health services to the unborn AI/AN child.

~~J.~~N. Non-AI/AN Spouses. Section ~~813(a)(2~~1680c(b) of the IHCIA, states in part: "Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but not otherwise eligible for the health services provided by the service, shall be eligible for such health services if all of such spouses are made eligible, as a class, by an appropriate resolution of the governing body of the Indian Tribe of the eligible Indian~~.~~ ."

~~K.~~O. Non-Indian. A non-~~Indian~~AI/AN member of an eligible AI/~~AN s~~ANs household who resides within a PRC~~HS~~DA is eligible for ~~CHS~~PRC if the medical officer in charge determines that services are necessary to prevent the spread of a communicable disease, control a public health hazard ~~such as~~or an acute infectious disease, which constitutes a public health hazard.

The facility staff after determining that the patient is NOT eligible for PRC, shall obtain the

signature(s) of the individual(s) acknowledging that they are not eligible for PRC, e.g., not residing within the PRCDA.

2-3.7 PURCHASED/REFERRED CARE MEDICAL PRIORITIES

~~Federal regulations~~Regulations [42 CFR 136.23(e)] permit the establishment of priorities based on relative medical need when funds are insufficient to provide the volume of ~~CHS~~PRC indicated as needed by the population residing in a ~~CHSDA.~~ PRCDA. The ~~list of~~ IHS medical and dental priorities ~~is found in Manual Exhibit 2-3-D. (Tribal programs that elect to follow IHS regulations may use Manual Exhibit 2-3-D~~health priorities ~~as guidelines.)~~are found on the PRC Web site:
https://www.ihs.gov/PRC/index.cfm?module=PRC_requirements_priorities_of_care

~~Area-wide priorities are established to ensure an equivalent level of services in all Service Units, taking into consideration the availability and accessibility of IHS or Tribal facilities, the population being served, the relative cost of services, and the availability of alternate resources. Priorities established to limit services, whether on an Area-wide or Service Unit basis, shall be made known to the AI/AN population being served through publication in local community and/or Tribal newspapers and posting of notices on bulletin boards in patient waiting areas of IHS or Tribal facilities.~~

Tribal programs when developing their own PRC Medical Priorities to meet Tribal needs may utilize IHS medical and dental priorities as guidelines.

The CMS *Medicare National Coverage Determinations Manual* and current medical literature will be used as a basis for decision-making.

2-3.8 PAY~~O~~ER OF LAST RESORT REQUIREMENTS

A. Payor of Last Resort ~~Title~~. Under 42 CFR ~~§~~136.61 ~~.~~the IHS is the payor of last resort for services provided to patients defined as eligible for ~~CHS under these regulations, notwithstanding~~PRC, regardless of any State or local law or regulation to the contrary. Under 25 U.S.C. 1623(b), Congress elevated IHS payer of last resort status, superseding federal laws to the contrary. Whether the alternate resource is regulated by federal, state or local law, IHS intends to implement its statutory payor of last resort authority in accordance with existing regulations. Accordingly, the IHS ~~is~~will not be responsible for ~~paying~~ or authorize~~ing~~e payment for ~~CHS if~~ PRC to the extent that: ~~a victim of a crime (see Section 2-3.24), unless:~~

(1) ~~the AI/AN is~~ the AI/AN is eligible for alternate resources, defined in ~~Section~~paragraph 2-3.9G, or

(2) the AI/AN would be eligible for alternate resources if he or she were to apply for them, or

(3) the AI/AN would be eligible for alternate resources under State or local law or regulation but for the Indian's eligibility for ~~CHS~~PRC or other health services, from the IHS or IHS programs. Note; a "charity program" is not considered an alternate resource if the provider of services is absorbing the full cost of the care, but the charity program would be an alternate resource if the provider of

services receives reimbursement for the costs of providing such care.

~~B. Eligibility. The facility s CHS Director must first determine whether the patient applying for CHS funds is eligible pursuant to Title 42 CFR §136.12 and §136.23. In addition, the facility s CHS Director must determine that the medical services requested for payment from CHS funds are within medical priorities. The CHS program is not an entitlement program, therefore when funds are insufficient to provide the volume of CHS needed, priorities for service shall be determined on the basis of relative medical need (Title 42 CFR §136.23(e)). Before authorizing payment with CHS funds for services received by an eligible AI/AN patient the CHS Director, must:~~

~~Ddetermine, upon reasonable inquiry, whether the patient is potentially eligible~~

B. Eligibility for Alternate Resources.

(1) Refer to the Benefit Coordinator to determine whether the patient is eligible for alternate resources.

GUIDELINE: ~~Based upon reasonable inquiry~~ Initially, the IHS should ~~determine~~make a determination based upon reasonable inquiry whether the IHS patient applying for ~~CHS~~PRC is potentially eligible for alternate resources. Reasonable inquiry consists of ascertaining the ~~patient s~~patients household size, income, and assets, and applying alternate resource program standards to the ~~patient s~~patients information. Only IHS patients who, upon reasonable inquiry, are determined to be potentially eligible for alternate resources are required to apply for such resources. The IHS patients should not automatically be denied ~~CHS~~PRC benefits simply because of the possibility they might be eligible for an alternate resource.

(2) Advise the patient of the need to apply for alternate resources~~.~~ and refer to the Benefit Coordina

GUIDELINE: The IHS ~~should~~will provide the patient with a written notice that explains why it is necessary for him~~/~~ or her to make a "good faith" application to the alternate resource program. The notice should include information such as the ~~availability of transportation to appointments, the~~ need to schedule and attend scheduled appointments, ~~and~~ the ~~importance of bringing the~~ necessary documentation to bring to the appointments, and availability of transportation to appointments. ~~(See sample written notice, Manual Exhibit 2-3-A.)~~

(3) Benefit Coordinator will assist the patient in applying, especially where it is evident that the patient is unable to apply or is having difficulty with the application process.

GUIDELINE: The ~~Area or Service Unit~~IHS shall include in its written notice that if a patient is unable to apply or is having difficulty applying for alternate resources, the ~~CHS Officer or an individual from social services~~facility staff (Benefit Coordinator) will assist ~~the patient~~ with the application process.

~~The Area or Service Unit shall include with the written notice an IHS-810 authorization form and an assignment of rights form for the patient to sign and~~

~~return to CHS Officer. The IHS-810 form authorizes the IHS to obtain information from the alternate resource program files and allows the IHS to intervene on behalf of the patient to ensure completion of the application. (See Manual Exhibit 2-3-B.)~~

~~The CHS Officer or social services personnel will ensure **everyone** completes an alternate resource application during the intake process. Should the individual or the patient experience difficulty filling out the alternate resource application, either the CHS Officer or the social services personnel will assist the individual or the patient complete the alternate resource application. This practice is encouraged; however, the IHS should not deny CHS funds solely because an individual failed to fill out an alternate resource application before he/she received the needed medical services. This issue is most relevant in those States that have a limited retroactive eligibility rule.~~

~~fter determining that the patient is not eligible for CHS, the CHS Officer or social services personnel shall obtain the signature(s) of the individual(s) acknowledging that they are not eligible for CHS, e.g., not residing within the CHSDA.~~

~~When the CHS Officer or social services personnel determines an individual is not eligible for CHS, the CHS Officer or social services personnel shall assist the individual in completing the alternate resource application.~~

~~Each CHS Officer should~~Each facility will document attempts to assist patients in applying for or completing an alternate resource application. ~~This action~~ Documentation of assistance for application to the alternate resource program is necessary to support a decision ~~of~~ whether ~~or not~~ to authorize payment ~~from CHS~~of PRC funds.

~~The Area Office or Service Unit should attempt to pay for the medical services provided by utilizing alternate resource(s), then if no alternate resources are available, pay for the services provided, if the Indian is CHS eligible and if the alternate resource program denies payment of his/her medical bills for a valid reason, such as the patient is not a resident of the county or his/her income exceeds eligibility standards.~~

C. Completed Application to Alternate Resource Program. ~~The~~ If a completed application to the alternate resource program ~~denies~~results in a denial, the alternate resource program denied payment ~~of the AI/AN patient s medical bills~~ for a valid reason~~, such as~~ (e.g., the patient is over income eligibility standards or not a resident of the county), and the AI/AN patients medical bills and the AI/AN is otherwise ~~CHS~~PRC eligible, the ~~Area/Service Unit~~IHS should pay the AI/AN ~~patient s~~patients medical bill.

~~However,~~ An AI/AN patient cannot be denied alternate resources that he~~/~~ or she would be eligible for under State or local law or regulation simply because ~~he/she is eligible for~~of his or her eligibility through the IHS and ~~CHS programs~~PRC Program.

~~If a completed application to an alternate resource program results in a denial because of the alternate resource s policy that IHS should pay for on-reservation Indians, the IHS will pay the bill for the care provided and report the case to the respective regional~~

~~attorney.~~
~~As specified in Title 42 CFR § 136.61, the IHS will no longer pay an AI/AN patient s medical bills under protest because the patient refused to apply for alternate resources. It is essential that the AI/AN patient apply to the alternate resource program even if the alternate resource program denies payment of medical bills.~~

D. Failure to Follow Alternate Resource Procedures. There are two instances when ~~the~~ IHS will not pay the provider for medical bills incurred by an otherwise ~~CHS~~PRC eligible patient:

(1) When the patient willfully or intentionally fails to apply or fails to complete an alternate resource application. ~~If the IHS does not require its~~ The facility staff will provide written notice to patients ~~or beneficiaries, in good faith, to apply for and complete~~that if an alternate resource application~~, the alternate resource rule will have little effect on conserving contract health funds.~~ is not ~~The Director, CHS, will provide written notice to patients that if an alternate resource application is not~~ completed, or if ~~in 30 days~~ the patient does not contact the ~~CHS Officer~~facility staff for assistance in completing the application~~, then~~ within 10 days after the receipt of the notice, a ~~CHS~~PRC denial letter will be issued. If an alternate resource program issues a denial because the applicant failed to apply or failed to complete the application and the ~~CHS~~PRC file ~~documents all~~is well documented with attempts to assist the applicant, the ~~CHS~~PRC office should issue a ~~CHS letter of~~PRC denial to the patient and ~~forward~~ a copy should be forwarded to the provider.

(2) ~~When the provider fails to follow alternate resource procedures, such as notifying the CHS program within specified time constraints, the IHS trust responsibilities include a requirement that providers maximize the availability of alternate resources. Thus, if~~When the provider is not able to receive payment from an alternate resource program because of the ~~provider s~~providers failure to follow proper procedures~~,~~ e.g., non-timely filing of the patients alternate resource, neither the patient nor IHS will ~~not~~ be responsible for the medical bill, even if the AI/AN patient is otherwise ~~CHS~~PRC eligible~~.~~ (42 CFR 136.30(h)(3).

E. Notice to Providers. The Director, ~~CHS~~PRC, will inform ~~non-IHS~~private providers (i.e., non- IHS facilities and practitioners providing medical services to IHS ~~patients~~beneficiaries) of the ~~CHS~~PRC eligibility criteria and requirements. Such information can be provided through terms in a contract with the provider, by separate notice upon referral of a patient to the provider, or by general notification to a provider when there are ~~ongoing~~continuous referrals of patients to that same provider. The Director, ~~CHS,~~PRC will inform providers that:

(1) an IHS medical referral does not constitute a representation of eligibility under the ~~CHS~~PRC program~~;~~ (see Manual Exhibit 2-3-F);

~~(1)~~(2) the IHS expects the provider to apply for alternate resources as it would for its non-AI/AN patients;

~~(2)~~(3) the provider must investigate with each patient~~'s~~, his or her eligibility for

alternate resources and should assist the patient in completing necessary application forms; ~~and~~

~~(3)~~(4) if an alternate resource is available, its use is required and the IHS or the FI shall be promptly notified of any payment received; and

~~(4)~~(5) the IHS or FI will reject claims where the provider fails to investigate other party liability.

F. Payor of Last Resort Rule. The use of alternate resources is ~~specified in Title~~mandated by the Payor of Last Resort Rule, 42 CFR §136.61.

(1) An individual is required to apply for an alternate resource if there is reasonable indication that the individual may be eligible for the alternate resource.

(2) Refusal to apply for alternate resources when there is a reasonable possibility that one exists, or refusal to use an alternate resource, requires the denial of eligibility for ~~CHS~~PRC.

(3) An individual is not required to expend personal resources for health services to meet alternate resource eligibility or to sell valuables or property to become eligible for alternate resources.

G. ~~Other Alternate Resources~~Alternate Resources. ~~Either an~~ All IHS or Tribal ~~referral facility~~facilities that ~~is~~are available and accessible to an individual ~~but not in his/her area of residence.~~ are considered alternate resources. Other alternate resources to pay for private sector services ~~(non-IHS provided services)~~ would include, but not be limited to, Medicare, Medicaid, Vocational Rehabilitation, ~~Children s~~Childrens Rehabilitative Services, ~~private insurance, and~~ Local or Private Insurance, State Programs~~. The~~ and Crime Victims ~~of Crime~~ Act ~~of 1984 is not~~. Also see 42 CFR 136.61(c). A charity or indigent care program offered by a ~~acceptable~~provider of services is not considered an alternate resource if the provider of services is absorbing the full cost of the care, but the charity or indigent care program will be considered an alternate resource if it receives reimbursement for the costs of providing such care from state resources or other institutions.

H. Qualified Health Plan from a Federal or State Marketplace.

(1) Qualified Health Plans (QHP) are available through the Marketplace where consumers can compare health insurance options. Pub. L. 111-148, Patient Protection and Affordable Care Act (March 23, 2010) provides special protection for members of federally recognized tribes from cost- sharing (deductibles, coinsurance and copayments) for the provision of essential health benefits in a QHP.

(2) Zero Cost-Sharing plans are only available to members of federally recognized Tribes and Alaska Natives with incomes at or between 100% and 300% of the federal poverty level.

a. In-Network Providers – a referral is not needed for the patient to receive an EHB from an "in-network" non-Indian health care provider.

b. Out-of-Network Providers – an authorized PRC referral is required to cover out of network charges. Out of network charges are not a co-pay, co-insurance or deductible.

(3) Limited Cost-Sharing plans are available to members of federally recognized Tribes and Alaska Natives with any level of income. There is no cost sharing as long as the service is referred through a PRC program.

a. In-Network Providers - A PRC referral is required to avoid cost sharing for essential health benefits (EHB). The PRC referral must state it is for all EHB for the episode of care.

b. In-Network Providers – A QHP referral from the QHP primary care provider may be required (depending on the terms of the QHP). PRC staff need to confirm with the QHP and assist the beneficiary in acquiring this referral.

c. Out-of-Network Providers – An authorized PRC referral is required to cover any out-of-network charges and to cover authorized charges up to the PRC rate.

(4) Standard and Silver Cost-Sharing plans are QHPs that are available to IHS beneficiaries that are not members of a federally recognized tribe or Alaska native but are otherwise eligible for IHS.

a. All Providers – An authorized PRC referral is required to pay any cost sharing expenses after the QHP payment.

b. All Providers - A QHP referral from the QHP primary care provider may be required (depending on the terms of the QHP). PRC staff need to confirm with the QHP and assist the beneficiary in acquiring this referral.

AI/ANs with Medicaid who have ever received a service (e.g., a primary care, dental, behavioral health visit etc.) from the Indian Health Service, tribal health programs, or through a PRC referral are exempt from cost-sharing which includes copayments or coinsurance for Medicaid services. Therefore, there is no cost to the PRC program for Medicaid services provided. AI/ANs can self-attest that they have ever received services from IHS or a tribal health program.

Students whose grant includes funds for health services shall be required to use the grant funds to purchase available student health insurance. Individuals who receive funding to purchase

insurance shall be required to use such funds for health care purposes and such insurance shall be considered an alternate resource.

~~After alternate resources payment and~~ When an alternate resource is identified that ~~requires~~will require the IHS ~~or Tribal program~~ to pay a portion of the medical care costs, the appropriate IHS form ~~843-1A or comparable Tribal purchase order forms~~, IHS form 843 will be processed ~~and distributed~~ immediately to obligate the funds for the estimated ~~balances.~~ balance, after alternate resource payment, with corresponding distribution of the form. In these situations, the IHS form, IHS form 843 ~~1A~~, must clearly indicate that payment will not be processed unless and until the provider has billed and received payment from the alternate resource. It is proper and necessary to require either an explanation of benefits~~,~~ (EOB) or, in cases of denial from the alternate resource, a copy of the denial notice for the ~~medical~~ record.

I. Exception to the IHS Payor of Last Resort: Tribal Self-Insurance Plans. ~~The IHS is prohibited from seeking recovery when the health services provided to an eligible patient are covered by a self-insured health plan funded by a Tribe or Tribal organization under Section 206(f) of the IHCIA, P.L. 94-437, 25 U.S.C. §1621e(f). Consistent with congressional intent not to burden Tribal resources~~ For purposes of IHS administered PRC programs, the Agency ~~has made a determination that~~ will not consider tribally-funded self- insured health plans ~~are not~~ to be ~~considered~~ alternate resources for purposes of the IHS Payor of Last Resort Rule. ~~he decision not to treat Tribal self-insurance plans as an alternate resource is a narrow exception to the IHS Payor of Last Resort Rule consistent with congressional intent found in Section 206(f) of the IHCIA. Before a health plan is exempted from the Payor of Last Resort Rule requirements, the health plan must meet the definition of a Tribal self-insurance plan, as defined in this chapter, and include an exclusionary clause prohibiting payment if the patient is eligible for CHS.~~

~~(4) Alternate Resource. Tribal self-insurance plans without an exclusionary clause prohibiting payment to the IHS are considered to be an alternate resource and are subject to the IHS Payor of Last Resort.~~

~~(5) Verification. In order for a health plan to be exempted from the IHS Payor of Last Resort requirements, the coverage must meet the definition of a Tribal self-insurance plan. Documents needed to show that a plan is a Tribal self-insurance plan include:~~

~~a. Documentation that describes how and from what resources the plan is funded.~~

~~b. A copy of the self-insurance policy, with exclusionary clause clearly indicated.~~

~~(6) Refusal to Submit Documentation. If a Tribal health plan refuses to submit requested documentation, the IHS will not consider the plan to be a Tribal self-insurance plan. Plans that are not self-insured are considered to be an alternative resource and the Payor of Last Resort guidance is to be followed (See Section 2-3.7G).~~

~~(7) Procedures after Verification. After verification of a health plan as a Tribal self-insurance plan, the following procedures apply:~~

~~a. Purchase orders are to be provided when a Service Unit issues a medical referral authorized by CHS for eligible AI/AN patients who are~~

~~covered by the Tribal self-insurance plan with an exclusionary clause and otherwise meet the IHS CHS eligibility criteria.~~

~~b. Purchase orders are to be issued when patients who are covered by a Tribal self-insurance plan receive emergency care at a non-IHS facility and that otherwise meets the IHS CHS eligibility criteria.~~

~~c. Denials are to be issued when patients who are covered by a Tribal self-insurance plan self-refer without prior authorization to a non-IHS provider.~~

~~(8) Multiple Sources of Coverage Procedures. For purposes of this section, multiple sources of coverage refer to the situation where an individual who is covered by a Tribal self-insurance plan is also covered by private insurance and/or eligible for Medicare or Medicaid. In multiple eligibility situations, even if the Tribal self-insurance plan is not viewed by the IHS as an alternate resource, any other available private insurance, Medicare, and Medicaid are alternate resources as defined in 42 CFR §136.61 under the IHS Payor of Last Resort Rule. If a CHS claim is presented to the IHS for payment involving a dual eligible patient, the following procedures apply:~~

~~a. Medicare and Tribal Self-insurance Eligible. If a patient is covered by both Medicare and a Tribal self-insurance plan (with an exclusionary clause) the IHS must issue a denial because Medicare is a primary payor to the IHS pursuant to 42 CFR §136.61. After Medicare has paid, if the criteria for CHS is met, the IHS may issue a purchase order for the payment of any remaining patient CHS liability.~~

~~b. Medicaid and Tribal Self-insurance Eligible. If a patient is covered by both Medicaid and a Tribal self-insurance plan (with an exclusionary clause), the IHS must issue a denial because Medicaid is a primary payor to the IHS pursuant to 42 CFR §136.61.~~

~~c. Private Insurance and Tribal Self-insurance Eligible. If a patient is covered by both a private insurance plan and a Tribal self-insurance plan (with an exclusionary clause) the IHS must issue a denial because private insurance is a primary payor to the IHS pursuant to 42 CFR §136.61. After private insurance has paid, if the criteria for CHS payment have been met, the IHS may issue a purchase order for the payment of any remaining patient CHS liability.~~

J. Coordinating Benefits with Health Care Coverage Purchased under 25 U.S.C. 1642 ("sponsorship"). IHS considers sponsorship through indemnity to be an alternate resource under the payer of last resort rule.

2-3.9 AUTHORIZATION FOR ~~CHS~~PURCHASED/REFERRED CARE

A. Notification ~~Requirements.~~ . The following notification requirements apply to all categories of eligible AI/AN patients including students, transients, and patients who leave the ~~CHSDA.~~ PRCDA. A notification is not a guarantee that authorization will be provided for payment, but notification must be provided for authorization to be considered. Notification requirements as described in 42 CFR §136.24 will be followed, including:

(1) No payment will be made for medical care and services obtained from non-~~IHS~~Service providers or in non-~~IHS~~Service facilities unless the requirements listed below have been met and a purchase order for the care and services has been issued by the appropriate authorizing official to the medical/dental/behavioral health care provider ~~by the appropriate IHS ordering official~~.

(2) In non-emergency cases, an eligible AI/AN, an individual or agency acting on behalf of the patient, or the medical care provider~~,~~ shall~~:~~, prior to the provision of medical care and services, notify the appropriate ~~IHS ordering~~ official of the need for services and supply information that the ~~ordering~~authorizing official deems necessary to determine the relative medical need for the services and the ~~individual s~~individuals eligibility. The requirement for notice prior to providing medical care and services under this paragraph may be waived by the ~~ordering CHS Service Unit CEO~~appropriate official, if the ~~ordering~~ official determines that providing notice prior to obtaining the medical care and services was impracticable or that other good cause exists for the failure to provide prior notice.

(3) In emergency cases, the patient, an individual or agency acting on behalf of the patient, or the medical care provider~~,~~ shall, within 72 hours after the beginning of treatment for the condition or after ~~the patient s~~ admission to a health care facility, notify the appropriate ~~ordering~~ official of the admission or treatment and provide information to determine the ~~patient s~~ relative medical need for the services. The 72-hour period may be extended if the ~~ordering~~appropriate official determines that notification within the prescribed period was impracticable or that other good cause exists for the failure to comply.

(4) Section 1640~~4~~6 of the IHCIA ~~P.L. 94-437, as amended~~, allows the elderly and disabled 30 days to notify the ~~Service Unit s~~IHS or Tribal programs CEO of emergency medical care received from non-IHS medical providers or at non-IHS medical facilities.

(5) The following definitions for an elderly and disabled individual are to be used until further defined and published in the FR.

a. ~~An~~ The IHS defines elderly ~~Indian means~~as an ~~AI/AN~~individual who is 65 years of age or older.

b. A disabled ~~Indian is an AI/AN~~individual who has a physical or mental condition that ~~reasonably~~ prevents him~~/~~ or her from reasonably providing or cooperating in obtaining the information necessary to notify the IHS of his/her receipt of emergency care or services from a non-~~IHS provider or non-IHS facility within 72 hours after the non-IHS provider begins to deliver medical services.~~service provider or facility

within 72 hours after the non-service provider began to deliver the care.

B. Notification for ~~Students,~~ Transients~~, and Patients. .~~ . Authorization for ~~CHS for~~PRC to students, transients, and patients who leave the PRC~~CHS~~DA will be the responsibility of the ~~Service Unit~~IHS Area from which the patient left ~~except:~~.

1. ~~When the individual is eligible for CHS in his/her current place of residence, except for full-time students as defined at 42 CFR §136.23(b)(i). For the purpose of this section, a patient s area of residence is defined as the area where the patient currently resides, unless an exception applies such as the patient has moved to attend a university full-time. (See examples of clarification of the concept, .)~~

If a ~~CHS~~PRC eligible patient presents to ~~a Service Unit~~ an IHS facility other than ~~his/her Service Unit~~the facility of residence for direct care and ~~requires CHS, in this case~~needs PRC, the ~~Service Unit s~~facility Director, ~~CHS~~PRC, will contact the ~~patient s Service Unit~~patients facility of residence for instructions ~~for~~in patient management with respect to PRC authorization or ~~denying CHS.~~ denial. The patient will be informed ~~that this is done~~of his or ~~needs~~her responsibility to ~~be done by the treating~~modify his or her facility~~.~~ of residence. Payment for ~~CHS~~PRC is the responsibility of the ~~patient s~~patients area of residence in accordance with ~~CHS~~PRC regulations at 42 CFR §136.24, when notification is provided prior to the authorization and/or provision of ~~CHS~~PRC services that are referred out by a facility not in the patients area of residence. These guidelines do not preclude formal arrangement for fund transfers within or among Areas to provide ~~CHS~~PRC for patients from other ~~Service Units~~IHS Areas.

C. Payment. Payment ~~for CHS~~ shall be ~~in~~ made in accordance with the provisions of the contract or purchase order and other provisions ~~put forward in the~~including IHS payment ~~policy.~~ rules set forth in 42 CFR 136 Subpart D and Subpart I (collectively referred to as PRC rates). Every effort must be made to ~~ensure that~~assure the AI/AN patient~~, who is~~ being referred from an IHS ~~or Tribal~~ facility~~,~~ is notified at referral time of his~~/~~ or her eligibility status for ~~CHS prior to his/her referral time.~~ PRC. In cases where determination of eligibility cannot be made before referral, the individual will be notified in writing prior to obtaining care that the IHS or Tribe may not be responsible for bills incurred.

(1) PRC Rates for services furnished by Medicare-Participating Hospitals - 42 CFR 136 Subpart D Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173), requires hospitals and critical access hospitals to participate in PRC programs. Section 506 directed the Secretary to set forth a payment methodology, payment rates, and admission practices through regulation for the PRC services provided by Medicare-participating hospitals. Any payments made under the PRC program are considered payment in full and the patients must not be billed for any remaining balance. See 42 CFR 482.29, 42

CFR 136.30 and also 25 U.S.C. 1621u.

a. In the event a hospital is balance billing patients after PRC payment.

(i) Notify the hospital of the law, if the hospital refuses to comply.

(ii) Notify the Area PRC Officer who will notify the Regional CMS Native American Contact (NAC).

(iii) The NAC will notify the CMS Survey and Certification Division.

(iv) The Survey and Certification Division will contact the hospital and allow them to have a 90 day corrective action plan to remedy the infraction.

(v) After 90 days if the action has not been remedied, CMS will pull the hospitals CMS certification.

(2) PRC Rates for physicians and non-hospital supplies and services 42 CFR 136 Subpart I.

a. IHS will not do business with a provider or supplier who will not accept the PRC Rate or negotiate a fair and reasonable rate based upon the providers most favored customer rate, meaning the lowest rate the provider will accept from other payers, including any discounts.

b. The provider accepts the PRC rate and cannot balance bill the patient if any of the following have been done:

(i) The services were provided based on a Referral, as defined in 42 CFR 136.202; or

(ii) The health care provider or supplier submits a Notification of a Claim for payment to the I/T/U; or

(iii) The health care provider or supplier accepts payment for the provision of services from the I/T/U.

~~a.~~c. It is mandatory to enter a providers information into the Provider Tracking Tool located at: https://home.ihs.gov/OtherPrgms/IHPES/ORAP/TPICPSA/index.c fm?module=prc&option=admin&fn=doPRCvalidate

D. Patients under Treatment at the Expiration of 180-Day Eligibility Period.

Individuals under treatment for a condition that may be deferred to a later date (e.g., a person with a meniscal tear of the knee that will require surgery to repair at some point) will cease to be eligible ~~180 days~~ at the expiration of the 180-day period after leaving their ~~CHSDA.~~ PRCDA. Individuals under treatment for an acute condition shall remain eligible as long as the acute medical condition exists. ~~This requirement~~ For example, if a PRC eligible person is stricken with acute appendicitis 179 days after leaving the PRCDA, necessitating hospitalization and surgery extending beyond the 180- day eligibility period, the patient would remain eligible until he/she is deemed cured. This does not include continued treatment of chronic conditions, ~~or,~~ for example, obstetrical deliveries that occur after the 180 ~~day~~ period.

E. Responsibility to Notify ~~Indian~~AI/AN Community of PRC Requirements ~~for Authorization.~~ . American Indian/Alaska ~~Natives affected~~Native people served by the ~~CHS~~PRC program ~~must~~will be ~~kept aware~~informed of policies ~~and~~ regarding the administrative requirements for ~~approving CHS~~approval of PRC payments for services, ~~including~~and the title(s) of the person(s) who must be notified when ~~CHS~~PRC is required. ~~This~~ Examples of notification ~~will~~ include~~, at a minimum,~~ publication in local community and/or Tribal newspapers and posting of notices on bulletin boards in public ~~p~~waiti~~e~~n~~t~~g areas ~~of~~in IHS ~~or Tribal~~ facilities. Changes in local policies or administrative requirements will be published and posted ~~as outlined above and will be sent~~including notification to providers ~~commonly used by AI/AN patients,~~ who may or may not have contracts with the IHS service unit.

F. ~~Contract Health Services~~Purchase/Referred Care Authorization Numbering System. A uniform numbering system has been developed ~~for~~to use when the ~~Service Unit~~IHS facility is issuing the IHS ~~Form~~ 843 ~~1A~~ purchase order documents. The use of this system will preclude two or more facilities from using the same document number and will assist in identifying the Area and facility.

(1) The number has four components and consists of ~~10~~ten digits.

(2) The four components are: 00 0 00 00000.

(3) The first ~~digit~~two digits of ~~the first component is always 0, followed by~~this sequence are the last ~~2~~two digits of the ~~FY~~fiscal year being charged for the services. If the number less than ten, a 0 is used as the first digit. Example: the ~~FY 2007~~fiscal 2009 is ~~07~~09 and the fiscal year 2013 is 13.

(4) The second component is ~~alphabetically coded~~ an alpha code to identify the Area. The alpha codes are:

Great Plains	C	Navajo	N
Alaska	A	Oklahoma	O
Albuquerque	Q	Phoenix	X

Bemidji	D	Portland	P
Billings	B	Tucson	S
California	L	Nashville	U

(5) The third component consists of the ~~2-~~two digit site specific code that identifies the facility being charged for the services. The~~-2~~ digits are the standard location code as used in the fiscal accounting system.

(6) The fourth component has ~~5~~five digits and is the sequential number for the documents to be charged to each ~~is Service Unit~~ facility. These numbers will begin each ~~FY~~fiscal year with 00001 and continue sequentially ~~until the fiscal year's end. Service Unit~~for the year. Facility supplemental authorizations, if necessary, will be numbered with the original numbers plus a ~~Service Unit~~facility suffix of S-1, S-2, etc.

~~(7) The Service Unit staff will issue a new purchase order for any late or additional charges regardless of the FY.~~

G. ~~The CHS~~PRC Authorization Flow Chart. The ~~specific steps involved in~~flow of a ~~CHS~~PRC purchase order from ~~the~~ initial request through processing and closeout ~~are~~is diagramed in Manual Exhibit 2-~~-~~ 3~~-K. The flow chart provides an overview describing the process~~G. Many aspects of PRC and other activities are incorporated in this general flow.

2-3.10 ELECTRONIC SIGNATURES

A. Electronic Signature for ~~CHS~~PRC Purchase ~~Orders. The~~ Order. Pub. L. 106-229 (Electronic Signature Act~~, P.L. 106-229,~~) provides for the use of electronic signatures. ~~The IHS is mandated to implement the electronic signature (E-SIGN) for the IHS CHS Management Information System.~~ The electronic signature promotes the use of electronic contract formation, signatures, and record keeping in private commerce by establishing legal equivalence between:

(1) Contracts written on paper and contracts ~~conveyed electronically~~in electronic form;

(2) Pen and ink signatures and ~~electronic signatures;~~electronics, and;

(3) Other legally required written documents (termed "records~~)~~") and the same information in electronic form.

~~Accessing Electronic Signature.~~ This ~~section~~ establishes ~~the~~ guidance and direction for ~~the use of the~~ electronic signature of IHS ~~Form~~ -843~~-1A~~ in accordance with Pub. L. 106-229. Ensuring compliance with the Privacy Act, Health Insurance Portability and Accountability Act (HIPAA), and confidentiality requirements are the responsibility of each Area ~~Contract Health Service Officer (CHSO). Contract Health~~

~~Service staff~~PRCO.

B. Accessing Electronic Signature. Individuals will only be provided the ability to access the E-SIGN system if they have completed all security requirements and possess current procurement authority~~. The following are the guidelines for accessing the electronic signature within the Contract Health Services/Management Information System (CHS/MIS~~ (see Manual Exhibit 2-3-H).

~~1. Access to the electronic signature is accomplished through computer log on at the local Service Unit and Area Office. It is the Area CHSO responsibility to ensure that the Privacy Act, HIPAA, and any confidentiality requirements are met prior to allowing staff to log on to the Resource and Patient Management System (RPMS) CHS/MIS.~~

~~2. The Director, Office of Information Technology (OIT) is responsible for ensuring that the RPMS system is secure. Firewalls at each location site guard against unauthorized access.~~

~~3. Procedures must be developed and implemented at each facility to ensure that RPMS access is revoked when employees leave CHS employment or are no longer eligible to access CHS information.~~

~~4. Training of current or new staff will be provided by Area Office CHS staff via teleconferencing. Training will also be provided to current and new staff as changes and enhancements occur.~~

~~5. Any problems or incidents related to CHS access or security must be reported to the Area CHSO.~~

~~B. Training. The following staff training must be completed and documented:~~

~~1. Health Insurance Portability and Accountability Act training. (The Area CHSO and the facility HIPAA Compliance Officer are responsible for scheduling and documenting training.)~~

~~2. Office of Information Technology Training. (The Area CHSO is responsible for scheduling and documenting training.)~~

~~C. Responsibilities. Before an individual can access the electronic signature for CHS the following responsibilities must be accomplished:~~

~~1. Chief Executive Officer. The CEO will provide the Service Unit Site Manager with a delegation of procurement authority, including effective date and dollar limits.~~

~~2. Service Unit Site Manager. The Service Unit Site Manager:~~

~~a. will determine the appropriate parameters and assign keys for each individual.~~

~~b. will revoke access if the sign on and/or password are shared with other staff, contractors, or patients, regardless of the purpose.~~

~~c. will notify the alternate key individual, by memorandum that he/she is assigned the authority to sign documents electronically, when the key individual is unavailable.~~

~~3. Individuals will keep the key information (individual sign on and password) confidential.~~

~~D. Procedures. The following procedures must be followed to access the CHS electronic signature.~~

~~1. Access to the IHS Service Unit CHS/MIS through computer log on to the Service Unit RPMS.~~

~~2. Access the CHS/MIS main menu and choose E-SIGN.~~

~~3. Follow the prompts.~~

~~4. Exit E-SIGN~~

2-3.11 ~~CONTRACT HEALTH SERVICE~~ PAYMENT DENIALS AND APPEALS

When a patient is denied PRC or if a medical provider may reasonably think~~s~~ that the ~~CEO~~Director of the IHS/Tribal program is a party to payment for services provided to an eligible patient, ~~and if the a patient is denied CHS,~~ both the patient and the provider ~~and the patient~~ must be notified in writing of the denial with a statement containing all the reasons for the denial. Refer to the ~~CHS/MIS~~*PRC/Management Information System* ***Manual*** (version 3.2) denial package. An example of a denial letter can be found in Manual Exhibit 2-3-I.

A. Denial Notice. ~~A CHS~~ The denial notice must inform the ~~patient/beneficiary/~~applicant that within 30 days from ~~receiving~~ the receipt of the notice the ~~patient/beneficiary/~~applicant:

(1) May request a reconsideration of the denial (appeal) by the appropriate service unit CEO~~. However,~~ and the ~~appeal~~request for reconsideration must ~~provide~~contain additional information not previously ~~not submitted~~provided.

(2) ~~In accordance with Section 2-3.11(D), the applicant~~ May appeal the original ~~CHS~~ denial by the CEO to the appropriate Area Director, if there is no additional information on which to base reconsideration~~.~~ in accordance with Section (I), above. Requests for ~~appeal~~reconsideration and appeals may be submitted by ~~a~~providers. The provider will be considered as acting on behalf of the patient~~/beneficiary/applicant. In these instances, the Service Unit CEO must provide~~. A response ~~to the request~~must be made to the provider ~~with~~and a courtesy copy of ~~the~~such response is provided to the patient.

(3) May appeal ~~the original CHS denial by the Service Unit CEO~~ to the ~~appropriate~~ Area Director~~,~~ if ~~there~~the CEO upholds the service units original denial. When the Area Director upholds a denial, the applicant must be notified in writing of the denial and that an appeal may be submitted in writing to the Director, IHS, within 30 days.

~~(3)~~(4) May appeal to the Director, IHS, if the Area Director upholds the denial. The decision of the Director, IHS, is the final adjudication of the appeal of the denial. A written notice of the decision will be sent to the claimant stating they have no ~~additional information on which to base reconsideration~~further appeal rights.

B. Failure to Follow Appeal Proce~~dure~~s. If the ~~patient/beneficiary/applicant~~claimant fails to follow ~~these~~ procedures, the request for reconsideration ~~or~~of an appeal may be denied. A written notice of denial will be sent to the ~~patient/beneficiary/applicant~~claimant stating ~~there are~~they have no further appeal rights.

~~C. Appeal Procedure. When, on appeal, the Area Director upholds the denial, the patient/beneficiary/applicant must be notified in writing of the denial and that an appeal may be submitted in writing to the Director, IHS, within 30 days of the date of the Area Director s decision.~~

~~D.~~C. Three Levels of Appeal. The IHS appeals process applies to IHS ~~-~~administered ~~CHS~~PRC programs and those ~~CHS~~PRC programs administered under Title I and ~~Title~~ V programs that have negotiated and incorporated ~~the IHS appeals procedures~~ into their funding agreements~~. The CHS~~ that the IHS appeals procedures will be utilized. The PRC regulations currently in effect at 42 CFR ~~§~~136.25 ~~allow~~allows only three levels of appeal:

(1) ~~A~~ request for reconsideration of the appeal by the ~~Service Unit~~ CEO,

(2) ~~A request for~~ appeal to the Area Director, and

(3) ~~A~~ final administrative appeal to the Director, IHS.

~~E.~~D. Tribal Appeals Process - Contractors. The IHS will conduct the appeal process for a Tribally-managed ~~CHS~~PRC program ~~because conducting~~, if the ~~appeals process is a~~Tribe has retained IHS ~~function. A Tribe~~ functional shares with their respective Area Office. Therefore, before an Area Director or the Director, IHS, may ~~not reduce or increase the level of appeals.~~ agree to adjudicate a claim, the Tribe must~~:~~

~~(1) Provide a written appeals process to the patient:~~

- ~~negotiated and incorporated into the annual funding agreement;~~
- ~~s comparable to the IHS appeals process; and~~
- ~~is in accordance with the Administrative Procedures Act (5 U.S.C. 500, et seq.).~~

~~Ensure that it has~~have left sufficient resources with the IHS to conduct the appeal process. ~~NOTE:~~ It is not sufficient to have ~~the IHS appeals procedures~~it negotiated and incorporated into a ~~Tribe s~~Tribes funding agreement that the IHS appeals procedures will be ~~used~~utilized without ~~fiscal~~ evidence that sufficient funds have been withheld to pay for ~~a Tribe s~~the costs to operate the appeals process for a Tribe.

Tribal contractors are **not required** to utilize the IHS appeals process, however, pursuant to 25 U.S.C. 5324(g) and 25 U.S.C. 5397 (e), a Tribe must provide a written appeals process that is functionally equivalent to the process in 42 CFR 136.25.

D. Tribal Appeals Process - Title I and ~~Title~~ V Programs. Title I and ~~Title~~ V programs that have negotiated and incorporated into their funding agreement ~~provisions to use~~a provision that the IHS appeals procedures~~;~~ will be utilized; shall agree to the following terms and conditions:

(1) The Area Director and the Director, IHS, will ~~use~~utilize the IHS regulations and interpretations, not Tribal criteria and interpretations, to adjudicate ~~all CHS~~ claims. ~~Agency specified~~ The IHS utilizes its medical priorities and policies ~~will be used~~ to adjudicate ~~Tribal CHS~~IHS PRC claims.

(2) The Title I or ~~Title~~ V programs shall provide necessary documentation required for claims adjudication. Depending on the nature of the claim, documentation such as medical records, date of notification, residency documentation, etc., could be required.

(3) The IHS conducts the appeals process f~~o~~rom Title I and ~~Title~~ V programs without assuming any fiscal responsibility. When an Area Director, or the Director, IHS, ~~overturns a~~issues a determination overturning the Tribal denial of payment authorization, it is the responsibility of the Tribe not the IHS to pay ~~for medical services incurred~~the bill.

F. Title I and Title V Program Denials of ~~CHS~~PRC Payment. ~~Denials of CHS payment by Title I and Title V programs that do not use the~~ IHS ~~appeals process may not be appealed to an Area Director or the Director, IHS.~~ will not review appeals for those Tribes that have assumed ~~their own CHS~~the PRC appeals function.

~~F.~~G. Tribes are NOT Required to ~~provide administrative procedures pursuant to~~Implement Regulations the ~~Indian Civil Rights Act of 1968 (25 U.S.C. 1301 et seq.). The Office of~~Same as the ~~General Counsel (OGC) advises that~~IHS. Title I and Title V ~~health~~ programs must, in accordance with 25 U.S.C. 5324(g) and 25 U.S.C. 5397(e), make eligibility determinations in accordance with the IHS eligibility regulations in the CFR, Title 42, Part 136. However, there are provisions of the IHS eligibility regulations that ~~are subject to interpretation, and the Tribes are not required to interpret particular words in the regulations in the same way as the IHS.~~ allow different standards to be set. For example, Tribes and Tribal organizations may ~~have~~adopt a different ~~definition of~~ standard for "close economic and social ties~~,~~" for ~~CHS~~PRC eligibility (see ~~Title~~ 42 CFR §136.23~~); thus, individual Tribal contractors and compactors make CHS eligibility determinations consistent with the IHS eligibility regulations at Title 42 CFR, Part 136.~~), Tribes could also adopt different medical priorities. If the appeals process has been assumed by the Tribal contractor ~~or compactor~~ under Pub. L. 93-638, as amended, individuals who are dissatisfied with Tribal determinations of eligibility must pursue Tribal administrative remedies ~~if the Tribe does not use the IHS appeal process. Tribes developing~~. Issues that should be considered by Tribes in the development of appeals policies and procedures ~~need to consider the following~~include:

(1) ~~developing~~Development of a formal appeals procedure and levels of appeal~~;~~.

(2) ~~establishing~~Establishment of clear program policies concerning eligibility, medical
priorities, referrals, and notification of all parties ~~that clearly identify responsible parties; and~~.

(3) ~~protecting~~Protection of individual rights to due process.

~~2-3.12 APPEALS~~

~~G.~~H. Responsibilities.

(2) Chief Executive Officer. The CEO or ~~his/her~~ authorized designee is administratively responsible for creating and maintaining a file on each ~~CHS~~ denial of PRC.

(2) Area Director. The Area Director~~. The Area Director~~ or ~~his/her~~ authorized designee is responsible for~~ the following~~:

a. establishing individual alphabetical patient~~-specific~~ appeals files that contain all documentation in chronological order for all ~~CHS~~ appeals, and

b. for forwarding copies of ~~CHS appeals~~appeal case files to ~~IHS Headquarters~~ the Director, DCC, HQ upon request.

I. Information Copies. The Area Director~~,~~ or his~~/~~ or her authorized designee, ~~should~~will not routinely forward information copies of all ~~CHS~~ denials to the Director, DCC.~~ A file is to~~ The files will be sent only when ~~requested by~~the Director, DCC, or his or her designee requests a specific file.

~~A.~~ Controlled Correspondence. The Director, DCC~~.~~

~~B. Executive Secretariat Staff, Office of the Director, IHS. The Director, Executive Secretariat Staff, will fax~~, will send by secure fax or encrypted email (such as the IHS secure data transfer service) incoming controlled correspondence to the appropriate Area~~ Director or his/her authorized designee.~~

~~C. Area CHS Staff. The Area CHSO~~(s) PRCO with a request for information. Each PRCO will analyze the ~~controlled~~ correspondence and submit all necessary documentation to the Director, DCC, ~~within 10 working days of the date of the fax.~~

1. ~~The Director, DCC, must be notified~~ in order that he or she will be able to prepare a response. If there were no appeals to the ~~Service Unit s~~ Area Office PRCO or CEO~~ or~~, the ~~Area~~ Director~~.~~

~~H.~~J. , DCC, will be notified immediately. Copies of all ~~CHS~~ determinations issued within the Area ~~are to~~will be submitted to the Director, DCC. If ~~a CHS~~an appeal~~ or appeals are~~ (s) was submitted to either the CEO or ~~the~~ Area Director~~,~~ and the CEO or ~~the~~ Area Director has not issued a determination, a briefing memorandum ~~shall~~is to be submitted to ~~to the Director, DCC, in~~ support ~~of~~ the actions that have been taken.

~~I.~~K. Appeals Process - Division of Contract Care. The Director, DCC, is responsible for processing all ~~CHS~~PRC appeals ~~that will be~~ sent to the Director, IHS. The Director, DCC, or his~~/~~ or her ~~authorized~~ designee, will:

(1) Ensure that all required correspondence is included ~~and is~~ in chronological order~~;~~.

(2) Routinely request information from the Area PRCO and ~~discuss~~other sources as needed.

~~refer for review all CHS appeals that involve issues requiring a legal opinion to the Director, Division of Regulatory Affairs, Office of Management Services, prior to being forwarded if necessary, to the OGC.~~

(3) ~~analyze~~Analyze the issues contained in the appeal ~~pertaining to the patient s~~

~~CHS, and process~~and processes the appeal to the extent issues can be handled within established policy~~; and~~.

~~(3)~~(4) ~~refer for review~~ Refer all ~~CHS~~ appeals that involve ~~issues~~questions of medical judgment to the medical review to the Director, Office of Clinical and Preventive Services~~; or~~.

(5) Refer an appeal that involves legal questions or requires legal analysis review to the OGC for legal advice.

~~J.~~L. Final Decision. The decision of the Director, IHS, shall constitute the final administrative action in the ~~CHS appeals~~appeal process.

~~2.~~ Appeal File. The ~~CHS~~ appeal file shall contain: all ~~CHS~~ denial letters, all briefing documents~~,~~ or memorandums prepared in connection with any recommendation to the CEO or ~~the~~ Area Director regarding such denial; all correspondence to ~~the~~ IHS from ~~the~~claimant or claimants representative ~~of the patient/beneficiary/applicant/claimant;~~

~~3.~~2. ; any other relevant ~~documentation, i.e.,~~ correspondence, maps, bills, or receipts; records of telephone calls to or from ~~the patient/beneficiary/applicant/~~claimant or ~~the claimant s~~claimants representative; ~~and~~

~~K.~~M. correspondence relative to any inquiry (i.e., Congressional, State official, etc.) made on behalf of the claimant; and pertinent correspondence relative to prior appeal by the same claimant.

~~L.~~N. Retention Period. Each ~~CHS~~ appeal record/file will be maintained ~~wherever the response was initially received. The CHS appeal file records must be retained at the Service Unit, Area Office, and/or HQ~~ for a period of 6 years and 3 months after the IHS ~~CHS~~PRC appeals process has been exhausted. ~~After the 6 years 3 month period has elapsed, the records may be destroyed. If the CEO of the Service Unit where the CHS appeal files are located makes a decision to keep the records longer e.g., per a court order, the records may be sent to the National Archives and Records Administration.~~

2-3.~~13~~ 12 MANAGEMENT OF ~~CHS~~PURCHASED/REFERRED CARE FUNDS

A. Allocation of PRC Funds. The allocation of PRC funds to the Areas are determined by three primary methods: historical base funding, annual adjustments, and program increases. The PRC funds are then distributed from the Areas to the individual PRC programs. As a portion of the overall PRC funding methodology, the PRC Allocation Formula, is designed to accommodate for any new program increases and is in compliance with the IHS Budget Execution
Policy. However in consultation with Tribes, Areas have the authority to redistribute new program increases using a different methodology other than the PRC Allocation Formula.

Each Area, using an allocation formula other than the PRC Allocation Formula to distribute new program funding, shall notify the Director, DCC in writing. The notification must include a copy of the formula used, any relevant information that explains the method used, a description of the consultation held with affected Tribes,

and the distribution amounts to PRC programs in the Area. Notification must be provided before implementing any allocation formula other than the PRC Allocation Formula.

B. Use of PRC Funds for Staff Administering the PRC Program. PRC funds may be used for staff administrating the PRC program when the following conditions are met:

(1) The PRC program is purchasing care beyond Medical Priority II

(2) Each Area Service Unit PRC program reports annually the medical priority level the program is purchasing, the number, grade level and salary of full or part time employees supported by PRC funds and the number of denied and deferred services for Priority II care to the Area Director.

(3) The Area Director reports by October 10, annually to the Director, DCC, ORAP, for each Area Service Unit, the medical priority level each program is purchasing, the number, grade level and salary of full or part time employees supported by PRC funds and the number of denied and deferred services for Priority II care.

~~A.~~C. Commitment Register. Management of ~~CHS~~PRC funds in accordance with the FMFIA requires that the ~~CHS~~PRC Commitment ~~Registers are~~Register(s) will be maintained at each authorizing location. ~~A CHS~~ The PRC Commitment Register ~~must contain~~(s) is maintained electronically in CHS/MIS. The PRC Commitment Register contains the following minimum information ~~(See Manual Exhibit 2-3-H):~~:

(1) Date of Authorization

(2) Authorization Number~~.~~

(3) Provider Name~~.~~

(4) Patient Name~~.~~

(5) Date of Service~~.~~

(6) Allowance Amount~~.~~

(7) Estimated Cost of Service~~.~~

(8) Balance of Funds~~.~~

C. ~~Contract Health Service Fund~~ Funds Status Report. The ~~CHS fund~~PRC funds status report is to be submitted to the Area ~~Financial Management Office~~PRCO at least once a month. A summary of the ~~CHS~~PRC fund balance shall be provided to the CEO, the Clinical Director, and ~~the CHS~~PRC review committee at least once a month. NOTE:

The summary ~~of the CHS fund balance~~ may also be provided to the Tribal Health Director; however, using this process is purely optional for Tribal PRC programs. A sample of a Status of Funds report can be seen in Manual Exhibit 2-3-J.

D. Purchased/Referred Care Spending Plan. Programs are to maintain at least a weekly spending plan by prorating their allocations by the appropriate amount of weeks for each allocation. Weekly spending plans are to be monitored by the local PRC manager, shared with the PRC review committee and Service Unit administration. Spending plans must be available for review by the PRCO. For small PRC programs the frequency of the spending plan can be determined on a case by case basis. The PRC program must request a change for the spending plan frequency in writing to the Area Director through the Area PRCO. A sample spending plan can be found in Manual Exhibit 2-3-K.

~~D.~~E. Services Authorized That Working Day. An entry will be made on the commitment (document control) register for each obligation of funds, or modification of ~~funds,~~ or adjustment to obligation of funds. ~~Commitment~~ The entries will be made daily to reflect the services authorized ~~during~~ that working day. ~~Commitment entries must~~ Entries should not be ~~completed within~~delayed beyond 5 working days from the date of an authorized referral or notification of ~~services provided~~an authorized claim by the PRC review committee.

~~NOTE: This function can be performed electronically or manually.~~

~~1. Electronically. The CHS RPMS package performs these functions and should be used when available.~~

~~2. Manually. The CHS Commitment (document control) Register is used when the CHS RPMS package is not available.~~

2-3.~~14~~ 13 FOLLOW-UP OF OUTSTANDING AUTHORIZATIONS

Each ~~Service Unit shall~~IHS PRC program will establish a follow-up system for all ~~CHS~~ authorizations that have not been completed and returned ~~to the Service Unit for action~~ within 90 days of issuance. Manual Exhibit 2-3-~~G provides~~L has a recommended form letter for use in these ~~circumstances~~follow-ups.

2-3.~~15~~ 14 RECONCILIATION OF ~~COMMITMENT~~CHS/MIS to UFMS REGISTER

The ~~CHS~~PRC Commitment Register ~~is~~(CHS/MIS) will be reconciled ~~monthly~~ with the official financial management report, ~~throughout~~each month of the fiscal year. The recommended procedures for reconciliation of the Commitment Register are provided in Manual Exhibit 2-3-~~I~~M.

2-3.~~16~~ 15 DATA REPORTING

The appropriate workload and fiscal codes ~~are~~will be entered into the data system, as specified in the FR dated January ~~22, 1992, (57 FR 2642), and~~ 20, 1994, Volume 59, Number 13, "Core Data Set Requirements~~.~~; Notice."

2-3.~~17~~ 16 CATASTROPHIC HEALTH EMERGENCY FUND (CHEF)

A. Background. ~~The Indian Health Care Amendments of 1988, P.L. 100-713 established~~ The CHEF ~~solely to meet~~is the congressionally appropriated fund for the purpose of meeting the extraordinary medical costs associated with ~~treating~~the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the IHS ~~and Tribal programs~~.

~~The Appropriations Act directs that the CHEF shall not be allocated, apportioned, or delegated to an Area Office, Service Unit, or any other basis.~~
~~Effective FY 1993, the Federal Medical Care Recovery Act (FMCRA) funds were returned directly to the Service Units, pursuant to Section 207 of the IHCIA; the funds are no longer added to the CHEF.~~
~~The term "catastrophic illness" refers to conditions that are costly by virtue of the intensity and/or duration of their treatment. Cancer, burns, high-risk births, cardiac disease, end-stage renal disease, strokes, trauma-related cases such as automobile accidents and gunshot wounds, and certain acute mental illnesses are examples of conditions that frequently require multiple or prolonged hospital stays and/or extensive treatment post-discharge.~~
~~The IHCIA Amendments of 1987, P.L. 100-713, authorizes the IHS CHEF program and requires the IHS to publish regulations governing the program.~~
Until such time as regulations are published, the ~~Headquarters~~annually issued HQ CHEF guidelines ~~currently in place~~ will continue to serve as ~~the~~ interim policy governing the CHEF program for all ~~CHS~~PRC programs.

~~B. Use of CHEF Funds. The CHEF resources are expended according to the CHS requirements and while CHEF funds are available they are to be used to partially reimburse IHS direct and tribally contracted programs for patient expenditures that would qualify for the CHEF program.~~
~~Obligations against the CHEF in excess of $50,000 will be made only in cases where the local CHS management document that it is medically and fiscally inappropriate to transfer the patient to an IHS, Tribal, or less costly contract provider.~~
~~All~~

~~C.~~B. Access to the CHEF Fund is on a Cost Reimbursement Basis. All IHS PRC programs~~. For specific details on the CHEF, reference the current, annually issued CHEF guidelines~~ must first obligate and expend funds and meet the appropriate threshold to be reimbursed from the CHEF.

C. ~~Cost Threshold. The CHEF threshold is adjusted by the Director, IHS, within the range established by law. The Director, DCC, will provide instructions to the Director, IHS, regarding fluctuations in the CHEF cost threshold annually. Whether a case meets the CHEF cost threshold amount is determined by only including those costs remaining after payment has been made by Federal, State, local, private health insurance, or other applicable alternate resources.~~Cost Threshold. The CHEF threshold is adjusted by the Director, DCC, within the range established by law. The IHS Director, DCC, will provide instructions annually. Whether a case meets the threshold amount is determined by only including those costs remaining after payment has been made by Federal, State, local, private health insurance, or other applicable alternate resources.

D. Alternate Resources. The requirements for alternate resources must be met ~~before~~ to

access the CHEF.

~~D.~~E. Reimbursement. All PRC programs must submit CHEF cases through their Area PRC programs for coordination. Any CHEF reimbursement ~~can be made from the CHEF. The CHEF reimbursements~~ shall be applied only to cases that have been reviewed and approved by the CHEF Manager; any amounts not used because of payments by alternate resources or cancellations must be returned to the ~~Headquarters~~HQ CHEF account. For specific details on the CHEF, reference the current, annually issued CHEF guidelines located on the IHS PRC Web site: http://www.ihs.gov/PRC/ Instructions on catastrophic case processing and a check list for submitting/processing a CHEF case can be found in Manual Exhibit 2-3-N.

2-3.~~18~~ 17 FISCAL INTERMEDIARY

A. Purpose. The purpose of the fiscal intermediary (FI) is to operate a nationwide centralized medical ~~and~~, dental and behavioral health claims processing and payment system to:

(1) collect, compile, and organize workload and financial data; and

(2) provide statistical and financial reports to the IHS for the administration of its ~~CHS~~PRC program.

~~A. Service Class Codes. Service class codes indicate the type of service that is provided in an IHS facility, i.e., inpatient, ambulatory, emergency, laboratory services, dialysis, X-ray, dental, etc. The CHS funds are used to pay non-IHS providers who come to the IHS facility and provide their services there. For example, a cardiologist who comes every other week to a facility and sees patients. This is particularly beneficial in isolated locations as it means that patients who lack transportation are able to obtain the care for which they are eligible. The FI pays the following service class codes:~~

~~[The object class code conversion table is in Manual Exhibit 2-3-J. This table provides a crosswalk between the IHS service class codes (SCC) and the IHS health accounting system s object class codes.]~~
~~21.85 Patient and Escort Travel. Includes travel and related costs, e.g., lodging, meals, etc.~~
~~25.2A Medical Lab Services-Outpatient Non-IHS. Includes laboratory costs for outpatients at non-IHS contract facilities. If pathologists and lab fees are invoiced together use cost center 25.2A. Excludes pathologist's professional fee invoiced separately using cost center 25.4D.~~
~~25.2B Medical Lab Services-Inpatient and Outpatient IHS Facility. Includes all laboratory costs for inpatients and outpatients at IHS facilities referred to contract facilities. Excludes pathologist s professional fee invoiced separately using cost center 25.4C.~~
~~25.2D Dental Laboratory. Includes dental prosthetic fabrication services provided by dental laboratories. Excludes any dentist professional fee using cost center 25.4E.~~
~~25.2G Non-Federal Hospitalization. Includes inpatient services in non-Federal hospitals. (The other Federal Agency is the VA and we have service agreements with the VA.)~~
~~25.2H X-ray Services-Outpatient Non-IHS. Includes x-ray services for outpatients at non-IHS contract facilities. If radiologist and facility fees are invoiced together, use cost center 25.2H. Excludes radiologist s professional fee invoiced separately using cost center 25.4D.~~
~~25.2J X-ray Services-Inpatient and Outpatient IHS. Includes all radiology costs for inpatients and outpatients at IHS facilities referred to contract facilities. Excludes radiologist s professional fee invoiced separately using code 25.4C.~~
~~25.2L Hospital Outpatient. Includes ambulatory services at contract hospitals other than emergency~~

~~room (ER) services. Excludes any physician professional fee billed separately using code 25.4D.~~
~~25.2Q Emergency Room Services. Includes non-IHS hospital ER services. Includes any ER physician fees whether combined or billed separately.~~
~~25.2R Dialysis. Contract Hospital Inpatient Services FY 1991 and prior FY only.~~
~~25.2S Physical Therapy Services. Includes all contract therapy services invoiced separately. Excludes all physician professional fees using code 25.4D.~~
~~25.4A Physician Inpatient IHS Facility. Includes contract physician services for patients hospitalized in IHS facilities. Includes radiologist and pathologist professional fees, invoiced separately.~~
~~25.4B Physician Inpatient Non IHS Facility. Includes all physician services for patients hospitalized in non-IHS facilities.~~
~~25.4C Physician Outpatient IHS Facility. Includes all contract physician services for outpatients in IHS facilities. Includes radiologist and pathologist professional fees, invoiced separately.~~
~~25.4D Physician Outpatient Non-IHS Facility. Includes all physician services for outpatients in non-IHS facilities and physician offices.~~
~~25.4E Dentists. Includes all services provided by contract dentists to inpatients and outpatients. Includes combined dental laboratory costs and dental services.~~
~~25.4G Fee Basis Specialist IHS Facility. Includes all consultant services other than physician services. Examples are nurse anesthetists, audiologists, speech therapists, podiatrists, and dental hygienists using cost centers 268 and 368.~~
~~25.4J Fee Basis Specialist Non-IHS Facility. Includes all consultant services in non-IHS facilities other than physician services. Examples are: nurse anesthetists, audiologists, dental hygienists, and podiatrists.~~
~~25.4L Refractions IHS Non-IHS Facility. Eye and vision exams only, not for injuries or other medical reasons, by ophthalmologists and optometrists.~~
~~25.4M Extended Care Facilities. Includes rehabilitation facilities, skilled nursing facilities, psychiatric inpatient facilities; and psychiatric inpatient care in an acute facility exceeding 30 days. Excludes any physician fee using cost center 25.4D.~~
~~25.2N Dialysis Physician Outpatient and Inpatient Services in IHS Consumable Medical and Surgical Supplies. Includes medical, dental, and surgical supplies. Examples are dressings, bandages, and catheters.~~
~~26.3A Consumable Medical and Surgical Supplies. Includes medical, dental, and surgical supplies. Examples are dressings, bandages, and catheters.~~
~~26.3G Non-consumable Medical and Surgical Supplies. Includes rental and purchase of wheelchairs, apnea monitors, oxygen tanks, beds, etc.~~
~~26.3K Eyeglasses. Includes eyeglasses and repair to eyeglasses. If eyeglasses are billed with the professional fee use cost center 26.3K.~~
~~26.3L Hearing Aids. Includes costs of hearing aid devices and repairs to hearing aids.~~
~~43.19 Interest.~~

~~B. Authority. The authority for the use of a fiscal agent is contained in P.L. 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985, Section 17003:~~

~~...provides authority for the Secretary of the Department of Health and Human Services to contract with fiscal agents to perform claims payment, processing and audit function with respect to services purchased on a contract basis by the Public Health Service .... Fiscal agents must either be entities which could qualify as carriers for Medicare purposes, or Indian Tribes of Tribal organizations acting under Indian Self-Determination Act contracts. While the fiscal agents need not be Medicare carriers, they must meet the same requirements as Medicare carriers regarding efficiency and effectiveness of operations, surety bonds, and financial controls.~~

B. Authority. 42 U.S.C. 238m

~~B.~~C. Fiscal Intermediary Operations. ~~A listing of the payment by type of service the FI processes payments on are listed by object class code in Manual Exhibit 2-3-J.~~ For a description of the FI internal operations information and most current payment codes refer to the most current version of the *FI Reference Manual* for IHS/~~CHS.~~ PRC. The *FI Reference Manual* is updated to reflect changes or incorporate information on an as-needed basis. Obtaining access to this manual is provided in the following section.

~~C.~~D. Accessing the FI Data System. The IHS is ~~required~~mandated to protect patients medical information from all security risks. Changes to the FI data system allowing ~~data~~ access to data and the ability to communicate through local area networks shall include provisions to ensure ~~and safeguard~~ patient confidentiality. Ensuring compliance with the Privacy Act, HIPAA privacy regulations, and confidentiality requirements is the responsibility of each Area ~~CHSO.~~ PRCO. Each IHS employee, unless otherwise authorized, is responsible for limiting access to patient medical information to strictly direct need to know in the provision of patient care ~~as defined in the IHS mission statement. The following steps provide necessary guidance for FI data system access:~~. On-line Web access

~~1. Access to FI data is accomplished through computer log-on to the IHS Intranet at the OIT in Albuquerque, New Mexico.~~

~~The Director, OIT, is responsible~~

~~2.~~ request form and necessary guidance for ~~ensuring that the FI data systems are secure. Firewalls established at each site guard against unauthorized access.~~

~~3. Each IHS site must ensure that Intranet access to~~accessing the FI data system is ~~revoked when an employee ceases to have a direct involvement in CHS on a day-to-day basis.~~

~~4. Employee access to the FI data system can be revoked for a violation of the security requirements.~~

~~5. Access may be revoked for reasons other than a violation of the security requirements if requested by IHS officials.~~

~~6. Each authorized user of the FI data system will have an individual sign-on and password assigned. It is the responsibility of each user to keep this information confidential. Access must be revoked if the sign-on and password are shared with other staff members regardless of the purpose.~~

~~7. A walk-through will be provided by IHS and FI staff via teleconferencing for new users. Updates will also be provided to current staff as changes and enhancements occur.~~

~~8. All problems or incidents must be reported to the Area CHSO.~~

~~C. Fiscal Intermediary Access Procedures. In order for access to the FI data system to be granted, the following procedures must be followed:~~

~~Access Requests. The Area CHSO will submit the form to the FI staff. (See~~the FI Reference Manual ~~Exhibit~~ .

~~1.~~ 2-3 ~~C.)~~

~~2. Access Set-Up. The FI staff will receive approved requests and will assign sign-on and passwords.~~

~~3. Access Training. The FI staff is responsible for contacting the CHS employee granted access to the FI data system with their assigned sign-on and password. The FI staff will provide a practical orientation and ongoing user support for new users via teleconferencing.~~

~~4. Access Log. The FI staff will maintain a log of all users of the FI data system. Reports will be sent to the designated IHS FI Project Officer, as requested.~~

~~5. Other Reports. The FI staff will provide reports to the FI Project Officer as requested. These reports include information about who accessed the system, how often, and whose access was revoked.~~

~~6. Audit Conducted Prior To Implementation of the Data System. If the FI conducted an audit prior to implementation of the FI data system. The FI continues to monitor CHS access.~~

~~2-3.19~~ .18 MEDICAL ~~AND~~, DENTAL AND BEHAVIORAL HEALTH PRIORITIES

~~Medical Priorities.~~ The application of medical priorities is necessary to ensure that appropriated IHS/~~CHS~~PRC funds are adequate to provide services that are authorized in accordance with IHS approved policies and procedures. ~~(~~See ~~Manual Exhibit 2-3-D.)~~PRC Web site:
http://www.ihs.gov/PRC/index.cfm?module=PRC_requirements_priorities_of_care

~~A. Dental Priorities. See Manual Exhibit 2-3-E.~~

~~2-3.20~~
2-3.19 DEFERRED SERVICES

A. Deferred Services. Deferred Services are services that fall within IHS Medical Priorities but are not prioritized to warrant immediate authorization. Authorization for services that fall within but do not meet medical priorities may be deferred for future authorization rather than be denied as long as the services have not been provided. The service deferred must be elective (i.e., "deferrable"), not emergent or urgent. The patient must have accessed the IHS health care system during the FY. Deferred services are considered and reported by IHS as unmet need.

~~A.~~B. ~~Recording and Reporting.~~ Recording and Reporting. IHS evaluates and estimates need and the unmet need for the PRC program based upon information submitted per the annual unmet need request memo and tables, see Manual Exhibit 2-3-O, by Area PRC Officers, voluntarily submitted data by Tribal PRC programs and FI payment data for the average cost for inpatient admissions, outpatient visits and patient travel. This data is needed and used to accurately determine PRC financial needs and support program budget justifications to the HHS, OMB and Congress. The reporting formats and guidelines for deferred services accrued and deferred services expenditures are sent to the Areas ~~by the Director, DCC,~~ on an annual basis.

The formula used to estimate the need is as follows, the percentages used to illustrate the formula do not remain the same year to year and are dependent upon the number of Tribes that manage PRC funds through Title I and Title V contracts. Annually the FI provides the percentage of PRC funds expended for inpatient admissions (e.g., 38%), outpatient visits (e.g., 51%) and patient transportation (e.g., 11%) and the average cost per claim of an inpatient admission (e.g., $9,863), outpatient visit (e.g., $545) and patient transport (e.g., $2,161). For illustration purposes, the IHS manages 42% of the PRC budget and Tribes manage 58%. The methodology in the table below is used to estimate the unmet
need in PRC.

Unmet Need Methodology	Total Programs	Number of Programs that Reported Data	Percent of Programs that Reported Data	Percent of PRC Budget Accounted for	Apply Percent of Data Reported
Federal PRC Programs	67	67	100%	42%	42%
Tribal PRC Programs	177	68	38%	58%	22%
				Percent of Data Reported	64%
				Percent of Data Not Reported	36%

~~A. Guidelines. Guidelines for recording and reporting on deferred services cases must meet these criteria:~~

~~1. The patient must have accessed the IHS health care system during the FY reporting period. Although there will be no carry over in reporting deferred services from one year to the next, the Service Unit has the option to pay for care deferred in a prior FY.~~

~~2. Deferred services must be elective (i.e., deferrable), not emergent or urgent. Payment denials for care received that was not within stated medical priorities are reported through the denial reporting process, not as a deferred service.~~

~~3. The service required cannot be accessible or available to the patient in the IHS direct care system (care provided directly in IHS or tribally operated clinics or facilities, not CHS care) within the usual and customary treatment and referral patterns.~~

~~4. The deferred service must be within IHS medical priorities. Items listed in the IHS medical priorities as procedures that the IHS will not pay for cannot be reported as a deferred service.~~

~~2-3.21 CONTRACT HEALTH SERVICES MANAGED CARE~~

~~The purpose of managed care is to promote access to needed health care at the most affordable cost, maximize utilization of resources and alternate resources, and support greater continuity of care. To that end, each Service Unit shall maintain the following elements to review and monitor care referred for clinical and financial case management. Priority cases should be high cost and high risk cases. All Service Units will maintain the following elements to review and monitor the referral and expenditure of CHS funds:~~

~~A. Contract Health Service or Managed Care Committee. There shall be an active CHS or managed care committee (MCC) to review CHS referrals and emergency cases. Each Service Unit will establish MCC policies and procedures that define the purpose of the committee; the membership; and the roles and functions of the members, e.g., benefits coordination, continuity of care, referrals, and follow-up needs.~~

~~B. Membership. Members should include, at a minimum, the Clinical Director, Director of Nursing, or Clinical Manager (or other primary care provider), Utilization Review Nurse (if available), Administrative Officer, and the CHS Specialist.~~

*Estimated Number of Denied Services = (Reported Number of Denied Services / Percent of Data Reported) * (Percent of Data Not Reported)

**Cost for the Estimated Number of Denied Services = Average Cost per Claim (as provided by the FI) * Estimated Number of Denied Services

2-3.20 PURCHASED/REFERRED CARE REVIEW COMMITTEE

The PRC review committee function is to review PRC referred care and notifications regarding emergency episodes of care and to determine medical priority and rank based on relative medical need within the same medical priority level. Utilizing Area guidelines, the PRC review committee will monitor high cost cases including the progress of each case.

The IHS will maintain a PRC review committee to review and prioritize PRC referrals and

notifications regarding emergency episodes of care based on Medical Priorities of Care, as well as to review and monitor the referral and expenditure of PRC funds.

A. PRC Review Committee Requirements.

The following elements along with PRC staff will be maintained by all PRC Review Committees:

(1) Defined policies and procedures regarding the PRC referral process will include: Referral tracking methodology noting the disposition of each referral reviewed; and meeting notes summarizing decisions and activities of each meeting. Records will be maintained and made available for review as requested by IHS officials.

(2) Committee membership shall consist of the Clinical Director, or his or her designee and others, i.e., utilization review nurse or care coordinator/case manager, patient benefit coordinator and the PRC Specialist. Membership may change periodically based on local needs, medical staff members can serve a rotation.

(3) A committee member will record committee comments, medical priority and ranking information and communicate to PRC staff for referral data entry, issuance of purchase orders, denials, deferrals and notification requirements.

~~A.~~B. Meetings. Meetings must be held at least once a week to determine the ~~appropriateness~~medical priority and rank of referral requests for expenditure of ~~CHS funds~~PRC funds. Minutes will be maintained to accurately reflect decisions and actions for each case discussed.

~~NOTE: When an inquiry is being made by a relative of a committee member the committee member must~~

C. Managing PRC Referrals and Payment Authorizations for Family Members and Relatives

(1) PRC Review Committee members are required to recuse ~~himself or herself~~themselves from referral, case ~~discussion~~/care discussions and decisions~~. The record of the meeting must reflect~~ involving services for family members or relatives. Meeting records will include documentation indicating the reason ~~that~~ the committee member was recused.

(2) An IHS employee ~~removed his or herself from the case. An employee~~ with procurement authority ~~must not sign~~is prohibited from signing the purchase ~~or~~ delivery order for a ~~patient to whom he~~family member or ~~she~~relative.

(3) For the purposes of this section, the IHS will use the following definition of family/relative. Family/relative means and includes the following:

An individual who is related to the IHS employee as father, mother, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, husband,

wife, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother- in-law, sister-in- law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half-brother, or half-sister.

~~B.~~D. Criteria for Payment Decisions. The committee will consider the following criteria, at a minimum, for ~~CHS~~PRC cases:

(1) The patient must be PRC eligible.

~~(2) Funds must be available.~~

~~(3)~~(2) The care must be within medical priorities.

~~(4)~~(3) The requested ~~services must~~service is not ~~be~~available in an accessible ~~or available in an~~ IHS or Tribal facility.

(4) Funds must be available.

~~1. The patient~~When Funds are not available, PRC referrals must still be ~~CHS eligible.~~
~~2. The CHS referral shall be made to the appropriate provider based on cost or quality factors, or an exception justified.~~

a. ~~For a review of emergency cases, the care provided shall be verified~~ranked within medical priorities by the committee ~~as an emergency situation.~~

b. Obligation of PRC funds for a referral when no funds are available is a violation of the Anti-Deficiency Act. Federal employees who violate this act are subject to administrative and penal sanctions. Administrative sanctions may include suspension from duty without pay or removal from office. In addition, the offender(s) may also be subject to fines, imprisonment, or both.

(5) PRC referrals can then be authorized to the weekly spending limit after which all others must be deferred or denied.

~~(5)~~(6) Care must not be deferred for cases where full reimbursement through alternate resources is available.

~~C.~~E. Minutes. Minutes to accurately reflect decisions and actions for each case discussed of each committee meeting and will be maintained to accurately reflect the ~~decisions, actions, and determinations taken for~~determination of each case ~~discussed~~.

~~D.~~F. High ~~-~~Cost Cases. The ~~MCC~~PRC review committee will monitor high ~~-~~cost cases ~~(greater than $10,000),~~ including the progress of each case, ~~according to~~utilizing current Area/Tribal guidelines for high ~~-~~cost case management.

~~2-3.22~~ 2-3.21 PROMPT ACTION ON PAYMENT OF CLAIMS ALSO KNOWN AS THE ~~CHS "5~~PRC "FIVE-DAY~~"~~ RULE"

~~Section 220 of the IHCIA directs the CHS program to issue a purchase order or a denial within 5 days of notification of a CHS claim. Section 220 states the following:~~

~~The Service shall~~

A. Time of Response. 25 U.S.C. 1621s requires the IHS to respond to a notification of a claim by a provider of a ~~contract care~~PRC service with either an individual purchase order or a denial of the claim within 5 working days after ~~the~~ receipt of such notification. For the purposes of this rule the following definitions apply.

B. ~~If~~Notification of a Claim. For the ~~Service~~purposes of part 136, and also 25 U.S.C. 1621s and 1646, the submission of a claim that meets the requirements of 42 CFR 136.24.

(1) Such claims must be submitted within 72 hours after the beginning of treatment for the condition or after admission to a health care facility notify the appropriate ordering official of the fact of the admission or treatment, together with information necessary to determine the relative medical need for the services and the eligibility of the Indian for the services.

(2) The information submitted with the claim must be sufficient to:

a. Identify the patient as eligible for IHS services (e.g., name, address, home or referring service unit, Tribal affiliation),

b. Identify the medical care provided (e.g., the date(s) of service, description of services), and

c. Verify prior authorization by the IHS for services provided (e.g., IHS purchase order number or medical referral form) or exemption from prior authorization (e.g., copies of pertinent clinical information for emergency care that was not prior-authorized).

(3) To be considered sufficient notification of a claim, claims submitted by providers and suppliers for payment must be in a format that complies with the format required for submission of claims under title XVIII of the Social Security Act (42U.S.C. 1395 *et seq.*) or recognized under section 1175 of such Act (42U.S.C. 1320d-4).

~~B.~~C. Failure to Timely Respond. If IHS fails to respond to a notification of a claim ~~in within 5 working days, the Service~~as defined in 2-3.21A, IHS shall accept the claim as a valid ~~the claim submitted by the provider of a contract care service~~claim for PRC services.

~~C.~~D. Time of Payment. The Service shall pay a completed contract care service claim within 30 days after completion of the claim, in accordance with the Prompt Payment Act 31 U.S.C. 3901. (See Manual Exhibit 2-3-P).

~~If~~

2-3.22 NO PATIENT LIABILITY

The Affordable Care Act, enacted on March 23, 2010, reauthorized and amended the IHCIA.

The IHCIA [25 U.S.C. 25 §1621(s)], provides that patients are not liable for payment of services authorized and approved for payment under a PRC program, which pays for authorized PRC referrals for healthcare services to non-IHS providers. Section 222 of the IHCIA [25 U.S.C. § 1621u] provides:

A. No Patient Liability. A patient who receives PRC services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.

B. Notification. The Secretary shall notify a contract care provider and any patient who receives PRC services authorized by the Service that such patient is ~~potentially~~not liable for the payment of any charges or costs associated with the provision of such services not later than five business days after receipt of a notification of a claim by a provider of contract care services.

C. No Recourse. Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 220(b), the provider shall have no further recourse against the patient who received the PRC services.

In summary, a patient is not liable for services that have been authorized for payment by a PRC program carried out by the IHS or a Tribal health program. Providers are prohibited from collecting any payments for these services from the patient, whether directly or through referral to an agent for collection. Please note that not all visits or referrals of IHS eligible patients to non-IHS providers are authorized for ~~an alternate resource, issue a denial~~payment.

A sample letter to be sent to patients and ~~advise~~providers informing them that patients are not liable for payment of services authorized and ~~assist the patient~~approved for payment under a PRC program can be found in ~~the application process. (See~~ Manual Exhibit 2-3-~~N.)~~Q.

2-3.23 THIRD-PARTY TORTFEASOR CASES AND FMCRA

A. Definition. Third-party tortfeasor cases are cases where ~~the~~ IHS provides or pays for services to an injured individual where a third-party (the Tortfeasor) may be found to be responsible for the injury. ~~(~~See IHS Circular No. 2006-02, "Reporting Third-Party Tortfeasor Claims and Recovery of Funds under the Federal Medical Care Recovery Act~~.~~".

B. Claims. Under the FMCRA the ~~Federal~~ Government is authorized to recover the cost of these services. The various offices of the Regional Attorney are responsible for asserting any Government claim under the FMCRA. ~~The OGC advises that the procedure of withholding payment on purchase orders pending resolutions of third-party liability...does not follow the procedures for recovery under FMCRA. Bills submitted to the IHS where CHS have been authorized in a third-party case must be paid if otherwise valid and funds are available. Payment is not to be withheld pending final determination of any claim the patient may have against a third-party.~~ Payment is not to be withheld pending final determination of any claim the patient may have against a third party.

~~B.~~C. Alternate Resource. ~~In addition,~~ Authorization of ~~CHS~~PRC may not be denied based

on any theory that potential recovery from an alleged third-party tortfeasor constitutes an "alternate resource" under the ~~CHS~~PRC regulations.

~~C.~~D. Recovery. Any ~~funds recovered~~recovery made by the ~~Federal~~ government must go back to the respective ~~CHS~~PRC Program. ~~All recovered FMCRA funds are returned to the CHS program that originally paid for the services provided to the patient. Applicable~~ The reporting and payment requirements are mandatory and must be followed.

~~D.~~E. Cost of Services Settlement. ~~There is a positive motivating factor that should be kept in mind.~~ Failure to report FMCRA cases could possibly harm the patient or the ~~patient s~~patients family. If the injured party should make a settlement that does not reflect the cost of services provided by the IHS, the ~~Federal~~ Government might still have claim against the settlement for the cost of services. Though ~~it is problematic~~ whether the ~~Federal~~ Government ~~would~~may or may not pursue ~~its~~a claim in such a situation, the possibility cannot be ~~totally discounted.~~ ruled out. Therefore, prompt reporting can act to protect the interest of the injured party.

~~E.~~F. Third-Party Report Forms. ~~All possible third-party Tortfeasor cases are to be promptly reported to the CHSO.~~ All third-party report forms should be completed by the ~~Service Unit CHS~~facility staff as indicated by local policy and contain the following information:

(1) Patient Name~~.~~

(2) Date of Service, explanation of situation~~.~~

(3) Name of third ~~-~~party, which may be responsible for payment in the case~~.~~

(4) Costs paid by IHS~~.~~

(5) Any related correspondence~~.~~

~~2-3.24 VICTIMS OF CRIME ACT~~

~~The Victims of Crime Act of 1984,Title 42, Chapter 112 U.S.C., established a crime victim compensation program. The program is operated by the Federal Government and provides compensation to criminal violence victims and survivors of criminal violence, including drunk driving and domestic violence for medical expenses attributable to a physical injury resulting from a compensable crime, and for certain other expenses. Accordingly the IHS CHS program must pay for care provided to eligible AI/ANs before the crime victim compensation program pays; consequently, the crime victim compensation program is an exception to the IHS payer of last resort policy.~~

[Tribal Letterhead]

[Date]

RADM Michael D. Weahkee
Acting Director
Indian Health Service
5600 Fishers Lane, Mail Stop 08E86
Rockville, MD 20857
[*Via Email*: consultation@ihs.gov]

Re: PRC Chapter Update Tribal Consultation

Dear RADM Weahkee:

On behalf of [Tribe Name], I submit these written comments responding to the Indian Health Service's (IHS) May 18, 2018 Dear Tribal Leader Letter (DTLL) initiating tribal consultation on changes to the Indian Health Manual (the "Manual"), Part 2, Chapter 3 "Services to Indians and Others" (also known as "Purchased/Referred Care" or "PRC") (the "PRC Chapter"). Included with these written comments is a redline of the Draft PRC Chapter available at https://www.ihs.gov/prc/draft-prc-chapter-of-the-ihm/. We believe that this redline document communicates our recommendations more concisely than written comments could; however, we explain our suggested changes below.

Background

IHS's legal authority for issuing the Manual is addressed in the eligibility regulation at 42 C.F.R. § 136.3, which provides that the IHS will periodically issue administrative instructions to its officers and employees that are primarily found in the Manual: "These instructions are operating instructions to assist IHS officers and employees in carrying out their responsibilities and are not regulations establishing program requirements which are binding upon members of the general public." Thus, the IHS cannot use the Manual to rewrite the PRC regulations at 42 C.F.R. Part 136, Subpart C and 42 C.F.R. § 136.61, which establishes the payor of last resort rule.

If the IHS wants to issue "substantive rules of general applicability adopted as authorized by law or statements of general policy or interpretations of general applicability," the IHS must publish them in the Federal Register in accordance with the Administrative Procedure Act (APA), 5 U.S.C. §§ 552(a) and 553 (notice and comment rulemaking). Thus, the IHS cannot use the Draft PRC Chapter to (1) redline/edit and paraphrase the actual language of the regulations as a means to change the regulations without going through APA procedures; (2) establish formal agency interpretations of statutes and regulations again without complying with the APA; or (3)

declare, in certain instances, that the IHS will no longer adhere to specific requirements in the regulations. Furthermore, as stated in 42 C.F.R. § 136.3 noted above, the Manual provides administrative instructions to IHS officers and employees carrying out PRC programs operated by the IHS. It is not binding on Indian tribes and tribal organizations carrying out contracted or compacted PRC programs under the Indian Self-Determination and Education Assistance Act (ISDEAA), unless a tribe or tribal organization expressly agrees in its contract, compact, or funding agreement to be bound by the Manual.[1]

General Recommendations for the Draft PRC Chapter

In the future, we encourage the IHS to meet with Tribal Workgroups and technical advisors to hear and incorporate their recommendations before issuing a DTLL, particularly on detailed matters such as this.

In general, throughout the Draft PRC Chapter, there are numerous errors, including but not limited to: (1) terms are incorrectly phrased as plural or singular when it should be the opposite; (2) undefined or vague terms or phrases are used instead of those with specific meaning in the definitions section;[2] (3) specific terms are used inconsistently (*e.g.,* "Indian" versus "American Indian/Alaskan Natives"); (4) phrases and terms with acronyms are spelled out instead of identified by their acronyms; and (5) citations reference the wrong authority, and links do not work or reference incorrect materials. Some, but not all, of these errors are identified in the enclosed redline document.

Additionally, we suggest returning to the numbering of subsections to A, B, C, then (1), (2), (3), and a, b, c.[3] Similarly, the definitions in Section 2-3.1.5 should be ordered alphabetically. Furthermore, we cannot properly comment at this time on the proposed changes to numerous provisions referencing Manual Exhibits or the documents themselves because the IHS has not released or made public revised versions.[4]

The following is a summary of the major issues we have identified with IHS's proposed revisions to the PRC Chapter, and our recommendations.

Definitions

Since the PRC Chapter cannot re-define terms already defined by statute or regulation, Section 2-3.1.5 should contain definitions as already prescribed by law. For example, Section 2-3.1(5)(25) deletes "former reservations in Oklahoma" from the definition of "Reservation," even

[1] 25 U.S.C. §§ 5329(c)(1) (model self-determination contract § 1(b)(11)), 5397(e).
[2] For example, "facility" compared to "IHS facility." Facility alone is an undefined term. Since the PRC Chapter does not regulate tribal health programs, we suggest identifying, where appropriate, the phrase as an IHS facility. Otherwise, this statement would infringe on tribal self-governance.
[3] These written comments reference the sections of the PRC Chapter using the numbering system in the Draft.
[4] The Manuel Exhibits that are unavailable for comment include: Manual Exhibit 2-3-B (Authorization for Use or Disclosure of Health Information); Manual Exhibit 2-3-J (Object Class Code Narratives and Service Class Code Narratives); Manual Exhibit 2-3-P (New; Discusses Time of Payment by IHS); Manual Exhibit 2-3-Q (New; Sample letter to patients notifying them that they are not liable for payment of services authorized and approved for payment under a PRC Program).Manual Exhibit 2-3-B; Manual Exhibit 2-3-J; Manual Exhibit 2-3-P; Manual Exhibit 2-3-Q.

through the phrase is in the definition of the term in 25 U.S.C § 1603(16) and 42 C.F.R. § 136.21(i). If clarification is necessary for IHS officers and employees to understand terms, the PRC Chapter should set off the legal definition in quotes to contrast it with the Agency's own explanation.

Problematically, the definition of "Tribally-Operated Program," which is defined in Section 2-3.1(5)(31) as "a program operated by a Tribe or Tribal organization that has contracted under Pub. L. 93-638 to provide a PRC program," is inconsistent with the court's ruling in the *Redding Rancheria* case.

The court in *Redding Rancheria* interpreted the following provision, codified by the Affordable Care Act (ACA) at 25 USC § 1623(b):

> Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act [IHCIA] (25 U.S.C. § 1603) shall be the payer of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary.

During litigation, the IHS took the position that this language referred to the definition of the term "tribal health program" in Section 4(25) of the IHCIA, 25 U.S.C. § 1603(25), which is defined as a program compacted or contracted with the IHS under the ISDEAA. The effect of the IHS's interpretation was to exclude tribal self-insured health plans and make them alternate resources. The court rejected this argument, determining that the parenthetical language—"(as those terms are defined in section 4 of the IHCIA)"—referred to how all of the entities listed (the IHS, tribes, tribal organizations, and urban Indian organizations) are defined in the IHCIA. The result of the court's holding was that "health programs operated by Indian tribes, tribal organizations" meant *any* health program operated by tribes and tribal organizations, including tribal self-insurance plans.

Therefore, we recommend that the term "Tribally-Operated Program" be removed from the PRC Chapter and that the IHS instead use the term "Tribal Health Program," which is defined in Section 1603(25) of the IHCIA, for references to tribally compacted or contracted programs, as appropriate.

Payor of Last Resort Requirements

Alternate Resources

In numerous places throughout the Draft PRC Chapter, the IHS defines and provides criteria for determining what it would consider an "alternate resource." The definitions section includes programs under "the Social Security Act (*i.e.,* Medicaid, Medicare and Children's Health Insurance Program), other Federal healthcare programs, State and local healthcare programs, [the] Veterans Health Administration, and private insurance" (Section 2-3.1(5)(1)). The payor of last resort rule section also adds Vocational Rehabilitation, Children's

Rehabilitative Services and the Crime Victims Act (Section 2-3.8(7)). Instead of multiple, inconsistent definitions, the Draft PRC Chapter should cite the current regulation at 42 C.F.R. § 136.21, referring to the definition of "alternate resources" at 42 C.F.R. § 136.61(c), for the definition. Then, in Section 2-3.8(7), the IHS may expand upon the definition with more information. Furthermore, the alternate resources section should state that "local" does not mean "tribal," and "private health insurance" does not mean tribal self-insured health plans.

In Section 2-3.8(7), the statement "All IHS or Tribal facilities that are available and accessible to an individual are considered alternate resources" appears to be intended to capture the requirement that an individual may not access PRC if services are available at the IHS/Tribal facility. However, that requirement is already in the regulations, and it is inappropriate to add here. As drafted, the language suggests that both the IHS and/or a tribe could be considered an alternate resource— i.e., alternate to themselves. This is inconsistent with the law, and inconsistent with the *Redding* decision. We recommend deleting the statement.

Sponsorship of Plans. In terms of other coverage provided by tribes, from the language of Section 2-3.8(10) it appears the IHS would consider insurance purchased by a tribe for its members (also known as "sponsorship" plans) as an alternate resource, unlike tribal self-insurance but separate from reinsurance. Section 402 of the IHCIA, 25 U.S.C. § 1642, authorizes Indian tribes, tribal organizations, and urban Indian organizations to use federal funds available to them under the ISDEAA, Social Security Act programs (such as Medicare, Medicaid, and Children's Health Insurance Plan reimbursements), or under other federal laws, to purchase "health care benefits coverage" for IHS eligible beneficiaries. It is unclear what the IHS means by "sponsorship through indemnity" in Section 2-3.8(10) of the Draft PRC Chapter. This should be clarified to simply state "sponsorship of insurance plans." Furthermore, for ease of reading, we suggest moving this provision up to be included within the provision about alternate resources in Section 2-3.8(7).

Charity or Indigent Care Programs. In Sections 2-3.8(1)(3) and 2-3.8(1)(7), the IHS states that a charity or indigent care program is not considered an "alternate resource" for purposes of the payor of last resort rule when the PRC provider absorbs the full cost of services provided. In other words, the IHS does not consider a non-Indian provider an available source of payment to himself or itself. One example of this could be when a hospital charity program writes-off the cost of care for services provided to persons eligible for the charity program. However, such programs may still be "health care resources" under the IHS payor of last resort rule at 42 C.F.R. § 136.61, and we think it is reasonable to conclude under the statutory language at 25 U.S.C. § 1623(b) that a charitable source of coverage—including write-offs by providers under established charity or indigent care programs—should be accessed before a PRC program would have to be the payer for care. We thus suggest that the language on charitable programs in Section 2-3.8(1)(3) be removed and the language in Section 2-3.8(1)(7) be revised to clarify that available charity or indigent care programs are considered alternate resources for purposes of PRC if an individual is eligible for the program or would be eligible but for having PRC.

Student Grant Funds. As drafted, the provision requiring students to purchase health insurance with grant funds places a requirement on students that may be incompatible with the terms of a grant(s). Additionally, it is unclear whether "individuals" in the next sentence means

to require *any* person receiving funds for health insurance to purchase it, or only students. We recommend that the IHS clarify and move the provision up to be included within the provisions for alternate resources in section 2-3.8(7).

Tribal Self-Insurance

Section 2-3.8(9) would expressly exempt "tribally funded self-insurance plans"[5] from consideration as an alternate resource but "[a]ny portion of the plan that is reinsured will not be considered Tribal Self-Insurance." While the proposed language as drafted may be intended to only include the reinsurance itself as an alternate resource, that is not how it reads. The language as drafted states that the IHS would consider the entire reinsurance plan an alternate resource if a tribe has any reinsurance on it. While it may be appropriate for reinsurance to be considered an alternate resource when the reinsurance is paying, rather than the tribe, it is not appropriate for a Tribal Self-Insured plan to be considered an alternate resource simply because it is reinsured. Furthermore, the Draft PRC Chapter's exclusionary clause does not recognize that the IHS may bill tribal self-insurance if the tribe gives permission.[6] The PRC Chapter should not foreclose this option. The redline document revises provisions for the tribal self-insurance to reflect these recommendations. Lastly, for ease of reading, we recommend moving this provision directly below the alternate resources provision and above the qualified health plan provision.

Failure to Follow Alternate Procedures

As Section 2-3.8(4)(1) is structured in the Draft PRC Chapter, it is not clear what action the 10-day timeframe applies to. Is it for contacting facility staff for help, to complete an application, or both? Or, does it reference the issuance of a denial letter? As currently drafted, it is unlikely that providers would be able to understand the requirements of this provision. Our redline document attempts to make this clearer but we recommend that the IHS revise this section to more accurately communicate the requirements. Furthermore, the current PRC Chapter provides for a 30-day timeframe, which the IHS changed to 10-days in the Draft PRC Chapter. The IHS should change it back to 30 days or provide a citation authorizing the change.

PRCDAs and the Process for Redesignation

In Section 2-3.3(1), the IHS takes the position that it may only provide services in Purchased/Referred Care Delivery Areas (PRCDAs) under the current regulations, stating that it would have to amend the regulations by notice and comment rulemaking in order to recognize new PRCDAs. While the IHS does not directly state it, they appear to be taking the position that new PRCDAs established by Congress cannot be implemented until the IHS changes its regulations. This position is contrary to current law because acts of Congress supersede conflicting agency regulations.

Another confusing change seems to expand the consultation requirement. Currently, the

[5] We note that the phrase "tribally funded self-insurance plans" differs from the specifically defined term "Tribal Self-Insurance," and the defined term "Tribal Self-Insurance" should be used.
[6] *See* 25 U.S.C. § 1621e(f).

regulations only require consultation with tribes *within* a PRCDA;[7] but as we read the new provision in Section 2-3.4(3)(1) of the Draft PRC Chapter, an Area PRC Officer must consult with *any* tribe affected by a designation or redesignation of a PRCDA. The intent behind the provision could be to simply reiterate the consultation requirement instead of creating a new one, but this is not clear from how the IHS phrased it.

In Section 2-3.4(3)(3), the IHS includes an ad hoc PRCDA Designation/Re-Designation Committee—a committee with which we are not familiar. It is unclear whether this Committee is new or if it is already existing practice that is just now being written down. As provided for in the Draft PRC Chapter, this Committee would review redesignation requests submitted to the Director of the Division of Contract Care (DCC) to determine if the information submitted meets the criteria set forth in Section 2-3.4(1). The Director of the DCC would then send the Committee's findings and recommendation to the Director of the IHS for a final determination. As drafted, the Committee's recommendation would replace that of the Director of the DCC. There is not much information about the Committee besides that its membership would include leadership from numerous offices within the IHS. We suggest including more information about the role and responsibilities of the Committee. Furthermore, stating that the PRCDA designation/redesignation cannot be appealed suggests that the IHS's decision cannot be appealed under the APA, which is incorrect.

Eligibility Requirements

The way in which both the current and Draft PRC Chapter outline the PRC eligibility requirements is different from how they are outlined in the PRC eligibility regulations, which creates significant confusion. In the enclosed redline document, we suggest that this be fixed in the Draft PRC Policy at Section 2-3.6(2), in order to mirror the outline in the regulations as follows:

> To be eligible for PRC, an individual must be eligible for direct care as defined in 42 C.F.R. § 136.12; and either
>
> 1. reside within the U.S. on a Federally-recognized Indian reservation; or
>
> 2. reside within a PRCDA and;
>
>   a. be a member of the Tribe or Tribes located on that reservation; or
>
>   b. maintain close economic and social ties with that Tribe or Tribes.

We support several changes by the IHS in the eligibility section including: (1) a change to Section 2-3.6(3), which recognizes the ability of tribes to define who is eligible for PRC though close economic and social ties; and (2) the addition of "high school" students as full-time students eligible for care outside of their PRCDA (Section 2-3.6(4)).

[7] *See* 42 C.F.R. § 136.22(b).

However, we have several recommendations for the new provision about PRC for persons in custody. The Draft PRC Chapter does not define what the IHS would consider "Indian law enforcement." We recommend the IHS clarify that the phrase "Indian law enforcement" includes both the Bureau of Indian Affairs (BIA) and tribal law enforcement, and explain how the IHS would identify law enforcement agencies operating under a contract or compact with a tribe to provide law enforcement services. Similarly, the purpose of putting "non-Indian" in parentheses is unclear.

Tribal Appeals Process

We support the new provision at the end of Section 2-3.11(4), which is the tribal appeals process for contractors, because it recognizes that tribal contractors are not legally required to use the IHS appeals process for their PRC program. However, it appears to only discuss the Tribal Appeals Process in terms of retained authority but does not refer to the option to buy back the appeals process. Our redline document adds language to recognize that tribes have this option.

Additionally, Section 2-3.11(5)(1) states that the IHS will not use "Tribal criteria and interpretations" in the appeals process. This is not consistent with several other provisions: Section 2-3.6(3), which states that the IHS will recognize tribally defined criteria for PRC eligibility; Section 2-3.11(7) (following this provision) that recognizes that tribes may set different standards for PRC eligibility and medical priorities; and Section 2-3.20(6), recognizing tribal criteria for high cost cases. This provision should allow for a process that includes review by the aforementioned tribal standards, not those set by the IHS. As an aside, we support all of the provisions recognizing the authority of tribes to set their own criteria and standards.

Notification of a Claim

The definition of "Notification of a Claim" in Section 2-3.1(5)(22) is duplicative of Section 2-3.21(2)(1) and (2). As this term requires significant explanation, more in the form of requirements than a definition, we recommend that Section 2-3.1(5)(22) be deleted.

Section 2-3.21(2)(1) is paraphrased from 42 C.F.R. § 136.24(b), and is not an accurate statement of the regulations. This provision should accurately reflect the law. Similarly, Section 2-3.21(2) prefaces all the requirements that follow with citations to statutes and the regulations. This could lead the reader to presume that those statutes and regulations legally oblige the provider to meet the requirements. However, the three requirements in Section 2-3.21(2)(2) are not mandated by any law and are only provided for in policy. The enclosed redline document provides solutions to these problems.

Additionally, Section 2-3.21(2)(2)(1) appears to require information from a provider (whether a patient is eligible for care) that a provider would not have. It is the IHS's responsibility to determine whether a patient is eligible. If the IHS's intent is that this provision require sufficient information about the patient from the provider so that *the IHS* can identify a patient as eligible on its end, that is unclear and should not be a requirement. Similarly, the use

of "IHS services" in this provision is unclear because it is an undefined term. We recommend removing this provision.

Other Issues

In Section 2-3.9(3), Authorization for PRC, the IHS appears to place a mandate on the Centers for Medicare and Medicaid Services (CMS). The IHS cannot govern the activities of the CMS. If there is an agreement between the IHS and the CMS recognizing that the CMS will take these actions, the IHS should reference it in this section.

We thank the IHS for providing tribes with the flexibility to adjust funding based on local needs in Section 2-3.12(1), Allocation of PRC Funds. However, we note that the ability of individual PRC programs to make a determination about using PRC funds for staff administering the PRC program is problematically conditioned on the Area Director making annual reports (Section 2-3.12(3)(1)). As reflected in the enclosed redline document, the provision can be kept but should be made into a separate criteria instead of a condition for using PRC funds for staff administering the PRC program.

Conclusion

We appreciate the opportunity to provide our input into the IHS's revisions to the PRC Chapter, and thank you for considering our written comments.

Sincerely,

[Tribal Representative]

Attachment

As noted in our comment letter, we believe that this redline document communicates our recommendations more concisely than written comments could. However, we explain many of our suggested changes in greater detail in the letter.

Indian Health Service (IHS) Indian Health Manual, Part 2 Chapter 3

Below are draft revisions to the Indian Health Service (IHS) Indian Health Manual, Part 2 – Services to Indians and Others, Chapter 3 – Purchased Referred Care. Proposed revisions and additions are in BOLD

~~1.~~ 2-3.1 INTRODUCTION

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1. Purpose. This revised chapter publishes the policy, procedures, and guidance for the effective management of the Indian Health Service (IHS) Purchased/Referred Care (PRC) Program. The authority to manage the operation of the PRC Program is delegated to the greatest degree possible, within the limits of available funds, to Area Directors and Chief Executive Officers (CEO). In the event PRC funds are depleted, PRC payment for services must be denied or deferred and the CEO must notify the Area Director.

2. Authorities.

    1. 25 U.S.C. 13 (Snyder Act)

    2. 42 U.S.C. 2001 et seq. (the Transfer Act of 1954)

    3. 42 *Code of Federal Regulations* (CFR) 136 Subparts C, D, I and G

    4. Public Law (Pub. L.) 111-148, Patient Protection and Affordable Care Act (March 23, 2010) — (Payer of Last Resort)

    5. Pub. L. 111-5 "The American Recovery and Reinvestment Act of 2009" — (Medicaid Cost Sharing)

    6. Pub. L. 108-173 "Medicare Prescription Drug Improvement and Modernization Act of 2003" — (PRC Rates for services furnished by Medicare-Participating Hospitals)

3. Policy. It is IHS policy to ensure that PRC funds are used to supplement and complement other health care resources available to eligible American Indian and Alaska Native (AI/AN) people. The funds are utilized in situations where:

    1. no IHS direct care facility exists;

    2. the direct care element is incapable of providing required emergency and/or specialty care;

    3. the direct care element has an overflow of medical care workload; and

    4. supplementation of alternate resources ~~(i.e., Medicare, Medicaid, private insurance, Veterans Health Administration)~~ is required to provide comprehensive health care to eligible AI/ANs.

4. Acronyms.

    1. AMA — Against Medical Advice

    2. ARRA — American Recovery and Reinvestment Act

    3. CY — Calendar Year

    4. CHEF — Catastrophic Health Emergency Fund

5. CEO — Chief Executive Officer

6. CFR — *Code of Federal Regulations*

7. CHS/MIS — Contract Health Services/Management Information System

8. CDSR — Core Data Set Requirement

9. CMS — Centers for Medicare and Medicaid Services

~~9.~~10. DCC — Division of Contract Care

~~10.~~11. EHR — Electronic Health Record

~~11.~~12. EPHI — Electronic Personal Health Information

~~12.~~13. FMFIA — Federal Managers Financial Integrity Act

~~13.~~14. FMCRA — Federal Medical Care Recovery Act

~~14.~~15. FR — *Federal Register*

~~15.~~16. FI — Fiscal Intermediary

~~16.~~17. FY — Fiscal Year

~~17.~~18. HITECH — Health Information Technology for Economic and Clinical Health Act

~~18.~~19. HIPAA — Health Insurance Portability and Accountability Act

~~19.~~20. IHCIA — Indian Health Care Improvement Act

21. MMA — Medicare Modernization Act

~~20.~~22. ORAP — Office of Resource Access and Partnership

~~21.~~23. PHI — Protected Health Information

~~22.~~24. PRC — Purchased/Referred Care

~~23.~~25. PRCDA — Purchased/Referred Care Delivery Area

~~24.~~26. PRCO — Purchased/Referred Care Officer

~~25.~~27. RCIS — Referred Care Information System

~~26.~~28. RPMS — Resource and Patient Management System

~~27.~~29. UFMS — Unified Financial Management System

30. U.S. — United States

~~28.~~31. U.S.C. — *United States Code*

~~29.~~32. VA — Veterans Health Administration

5. Definitions (Also see 42 CFR 136.21).

    1. Alternate Resources. Alternate resources are "health care resources other than those of the Indian Health Service. Such resources include health care providers and institutions, and health care programs for the payment of health services including but not limited to programs under titles XVIII or XIX of the Social Security Act (i.e., Medicare, Medicaid), State or local health care programs, and private insurance," as defined by 42 CFR 136.61(c).~~any Federal, State, local, or private source of coverage for which the patient is eligible. Such resources include health care providers and institutions and health care programs for the payment of health services including but not limited to programs under the Social Security Act (i.e., Medicare and Medicaid, Children's Health Insurance Program), other Federal health care programs, State and local health care programs, Veterans Health Administration and private insurance~~

    2. Appropriate Ordering Official. The ordering official for the PRCDA in which the individual requesting PRC or on whose behalf the services are requested, resides, unless otherwise specified by contract with the health care facility or provider. This usually means ~~T~~the person, with documented delegated procurement authority, who signs the purchase order authorizing the obligation of PRC funds.

    3. Area Director. The Director of an IHS Area Office designated for purposes of administration of IHS programs.

    4. Catastrophic Health Emergency Fund. The Catastrophic Health Emergency Fund (CHEF) is the fund established by Congress to reimburse extraordinary medical expenses incurred for catastrophic illnesses and disasters covered by a PRC program of the IHS, whether such program is carried out by IHS or an Indian Tribe or Tribal organization under the Indian Self-Determination and Education Assistance Act.

    5. Catastrophic Illness. Catastrophic illness is a medical condition that is costly by virtue of the intensity and/or duration of its treatments. Examples of conditions that frequently require multiple hospital stays and extensive treatment are cancer, burns, premature births, cardiac disease, end-stage renal disease, strokes, trauma-related cases such as automobile accidents and gunshot wounds and some mental disorders.

    6. Medicare Approved Transplant Program. A facility or institution that has met or exceeded defined standards of care in which transplants of organs are performed. The transplant program is a component within a transplant hospital that provides transplantation of a particular type of organ.

    7. CHEF Case. A CHEF case is an episode of acute medical care for a condition from an illness or injury, requiring extensive treatment that incurs medical costs to the IHS in excess of the CHEF threshold.

    8. CHEF Threshold Cost. A designated amount above which incurred medical costs will be considered for CHEF reimbursement after a review of the authorized expenses and diagnosis.

    9. Chief Executive Officer. The Chief Executive Officer (CEO) is the Director of the IHS program at the service unit level for the purposes of administration of the health service programs for that location.

    10. Medical Referral. A referral for health care services authorizes care but ~~that~~ does~~is~~ not represent that a patient is eligible for PRC and does not authorize~~d for~~ payment by PRC.

11. Purchased/Referred Care Delivery Area. The Purchased/Referred Care Delivery Area (PRCDA) is the geographic area within which PRC will be made available by the IHS and Tribal Health Programs.

12. Purchased/Referred Care. Purchased/Referred Care (PRC) is any health service that is:

    1. delivered based on a referral by, or at the expense of, an Indian health program; and

    2. provided by a public or private medical provider or hospital which is not a provider or hospital of the IHS or Tribal health program.

13. Purchased/Referred Care in Support of Direct Care. These are contracted specialty physician and non-physician specialty medical services provided within an IHS/Tribal facility when the patient is under direct supervision of an IHS physician or a contract physician practicing under the auspices (or authority) of the IHS facility.

14. Core Data Set. The PRC Core Data Set consists of required data for management of the PRC program that constitutes a subset of data collected in the IHS information system. The purpose of the data is to assist the IHS in its internal management and to satisfy Congressional and other mandatory reporting requirements.

~~15.~~ Deferred Services. Deferred services are services referred for PRC that do not meet immediate medical priority for payment guidelines for which the provision of treatment can be postponed or delayed and the service has not been provided.

~~16. Descendaent of a Tribal Member. An individual biologically descended from an enrolled member of the Tribe.~~

~~17.~~15. E-SIGN. E-SIGN is the electronic equivalent of a hand-written signature requiring user authentication, such as a digital certificate, smart card or biometric method for verification.

~~18.~~16. Emergency. An emergency is any medical condition for which immediate medical attention is necessary to prevent the death or serious impairment of the health of an individual.

~~19.~~17. Episode of Care. The period of consecutive days for a discrete health condition during which reasonable and necessary medical services related to the condition occur.

~~20.~~18. Fiscal Intermediary. The Fiscal Intermediary (FI) is the fiscal agent contracted by IHS to provide and implement a system to process PRC medical, dental and behavioral health claims for payment (42 U.S.C. 238m).

~~21.~~19. Indian Tribe. Any Indian Tribe, band, nation, group, pueblo, or community, including any Alaska Native village or Native group, which is Federally-recognized as eligible for the special programs and services provided by the ~~United States (~~U.S.~~)~~ to Indians, because of their status as Indians.

~~22. Notification of a Claim. For the purposes of 42 CFR part 136, and also 25 U.S.C. 1621s and 1646, the submission of a claim that meets the requirements of 42 CFR 136.24.~~

~~1. Such claims must be submitted within 72 hours after the beginning of treatment for the condition or after admission to a health care facility, notify the appropriate~~

Commented [1]: The purpose of this definition is unclear, as the term is not used within the PRC Chapter.

If it is intended to reference "descendant of an Indian" under the eligibility of California Indians section, the definition is redundant, as the term is already defined in Section 2-3.6.10. Thus, we recommend deleting this definition.

Commented [2]: This definition is duplicative of Section 2-3.21(2)(1) and (2). We suggest removing it from the definitions section for clarity. Our comments regarding notification of a claim are below in Section 2-3.21.

ordering official of the fact of the admission or treatment, together with information necessary to determine the relative medical need for the services and the eligibility of the Indian for the services.

2. The information submitted with the claim must be sufficient to:

1. Identify the patient as eligible for IHS services (e.g., name, address, home or referring service unit, Tribal affiliation),

2. Identify the medical care provided (e.g., the date(s) of service, description of services), and

3. Verify prior authorization by the IHS for services provided (e.g., IHS purchase order number or medical referral form) or exemption from prior authorization (e.g., copies of pertinent clinical information for emergency care that was not prior-authorized).

23.20. PRC Rates. The PRC rates are the rates IHS adopted in 42 CFR 136 Subpart D and Subpart I for payment of services authorized for payment through a PRC program. These rates are commonly referred to as Medicare-like rates.

24.21. PRC Referral. An authorization for medical care by the appropriate ordering official in accordance with 42 CFR part 136 subpart C.

25.22. Reservation. Any Federally-recognized Indian Tribe's reservation, pueblo, colony, including former reservations in Oklahoma Indian allotments, or Rancheria, including Alaska Native regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 *et seq*), and Indian allotments.

26.23. Residence. In general usage, a person "resides" where he or she lives and makes his or her home as evidenced by acceptable proof of residency or established by the IHS facility or tribally-operated PRC programtribal health program.

27.24. Secretary. Secretary of the Department of Health and Human Services (HHS).

28.25. Service. The Indian Health Service.

29.26. Tribal Health Director. The Director of a Tribally-operated programtribal health program, or his/her designee, authorized to make decisions on payment of PRC funds pursuant to a Pub. L. 93-638 contract.

30.27. Tribal Member. A person who is an enrolled member of a Tribe or is granted Tribal membership by some other criteria by the appropriate Tribal governing policy/document.

31.28. Tribally Operated Health Program. An Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).A program operated by a Tribe or Tribal organization that has contracted under Pub. L. 93-638 to provide a PRC program

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

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Commented [3]: The purpose of deleting "former reservations in Oklahoma" from the definitions is unclear. The proposed change to this definition is not compliant with 25 U.S.C § 1603(16) or 42 CFR § 136.21(i).

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30. Tribal Self-Insurance. A health plan that is funded ~~solely~~ by a Tribe or Tribal organization and for which the Tribe or Tribal organization assumes the burden of payment for health services covered under the plan either directly or through an administrator. To the extent any Tribal self-insurance plan has reinsurance or stop loss insurance from which claims are paid by entities other than the Tribe or Tribal organization, such reinsurance or stop loss insurance shall not be considered tribal self-insurance; provided that the fact that a tribal self-insurance plan has reinsurance or stop loss insurance does not mean that the tribal self-insurance shall be considered an alternate resource. ~~Any portion of the plan that is reinsured will not be considered Tribal Self-Insurance.~~

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~~32.~~31. Unmet need - PRC. The IHS collects data on cases of unfunded PRC services—services for which funding was not available—from the individual federal~~ly~~ PRC progams and voluntarily from ~~tribally-operated PRC programs~~ tribal health programs. Counts of deferral and denial cases are recorded by the individual PRC programs, collected by the Area Offices, and submitted to HQ. The aggregate count of cases is multiplied by the average cost per PRC claim (weighted average of the costs for inpatient, outpatient and transportation paid PRC claims) provided by the FI to estimate PRC program resource unmet need.

~~33.~~32. Urgent Care. The delivery of ambulatory care in a facility dedicated to the delivery of medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency department.

~~34.~~33. Veterans Eligible for VA Resources. Eligibility for VA resources is dependent upon a number of variables, which may influence the final determination of services for which the veteran qualifies. These factors include the nature of a veterans discharge from the military service (e.g., honorable, other than honorable), length of service, VA adjudicated disabilities (commonly referred to as service connected disabilities), income level and available VA resources among others.

~~2.~~ 2-3.2 RESPONSIBILITIES

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1. Director, Division of Contract Care. The Director, Division of Contract Care (DCC), IHS Headquarters (HQ) will:

    1. Establish general policies regarding the administration of the PRC program in the IHS.
    2. Establish standards of performance for Area, service unit and FI operations of PRC.
    3. Assess the performance of the PRC program at Area, service unit and FI against established standards.
    4. Assess long-term purpose and direction of the PRC program to ensure maximum effectiveness of the program in meeting the health needs of AI/AN people.
    5. Develop long-term plans and objectives for the future development of the PRC program.
    6. Provide staff assistance to Area Offices in matters of general policies and procedures.
    7. Prepare budget justification for the total PRC program.
    8. Allocate funds through the Office of Finance and Accounting to Area Directors.

9. Promptly and appropriately respond to appeals of denials of PRC by IHS Area Offices.

10. Provide guidance in the establishment of medical priorities.

11. Provide project officer services for the FI contract and all FI evaluation projects.

12. Respond to congressional questions and requests for information from the PRC program.

13. Centrally manage the CHEF.

14. Establish general guidelines and policies for applying coordination of care practices and PRC quality assurance activities in the Areas and service units.

15. Continue to operate and refine a Management Control System for the PRC function that conforms to the requirements of the Federal Managers' Financial Integrity Act (FMFIA), Section 2 [31 U.S.C. 3512 (b)] and IHS policies and procedures cited in Part 5, Chapter 16, "Management Control Systems," *Indian Health Manual* (IHM).

2. Area Director. The Area Director administers the PRC program, ensuring the program operates within regulations, policies, procedures and the budget. The Area Director through the respective Area PRC Officer shall:

    1. Develop and establish policies and methods for the direction, control, review and evaluation of the Area and service unit PRC programs.

    2. Establish medical priorities for the care of eligible AI/AN people that will most effectively meet their needs within the funds available and are consistent with the National IHS medical priorities.

    3. Maintain records for planning and for controlling funds and furnish reports to the Director, DCC, at HQ as required.

    4. Allocate an equitable share of funds among the IHS/Tribal PRC programs based on established formulas agreed to by the Tribes.

    5. Coordinate appropriate contract activities with the Area Contracting Officer.

    6. Act promptly and appropriately on appeals of service unit PRC denials.

    7. Act promptly and appropriately on appeals from Pub. L. 93-638 operated PRC programs if the program has elected to follow the IHS appeals process.

    8. Monitor the CHEF cases.

    9. Establish general guidelines and policies for applying coordination of care practices and PRC quality assurance activities in the IHS Area facilities.

    10. Be responsible for internal controls related to the FMFIA.

~~3.~~ 2-3.~~3~~2 PURCHASED/REFERRED CARE DELIVERY AREA

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1. Purchased/Referred Care Delivery Area (PRCDA). ~~Currently the IHS provides services under regulations in effect on September 15, 1987 republished at 42 CFR Part 136, Subparts A-C, and which may be changed only in accordance with the Administrative Procedures Act (5 U.S.C. 553). 42 CFR Part 136, Subpart C defines a PRCDA as the geographic area within which PRC will be~~

made available to members of an identified Indian community who reside in the PRCDA. It should be clearly understood that residence within a PRCDA by a person who is within the scope of the Indian health program, as set forth in 42 CFR 136.12, creates no legal entitlement to PRC but only potential eligibility for services.

2. Services Needed But Not Available. Services needed but not available at an IHS or Tribal facility are provided under the PRC program depending on the availability of funds, the person's relative medical priority and the actual availability and accessibility of alternate resources in accordance with the regulations.

3. Established Purchased/Referred Care Delivery Areas. Established PRCDA are listed in the *Federal Register* (FR) Notices. The current PRCDA *Federal Register* Notice can be found on the IHS PRC Web site: https://www.ihs.gov/PRC/documents/PRCDA_FEDERAL_REGISTER_NOTICE_June_21_2007.doc

    1. A PRCDA typically consists of a county that includes all or part of a reservation, and any county or counties that have a common boundary with the reservation.

    2. Congress has statutorily created or re-designated a PRCDA through legislative enactments such as appropriations, restoration and/or recognition acts, public laws, etc.

    3. Some Tribes and particularly many of the newly recognized Tribes do not have reservations. When congress has not legislatively designated counties to serve as a PRCDA for such a Tribe, the Director, IHS, exercises reasonable administrative discretion to designate a PRCDA to effectuate the intent of Congress for the Tribe.

    4. The Director, IHS, publishes a notice in the FR when there are revisions or updates to the list of PRCDAs, including the designation of a PRCDA for a newly recognized Tribe.

4. 2-3.4 REDESIGNATION OF A PRCDA

1. Re-designation Request. The Tribal group(s) affected, or the IHS, (after working with the affected Tribal group(s)) may request for re-designation of a PRCDA. All requests for re-designation shall contain the following information:

    1. The estimated number of AI/AN people who will be included and/or excluded for eligibility of PRC. Note: The re-designation of a PRCDA may not result in the exclusion of AI/AN people eligible under 42 CFR 136.23(a)(1), i.e., reservation residents.

    2. The Tribal governing body's designation of the categories of AI/AN people to be included and/or excluded from eligibility for PRC; such as:

        1. members of the Tribe who live near the reservation; or

        2. AI/AN people who are not members of the Tribe but have close economic and social ties with the Tribe.

    3. The impact of the change in the PRCDA on the level of PRC being provided to eligible AI/AN people in the original PRCDA.

    4. The justification for the change in the PRCDA. The justification may include criteria used in establishing the PRCDA for the States outlined in 42 CFR 136.22, but are not limited to these criteria.

Commented [4]: This is redundant from the Definition's Section.

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Commented [6]: This is an undefined term. Please clarify who may make a request.

2. Submission of a Proposed PRCDA Change. Proposals for a change in a PRCDA must be submitted to the Director of the Area Office of the affected Tribe for review and forwarded to the Director, DCC, for appropriate action.

3. Requirements.

    1. The Area PRC Officer will analyze the request and will recommend acceptance or rejection of the request to the Area Director. For tribally-managed programs, analysis will be coordinated with the Area Tribal Project Officer for contracted programs or Self-Governance Coordinator for compacted programs. If another Tribe(s) is affected by the PRCDA designation/re-designation there must be consultation by the Area with the affected Tribe(s).

    2. The Area Director will then forward the recommendation, in writing to the Director, DCC, for appropriate action on the proposal.

    3. The Director, DCC, will review the request for the re-designation of the PRCDA, and apply the criteria outlined in Paragraph A above to the information submitted to support the request. If the submittal from the Area is complete, the Director, DCC will convene a meeting of an ad hoc PRCDA Designation /Re-designation Committee to consider the request.

        1. The committee members consist of IHS HQ representatives from the DCC; Office of Finance and Accounting/Division of Budget Formulation; Office of Public Health Support/Division of Program Statistics; Office of Management Services/Division of Regulatory Affairs; Office of Tribal Self-Governance; and Office of Direct Service and Contracting Tribes. The Director, DCC will chair the committee meeting.

        ~~3.~~2. [Information about the role and responsibilities of the Committee]

    4. The Director, DCC, shall prepare a report containing the findings of the PRCDA Designation /Re-designation Committee as to whether the criteria have been met. The Director, DCC, will submit the findings and recommendation to approve or deny the request via memorandum to the Director, IHS. If approval is recommended, the Director, DCC will draft the PRCDA re-designation *Federal Register* notice.

    5. The Director, IHS will inform the Tribe requesting the PRCDA designation/re-designation and the corresponding Area Director of the decision. The decision is final for the IHS ~~and cannot be appealed~~.

4. Tribal Consultation. The regulations at 42 CFR 136.22(b) state that after consultation with the Tribal governing body or bodies of those reservations included in the PRCDA, the Secretary may from time to time, re-designate areas within the U.S. for inclusion in or exclusion from a PRCDA. Consultation with the affected Tribe(s) occurs during the review of the request for re-designation, ~~but~~ and the IHS publishes a notice with requests for comments as part of the consultation process. (See Manual Exhibit 2-3-A for sample materials on re-designation of a PRCDA.)

    1. If IHS determines that a re-designation of a Tribe's PRCDA should be made, the IHS shall publish a notice with request for comments in the FR advising the public that the IHS proposes to re-designate a particular Tribe's PRCDA.

    2. The notice with request for comments shall include:

        1. a. The proposed action and the background information sufficient to provide the public an explanation for the Agency's decision.

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2. b. A statement as to the date when comments must be received. There must be at least a 30-day "comment" period from date of publication of the notice.

3. c. Reference to the legal authority and the name and address of the public official to whom comments should be addressed.

5. Effective Date of PRCDA Change. After a review of any comments received by the IHS after the publication of its notice with the request for comments, and after determining the Tribe's PRCDA should still be re-designated, the IHS shall publish a final notice advising the public that the IHS is re-designating a particular Tribe's PRCDA. The change in the PRCDA will be effective on the date of the final notice in the FR.

6. ~~F.~~Exception. Under certain circumstances, the notice and comment process described above, in paragraphs 2-3.4A-E, is not necessary in order to add counties to a Tribe's PRCDA. Instead, a memorandum from the Director, IHS, is mailed to the respective Area Director regarding the action resulting in a correction to, expansion of, or the creation of the Tribe's PRCDA with instructions to the Area Director to contact the Tribe with this information. Such circumstances include the following:

    1. the IHS inadvertently or mistakenly omitted the county from the Tribe's PRCDA list; or

    ~~2.~~ the Tribe's reservation was expanded or created by a proclamation issued by the Secretary of Interior or by congressional statute, e.g., Federal recognition of a Tribe.

~~5.~~ 2-3.5 PERSONS TO WHOM PRC WILL BE PROVIDED

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1. Authority. 42 CFR Part 136.23 is the appropriate citation for all correspondence to providers and AI/AN patients regarding eligibility for PRC. NOTE: This chapter should not be cited as the authority for making decisions on eligibility or payment denials.

2. Funds Available. There is no authority to authorize payment for services under the PRC program unless funds are in fact available.

3. Insufficient Funds. When funds are insufficient to provide the volume of purchased/referred care indicated as needed by the population residing in a PRCDA, priorities for service shall be determined on the basis of relative medical need, 42 CFR 136.23(e).

    1. Manual Exhibit 2-3-B demonstrates the process for determining the disposition for a patient being considered for PRC funding.

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    2. In the event that all PRC funds are depleted, referrals will be denied PRC payment or deferred. Medical referrals will still be made based on services needed by the patient. However, no payment or promise of payment can be made when there are no funds available.

    3. The Service Unit CEO will notify the Area Director when PRC funds are insufficient.

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4. Services.

    1. Any expenditure of PRC funds is limited to services that are medically indicated. See the Medical Priority list for services that may be included and those specifically excluded. The listing for PRC Medical Priorities can be found at the PRC Web site: https://www.ihs.gov/PRC/index.cfm?module=PRC_requirements_priorities_of_care

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    2. No PRC funds may be expended for services that are reasonably accessible and available at IHS facilities.

3. The determination of whether an IHS facility is "reasonably accessible and available" is made by the CEO based on the following criteria:

    1. Determination of the actual medical condition of the patient, i.e., emergent, urgent, or routine.

    2. The ability of the IHS to provide the necessary service.

    3. The level of funding available to provide PRC.

    4. Distance from the IHS facility.

    5. Inclement weather and/or unsafe travel conditions must be taken into consideration for time/distance to an IHS facility.

5. Guidelines. The following guidelines will be used in applying the above criteria:

    1. There must be a compelling reason to believe, upon review of the medical record and assessment of the patient's situation that without immediate medical treatment an individual's life or limb would have been endangered.

    2. Available PRC funds may be authorized for an emergency to the extent that the contract facility was the nearest available provider capable of providing the necessary services and the patient's condition dictated that he/she be transported to the nearest hospital.

    3. A list of diagnostic categories that have been administratively determined to be emergencies is included. This list is not all inclusive and other conditions may be included as an emergency when so determined by qualified IHS professionals. Medical and dental priorities may be found at the following: http://www.ihs.gov/PRC/index.cfm?module=PRC_requirements_priorities_of_care)

    4. Final decision as to classification of medical services as "emergency" will be based on review by an appropriate clinical health professional or by documented medical history.

    5. Services for an acute condition (urgent but not emergent) may be provided through PRC funds when the nature of the medical need of the patient, as determined by a professional, can best be met by using a private facility and sufficient PRC funds are available for this level of service.

    6. Routine health services (not emergent or urgent) should ordinarily be provided by IHS staff and facilities. Routine health services may be provided through PRC when the CEO has determined that sufficient PRC funds are available for this priority of medical service. As a general rule, routine health services will not be provided through PRC when an IHS facility capable of providing these services is within 90 minutes one-way surface transportation time from the person's place of residence. Weather conditions at the time of the illness should be considered when estimating time to the facility.

    7. If an IHS facility desires to change the criteria in 2-3.5E(6) for their patients, on the availability and accessibility of IHS facilities for routine health services, ~~they~~ it must request that the Area Office ~~to~~ issue a supplement on the criteria to be used for their facility. The new criteria should be developed with Tribal consultation and issued by the Area Office as stipulated in 1-1.2 IHM. This change will be posted and published to maximize knowledge among the AI/AN population served. This can be done through

Commented [10]: This link, both when copied into a browser and when clicked, takes the reader to the main PRC webpage, where there is no list of "medical and dental priorities." Previously, Manual Exhibits 2-3-D and E were listed as the resource containing the list. We recommend providing a direct link or instructions for accessing the list.

posters in clinic and hospital waiting areas, local media, brochures and wallet size information cards.

8. Purchased/Referred Care funds may be expended for services to support direct care individuals treated in an IHS facility to the extent that the individual is eligible for direct services. However, hospitals and clinics funds shall be used to support direct care whenever possible. Payment of costs for "contract to support direct care" specialty services (e.g., prenatal, podiatry, or orthopedic clinics) provided within the facility are permitted when patients are under the direct supervision of an IHS physician or a contract physician practicing under the auspices of the medical staff rules and regulations of the IHS facility. PRC funds are not to be used to support routine primary care that the facility is designed to provide. Manual Exhibit 2-3-C includes directives from IHS DCC, HQ on when PRC can be used in support of direct care. Expenditures must be consistent with the directives set forth therein.

~~6.~~ 2-3.6 ELIGIBILITY REQUIREMENTS

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1. Documentation. An AI/AN claiming eligibility for PRC has the responsibility to furnish the CEO with verifiable documentation to substantiate the claim. Each IHS facility should establish a policy on documentation. Manual Exhibit 2-3-D lists examples of acceptable documentation and examples to clarify the concept of residency.

2. Eligibility. Eligibility for PRC is governed by 42 CFR 136.23. The PRC program is not an entitlement program and thus, when funds are insufficient to provide the volume of PRC needed, services shall be determined on the basis of relative medical need in accordance with established medical priorities [42CFR 136.23(e)].

~~1.~~ To be eligible for PRC, an individual~~:~~ must be eligible for direct care as defined in 42 CFR 136.12; and either

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~~2.~~1. reside within the U.S. on a Federally-recognized Indian reservation; or

~~3.~~2. reside within a PRCDA and;

1. ~~are~~ be a member~~s~~ of the Tribe or Tribes located on that reservation; or

2. maintain close economic and social ties with that Tribe or Tribes.

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3. Close Economic And Social Ties. The basis for determining close economic and social ties is established by the Tribe(s) served and may include criteria such as:

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1. employment with a Tribe whose reservation is located within a PRCDA in which the applicant lives;

2. marriage to an eligible member of the Tribe; or

3. determination by the Tribe(s), including certification (a written decision by the legal governing body of a Tribe which has legal authority) from the Tribe(s) near where the individuals live that he/she have close economic and social ties with the Tribe whose reservation is located within the PRCDA in which the applicant resides.

4. Full-time Student. PRC will be made available to students who would be eligible at the place of their permanent residence, but who are temporarily absent from their residence, as follows:

1. Full time student programs such as high school, college (undergraduate and graduate) vocational, technical, or other academic education, during their attendance and normal school breaks. The service unit where the student was eligible for PRC prior to leaving for school is responsible for the student. These students remain eligible after the completion of the courses of study up to 180 days. After 180 days has elapsed the student is no longer eligible for PRC.

2. At all Bureau of Indian Affairs (BIA) Boarding Schools, PRC is provided for students during their full-time attendance, by the Area where the boarding school is located. Included are BIA off-reservation schools such as:

    1. Flandreau Indian School, Moody County, South Dakota;

    2. Circle of Nation School Wahpeton, Richland County, North Dakota;

    3. Sherman Indian High School, Riverside County, California;

    4. Riverside Indian School, Caddo County, Oklahoma; and

    5. Chemawa Indian School, Marion County, Oregon.

    Boarding school students can receive PRC whether or not they resided in a PRCDA before attending the school. While the student is on a scheduled break or vacation, the student's PRC permanent area of residence is responsible for payment of PRC services.

5. Transients. PRC eligible persons who are on travel or are temporarily employed, such as seasonal or migratory workers, remain eligible for PRC at their permanent residence during their temporary absence.

6. Persons in Custody. Usually, t~~T~~he cost of medical and related health services for eligible beneficiaries in custody of ~~(~~non-Indian~~)~~ law enforcement agencies is not the responsibility of the IHS, but is the responsibility of that particular agency. Where a tribe has contracted with non-Indian law enforcement for services, eligible beneficiaries in their custody is the responsibility of the IHS. All p~~P~~ersons in the custody of Indian law enforcement agencies, including the Bureau of Indian Affairs, will be considered eligible on the same basis as other beneficiaries of the Service. IHS does not provide the same health services in each area served and services provided will depend upon the facilities and services available (42 CFR 136.11(c)).

7. Persons outside the United States. Persons visiting a foreign country are eligible for PRC if the beneficiary is eligible for the PRC program and the purchase of care complies with the PRC regulations and the *Federal Acquisition Regulations* (FAR). See guidance in Manual Exhibit 2-3-E.

8. Other Persons outside the PRCDA. Persons, who leave the PRCDA in which they are eligible for PRC and are neither students nor transients, will be eligible for PRC for a period not to exceed 180 days from such departure.

9. Other Eligibility Considerations. An AI/AN is not required to be a citizen of the U.S. to be eligible for PRC. The AI/AN (e.g., a citizen of Canada or Mexico) must reside in the U.S. and be a member of a Federally recognized Tribe whose traditional land is divided by the Canadian border (e.g., St. Regis Mohawk, Blackfeet) or Mexican border (e.g., Tohono O~~"~~'O'odham, Kickapoo).

10. California Indians. Section 1679(a) of the Indian Health Care Improvement Act (IHCIA), states that the following California Indians shall be eligible for health services provided by the Service:

    1. Any member of a Federally-recognized Indian Tribe;

2. Any descendaent of an Indian who was residing in California on June 1, 1852, ~~but only~~ if such descendaent:

    1. is a member of the AI/AN community served by a local program of the Service, and

    2. is regarded as an Indian by the community in which such descendant lives.~~,~~

3. Any AI/AN who holds trust interests in public domain, national forest, or ~~AI/AN~~ reservation allotments in California.~~; and~~

4. Any AI/AN in California who is listed on the plans for distribution of assets of ~~California~~ ~~R~~rancherias and reservations under the Rancheria Act of August 18, 1958 (72 STAT. 619), and any descend~~e~~ant of such an Indian.

~~5.~~ Section 1679(b) of the IHCIA states that nothing in this Section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

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11. Indians Adopted By Non-AI/AN Parents. Indians adopted by non-AI/AN parents must meet all PRC requirements to be eligible for care (e.g., reside within a PRCDA).

12. Foster Children. American Indian/Alaska Native children who are placed in foster care outside a PRCDA by order of a court of competent jurisdiction and who were eligible for PRC at the time of the court order shall continue to be eligible for PRC while in foster care. Section 1680c(a) of the IHCIA, states in part:

    ~~1.~~ (a)(1) Any individual who— (1) has not attained 19 years of age;~~,~~ (2) is the natural or adopted child, step-child, foster-child, legal ward, or orphan of an eligible Indian;~~,~~ and (3) is not otherwise eligible for the health services provided by the Service, shall be eligible for all health services provided by the ~~s~~Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age."~~|~~.. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for services until 1 year after the date of a determination of competency."

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13. Non-AI/AN Pregnant Woman. A non-AI/AN woman pregnant with an eligible AI/AN's child who resides within a PRCDA is eligible for PRC during pregnancy through post-partum (usually 6 weeks). If unmarried, the non-AI/AN pregnant woman is eligible for PRC if the eligible AI/AN male states in writing that he is the father of the unborn child or such are determined by order of a court of competent jurisdiction. This will ensure health services to the unborn AI/AN child.

14. Non-AI/AN Spouses. Section 1680c(b) of the IHCIA, states in part: "Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but not otherwise eligible for the health services provided by the Sservice, shall be eligible for such health services if all of such spouses or spouses who are married to members of each Indian tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian Tribe or tribal organization providing such services~~of the eligible Indian~~."

15. Non-Indian. A non-AI/AN member of an eligible AI/AN's household who resides within a PRCDA is eligible for PRC if the medical officer in charge determines that services are necessary to prevent the spread of a communicable disease, control a public health hazard or an acute infectious disease, which constitutes a public health hazard.

The facility staff after determining that the patient is NOT eligible for PRC, shall obtain the signature(s) of the individual(s) acknowledging that they are not eligible for PRC, e.g., not residing within the PRCDA.

~~7.~~ 2-3.7 PURCHASED/REFERRED CARE MEDICAL PRIORITIES

Regulations [42 CFR 136.23(e)] permit the establishment of priorities based on relative medical need when funds are insufficient to provide the volume of PRC indicated as needed by the population residing in a PRCDA. The IHS medical and dental priorities health priorities are found on the PRC Web site: https://www.ihs.gov/PRC/index.cfm?module=PRC_requirements_priorities_of_care Tribal programs when developing their own PRC Medical Priorities to meet Tribal needs may utilize IHS medical and dental priorities as guidelines.

The CMS *Medicare National Coverage Determinations Manual* and current medical literature will also be used as a basis for decision-making.

~~8.~~ 2-3.8 PAYER OF LAST RESORT REQUIREMENTS

1. Payor of Last Resort. Under 42 CFR 136.61 the IHS is the payor of last resort for services provided to patients defined as eligible for PRC, regardless of any State or local law or regulation to the contrary. Under 25 U.S.C. 1623(b), Congress ~~elevated~~ statutorily designated the IHS as a payer of last resort ~~status, superseding federal laws to the contrary~~ to the extent that other laws provide otherwise. Whether the alternate resource is regulated by contrary federal, state or local law, IHS intends to implement its statutory payor of last resort authority in accordance with existing regulations. Accordingly, the IHS will not be responsible for or authorize payment for PRC to the extent that:

    1. the AI/AN is eligible for alternate resources, defined in paragraph 2-3.89(G), or

    2. the AI/AN would be eligible for alternate resources if he or she were to apply for them, or

    3. the AI/AN would be eligible for alternate resources under State or local law or regulation but for the Indian's eligibility for PRC or other health services, from the IHS or IHS programs. ~~Note; a "charity program" is not considered an alternate resource if the provider of services is absorbing the full cost of the care, but the charity program would be an alternate resource if the provider of services receives reimbursement for the costs of providing such care.~~

2. Eligibility for Alternate Resources.

    1. Refer to the Benefit Coordinator to determine whether the patient is eligible for alternate resources.

       GUIDELINE: Initially, the IHS should make a determination based upon reasonable inquiry whether the IHS patient applying for PRC is potentially eligible for alternate resources. Reasonable inquiry consists of ascertaining the patient's household size, income, and assets, and applying alternate resource program standards to the patient's information. Only IHS patients who, upon reasonable inquiry, are determined to be potentially eligible for alternate resources are required to apply for such resources. The IHS patients should not automatically be denied PRC benefits simply because of the possibility they might be eligible for an alternate resource.

    2. Advise the patient of the need to apply for alternate resources and refer to the Benefit Coordinator.

Commented [11]: Without a section number, this provision appears to relate only to provision 15. We suggest moving it up in the Section so that it immediately follows the documentation provision at Section 2-3.6.1.

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GUIDELINE: The IHS will provide the patient with a written notice that explains why it is necessary for him or her to make a "good faith" application to the alternate resource program. The notice should include information such as the need to schedule and attend scheduled appointments, the necessary documentation to bring to the appointments, and availability of transportation to appointments.

3. Benefit Coordinator will assist the patient in applying, especially where it is evident that the patient is unable to apply or is having difficulty with the application process.

   GUIDELINE: The IHS shall include in its written notice that if a patient is unable to apply or is having difficulty applying for alternate resources, the facility staff (Benefit Coordinator) will assist with the application process.

   Each facility will document attempts to assist patients in applying for or completing an alternate resource application. Documentation of assistance for application to the alternate resource program is necessary to support a decision whether to authorize payment of PRC funds.

3. Completed Application to Alternate Resource Program. If a completed application to the alternate resource program results in a denial, the alternate resource program denied payment for a valid reason (e.g., the patient is over income eligibility standards or not a resident of the county), and the AI/AN patient's medical bills and the AI/AN is otherwise PRC eligible, the IHS should pay the AI/AN patient's medical bill.

   An AI/AN patient cannot be denied alternate resources that he or she would be eligible for under State or local law or regulation simply because of his or her eligibility through the IHS and PRC Program.

4. Failure to Follow Alternate Resource Procedures. There are two instances when IHS will not pay the provider for medical bills incurred by an otherwise PRC eligible patient:

   1. When the patient willfully or intentionally fails to apply or fails to complete an alternate resource application,. ~~The~~the IHS facility staff will provide written notice to the patient~~s~~ that a PRC denial letter will be issued, unless the patient—within 30 days after receiving the notice—either (1) ~~if~~ completes an alternate resource application ~~is not completed~~, or (2) ~~if the patient does not~~ contacts the facility staff for assistance in completing the application ~~within 10 days after the receipt of the notice, a PRC denial letter will be issued~~.

      ~~1.~~ If an alternate resource ~~program~~ issues a denial because the applicant failed to apply or failed to complete the application and the PRC file is well documented with attempts to assist the applicant, the PRC office should issue a PRC denial to the patient and a copy should be forwarded to the provider.

   2. When the provider is not able to receive payment from an alternate resource ~~program~~ because of the provider's failure to follow proper procedures (e.g., non-timely filing of the patient's alternate resource, 42 CFR 136.30(h)(3)), neither the patient nor IHS will be responsible for the medical bill, even if the AI/AN patient is otherwise PRC eligible ~~(42 CFR 136.30(h)(3)~~.

5. Notice to Providers. The Director, PRC, will inform private providers (i.e., non-IHS facilities and practitioners providing medical services to IHS beneficiaries) of the PRC eligibility criteria and requirements. Such information can be provided through terms in a contract with the provider, by separate notice upon referral of a patient to the provider, or by general notification to a provider when there are continuous referrals of patients to that same provider. The Director, PRC will inform providers that:

Commented [13]: The reference to Manual Exhibit 2-3-A, Written Notice, Patient Requirement for Application to Alternate Resources, was removed. We recommend that the IHS retain this reference because it is useful.

Commented [14]: Similarly, the reference to Manual Exhibit 2-3-B, Authorization for Use or Disclosure of Health Information (Form 810), was removed. We recommend that the IHS retain this reference because it is useful.

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1. an IHS medical referral does not constitute a representation of eligibility under the PRC program (see Manual Exhibit 2-3-F);

2. the IHS expects the provider to apply for alternate resources as it would for its non-AI/AN patients;

3. the provider must investigate with each patient, his or her eligibility for alternate resources and should assist the patient in completing necessary application forms;

4. if an alternate resource is available, its use is required and the IHS or the FI shall be promptly notified of any payment received; and

5. the IHS or FI will reject claims where the provider fails to investigate other party liability.

6. Payor of Last Resort Rule. The use of alternate resources is mandated by the Payor of Last Resort Rule, 42 CFR 136.61.

    1. An individual is required to apply for an alternate resource if there is reasonable indication that the individual may be eligible for the alternate resource.

    2. Refusal to apply for alternate resources when there is a reasonable possibility that one exists, or refusal to use an alternate resource, requires the denial of eligibility for PRC.

    3. An individual is not required to expend personal resources for health services to meet alternate resource eligibility or to sell valuables or property to become eligible for alternate resources.

7. Alternate Resources. ~~All IHS or Tribal facilities that are available and accessible to an individual are considered alternate resources.~~ Alternate resources, as defined by 42 CFR 136.61(c), means "health care resources other than those of the Indian Health Service. Such resources include health care providers and institutions, and health care programs for the payment of health services including but not limited to programs under titles XVIII or XIX of the Social Security Act (i.e., Medicare, Medicaid), State or local health care programs, and private insurance." ~~Other alternate resources to pay for private sector services would include, but not be limited to, Medicare, Medicaid, Vocational Rehabilitation, Children's Rehabilitative Services, Local or Private Insurance, State Programs and Crime Victims Act. Also see 42 CFR 136.61(c).~~ The reference to "local" does not mean "tribal," and "private health insurance" does not mean tribal self-insurance.

    1. Such resources also include, but are not limited to: the Children's Health Insurance Program under the Social Security Act; the Veterans Health Administration; other Federal health care programs; Vocational Rehabilitation; Children's Rehabilitative Services; Crime Victim Compensation Program under the Victims of Crime Act, 34 U.S.C. § 20101-20111; and student health insurance purchased by students with grants provided for that purpose.

    ~~4.~~2. A charity or indigent care program for which an individual is eligible, or would be eligible but for being eligible for PRC, shall be considered an alternate resource.~~A charity or indigent care program offered by a provider of services is not considered an alternate resource if the provider of services is absorbing the full cost of the care, but the charity or indigent care program will be considered an alternate resource if it receives reimbursement for the costs of providing such care from state resources or other institutions~~.

    3. Coordinating Benefits with Health Care Coverage Purchased under 25 U.S.C. 1642 ('sponsorship"). IHS considers sponsorship ~~through indemnity~~of insurance plans to be an alternate resource under the payer of last resort rule.

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8. Tribal Self-Insurance Plans. Tribal self-insurance plans are not alternate resources, for any purpose except as provided for in 25 U.S.C. § 1621e(f). Reinsurance or stop loss insurance on tribal self-insurance may be considered an alternate resource when the reinsurance ~~assume~~or stop loss insurance is paying the costs~~ payment for costs~~. However, tribal self-insurance that has reinsurance or stop loss insurance does not become an alternate resource because of the reinsurance or stop loss insurance.

~~7.~~9. Qualified Health Plan from a Federal or State Marketplace.

1. Qualified Health Plans (QHP) are available through the Marketplace where consumers can compare health insurance options. Pub. L. 111-148, Patient Protection and Affordable Care Act (March 23, 2010) provides special protection for members of federally recognized tribes from cost-sharing (deductibles, coinsurance and copayments) for the provision of essential health benefits in a QHP.

2. Zero Cost-Sharing plans are only available to members of federally recognized Tribes and Alaska Natives with incomes at or between 100% and 300% of the federal poverty level.

    1. In-Network Providers — a referral is not needed for the patient to receive an EHB from an "in-network" non-Indian health care provider.

    2. Out-of-Network Providers — an authorized PRC referral is required to cover out of network charges. Out of network charges are not a co-pay, co-insurance or deductible.

3. Limited Cost-Sharing plans are available to members of federally recognized Tribes and Alaska Natives with any level of income. There is no cost sharing as long as the service is referred through a PRC program.

    1. In-Network Providers - A PRC referral is required to avoid cost sharing for essential health benefits (EHB). The PRC referral must state it is for all EHB for the episode of care.

    2. In-Network Providers — A QHP referral from the QHP primary care provider may be required (depending on the terms of the QHP). PRC staff need to confirm with the QHP and assist the beneficiary in acquiring this referral.

    3. ~~c.~~Out-of-Network Providers — An authorized PRC referral is required to cover any out-of-network charges and to cover authorized charges up to the PRC rate.

4. Standard and Silver Cost-Sharing plans are QHPs that are available to IHS beneficiaries that are not members of a federally recognized tribe or Alaska native but are otherwise eligible for IHS.

    1. All Providers — An authorized PRC referral is required to pay any cost sharing expenses after the QHP payment.

    2. All Providers - A QHP referral from the QHP primary care provider may be required (depending on the terms of the QHP). PRC staff need to confirm with the QHP and assist the beneficiary in acquiring this referral.

5. AI/ANs with Medicaid who have ever received a service (e.g., a primary care, dental, behavioral health visit etc.) from the Indian Health Service, tribal health programs, or through a PRC referral are exempt from cost-sharing which includes copayments or

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coinsurance for Medicaid services. Therefore, there is no cost to the PRC program for Medicaid services provided. AI/ANs can self-attest that they have ever received services from IHS or a tribal health program.

6. Students whose grant includes funds ~~for health services shall be required to use the grant funds~~ to purchase available student health insurance shall be required to do so~~. Individuals who receive funding to purchase insurance shall be required to use such funds for health care purposes~~ and such insurance shall be considered an alternate resource.

7. When an alternate resource is identified that will require the IHS to pay a portion of the medical care costs, the appropriate IHS form, IHS form 843 will be processed immediately to obligate the funds for the estimated balance, after alternate resource payment, with corresponding distribution of the form. In these situations, the IHS form, IHS form 843, must clearly indicate that payment will not be processed unless and until the provider has billed and received payment from the alternate resource. It is proper and necessary to require either an explanation of benefits (EOB) or, in cases of denial from the alternate resource, a copy of the denial notice for the record.

~~8. Exception to the IHS Payor of Last Resort: Tribal Self-Insurance Plans. For purposes of IHS administered PRC programs, the Agency will not consider tribally-funded self-insured health plans to be alternate resources for purposes of the IHS Payor of Last Resort Rule.~~

~~9. Coordinating Benefits with Health Care Coverage Purchased under 25 U.S.C. 1642 ("sponsorship"). IHS considers sponsorship through indemnity to be an alternate resource under the payer of last resort rule~~.

~~9.~~ 2-3.9 AUTHORIZATION FOR PURCHASED/REFERRED CARE

1. Notification. The following notification requirements apply to all categories of eligible AI/AN patients including students, transients, and patients who leave the PRCDA. A notification is not a guarantee that authorization will be provided for payment, but notification must be provided for authorization to be considered. Notification requirements as described in 42 CFR 136.24 will be followed, including:

    1. No payment will be made for medical care and services obtained from non-Service providers or in non-Service facilities unless the requirements listed below have been met and a purchase order for the care and services has been issued by the appropriate authorizing official to the medical/dental/behavioral health care provider.

    2. In non-emergency cases, an eligible AI/AN, an individual or agency acting on behalf of the patient, or the medical care provider shall, prior to the provision of medical care and services, notify the appropriate official of the need for services and supply information that the authorizing official deems necessary to determine the relative medical need for the services and the individual's eligibility. The requirement for notice prior to providing medical care and services under this paragraph may be waived by the appropriate official, if the official determines that providing notice prior to obtaining the medical care and services was impracticable or that other good cause exists for the failure to provide prior notice.

    3. In emergency cases, the patient, an individual or agency acting on behalf of the patient, or the medical care provider shall, within 72 hours after the beginning of treatment for the condition or after admission to a health care facility, notify the appropriate official of the admission or treatment and provide information to determine the relative medical need for the services. The 72-hour period may be extended if the appropriate official determines

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that notification within the prescribed period was impracticable or that other good cause exists for the failure to comply.

4. Section 1646 of the IHCIA, allows the elderly and disabled 30 days to notify the IHS or Tribal program's CEO of emergency medical care received from non-IHS medical providers or at non-IHS medical facilities.

5. The following definitions for an elderly and disabled individual are to be used until further defined and published in the FR.

    1. The IHS defines elderly as an individual who is 65 years of age or older.

    2. A disabled individual who has a physical or mental condition that prevents him or her from reasonably providing or cooperating in obtaining the information necessary to notify the IHS of his/her receipt of emergency care or services from a non-service provider or facility within 72 hours after the non-service provider began to deliver the care.

2. Notification for Students, Transients and Patients. Authorization for PRC to students, transients, and patients who leave the PRCDA will be the responsibility of the IHS Area from which the patient left.

    If a PRC eligible patient presents to an IHS facility other than the facility of residence for direct care and needs PRC, the facility Director, PRC, will contact the patient's facility of residence for instructions in patient management with respect to PRC authorization or denial. The patient will be informed of his or her responsibility to modify his or her facility of residence. Payment for PRC is the responsibility of the patient's area of residence in accordance with PRC regulations at 42 CFR 136.24, when notification is provided prior to the authorization and/or provision of PRC services that are referred out by a facility not in the patients area of residence. These guidelines do not preclude formal arrangement for fund transfers within or among Areas to provide PRC for patients from other IHS Areas.

3. Payment. Payment shall be made in accordance with the provisions of the contract or purchase order and other provisions including IHS payment rules set forth in 42 CFR 136 Subpart D and Subpart I (collectively referred to as PRC rates). Every effort must be made to assure the AI/AN patient being referred from an IHS facility is notified at referral time of his or her eligibility status for PRC. In cases where determination of eligibility cannot be made before referral, the individual will be notified in writing prior to obtaining care that the IHS or Tribe may not be responsible for bills incurred.

    1. PRC Rates for services furnished by Medicare-Participating Hospitals - 42 CFR 136 Subpart D Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173), requires hospitals and critical access hospitals to participate in PRC programs. Section 506 directed the Secretary to set forth a payment methodology, payment rates, and admission practices through regulation for the PRC services provided by Medicare-participating hospitals. Any payments made under the PRC program are considered payment in full and the patients must not be billed for any remaining balance. See ~~42 CFR 482.29~~, 42 CFR 136.30 and also 25 U.S.C. 1621u.

        1. In the event a hospital is balance billing patients after PRC payment.

            1. Notify the hospital of the law, if the hospital refuses to comply.

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2. Notify the Area PRC Officer who will notify the Regional CMS Native American Contact (NAC).

3. The NAC, pursuant to [cite source], will notify the CMS Survey and Certification Division.

4. The Survey and Certification Division, pursuant to [cite source], will contact the hospital and allow them to have a 90 day corrective action plan to remedy the infraction.

5. After 90 days if the action has not been remedied, CMS will pull the hospital's CMS certification, pursuant to [cite source].

~~6.~~ 2. (2) PRC Rates for physicians and non-hospital supplies and services 42 CFR 136 Subpart I.

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~~2.~~ a. IHS will not do business with a provider or supplier who will not accept the PRC Rate or negotiate a fair and reasonable rate based upon the providers most favored customer rate, meaning the lowest rate the provider will accept from other payers, including any discounts.

2. ~~b.~~ The provider accepts the PRC rate and cannot balance bill the patient if any of the following have been done:

    1. The services were provided based on a Referral, as defined in 42 CFR 136.202; or

    2. The health care provider or supplier submits a Notification of a Claim for payment to the I/T/U; or

    3. The health care provider or supplier accepts payment for the provision of services from the I/T/U.

3. ~~c.~~ It is mandatory to enter a provider's information into the Provider Tracking Tool located at:

    https://home.ihs.gov/OtherPrgms/IHPES/ORAP/TPICPSA/index.cfm?module=prc&option=admin&fn=doPRCvalidate

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4. Patients under Treatment at the Expiration of 180-Day Eligibility Period. Individuals under treatment for a condition that may be deferred to a later date (e.g., a person with a meniscal tear of the knee that will require surgery to repair at some point) will cease to be eligible at the expiration of the 180-day period after leaving their PRCDA. Individuals under treatment for an acute condition shall remain eligible as long as the acute medical condition exists. For example, if a PRC eligible person is stricken with acute appendicitis 179 days after leaving the PRCDA, necessitating hospitalization and surgery extending beyond the 180-day eligibility period, the patient would remain eligible until he/she is deemed cured. This does not include continued treatment of chronic conditions, for example, obstetrical deliveries that occur after the 180 period.

5. Responsibility to Notify AI/AN Community of PRC Requirements. American Indian/Alaska Native people served by the PRC program will be informed of policies regarding the administrative requirements for approval of PRC payments for services, and the title(s) of the person(s) who must be notified when PRC is required. Examples of notification include publication in local community and/or Tribal newspapers and posting of notices on bulletin boards in public waiting areas in IHS facilities. Changes in local policies or administrative requirements will be published

and posted including notification to providers who may or may not have contracts with the IHS service unit.

6. Purchase/Referred Care Authorization Numbering System. A uniform numbering system has been developed to use when the IHS facility is issuing the IHS-843 purchase order documents. The use of this system will preclude two or more facilities from using the same document number and will assist in identifying the Area and facility.

    1. The number has four components and consists of ten digits.

    2. The four components are: 00 0 00 00000.

    3. The first two digits of this sequence are the last two digits of the fiscal year being charged for the services. If the number less than ten, a 0 is used as the first digit. Example: the fiscal 2009 is 09 and the fiscal year 2013 is 13.

    4. The second component is an alpha code to identify the Area. The alpha codes are:

        - Great Plains C Navajo N
        - Alaska A Oklahoma O
        - Albuquerque Q Phoenix X
        - Bemidji D Portland P
        - Billings B Tucson S
        - California L Nashville U

    5. The third component consists of the two digit site specific code that identifies the facility being charged for the services. The digits are the standard location code as used in the fiscal accounting system.

    6. The fourth component has five digits and is the sequential number for the documents to be charged to each facility. These numbers will begin each fiscal year with 00001 and continue sequentially for the year. Facility supplemental authorizations, if necessary, will be numbered with the original numbers plus a facility suffix of S-1, S-2, etc.

7. The PRC Authorization Flow Chart. The flow of a PRC purchase order from initial request through processing and closeout is diagramed in Manual Exhibit 2-3-G. Many aspects of PRC and other activities are incorporated in this general flow.

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2-3.10 ELECTRONIC SIGNATURES

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1. Electronic Signature for PRC Purchase Order. Pub. L. 106-229 (Electronic Signature in Global National Commerce Act) provides for the use of electronic signatures. The electronic signature promotes the use of electronic contract formation, signatures, and record keeping in private commerce by establishing legal equivalence between:

    1. Contracts written on paper and contracts in electronic form;

    2. Pen and ink signatures and electronics, and;

3. Other legally required written documents (termed "records") and the same information in electronic form.

4. This establishes guidance and direction for electronic signature of IHS-843 in accordance with Pub. L. 106-229. Ensuring compliance with the Privacy Act, Health Insurance Portability and Accountability Act (HIPAA), and confidentiality requirements are the responsibility of each Area PRCO.

2. Accessing Electronic Signature. Individuals will only be provided the ability to access the E-SIGN system if they have completed all security requirements and possess current procurement authority (see Manual Exhibit 2-3-H).

2-3.11 PAYMENT DENIALS AND APPEALS

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When a patient is denied PRC or if a medical provider may reasonably think that the Director of the IHS/Tribal program is a party to payment for services provided to an eligible patient, both the patient and the provider must be notified in writing of the denial with a statement containing all the reasons for the denial. Refer to the *PRC/Management Information System Manual* (version 3.2) denial package. An example of a denial letter can be found in Manual Exhibit 2-3-I.

1. Denial Notice. The denial notice must inform the applicant that within 30 days from the receipt of the notice the applicant:

    1. May request a reconsideration of the denial (appeal) by the appropriate service unit CEO and the request for reconsideration must contain additional information not previously provided.

    2. May appeal the original denial by the CEO to the appropriate Area Director, if there is no additional information on which to base reconsideration in accordance with Section (I), above. Requests for reconsideration and appeals may be submitted by providers. The provider will be considered as acting on behalf of the patient. A response must be made to the provider and a courtesy copy of such response is provided to the patient.

    3. May appeal to the Area Director if the CEO upholds the service unit's original denial. When the Area Director upholds a denial, the applicant must be notified in writing of the denial and that an appeal may be submitted in writing to the Director, IHS, within 30 days.

    4. May appeal to the Director, IHS, if the Area Director upholds the denial. The decision of the Director, IHS, is the final adjudication of the appeal of the denial. A written notice of the decision will be sent to the claimant stating they have no further appeal rights.

2. Failure to Follow Appeal Process. If the claimant fails to follow procedures, the request for reconsideration of an appeal may be denied. A written notice of denial will be sent to the claimant stating they have no further appeal rights.

3. Three Levels of Appeal. The IHS appeals process applies to IHS administered PRC programs and those PRC programs administered under Title I and V programs that have negotiated and incorporated into their funding agreements that the IHS appeals procedures will be utilized. The PRC regulations currently in effect at 42 CFR 136.25 allows only three levels of appeal:

    1. request for reconsideration of the appeal by the CEO,

    2. appeal to the Area Director, and

3. final administrative appeal to the Director, IHS.

4. Tribal Appeals Process - Contractors. The IHS will conduct the appeal process for a Tribally-managed PRC program, if the Tribe has retained IHS functional shares with their respective Area Office. Therefore, before an Area Director or the Director, IHS, may agree to adjudicate a claim, the Tribe must have left sufficient resources with the IHS to conduct the appeal process. It is not sufficient to have it negotiated and incorporated into a Tribe's funding agreement that the IHS appeals procedures will be utilized without evidence that (1) sufficient funds have been withheld to pay for the costs to operate the appeals process for the ~~a~~ Tribe or tribal organization; or (2) the PRC appeals process is included in the Tribe or tribal organization's buyback agreement with the IHS.

~~5.~~ Tribal contractors are not required to utilize the IHS appeals process described in the IHM, however, pursuant to 25 U.S.C. 5324(g) and 25 U.S.C. 5397~~-~~(e), a Tribe must provide a written appeals process that is functionally equivalent to the process in 42 CFR 136.25.

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~~6.~~5. Tribal Appeals Process - Title I and V Programs. Title I and V programs that have negotiated and incorporated into their funding agreement a provision that the IHS appeals procedures will be utilized; shall agree to the following terms and conditions:

1. The Area Director and the Director, IHS, will utilize ~~the IHS regulations and interpretations, not~~ Tribal criteria and interpretations~~,~~ to adjudicate claims. The IHS utilizes its medical priorities and policies to adjudicate IHS PRC claims.

2. The Title I or V programs shall provide necessary documentation required for claims adjudication. Depending on the nature of the claim, documentation such as medical records, date of notification, residency documentation, etc., could be required.

3. The IHS conducts the appeals process from Title I and V programs without assuming any fiscal responsibility. When an Area Director, or the Director, IHS, issues a determination overturning the Tribal denial of payment authorization, it is the responsibility of the Tribe not the IHS to pay the bill.

~~7.~~6. Title I and Title V Program Denials of PRC Payment. IHS will not review appeals for those Tribes that have assumed the PRC appeals function.

~~8.~~7. Tribes are NOT Required to Implement Regulations the Same as the IHS. Title I and Title V programs must, in accordance with 25 U.S.C. 5324(g) and 25 U.S.C. 5397(e), make eligibility determinations in accordance with the IHS eligibility regulations in the CFR, Title 42, Part 136. However, there are provisions of the IHS eligibility regulations that allow different standards to be set. For example, Tribes and Tribal organizations may adopt a different standard for "close economic and social ties" for PRC eligibility (see 42 CFR 136.23), Tribes could also adopt different medical priorities. If the appeals process has been assumed by the Tribal contractor under Pub. L. 93-638, as amended, individuals who are dissatisfied with Tribal determinations of eligibility must pursue Tribal administrative remedies. Issues that should be considered by Tribes in the development of appeals policies and procedures include:

1. Development of a formal appeals procedure and levels of appeal.

2. Establishment of clear program policies concerning eligibility, medical priorities, referrals, and notification of all parties.

3. Protection of individual rights to due process.

~~9.~~8. Responsibilities.

1. Chief Executive Officer. The CEO or authorized designee is administratively responsible for creating and maintaining a file on each denial of PRC.

2. Area Director. The Area Director or authorized designee is responsible for:

    1. establishing individual alphabetical patient appeals files that contain all documentation in chronological order for all appeals, and

    2. for forwarding copies of appeal case files to the Director, DCC, HQ upon request.

~~10.~~9. Information Copies. The Area Director or his or her authorized designee, will not routinely forward information copies of all denials to the Director, DCC. The files will be sent only when the Director, DCC, or his or her designee requests a specific file.

~~11.~~10. Controlled Correspondence. The Director, DCC, will send by secure fax or encrypted email (such as the IHS secure data transfer service) incoming controlled correspondence to the appropriate Area(s) PRCO with a request for information. Each PRCO will analyze the correspondence and submit all necessary documentation to the Director, DCC, in order that he or she will be able to prepare a response. If there were no appeals to the Area Office PRCO or CEO, the Director, DCC, will be notified immediately. Copies of all determinations issued within the Area will be submitted to the Director, DCC. If an appeal(s) was submitted to either the CEO or Area Director and the CEO or Area Director has not issued a determination, a briefing memorandum is to be submitted to support the actions that have been taken.

~~12.~~11. Appeals Process - Division of Contract Care. The Director, DCC, is responsible for processing all PRC appeals sent to the Director, IHS. The Director, DCC, or his or her designee, will:

1. Ensure that all required correspondence is included in chronological order.

2. Routinely request information from the Area PRCO and other sources as needed.

3. Analyze the issues contained in the appeal and processes the appeal to the extent issues can be handled within established policy.

4. Refer all appeals that involve questions of medical judgment to the medical review to the Director, Office of Clinical and Preventive Services.

5. Refer an appeal that involves legal questions or requires legal analysis review to the OGC for legal advice.

~~13.~~12. Final Decision. The decision of the Director, IHS, shall constitute the final administrative action in the appeal process.

~~14.~~13. Appeal File. The appeal file shall contain: all denial letters, all briefing documents or memorandums prepared in connection with any recommendation to the CEO or Area Director regarding such denial; all correspondence to IHS from claimant or claimants representative; any other relevant correspondence, maps, bills, or receipts; records of telephone calls to or from claimant or claimant's representative; correspondence relative to any inquiry (i.e., Congressional, State official, etc.) made on behalf of the claimant; and pertinent correspondence relative to prior appeal by the same claimant.

~~15.~~14. Retention Period. Each appeal record/file will be maintained for a period of 6 years and 3 months after the IHS PRC appeals process has been exhausted.

2-3.12 MANAGEMENT OF PURCHASED/REFERRED CARE FUNDS

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1. Allocation of PRC Funds. The allocation of PRC funds to the Areas are determined by three primary methods: historical base funding, annual adjustments, and program increases. The PRC funds are then distributed from the Areas to the individual PRC programs. As a portion of the overall PRC funding methodology, the PRC Allocation Formula, is designed to accommodate for any new program increases and is in compliance with the IHS Budget Execution Policy. However in consultation with Tribes, Areas have the authority to redistribute new program increases using a different methodology other than the PRC Allocation Formula.

2. Each Area, using an allocation formula other than the PRC Allocation Formula to distribute new program funding, shall notify the Director, DCC in writing. The notification must include a copy of the formula used, any relevant information that explains the method used, a description of the consultation held with affected Tribes, and the distribution amounts to PRC programs in the Area. Notification must be provided before implementing any allocation formula other than the PRC Allocation Formula.

3. Use of PRC Funds for Staff Administering the PRC Program. PRC funds may be used for staff administrating the PRC program when the following conditions are met:

    1. The PRC program is purchasing care beyond Medical Priority II

    2. Each Area Service Unit PRC program reports annually the medical priority level the program is purchasing, the number, grade level and salary of full or part time employees supported by PRC funds and the number of denied and deferred services for Priority II care to the Area Director.

    ~~3.~~ The Area Director shall report~~s~~ by October 10, annually to the Director, DCC, ORAP, for each Area Service Unit, the medical priority level each program is purchasing, the number, grade level and salary of full or part time employees supported by PRC funds and the number of denied and deferred services for Priority II care.

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4. Commitment Register. Management of PRC funds in accordance with the FMFIA requires that the PRC Commitment Register(s) will be maintained at each authorizing location. The PRC Commitment Register(s) is maintained electronically in CHS/MIS. The PRC Commitment Register contains the following minimum information:

    1. Date of Authorization

    2. Authorization Number

    3. Provider Name

    4. Patient Name

    5. Date of Service

    6. Allowance Amount

    7. Estimated Cost of Service

    8. Balance of Funds

5. Funds Status Report. The PRC funds status report is to be submitted to the Area PRCO at least once a month. A summary of the PRC fund balance shall be provided to the CEO, the Clinical

Director, and PRC review committee at least once a month. NOTE: The summary may also be provided to the Tribal Health Director; however, using this process is purely optional for Tribal PRC programs. A sample of a Status of Funds report can be seen in Manual Exhibit 2-3-J.

6. Purchased/Referred Care Spending Plan. Programs are to maintain at least a weekly spending plan by prorating their allocations by the appropriate amount of weeks for each allocation. Weekly spending plans are to be monitored by the local PRC manager, shared with the PRC review committee and Service Unit administration. Spending plans must be available for review by the PRCO. For small PRC programs the frequency of the spending plan can be determined on a case by case basis. The PRC program must request a change for the spending plan frequency in writing to the Area Director through the Area PRCO. A sample spending plan can be found in Manual Exhibit 2-3-K.

7. Services Authorized That Working Day. An entry will be made on the commitment (document control) register for each obligation of funds, or modification of or adjustment to obligation of funds. The entries will be made daily to reflect the services authorized that working day. Entries should not be delayed beyond 5 working days from the date of an authorized referral or notification of an authorized claim by the PRC review committee.

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2-3.13 FOLLOW-UP OF OUTSTANDING AUTHORIZATIONS

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Each IHS PRC program will establish a follow-up system for all authorizations that have not been completed and returned within 90 days of issuance. Manual Exhibit 2-3-L has a recommended form letter for use in these follow-ups.

2-3.14 RECONCILIATION OF CHS/MIS to UFMS REGISTER

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The PRC Commitment Register (CHS/MIS) will be reconciled with the official financial management report, each month of the fiscal year. The recommended procedures for reconciliation of the Commitment Register are provided in Manual Exhibit 2-3-M.

2-3.15 DATA REPORTING

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The appropriate workload and fiscal codes will be entered into the data system, as specified in the FR dated January 20, 1994, Volume 59, Number 13, "Core Data Set Requirements; Notice."

2-3.16 CATASTROPHIC HEALTH EMERGENCY FUND (CHEF)

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1. Background. The CHEF is the congressionally appropriated fund for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the IHS.
   Until such time as regulations are published, the annually issued HQ CHEF guidelines will continue to serve as interim policy governing the CHEF program for all PRC programs.

2. Access to the CHEF Fund is on a Cost Reimbursement Basis. All IHS PRC programs must first obligate and expend funds and meet the appropriate threshold to be reimbursed from the CHEF.

3. Cost Threshold. The CHEF threshold is adjusted by the Director, DCC, within the range established by law. The IHS Director, DCC, will provide instructions annually. Whether a case meets the threshold amount is determined by only including those costs remaining after payment has been made by Federal, State, local, private health insurance, or other applicable alternate resources.

4. Alternate Resources. The requirements for alternate resources must be met to access the CHEF.

5. Reimbursement. All PRC programs must submit CHEF cases through their Area PRC programs for coordination. Any CHEF reimbursement shall be applied only to cases that have been reviewed and approved by the CHEF Manager; any amounts not used because of payments by alternate resources or cancellations must be returned to the HQ CHEF account. For specific details on the CHEF, reference the current, annually issued CHEF guidelines located on the IHS PRC Web site: http://www.ihs.gov/PRC/Instructions on catastrophic case processing and a check list for submitting/processing a CHEF case can be found in Manual Exhibit 2-3-N.

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If the link is intended to be http://www.ihs.gov/prc, then we note that it is not obvious where to find these instructions. We recommend providing a direct link or instructions for accessing the annually issued CHEF guidelines.

2-3.17 FISCAL INTERMEDIARY

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1. Purpose. The purpose of the fiscal intermediary (FI) is to operate a nationwide centralized medical, dental and behavioral health claims processing and payment system to:

    1. collect, compile, and organize workload and financial data; and

    2. provide statistical and financial reports to the IHS for the administration of its PRC program.

2. Authority. 42 U.S.C. 238m

3. Fiscal Intermediary Operations. For a description of the FI internal operations information and most current payment codes refer to the most current version of the *FI Reference Manual* for IHS/PRC. The *FI Reference Manual* is updated to reflect changes or incorporate information on an as-needed basis. Obtaining access to this manual is provided in the following section.

4. Accessing the FI Data System. The IHS is mandated to protect patient's medical information from all security risks. Changes to the FI data system allowing access to data and the ability to communicate through local area networks shall include provisions to ensure patient confidentiality. Ensuring compliance with the Privacy Act, HIPAA privacy regulations, and confidentiality requirements is the responsibility of each Area PRCO. Each IHS employee, unless otherwise authorized, is responsible for limiting access to patient medical information to strictly direct need to know in the provision of patient care. On-line Web access request form and necessary guidance for accessing the FI data system is the FI Reference Manual.

2-3.18 MEDICAL and Dental PRIORITIES

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The application of medical priorities is necessary to ensure that appropriated IHS/PRC funds are adequate to provide services that are authorized in accordance with IHS approved policies and procedures. See PRC Web site: https://www.ihs.gov/PRC/index.cfm?module=PRC_requirements_priorities_of_care

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2-3.19 DEFERRED SERVICES

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1. Deferred Services. Deferred Services are services that fall within IHS Medical Priorities but are not prioritized to warrant immediate authorization. Authorization for services that fall within but do not meet medical priorities may be deferred for future authorization rather than be denied as long as the services have not been provided. The service deferred must be elective (i.e., "deferrable"), not emergent or urgent. The patient must have accessed the IHS health care system during the FY. Deferred services are considered and reported by IHS as unmet need.

2. Recording and Reporting. IHS evaluates and estimates need and the unmet need for the PRC program based upon information submitted per the annual unmet need request memo and tables, see Manual Exhibit 2-3-O, by Area PRC Officers, voluntarily submitted data by Tribal PRC programs and FI payment data for the average cost for inpatient admissions, outpatient visits and patient travel. This data is needed and used to accurately determine PRC financial needs and support program budget justifications to the HHS, OMB and Congress. The reporting formats and

guidelines for deferred services accrued and deferred services expenditures are sent to the Areas on an annual basis.

3. The formula used to estimate the need is as follows, the percentages used to illustrate the formula do not remain the same year to year and are dependent upon the number of Tribes that manage PRC funds through Title I and Title V contracts. Annually the FI provides the percentage of PRC funds expended for inpatient admissions (e.g., 38%), outpatient visits (e.g., 51%) and patient transportation (e.g., 11%) and the average cost per claim of an inpatient admission (e.g., $9,863), outpatient visit (e.g., $545) and patient transport (e.g., $2,161). For illustration purposes, the IHS manages 42% of the PRC budget and Tribes manage 58%. The methodology in the table below is used to estimate the unmet need in PRC.

Unmet Need Methodology	Total Programs	Number of Programs that Reported Data	Percent of Programs that Reported Data	Percent of PRC Budget Accounted for	Apply Percent of Data Reported
Federal PRC Programs	67	67	100%	42%	42%
Tribal PRC Programs	177	68	38%	58%	22%
		Percent of Data Reported			64%
		Percent of Data Not Reported			36%

4. *Estimated Number of Denied Services = (Reported Number of Denied Services / Percent of Data Reported) * (Percent of Data Not Reported)

5. **Cost for the Estimated Number of Denied Services = Average Cost per Claim (as provided by the FI) * Estimated Number of Denied Services

2-3.20 PURCHASED/REFERRED CARE REVIEW COMMITTEE

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The PRC review committee function is to review PRC referred care and notifications regarding emergency episodes of care and to determine medical priority and rank based on relative medical need within the same medical priority level. Utilizing Area guidelines, the PRC review committee will monitor high cost cases including the progress of each case.

The IHS will maintain a PRC review committee to review and prioritize PRC referrals and notifications regarding emergency episodes of care based on Medical Priorities of Care, as well as to review and monitor the referral and expenditure of PRC funds.

1. PRC Review Committee Requirements.

   The following elements along with PRC staff will be maintained by all PRC Review Committees:

   1. Defined policies and procedures regarding the PRC referral process will include: Referral tracking methodology noting the disposition of each referral reviewed; and meeting notes summarizing decisions and activities of each meeting. Records will be maintained and made available for review as requested by IHS officials.

   2. Committee membership shall consist of the Clinical Director, or his or her designee and others, i.e., utilization review nurse or care coordinator/case manager, patient benefit coordinator and the PRC Specialist. Membership may change periodically based on local needs, medical staff members can serve a rotation.

3. A committee member will record committee comments, medical priority and ranking information and communicate to PRC staff for referral data entry, issuance of purchase orders, denials, deferrals and notification requirements.

2. Meetings. Meetings must be held at least once a week to determine the medical priority and rank of referral requests for expenditure of PRC funds. Minutes will be maintained to accurately reflect decisions and actions for each case discussed.

3. Managing PRC Referrals and Payment Authorizations for Family Members and Relatives

    1. PRC Review Committee members are required to recuse themselves from referral, case/care discussions and decisions involving services for family members or relatives. Meeting records will include documentation indicating the reason the committee member was recused.

    2. An IHS employee with procurement authority is prohibited from signing the purchase delivery order for a family member or relative.

    3. For the purposes of this section, the IHS will use the following definition of family/relative. Family/relative means and includes the following:

    4. An individual who is related to the IHS employee as father, mother, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, husband, wife, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in- law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half-brother, or half-sister.

4. Criteria for Payment Decisions. The committee will consider the following criteria, at a minimum, for PRC cases:

    1. The patient must be PRC eligible.

    2. The care must be within medical priorities.

    3. The requested service is not available in an accessible IHS or Tribal facility.

    4. Funds must be available.

        1. When Funds are not available, PRC referrals must still be ranked within medical priorities by the committee.

        2. Obligation of PRC funds for a referral when no funds are available is a violation of the Anti-Deficiency Act. Federal employees who violate this act are subject to administrative and penal sanctions. Administrative sanctions may include suspension from duty without pay or removal from office. In addition, the offender(s) may also be subject to fines, imprisonment, or both.

    5. PRC referrals can then be authorized to the weekly spending limit after which all others must be deferred or denied.

    6. Care must not be deferred for cases where full reimbursement through alternate resources is available.

5. Minutes. Minutes to accurately reflect decisions and actions for each case discussed of each committee meeting and will be maintained to accurately reflect the determination of each case.

6. High Cost Cases. The PRC review committee will monitor high cost cases, including the progress of each case, utilizing current Area/Tribal guidelines for high cost case management.

2-3.21 PROMPT ACTION ON PAYMENT OF CLAIMS ALSO KNOWN AS THE PRC "FIVE-DAY RULE"

1. Time of Response. 25 U.S.C. 1621s requires the IHS to respond to a notification of a claim by a provider of a PRC service with either an individual purchase order or a denial of the claim within 5 working days after receipt of such notification. For the purposes of this rule the following definitions apply.

2. Notification of a Claim.

~~2.~~1. For the purposes of 42 CFR part 136, and also 25 U.S.C. 1621s and 1646, the submission of a claim that meets the requirements of 42 CFR 136.24. In nonemergency cases, a sick or disabled Indian, an individual or agency acting on behalf of the Indian, or the medical care provider shall, prior to the provision of medical care and services notify the appropriate ordering official of the need for services and supply information that the ordering official deems necessary to determine the relative medical need for the services and the individual's eligibility.

~~1.~~ The requirement for notice prior to providing medical care and services under this paragraph may be waived by the ordering official if: (1) Such notice and information are provided within 72 hours after the beginning of treatment or admission to a health care facility; and (2) The ordering official determines that giving of notice prior to obtaining the medical care and services was impracticable or that other good cause exists for the failure to provide prior notice.~~Such claims must be submitted within 72 hours after the beginning of treatment for the condition or after admission to a health care facility notify the appropriate ordering official of the fact of the admission or treatment, together with information necessary to determine the relative medical need for the services and the eligibility of the Indian for the services.~~

2. The information submitted with the claim must be sufficient to:

~~1. Identify the patient as eligible for IHS services (e.g., name, address, home or referring service unit, Tribal affiliation),~~

~~2.~~1. Identify the medical care provided (e.g., the date(s) of service, description of services), and

~~3.~~2. Verify prior authorization by the IHS for services provided (e.g., IHS purchase order number or medical referral form) or exemption from prior authorization (e.g., copies of pertinent clinical information for emergency care that was not prior-authorized).

3. To be considered sufficient notification of a claim, claims submitted by providers and suppliers for payment must be in a format that complies with the format required for submission of claims under title XVIII of the Social Security Act (42 U.S.C. 1395 *et seq.*) or recognized under section 1175 of such Act (42U.S.C. 1320d-4).

3. Failure to Timely Respond. If IHS fails to respond to a notification of a claim as defined in 2-3.21A, IHS shall accept the claim as a valid claim for PRC services.

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4. Time of Payment. The Service shall pay a completed contract care service claim within 30 days after completion of the claim, in accordance with the Prompt Payment Act 31 U.S.C. 3901 (See Manual Exhibit 2-3-P).

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2-3.22 NO PATIENT LIABILITY

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The Affordable Care Act, enacted on March 23, 2010, reauthorized and amended the IHCIA. The IHCIA [25 U.S.C. 25 Â§ 1621~~(us)~~], provides that patients are not liable for payment of services authorized and approved for payment under a PRC program, which pays for authorized PRC referrals for healthcare services to non-IHS providers.

Section 222 of the IHCIA [25 U.S.C. Â§ 1621u] provides:

1. No Patient Liability. A patient who receives PRC services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.

2. Notification. The Secretary shall notify a contract care provider and any patient who receives PRC services authorized by the Service that such patient is not liable for the payment of any charges or costs associated with the provision of such services not later than five business days after receipt of a notification of a claim by a provider of contract care services.

3. No Recourse. Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 220(b), 42 U.S.C. § 1621s(b), the provider shall have no further recourse against the patient who received the PRC services.

In summary, a patient is not liable for services that have been authorized for payment by a PRC program carried out by the IHS or a Tribal health program. Providers are prohibited from collecting any payments for these services from the patient, whether directly or through referral to an agent for collection. Please note that not all visits or referrals of IHS eligible patients to non-IHS providers are authorized for payment.

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A sample letter to be sent to patients and providers informing them that patients are not liable for payment of services authorized and approved for payment under a PRC program can be found in Manual Exhibit 2-3-Q.

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2-3.23 THIRD-PARTY TORTFEASOR CASES AND FMCRA

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1. Definition. Third-party tortfeasor cases are cases where IHS provides or pays for services to an injured individual where a third-party (the Tortfeasor) may be found to be responsible for the injury. See IHS Circular No. 2006-02, "Reporting Third-Party Tortfeasor Claims and Recovery of Funds under the Federal Medical Care Recovery Act".

2. Claims. Under the FMCRA the Government is authorized to recover the cost of these services. The various offices of the Regional Attorney are responsible for asserting any Government claim under the FMCRA. Payment is not to be withheld pending final determination of any claim the patient may have against a third party.

3. Alternate Resource. Authorization of PRC may not be denied based on any theory that potential recovery from an alleged third-party tortfeasor constitutes an "alternate resource" under the PRC regulations.

4. Recovery. Any recovery made by the government must go back to the respective PRC Program. The reporting and payment requirements are mandatory and must be followed.

5. Cost of Services Settlement. Failure to report FMCRA cases could possibly harm the patient or the patient's family. If the injured party should make a settlement that does not reflect the cost of

services provided by the IHS, the Government might still have claim against the settlement for the cost of services. Though whether the Government may or may not pursue a claim in such a situation, the possibility cannot be ruled out. Therefore, prompt reporting can act to protect the interest of the injured party.

6. Third-Party Report Forms. All third-party report forms should be completed by the facility staff as indicated by local policy and contain the following information:

    1. Patient Name
    2. Date of Service, explanation of situation
    3. Name of third party, which may be responsible for payment in the case
    4. Costs paid by IHS
    5. Any related correspondence

Manual Exhibit 2-3-F

NOTICE TO PURCHASED/REFERRED CARE PROVIDERS CONCERNING ALL PATIENTS BEING REFERRED BY THE INDIAN HEALTH SERVICE

A patient may be referred by an authorizing official of the Indian Health Service (IHS) when the medical care required cannot be provided at the IHS facility. The referral is not an implication that the IHS will authorize payment for the cost of the care to be provided. The IHS will assume financial responsibility for referrals if the patient is eligible within a Purchased Referred Care Delivery Area under the Purchased/Referred Care (PRC) regulations and is not eligible for or does not have an alternate resource. Patients who are ineligible under the PRC regulations will be financially responsible for the medical costs incurred for a referral made by the IHS.

The basic criterion for determination of an Indian person's eligibility for the PRC program is contained in the PRC regulations 42 Code of Federal Regulations. Generally, Aan Indian person is deemed eligible for PRC when heis/she resides on a Federally-recognized Indian reservation; or resides near the reservation of which he/she is a member; or it ihas been determined that he/she to hasve close social and economic ties with the Tribes located on the reservation.

Further clarification and/or additional information concerning PRC may be obtained from the Chief Executive Officer and/or the Supervisory Health Systems Specialist, PRC.

New SAMHSA FOA Announcement: Tribal Opioid Response Grant (TOR)

Dear Tribal Leader and Tribal Health Representatives,

The Substance Abuse and Mental Health Services Administration recently released a grant funding opportunity announcement (FOA) entitled, "Tribal Opioid Response Grants". The short title for this program is "TOR" and applications are due no later than August 20, 2018! Please share it with your colleagues and tribal stakeholders. Information on the FOA is below and the link for additional information is: https://www.samhsa.gov/grants/grant-announcements/ti-18-016.

- FOA Number: TI-18-016
- Application Due Date: Monday, August 20, 2018
- Purpose: The program aims to address the opioid crisis in tribal communities.
- Eligibility: Federally recognized tribes, and tribal organizations. Tribes and tribal organizations may apply individually, or in partnership with an urban Indian organization.
- Anticipated Total Available Funding: $50,000,000
- Anticipated Number of Awards: 263
- Anticipated Award Amount: Funds will be distributed noncompetitively. For more information, view Appendix K in the FOA.
- Length of Project: Up to 2 years
- Cost Sharing/Match Required?: No

APPLY NOW! The Rural Communities Opioid Response Funding Opportunity!

U.S. Department of Health & Human Services
Health Resources and Services Administration
HRSA NEWS ROOM
http://newsroom.hrsa.gov
FOR IMMEDIATE RELEASE
June 15, 2018
CONTACT: HRSA PRESS OFFICE 301-443-3376

The Health Resources and Services Administration's (HRSA) Federal Office of Rural Health Policy (FORHP) has released the Notice of Funding Opportunity (NOFO) for the new Rural Communities Opioid Response (Planning) (RCORP) initiative for FY 18. HRSA plans to award approximately 75 grants to rural communities as part of this funding opportunity.

All eligible high risk rural communities are encouraged to apply.

You can review the funding opportunity at: https://www.grants.gov/web/grants/view-opportunity.html?oppId=305116

Successful awardees will receive up to $200,000 for one year to develop plans to implement opioid use disorder prevention, treatment, and recovery interventions designed to reduce opioid overdoses among rural populations.

All domestic public and private entities, nonprofit and for-profit are eligible to apply and all services must be provided in high risk rural communities.

The lead applicant must be part of a group including at least three other partners that have committed to forming a consortium or are part of an established consortium.

This initiative is part of a multi-year Rural Communities Opioid Response initiative by HRSA aimed at supporting treatment for and prevention of substance use disorder.

Again, please visit www.hrsa.gov and www.grants.gov to review the Notice of Funding Opportunity and apply. For more information please contact Federal Office of Rural Health Policy.

Eric W. Bradford PT, DPT, MBA, GCS
Commander, United States Public Health Service
Deputy Regional Administrator, Office of Regional Operations
Health Resources and Services Administration, Region 10
701 Fifth Avenue
15th Floor, Suite 1520, MS-23
Seattle, WA 98104
Office: (206) 615-2518 Fax: (206) 615-2500
ebradford@hrsa.gov

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
Kalispel 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

2121 SW Broadway
Suite 300
Portland, OR 97201
Phone: (503) 228-4185
Fax: (503) 228-8182
www.npaihb.org

"Response Circles" Funding Request for the Northwest Tribes

This form is to be used when requesting funding for an activity, event, or training that is associated with domestic & sexual violence prevention. The funds may be used for: meeting expenses, materials and supplies for activities, incentives, travel, and training fees. Funds may not be used for wages, food, or promotional clothing items i.e. t-shirts. Page 2 includes opportunities that can be funded. About $15,000 is available for these requests by the Northwest Tribes and will be available until the money runs out. **Requests can be submitted anytime January 8 to August 15, 2018.**

Date: _____
Tribe: _____
Department: _____
Address: _____
Contact Person: _____ Phone: _____

Briefly describe the activity, event, training that the funds will be used for:
Total Amount For Request ($2,000 max)
*Please be sure your total request includes all your needs including: indirect, travel, lodging, per diem, registration fees, internet, supplies, print materials, incentives, honoraria, stipends, trainer fees and travel, and/or facility costs. ** Funds may not be used for wages, food, or promotional clothing items i.e. t-shirts.

*Depending on the event/training chosen NPAIHB staff may ask you to provide a short evaluation, survey, or post-description of the event/training. Please fax this document to 503-228-8182, Attn: Colbie, or email ccaughlan@npaihb.org. If you have any further questions, please call Colbie Caughlan: (503) 416-3284.

List of Upcoming Opportunities for Domestic & Sexual Violence Prevention

- At your own pace Online Sexual Assault Nurse Examiner's training http://www.forensicnurses.org/?page=40HourSANE

- May 21-23, 2018 – 40th Annual Conference for the Oregon Coalition Against Domestic & Sexual Violence - *New Visions for Safety, Equity, and Justice* – Sunriver, OR https://www.ocadsv.org/our-work/annual-conference

- June 4-6, 2018 – Native HOPE Training Conference – Albuquerque, NM http://www.nativeprideus.org/registration.html?utm_source=phplist748&utm_medium=email&utm_content=HTML&utm_campaign=REGISTER%3A+Native+HOPE+training+conference+June+4-6%2C+2018-Albuquerque%2C+NM

- June 5-8, 2018 – Advanced Domestic Violence Sexual Assault Training – Reno, NV http://nicp.net/event/reno-nv-june-5-8-2018/

- June 21-22, 2018 – Tribal Forensic Sexual Assault Examiner Clinical Skills Trainings for RN's, APRN's, PA's, and Physicians – Colorado Springs, CO http://www.tribalforensichealthcare.org/?page=AdultClinical

- June 26-28, 2018 – 13th Women Are Sacred Conference hosted by the National Indigenous Women's Resource Center – Albuquerque, NM - http://www.niwrc.org/events/women-are-sacred-conference

- July 10-13, 2018 – Advanced Domestic Violence Sexual Assault Training – Las Vegas, NV http://nicp.net/event/las-vegas-july-10-13-2018/

- July 25-27, 2018 – National Indian Health Board's AI/AN National Behavioral Health Conference with domestic violence prevention workshops – *Promoting Connections Between Culture and Purpose* – Washington, D.C. http://www.cvent.com/events/2018-american-indian-and-alaska-native-national-behavioral-health-conference/event-summary-d829c15370e04f169d3988378f90a81d.aspx

- August 13-17, 2018 – Domestic Violence, Sexual Assault, & Elder Abuse Training – Louisville, KY http://nicp.net/event/louisville-kentucky-august-13-17-2018/

- August 29-30, 2018 – National Sexual Assault Conference 2018 - *BOLD MOVES: Ending Sexual Violence in One Generation* – Anaheim, CA http://www.calcasa.org/events/nsac/2018-national-sexual-assault-conference/save-the-date/

- Sexual Assault Response Team (SART) Toolkit – training on your own, check out https://ovc.ncjrs.gov/sartkit/about.html

Websites to find more opportunities & dates

- National Center on Domestic & Sexual Violence - http://www.ncdsv.org/ncd_upcomingtrainings.html

- Sexual Assault Forensic Examinations, Support, Training, Access and Resources (SAFESTAR) - http://www.safestar.net/training/

- International Assoc. of Forensic Nurses - http://www.forensicnurses.org/?page=registerforSANE

- IHS Tribal Forensic Healthcare http://tribalforensichealthcare.site-ym.com

- Idaho Coalition Against Sexual & Domestic Violence - https://idvsa.org/

- Oregon Attorney General's Sexual Assault Task Force - http://oregonsatf.org/calendar/trainings/

- Oregon Coalition Against Domestic & Sexual Violence - https://www.ocadsv.org/

- Washington State Coalition Against Domestic Violence - https://wscadv.org/

- Washington Coalition of Sexual Assault Programs - http://www.wcsap.org/

OHSU-PSU School of Public Health
Oregon governmental and Tribal public health employees Course Application

The OHSU-PSU School of Public Health has five spaces reserved in each the Public Health Program Planning and Public Health Program Evaluation online courses at no enrollment cost for Oregon governmental and Tribal public health (Oregon Public Health Division, Tribal Health or Local Public Health Authority) employees. The courses are **Public Health Program Planning** and **Public Health Program Evaluation**. These courses were selected based on a public health employee continuing education needs assessment. Each of the two courses is in asynchronous format, meaning students may log on as is convenient during the week; both courses do follow the academic term, meaning readings, postings, and assignments will be due weekly. Students actively participate through online discussions and posts, readings, and written assignments. Participants can expect approximately 9-12 hours of work per week. Individuals can apply for both courses or just one course depending on their professional development goals.

Participants will interact with instructors and other students and will receive feedback on assignments, as would any other student. The courses are being made available for professional development and will not be taken for credit.

The cost of enrolling in the courses will be waived, but the cost of course materials (textbooks, etc.) will not be covered. Most readings are online; the primary textbooks can be rented from Amazon for approximately $25/term or purchased directly. Participants are expected to already have a basic understanding of public health.

To ensure the employee is successful in the course, please review the following questions with your manager.

- Course materials are estimated to cost about $25-100. Who will be responsible for covering the course materials cost?
- Will the employee be expected to complete the course during their working or non-working hours?
- Will the employee be allowed to access the course materials using work computer and email? If so, are there any internet security blocks that would prohibit access to the OHSU/PSU online system?

To apply, please fill out the application below and send with your resumé by August 1, 2018. The application below should be completed and reviewed with the employee's manager. If you would like to be considered for both courses, please fill out one application for each course.

Public Health Division and Tribal Health employees: Send your completed application to Julie Black at Julie.black@state.or.us.

LPHA employees: Send your completed application to Caitlin Hill at caitlin@oregonclho.org.

OHSU-PSU School of Public Health
Oregon governmental and Tribal public health employees Course Application

Name:
Place of employment:
Position:
Email:
Phone number:
Course ☐ Program Planning (Fall 2018) ☐ Program Evaluation (Winter 2019)
Briefly describe your work and education experience in public health.
Briefly describe your previous experience with the course content you are applying for (either Program Planning or Program Evaluation), including previous coursework completed and when.
Why do you want to be considered for this opportunity? Include in your answer why completing these courses will support your current position/role and your career.
Is there anything else you would like to share?

_____ _____

Employee Signature Manager Signature

OHSU-PSU School of Public Health

CPH 550/650: Public Health Program Planning

Fall 2017

Course Description

This course provides an introduction to program planning and experience in the grant writing process, with an emphasis on public health intervention programs. Students will be introduced to program planning, with an emphasis on logic models. Students will be introduced to the key areas of a proposal that must be addressed in grant writing

Credit Hours

Didactic: 3 credit hours

Prerequisites or Concurrent Enrollment Requirements

None

Faculty Information

Name: Katherine J Bradley, PhD, RN
Associate Professor
Email: bradleyk@ohsu.edu
Office: OHSU School of Nursing, Room 584
Phone: 503-494-1137
Office Hours: By appointment

General Course Meeting Day and Time

On-line course, meets asynchronously throughout each week. Students will engage in independent learning activities from Tuesday to Monday of each week, with assignments and discussions due Tuesday evening at 5pm PST.

Course Delivery Mode

This course is conducted fully online. Students are expected to log into the site regularly in order to meet course requirements and check their student email accounts for notifications. Assignments are posted and submitted through the Sakai course site.

Course Objectives, Competencies, or Outcomes

At the conclusion of this course students will be able to:

1. Apply theory in the development, implementation, and evaluation of public health intervention programs.

2. Understand and apply logic model(s)/planning models to the development of public health plans.
3. Develop interventions and programs to effect change at multiple levels, (e.g., individual, community, and organizations, and policy).
4. Design and implement strategies to promote health, including delivery of health messages.
5. Understand how to seek and integrate input from community organization stakeholders.
6. Define research problems, frame research questions, design research procedures, and outline methods of analysis.
7. Demonstrate an understanding of ethical principles that govern the practice of public health and incorporate these in the development of programs.

In addition, students enrolled in NURS 650 will be able to: Develop a grant proposal that effectively demonstrates competency in the areas above.

Required Texts and Readings

Required text:

Green, L.W. & Kreuter, M.W. (2005). *Health Promotion Planning: An Educational and Ecological Approach* (4th ed). New York: McGraw Hill. ISBN-13: 978-0-07-255683-4

Recommended source:

Gerin, W. & Kapelewski, C. (2011). *Writing the NIH Proposal: A Step-by-Step Guide* (2nd ed). Thousand Oaks, CA: Sage. ISBN: 978-1-4129-7516-2

Publication Manual of the American Psychological Association (6th ed). (2010). Washington, D.C.: American Psychological Association. ISBN: 978-1-4338-0561-5.

Supplemental Suggested Readings or Reference Material

Course readings that are not in the text are available electronically through the Sakai course site and through hyperlinks embedded in this document. OHSU and PSU libraries are easily accessible. Library research as needed is expected of graduate students to fill gaps in your knowledge base and to support your writings.

Attendance Requirements

This is an on-line course; there are no "live" attendance requirements. It IS expected, however, that students will maintain a regular presence on-line in discussion Forums (and this "attendance" is a substantial graded element of the course).

Grading Criteria and Release of Final Grades

The final course grades will be posted with the OHSU registrar the Monday following the last day of the term. The grading system for official grade reports includes:

Letter Grades	Numerals used by Registrar for GPA	Percentage	Grade Description from the University Grading Policy
A	4.0	93 - 100	Honors or Excellent
A-	3.7	90 - 92	
B+	3.3	87- 89	Near Honors or Very Good
B	3.0	83 - 86	
B-	2.7	80 - 82	
C+	2.3	77 - 79	Satisfactory or Fair
C	2.0	73 - 76	
C-	1.7	70 - 72	
F	0.0	0 - 69	Failure

Please note: OHSU policy requires Sakai sites to close three weeks after grades have been submitted to the registrar in compliance with us copyright law and adherence to the fair use doctrine of copyrighted materials in educational settings. You have the right to retain a copy of any downloadable material posted to an online class. You are encouraged to download any needed material before sites are permanently closed.

Course Content Outline

Weekly course assignments, including but not limited to readings, written memos, and online forum discussions, are posted on the course website on Sakai. Online lectures, selected readings and other content are also posted on the course site.

Week	Topic(s)
1	Overview & Introduction to Program Planning and Grant Writing
2	Introduction to Program Planning & Social Assessment
3	Introduction to Program Planning Design
4	Logic Models
5	Ecological and Educational Diagnosis and Theories
6	Program Design and Methods
7	Ethical Issues in Human Research
8	Program, Administration & Policy Design
9	Budgets & Budget Justification
10	Community Engagement Implications
11	Final Proposal Due & Peer Review Feedback

Course Specific Grading Standards

Graded Assignments		
Assignment	**Competencies Addressed**	**Percent of Grade**

9 Forum Discussions (Weeks 1-10)	Course Outcomes: 1, 3, 4, 5 & 7	50%
5 Written Assignments (Weeks 3, 4, 6, 8 & 9)	Course Outcomes: 2 & 6	25%
Final Proposal (Paper 20%; Peer Feedback 5%)	Course Outcomes: 1, 2, 3 & 6	25%

Copyright Information

Every reasonable effort has been made to protect the copyright requirements of materials used in this course. Class participants are warned not to copy, audio, or videotape in violation of copyright laws. Journal articles will be kept on reserve at the library or online for student access. Copyright law does allow for making one personal copy of each article from the original article. This limit also applies to electronic sources.

Syllabus Changes and Retention

This syllabus is not to be considered a contract between the student and the OHSU-PSU School of Public Health. It is recognized that changes may be made as the need arises. Students are responsible for keeping a copy of the course syllabus for their records.

Accommodations

Our MPH degree programs and the OHSU-PSU School of Public Health are committed to all students achieving their potential. If you have a disability or think you may have a disability (including but not limited to physical, hearing, vision, psychological and learning disabilities), which may need an accommodation, please contact the OHSU Office for Student Access at email studentaccess@ohsu.edu or tel 503-494-0082 to discuss your request. All information regarding a student's disability is kept in accordance with state and federal laws. http://www.ohsu.edu/xd/education/studentservices/education-diversity/student-access/index.cfm.

Portland State students also have similar resources available via the PSU Disability Resource Center (website http://www.pdx.edu/drc). Please contact the DRC at tel. (503) 725-4150 or email at drc@pdx.edu.

Students with special learning needs or testing accommodations must contact Dr. Elizabeth Waddell (Program Director) in the first week of the course to formulate an appropriate learning and evaluation plan.

Commitment to Equity and Inclusion

Oregon Health & Science University is committed to creating and fostering a learning and working environment based on open communication and mutual respect. If you encounter

sexual harassment, sexual misconduct, sexual assault, or discrimination based on race, color, religion, age, national origin or ancestry, veteran or military status, sex, marital status, pregnancy or parenting status, sexual orientation, gender identity, disability or any other protected status please contact the Affirmative Action and Equal Opportunity Department at 503-494-5148 oraaeo@ohsu.edu. Inquiries about Title IX compliance or sex/gender discrimination and harassment may be directed to the **OHSU Title IX Coordinator** at 503-494-0258 or titleix@ohsu.edu.

School of Public Health Handbook

All students are responsible for following the policies and expectations outlined in the student handbook for their program of study. Students are responsible for their own academic work and are expected to have read and practice principles of academic honesty, as presented in the handbook: http://ohsu-psu-sph.org/index.php/student_life/.

Technical Support

The OHSU ITG Help Desk is available to assist students with email account or network account access issues between 6 a.m. and 6 p.m., Monday through Friday at 503-494-2222. For technical support in using the Sakai Course Management System, please contact the Sakai Help Desk at 877-972-5249 or email us at sakai@ohsu.edu.

Reading Assignments

Please note that you should complete the readings listed under each week prior to posting in the forum on Tuesday. This information is also in the weekly course materials in Sakai. The exception is obviously Week 1 as you will likely not have enough time to complete the readings before posting.

Wherever possible, hyperlinks are embedded in the title of the article to direct you to a library copy of the assigned reading. “Cntrl + click” on the underlined text to follow the link. OHSU login is generally required to access library holdings. Please notify me if you are unable to access any of the readings or if you discover that a link is not working.

RESOURCE: For students in the Portland area, a copy of the Green textbook is on reserve at the OHSU Library Service Desk at the BICC on Marquam Hill and at the Collaborative Life Sciences Building (CLSB) at the waterfront campus.

OHSU-PSU School of Public Health

CPH 538/638: Public Health Program Evaluation

Winter 2018

Course Description

Using case study methodology, this course focuses on the acquisition of technical skills in design, data collection, and analysis for the purpose of evaluating public health programs. Program justification and evaluation for policy making purposes will be emphasized. In addition, alternative forms of evaluation will be examined including Rapid Assessment, Participatory Evaluation and historical, social networking, and other techniques. Students will have the opportunity to examine public health data sets and to design an evaluation focused on a disparate population, as well as develop policy based on critical analysis of several types of evaluations.

Credit Hours

Didactic: 3 credit hours

Prerequisites or Concurrent Enrollment Requirements

None

Faculty Information

Name: Katherine J Bradley, PhD, RN
Associate Professor
Email: bradleyk@ohsu.edu
Office: OHSU School of Nursing, Portland Campus, Room 584
Phone: 503-494-1137
Office Hours: In person, by phone or Nexus: Tuesdays 9-11, Thursdays 3-5 and by appointment

General Course Meeting Day and Time

On-line course, meets asynchronously throughout each week. Students will engage in independent learning activities from Tuesday to Monday of each week, with assignments and discussions due Tuesday evening at 5pm PST.

Course Delivery Mode

This course is conducted fully online. Students are expected to log into the site regularly in order to meet course requirements and check their student email accounts for notifications. Assignments are posted and submitted through the Sakai course site.

Course Objectives, Competencies, or Outcomes

At the conclusion of this course students will be able to:

1. Understand and apply principles of program evaluation to selected case studies.

2. Explore, analyze and critique several types of program evaluations.
3. Analyze and critique program evaluations from ethical and community perspectives.
4. Design an evaluation to analyze the impact of a public health program change.
5. Make recommendations for public health policy from population data and program evaluation outcomes.

In addition, students enrolled in CPH 638 will be able to: Design and submit a program evaluation proposal with a funding request.

Required Texts and Readings

Required text:
Harris, M.J. (2017). *Evaluating Public and Community Health Programs, 2nd Edition*. San Francisco, CA: Jossey-Bass. ISBN: 9781119151074

Recommended source:
Knowlton W., Phillips, C.C. (2013). *The logic model guidebook: better strategies for great result*s. (2nd Ed.). Thousand Oaks: Sage Publications.

Publication Manual of the American Psychological Association (6th ed). (2010). Washington, D.C.: American Psychological Association. ISBN: 978-1-4338-0561-5.

Supplemental Suggested Readings or Reference Material

Course readings that are not in the text are available electronically through the Sakai course site and through hyperlinks embedded in this document. OHSU and PSU libraries are easily accessible. Library research as needed is expected of graduate students to fill gaps in your knowledge base and to support your writings.

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C+	2.3	77 - 79	Satisfactory or Fair
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F	0.0	0 - 69	Failure

Please note: OHSU policy requires Sakai sites to close three weeks after grades have been submitted to the registrar in compliance with us copyright law and adherence to the fair use doctrine of copyrighted materials in educational settings. You have the right to retain a copy of any downloadable material posted to an online class. You are encouraged to download any needed material before sites are permanently closed.

Course Content Outline

Weekly course assignments, including but not limited to readings, written memos, and online forum discussions, are posted on the course website on Sakai. Online lectures, selected readings and other content are also posted on the course site.

Week	Topic(s)
1	Introduction to Program Evaluation
2	Needs Assessment & Stakeholder Engagement
3	Program Theory & Logic Models
4	Developing Evaluation Questions
5	Evaluation Design & Data Collection – Qualitative
6	Evaluation Design & Data Collection – Quantitative
7	Program Process Evaluation & Monitoring
8	Outcome & Impact Evaluation
9	Ethical Implications
10	Case Study
11	Final: Program Evaluation Poster with Voice Recording

Course Specific Grading Standards

Graded Assignments		
Assignment	**Competencies Addressed**	**Percent of Grade**
Forums & written assignments	Course Outcomes: 1, 2, 3, 4 & 5	40%
Midterm Paper	Course Outcome: 2	25%
Final: Poster Presentation & voice recording	Course Outcomes: 4	35%

Copyright Information

Every reasonable effort has been made to protect the copyright requirements of materials used in this course. Class participants are warned not to copy, audio, or videotape in violation of copyright laws. Journal articles will be kept on reserve at the library or online for student access. Copyright law does allow for making one personal copy of each article from the original article. This limit also applies to electronic sources.

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Portland State students also have similar resources available via the PSU Disability Resource Center (website http://www.pdx.edu/drc). Please contact the DRC at tel. (503) 725-4150 or email at drc@pdx.edu.

Students with special learning needs or testing accommodations must contact Dr. Elizabeth Waddell (Program Director) in the first week of the course to formulate an appropriate learning and evaluation plan.

Commitment to Equity and Inclusion

Oregon Health & Science University is committed to creating and fostering a learning and working environment based on open communication and mutual respect. If you encounter sexual harassment, sexual misconduct, sexual assault, or discrimination based on race, color, religion, age, national origin or ancestry, veteran or military status, sex, marital status, pregnancy or parenting status, sexual orientation, gender identity, disability or any other protected status please contact the Affirmative Action and Equal Opportunity Department at 503-494-5148 oraaeo@ohsu.edu. Inquiries about Title IX compliance or sex/gender discrimination and harassment may be directed to the **OHSU Title IX Coordinator** at 503-494-0258 or titleix@ohsu.edu.

School of Public Health Handbook

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Wherever possible, hyperlinks are embedded in the title of the article to direct you to a library copy of the assigned reading. "Cntrl + click" on the underlined text to follow the link. OHSU login is generally required to access library holdings. Please notify me if you are unable to access any of the readings or if you discover that a link is not working.

Week 1: Introduction to Program Evaluation

- Harris, M.J. (2010). ***Evaluating Public and Community Health Programs***. San Francisco, Jossey Bass. Chapter 1. An Introduction to Public and Community Health Evaluation. pp. 1-18. NOTE: The first 2 weeks of readings are made available in case there are delays with acquiring the text book.
- American Evaluation Association. (2011). ***American Evaluation Association Public Statement on Cultural Competence in Evaluation***. Fairhaven, MA: Author. Retrieved from www.eval.org. pp 1-11.
- Download the following guide as there will be readings throughout the term. U.S. Department of Health and Human Services, Office of the Director, Office of Strategy and Innovation. ***Introduction to program evaluation for public health programs: A self-study guide.*** (2011). Atlanta, GA: Centers for Disease Control and Prevention. **http://www.cdc.gov/eval/guide/index.htm** **This week, pp 1-12.**

Week 2: Needs Assessment & Stakeholder Engagement

- Harris, Chapter 2: ***The Community Assessment.*** pp. 20-40.

- CDC ***Self Study Guide***: pp 13-24.
- Horne, M. & Costello, J. (2003). A public health approach to health needs assessment at the interface of primary care and community development: findings from an action research study. ***Primary Health Care Research and Development,*** 4, 340-352. doi:10.1191/1463423603pc173oa.
- Quinlisk P.; Jones M.J.; Bostick, N.A.; Walsh, L.E.; Curtiss, R.; Walker, R.; Mercer, S. & Subbarao, I. (2011). Results of rapid needs assessments in rural and urban Iowa following large-scale flooding events in 2008. ***Disaster Medicine and Public Health Preparedness***, 5, 287-292. doi:10.1001/dmp.2011.82.

Scan:

- Preskill,H. & Jones, N. (2009) ***A practical guide to engaging stakeholders in developing evaluation questions.*** Princeton, N.J.: Robert Wood Johnson Foundation. Download at http://www.rwjf.org/pr/product.jsp?id=49951

Week 3: Program Theory & Logic Models

- Harris. Chapter 3: ***Developing Initiatives***. pp. 42-60.
- Knowlton W., Phillips, CC. The ***Logic Model Guidebook: Better Strategies for Great Results***. (2nd Edition). Thousand Oaks, CA, Sage Publications, 2013.
  - Chapter 1:Introducing Logic Models
  - Chapter 3: Creating Program Logic Models
- CDC ***Self Study Guide***: pp 26-41.
- If you are new to logic model development, or prefer visual learning, the MetroWest Health Foundation video Logic Model Basics is a good resource (12 minutes).
- **Go to the website and download the Logic Model Guide as a resource**. The Kellogg Foundation website is a valuable resource to bookmark. : W.K. Kellogg Foundation. (2006). *Logic Model Development Guide*. Battle Creek, MI: W.K. Kellogg.

Week 4: Developing Evaluation Questions

- Harris. Chapter 4: ***Planning for Evaluation.*** pp.62- 78; Chapter 5: ***Designing the Evaluation: Describing the Program***. pp. 80-86; Chapter 6: ***Designing the Evaluation: Determining the Evaluation Questions and the Evaluation Design.*** pp. 88-106.
- CDC ***Self Study Guide***: pp 45-55
- CDC. (2011). Program Evaluation Tip Sheet: Constructing Survey Questions.

Week 5: Evaluation Design & Data Collection – Qualitative

- Harris: Chapter 9: ***Collecting the Data: Qualitative***.pp.124-138; Chapter 10: ***Analyzing and Interpreting the Data: Qualitative***. pp. 139-147.
- CDC ***Self Study Guide***: pp 56-62.
- Sobo, E.J.; Simmes, D.R.; Landsverk, J.A. & Kurtin, P.S. (2003). Rapid Assessment with Qualitative Telephone Interviews:Evaluation of California's Healthy Families program &

Medi-Cal for children ***American Journal of Evaluation.***24:3. pp. 399-408.. DOI:10.1177/109821400302400308.

Recommended

- Fleischer, D.N. & Christie, C.A. (2009). Evaluation use: Results from a survey of U.S. american evaluation association members. ***American Journal of Evaluation, 30:***2. pp. 158-175. DOI: 10.1177/1098214008331009

Week 6: Evaluation Design & Data Collection – Quantitative

- Harris: Chapter 7: ***Collecting the Data: Quantitative.*** pp.100-115; Chapter 8: ***Analyzing and Interpreting the Data: Quantitative.*** pp. 116-123.
- CDC ***Self Study Guide***: pp 63-73.
- Tucker-Brown, A. (2012). CDC Coffee Break: using mixed methods in program evaluation. Slide presentation. CDC Division of Heart Disease & Stroke Prevention.
- Hamilton, J., Begley, C. & Culler, R. (2014). Evaluation of partner collaboration to improve community-based mental health services for low income minority children and their families. ***Evaluation and Program Planning,*** 25. 50--60.

Recommended

- Green, J.C., Benjamin, L. & Goodyear, L. (2001). The merits of mixing methods in evaluation, ***Evaluation.7***:1. 25-44 at: DOI: 10.1177/13563890122209504

Week 7: Program Process Evaluation & Monitoring

- Harris. Review pp. 94-96.
- CDC.(2008). ***Introduction to process evaluation in tobacco use prevention and control.*** National Center for Chronic Disease Prevention and Health Promotion, Office of Smoking and Health pp. 1-8. http://wwww.cdc.gov/tabacco/publications/index.htm
- Berkowitz, J. M., Huhman, M., Heitzler, C. D., Potter, L. D., Nolin, M. J. & Banspach, S.W. (2008). Overview of formative, process, and outcome evaluation methods used in the VERB campaign. ***American Journal of Preventive Medicine***, 34(6S): S222-S229.

Optional Reading

- Robbins, L.B., Pfeiffer, K.A., Wesolek, S.M., & Lo, Y. (2014). Process evaluation for a school-based physical activity intervention for 6th and 7th grade boys: Reach, dose and fidelity. ***Evaluation and Program Planning***, 42. 21-31.

Week 8: Outcome & Impact Evaluation

- Harris: Review pp 97-103. (In Chapter 6).
- CDC ***Self Study Guide***: pp 74-90.

- CDC. (August 2011). ***CDC Program Evaluation Tip Sheet Reach and Impact***. National Center for Chronic Disease Prevention and Health Promotion.
- Mohan R, Sullivan K.(2006). Managing the politics of evaluation to achieve impact. ***New Directions for Evaluation***, 112. pp 7-23.

Week 9: Ethical Implications

- Download and review the 2003 American Evaluation Association Guiding Principles of Evaluators.
- Morris, M. (1999). Research on evaluation ethics: what have we learned and why is it important? ***New Directions for Evaluation***, 82:15-24.
- Schweigert, F.J. Predicament and promise: The internal evaluator as ethical leader. ***New Directions for Evaluation,***132:43-56.
- Rodi, M.S. & Paget, K.D. (2007). Where local and national evaluators meet: Unintended treats to ethical evaluation practice. ***Evaluation and Program Planning,*** 30: 416-421.

The following is a brief case study on an ethical challenge and response:

- Morris, M. (2001). Who is building this boat, anyway? ***American Journal of Evaluation***, 22: 107.
- Shulha, L. (2001). "Tinker, tailor, soldier, sailor": The evaluator role in high stakes program design. ***American Journal of Evaluation***, 22:111-115.

Recommended:

- Stevens, C.J., & Dial, M. (1994). What constitutes misuse? ***New Directions for Program Evaluation***, 64:3-13

Week 10: Case Study

- Sherwood, K.E. (2005). Evaluating home visitation:a case study of evaluation at the David and Lucile Packard foundation. ***New Directions for Evaluation***. 105:59-78.

Recommended Resources

- This paper introduces several tools for evidenced-based public health. Fielding, J.E. & Briss, P.A. (2006). Promoting evidence-based public health policy: can we have better evidence and more action? ***Health Affairs.*** 25(4):969-78.
- This paper provides recommendations from the Cochrane Collaboration on how to improve the quality of public health systemic reviews. . Waters, E., Doyle, J., Jackson, N., Howes, F., Brunton, G., & Oakley, A. (2006). Evaluating the effectiveness of public health interventions: the role and activities of the Cochrane Collaboration. ***Journal of Epidemiology and Community Health***. 60:285-289.
- This paper presents an evaluation approach that emphasises the importance of understanding group culture. The examples are drawn from tribal nations. LaFrance, J., Nicholas, R., & Kirkhart, K.E. (2012). Culture writes the script: on the centrality of

context in indigenous evaluation. In D.J. Rog, J.L.Fitzpatrick, & R.F. Conner (Eds.). ***Context: A framework for its influence on evaluation practice. New Directions for Evaluation,*** 135: 59-74.

- This paper provides an overview of the benefits and limitations of using online surveys. Ritter, L. & Sue, V.M. (2007). Introduction to using online surveys. ***New Directions for Evaluation.*** 115: 5-14.
- This paper is a practical outline to align program staff and evaluators around evaluation design that can have a program impact. Sridharan, S. & Nakaima, A. (2011). Ten steps in making evaluation matter. ***Evaluation and Program Planning.*** 35:135-146.

Save the Date

Embrace Your Sacredness

PULLING TOGETHER FOR WELLNESS

Tribal Youth Suicide Prevention Summit 2018

August 28 & 29, 2018 at Port Gamble S'Klallam Tribe

Registration information to follow. Contact: aubrey.aihc@gmail.com

8/29 TECPHI Webinar - AI/AN Cancer Data 101

Register Now! Please join us on August 29 @ 2:00-3:00 Eastern via Zoom for an AI/AN Cancer Data 101 webinar presented by the CDC.

Description:
Misclassification of American Indian/Alaska Native (AI/AN) people as non-AI/AN in cancer incidence has resulted in the underestimation of the disease burden in these populations. Linkages of IHS patient registration data and data from central cancer registries that are part of the CDC's National Program of Cancer Registries (NPCR) and the NCI's Surveillance, Epidemiology, and End Results Program (SEER) provided evidence that, when reporting national rates, the regional variations were masking the real burden of disease among AI/AN. We will describe our attempt to address racial misclassification through record linkage and characterize patterns of cancer incidence for 1999-2015 among AI/AN by IHS Region. We will also discuss sources of AI/AN data that can be used to develop public health strategies and programs to address health disparities.

Presenters:
Stephanie Melkonian, PhD is an Epidemiologist in the Epidemiology and Applied Research Branch in the Division of Cancer Prevention and Control at the Centers for Disease Control and Prevention in Albuquerque, New Mexico. Stephanie's work focuses on cancer surveillance and cancer control efforts in then American Indian/Alaska Native populations. Her recent work has focused on regional variation in liver and gastric cancer incidence rates in the AI/AN population. Prior to joining the CDC, Dr. Melkonian was a postdoctoral fellow at the University of Texas MD Anderson Cancer Center in Houston, Texas.

Melissa A. Jim, MPH (Diné) is an Epidemiologist with the Cancer Surveillance Branch in the Division of Cancer Prevention and Control at the Centers for Disease Control and Prevention that working in collaboration with the Indian Health Service Division of Epidemiology and Disease Prevention in Albuquerque, NM. She has been with the Cancer Surveillance Branch for over 12 years. Prior to working at CDC she worked at the New Mexico Tumor Registry.

This webinar is provided as part of the Tribal Epidemiology Centers Public Health Infrastructure (TECPHI) initiative, and is open to all Tribal Epidemiology Center staff.

Click here to register and add the event to your calendar.

TECPHI Network Coordinating Center
Visit our new collaborative space for TECs at www.tecconnect.org

SAMHSA
Substance Abuse and Mental Health Services Administration

NEW Webinar on Developing and Delivering Effective Suicide Prevention Messaging

Wednesday, July 25, 2018 | 1–2:30 p.m. Eastern Time

Join SAMHSA and the National Action Alliance for Suicide Prevention for a webinar to learn about developing and delivering effective suicide prevention messaging, in advance of National Suicide Prevention Week in September. The webinar presenters will highlight the Action Alliance's *Framework for Successful Messaging*, an online, research-based resource that offers guidance on developing suicide prevention messaging. Presenters will also offer tips on incorporating #BeThere messaging into your current efforts and provide an overview about our collective #BeThere messaging efforts in September.

Register for the Webinar

JOIN US FOR THE

Culture & Drugs Don't Mix Train the Trainer

When: July 25, 2018 8am-12pm ET

Where: 2018 AI/AN Behavioral Health Conference
Palladian Ballroom

Registration:
https://www.surveymonkey.com/r/CDDMTraining

Seats are limited and registration to both the conference and training are required to attend.

Alaska Native Epidemiology Center

TRAINING OPPORTUNITY

Tribal Grant Writing

This 2.5 day workshop will improve participant grant writing skills. Led by instructors from the national Office of Minority Health Resource Center, the training includes elements needed to complete successful state, federal, and foundation grant applications. Participants will learn principles of technical writing, and practice strategies to effectively convey information to funders through strong grant applications.

- When: **August 6-8, 2018**
- Where: **Anchorage, AK**
- Cost: **$125**

Register at: grantwriting-aug2018.eventbrite.com

- Limited travel scholarships available.
- Food provided.

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
EPIDEMIOLOGY CENTER

Visit our website

Alaska Native Epidemiology Center | 3900 Ambassador Drive, Anchorage, AK 99508

Motivational Interview Training

With Darryl Tonemah

August 1st - 2nd

The Point Casino and Hotel
7989 NE Salish Ln
Kingston, WA

Click Here To Register

Who should attend:

Clinical providers, practitioners, nurses, health educators, community health workers, etc.

Travel and Hotel

Travel will be reimbursed - Including hotel,mileage/rental, and flight. (Limit 2 hotel rooms per tribe)

Reservations:
1-866-547-6468

Group Code: 3291666

This training will provide participants with a well-researched tool for assisting patients in resolving ambivalence and working toward healthy change.

For Questions, Please Contact:
Nora Frank-Buckner
WEAVE-NW Project Coordinator
nfrank@npaihb.org
503.416.3253

NPAIHB
Indian Leadership for Indian Health

MARCH OF DIMES

SAVE THE DATE
OCTOBER 12, 2018

STRONGER TOGETHER: HEALING AND HOPE FOR NATIVE AMERICAN/ ALASKAN NATIVE MOTHERS AND FAMILIES

In collaboration with the Northwest Portland Area Indian Health Board, join tribal leaders from Idaho, Oregon, and Washington to focus on Maternal and Infant Health across Native Communities in the Pacific Northwest.

OCTOBER 12, 2018
NATIVE AMERICAN STUDENT AND COMMUNITY CENTER
PORTLAND STATE UNIVERSITY
PORTLAND, OREGON

REGISTRATION LINK TO FOLLOW
APPLY FOR TRAVEL SCHOLARSHIPS HERE:
HTTPS://WWW.SURVEYMONKEY.COM/R/6SLT55T

CONTACT:
KASEY RIVAS AT KRIVAS@MARCHOFDIMES.ORG | 206-452-6631 OR
JOANNE ROGOVOY AT JROGOVOY@MARCHOFDIMES.ORG | 971-270-2885

Job Opening at Project ECHO

We have a new ECHO Project Manager positon at the Board and we are looking for all applicants who may be interested. This position is a full time benefited position and the salary range is 60-70K depending on experience. Work for this position must be completed on-site in our office.

Please help us recruit for this position by passing this along to your contacts and anyone who may be interested in applying. All applications must be received by close of business on Friday, July 27th, 2018. To apply for this position, please complete and email the employment application and application documents to awagner@npaihb.org, fax to 503-228-8182 or mail to:

NPAIHB Attn: HR
2121 SW Broadway, Suite 300
Portland, OR 97201

For additional information, please contact Andra Wagner, PHR, SHRM-CP Human Resources Coordinator Northwest Portland Area Indian Health Board (503) 416-3297

2018-ISSUE 167

NCCDPHP

Good Health and Wellness in Indian Country
TRIBAL RESOURCE DIGEST

Welcome to Centers for Disease Control and Prevention's (CDC) tribal resource digest for the week of June 18, 2018. The purpose of this digest is to help you connect with the tools and resources you may need to do valuable work in your communities.

Announcements

In this issue:

CDC-RFA-DP18-1813: Racial and Ethnic Approaches to Community Health (REACH) - Applications for Funding DUE July 16, 2018

This five-year program will provide funding to communities to improve health, prevent chronic diseases, and reduce health disparities among racial and ethnic populations with the highest risk, or burden, of chronic disease (i.e., hypertension, heart disease, Type 2 diabetes, and obesity). Read more here.

Applications Due: July 16, 2018

Supporting Community-Led Conservation and Recreation Projects

The National Park Service works with local leaders to build partnerships, develop plans, and expand community support for outdoor recreation and conservation projects. Read more here.

Deadline: June 30, 2018

Call for Abstracts: 2018 Third Annual Conference on Native American Nutrition

Read more here.

Deadline: June 29, 2018

Tolani Lake Hoop House
Greens grown in the Tolani Lake Enterprises' Hoop House, Tolani Lake, Navajo Nation

—photo courtesy Dave Espey

Webinars

GPTCHB Community Health Webinar Series

Contact Jennifer William for details regarding the webinar.

Jennifer Williams, Program Manager
Great Plains Good Health and Wellness
Great Plains Tribal Chairmen's Health Board
(P) 605.721.1922 ext. 144

7/11/18	Providing Community Clinical Linkages in Indian Country	Tasha Peltier, MPH-Partnerships to Advance Tribal Health; Alayna Eagle Shield, SRST-Health Education Director
8/8/18	Traditional vs. Commercial Tobacco	Terra Houska, GPTCHB Tobacco Health Educator

Funding Opportunities

National Institute of Diabetes and Digestive and Kidney Diseases Travel Awards for AI/AN Undergraduate Students

Travel awards to attend the Association of American Indian Physicians Annual Conference. Awards will got to American Indian/ Alaska Native undergraduate students who have an interest in biomedical research relating to the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) mission areas. Students who receive travel awards will be given priority to participate in the NIDDK Summer Research Training Program in 2019. Read more here.

Application Deadline: July 2, 2018

On the look-out for photos!

Send any GHWIC related photos to AQUIROZ@cdc.gov. If you wish to feature a community garden, event, team meeting, etc., this is the place! Send your photo with a short description.

Tribal Maternal, Infant, and Early Childhood Home Visiting Program: Implementation and Expansion Grants

Grants to sustain and/or expand evidence-based home visiting services in tribal communities. Read more here.

Application Deadline: June 25, 2018

Healthy Homes Production Grant Program for Tribal Housing

Funding set aside for tribes to address multiple childhood diseases and injuries in the home by identifying and remediating housing-related environmental health and safety hazards in privately owned, low-income rental, and/or owner occupied housing, especially in units and/or buildings where families with children, the elderly, or persons with disabilities live. Read more here.

Application Deadline: July 18, 2018

Tolani Lake Chapter House
Community members with staff from the Navajo Nation Epidemiology Center, Tolani Lake Enterprises, and CDC. Navajo Nation.

—photo courtesy Dave Espey

Contact Information:

National Center for Chronic Disease Prevention and Health Promotion

Office of the Medical Director

4770 Buford Highway, MS F80

Atlanta, GA 30341

(770) 488-5131 / http://www.cdc.gov/chronicdisease/index.htm

The digest serves as your personal guide to repositories of open and free resources where you can find content to enrich your program or your professional growth. Please note that CDC does not endorse any materials or websites not directly linked from the CDC website. Links to non-Federal organizations found in this digest are provided solely as a courtesy. CDC is not responsible for the content of the individual organization web pages found at these links.

If you have comments or suggestions about this weekly update, please email Anisha Quiroz at AQUIROZ@cdc.gov with the words "TRIBAL DIGEST" in the subject line.

2018-ISSUE 168

N C C D P H P

Good Health and Wellness in Indian Country
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Applications Due: July 16, 2018

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Application Deadline: July 2, 2018

Karma for Cara

The foundation is offering grants of up to $1,000 to **youth aged 18 and under** to fund their community service projects. Past projects include a community garden, rebuilding a school playground, and helping senior citizens. For all questions related to microgrants, contact: k4cmicrogrants@livingclassrooms.org for more info. Read more here.

Deadline: July 1, 2018

Healthy Homes Production Grant Program for Tribal Housing

Funding set aside for tribes to address multiple childhood diseases and injuries in the home by identifying and remediating housing-related environmental health and safety hazards in privately owned, low-income rental, and/or owner occupied housing, especially in units and/or buildings where families with children, the elderly, or persons with disabilities live. Read more here.

Application Deadline: July 18, 2018

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Send any GHWIC related photos to AQUIROZ@cdc.gov. If you wish to feature a community garden, event, team meeting, etc., this is the place! Send your photo with a short description.

Robert Wood Johnson

The foundation is looking for: sports teams, athletes, and community based organizations to apply for the sports award. The award will be given to one winner along with $10,000 in each of the following categories: professional sports team, individual athlete, an organization improving their community through sports. The following criteria are used to select the winners: how they made the community healthier through sport, innovation, collaboration, impact and measurable results, and sustainability. Read more here.

Deadline: July 2, 2018

Tolani Lake Enterprises Staff
Left to right-Tolani Lake Enterprises Grower Trainees AJ, Jeff, and Keaneau, with Project Manager Johnthan Yazzie.
Tolani Lake, Navajo Nation

—photo courtesy Dave Espey

Contact Information:

National Center for Chronic Disease Prevention and Health Promotion

Office of the Medical Director

4770 Buford Highway, MS F80

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2018-ISSUE 170

N C C D P H P

Good Health and Wellness in Indian Country
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Announcements

In this issue:

Intertribal Food Sovereignty Summit

Intertribal Food Sovereignty Summit kicks off August 20, 2018! You won't want to miss the event that will take you to indigenous food landscapes in the forest, at the farm, and on the ocean. Visit the maple sugar shack to learn about traditional and modern maplesugaring, craft a berry basket to help you with next year's harvest, and taste the fruits of the sea cooked over an open hearth fire. Read more and register here.

Date: August 20-24, 2018
Location: Mashantucket, CT

Register for the 4th Annual Good Health and Community Wellness Symposium

Please join the Great Plains Good Health and Wellness Program for our 4th Annual Good Health and Community Wellness Symposium. This year the two day event will be held on August 28 – 29, 2018 and will showcase the work of their tribal communities and feature sessions focused on community-clinical linkages, Chronic Disease Self-Management Programs, Traditional Games, along with policy creation and implementation and more! Apply for a travel stipend. Read more here.

Date: August 28-29, 2018
Location: Rapid City, SD

Webinars

GPTCHB Community Health Webinar Series

Contact Jennifer William for details regarding the webinar.

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Great Plains Tribal Chairmen's Health Board / (P) 605.721.1922 ext. 144

8/8/18	Traditional vs. Commercial Tobacco	Terra Houska, GPTCHB Tobacco Health Educator

Funding Opportunities

Native Youth on the Move Grant Opportunity

This funding opportunity, made possible by the Nike N7 Fund, will support Native American communities in Albuquerque and surrounding pueblos working to increase the number of Native American children ages 7-18 participating in physical activity, play and sports. Read more here.

Application Deadline: August 3, 2018

Water First! Grant Opportunity

This funding opportunity, made possible by the Shakopee Mdewakanton Sioux Community (SMSC) and their "Seeds of Native Health" campaign, will expand NB3F's support of Native American communities working to improve the health of young children in Minnesota and Washington. Read more here.

Application Deadline: August 15, 2018

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Send any GHWIC related photos to AQUIROZ@cdc.gov. If you wish to feature a community garden, event, team meeting, etc., this is the place! Send your photo with a short description.

Cooking class at Pueblo of Santa Ana June 2018

—photo courtesy Audrianna Marzette

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