

## **ENCLOSURE SUMMARY**

### **Indian Health Service – *Proposed Realignment of Indian Health Service Headquarters Offices***

#### **Comment Period – October 5 – November 7, 2016**

During the initial comment period, the IHS received 14 letters providing written comments.

#### **List of Enclosures**

1. 10/17/2016 – Joint Letter – National Indian Health Board, National Council of Urban Indian Health, Inc., Tribal Self-Governance Advisory Committee, Direct Service Tribes Advisory Committee, and Unite South and Eastern Tribes, Inc. (Nationwide - All 12 IHS Areas)
2. 10/24/2016 – Southern Indian Health Council, Inc. (IHS California Area)
3. 10/25/2016 – Chickasaw Nation (IHS Oklahoma City Area)
4. 10/26/2016 – Gila River Indian Community (IHS Phoenix Area)
5. 10/31/2016 – Jamestown S' Klallam Tribe (IHS Portland Area)
6. 11/1/2016 – Pueblo de Cochiti (IHS Albuquerque Area)
7. 11/2/2016 – Choctaw Nation (IHS Oklahoma City Area)
8. 11/3/2016 – Navajo Nation (IHS Navajo Area)
9. 11/4/2016 – Tribal Self-Governance Advisory Committee (Nationwide - All 12 IHS Areas)
10. 11/4/2016 – Alaska Native Tribal Health Consortium (IHS Alaska Area)
11. 11/4/2016 – National Council of Urban Indian Health (Nationwide - Urban Programs)
12. 11/4/2016 – Saint Regis Mohawk Tribe (IHS Nashville Area)
13. 11/6/2016 - Sault Ste. Marie Tribe of Chippewa Indians (IHS Bemidji Area)
14. 11/7/2016 – United South and Eastern Tribes, Inc. (IHS Nashville Area)



October 17, 2016

Mary Smith  
Principal Deputy Director  
Indian Health Service  
5600 Fishers Lane  
Mail Stop: 08E86  
Rockville, MD 20857

**RE: Request to Extend Comment Period on Proposed IHS Realignment**

Dear Ms. Smith.

On behalf of the National Indian Health Board, the Tribal Self-Governance Advisory Committee, the Direct Service Tribes Advisory Committee, the National Council of Urban Indian Health and the United South and Eastern Tribes Sovereignty Protection Fund we write to request that the comment period be extended an additional 60 days to allow for a thoughtful response. Accordingly, we request that implementation of the proposal be delayed until meaningful Tribal Consultation has occurred with adequate notification. We ask this in light of the fact that much of the realignment as described by IHS is in direct response to the gaps in the delivery of the care in the Great Plains area. While we emphatically support addressing all the care provision issues experienced by the Great Plains nations, we wish to make sure that any realignment takes all regions into consideration; particularly those that have been performing well. We believe accountability at the level closest to the region will provide the best result and as such we should look to institute best practices in each region utilizing a structure at IHS headquarters that supports this effort. We ask for this extension for the following reasons:

1. This proposal fails to adhere to Presidential Executive Order 13175 as well as the Department of Health and Human Services (HHS) and the IHS Tribal Consultation Policies; and
2. Thirty (30) Days is not enough time to provide IHS with thoughtful, meaningful, input on the proposal; and
3. Missing and vague information in the proposal and subsequent Dear Tribal Leader Letter dated October 12<sup>th</sup> – which collectively indicate a clear lack of strategy for implementation and a need for more in-depth analysis.

Executive Order 13175 requires agencies to engage in widespread Tribal consultation through timely written notice before moving forward with new policies that have Tribal implications:

Policies that have [T]ribal implications” refers to regulations, legislative comments or proposed legislation, and other policy statements or actions that have substantial direct effects on one or more Indian [T]ribes, on the relationship between the

Federal Government and Indian [T]ribes, or on the distribution of power and responsibilities between the Federal Government and Indian [T]ribes.<sup>1</sup>

In IHS' Dear Tribal Leader Letter, dated October 5<sup>th</sup>, the stated purpose of the realignment is to provide greater Headquarters oversight, to clarify day-to-day functions and to create more transparent lines of accountability. In addition, IHS stated that they plan to make management processes changes to improve IHS area procurement planning and budget monitoring. Making fundamental changes to the way the Headquarters office operates has a direct effect on Tribes and will no doubt affect the relationship between the Federal Government and Tribes. Therefore this proposal has clear Tribal implications and formal Tribal consultation, as required by Executive Order 13175 and HHS' and IHS' own Tribal consultation policies, must occur.

Meaningful Tribal Consultation also means that there must be adequate notice to Tribes and provide enough time for thoughtful discussion and input. Thirty (30) days is not enough time to provide notice to Tribes about the substantive content of IHS' proposal, nor is it adequate time to decipher all of the potential consequences of IHS' proposal. For example, the Dear Tribal Leader Letter assures Tribes that this realignment will not impact Tribal shares, yet the cost of these administrative changes, in particular the formation of entirely new departments, must be accounted for somewhere. Clearly, an in-depth analysis is needed before Tribes can adequately analyze the information and provide thoughtful comments. While we appreciate that IHS has conducted an in-person session on the proposal, limiting consultation to one session is not within the spirit of meaningful consultation and does not respect the government-to-government relationship between Tribes and the Federal Government.

Of particular concern is the manner in which this proposal was presented to Tribes. On a conference call held September 29<sup>th</sup>, IHS provided a brief overview of the new Headquarters structure. It was unclear from the presentation exactly what the impact is for all regions (regardless of service delivery method) with regard to the development of new offices and divisions and shifting responsibilities. In requesting the extension for comments, our Tribal Nations wish to better understand the true impact of these changes and partner with IHS to ensure that the desired outcomes for all Tribal citizens are achieved. The presentation of additional new offices and divisions and shifted responsibilities has not been adequately outlined for Tribes to consider nor does it do enough to explain what the true impact the proposed IHS Headquarters realignment will have on the delivery of services to Tribes.

We appreciate IHS' effort to be responsive to the quality of care crisis and the prioritization of workforce development, but this proposal does not match the partnership and momentum Tribes, IHS and the Obama Administration have built over the last eight (8) years. We hope that you consider our request, provide additional time for consultation, and delay implementation until Tribes have developed a strategic vision and thoughtful feedback to bring IHS care to industry standards.

Sincerely,

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<sup>1</sup> Executive Order 13175, Sec. 2, 65 Fed. Reg. 67249 (November 9, 2000).

/Lester Secatero/

Lester Secatero  
Chairman, National Indian Health Board

/Merilynn Malerba/

Marilynn (Lynn) Malerba  
Chairwoman, Tribal Self-Governance Advisory Committee

/Nicolas Barton/

Nicolas Barton  
Chairman, Direct Service Tribes Advisory Committee

/Ashley Tuomi/

Ashley Tuomi  
President, National Council of Urban Indian Health

/Brian Patterson/

Brian Patterson  
President, United South and Eastern Tribes Sovereignty Protection Fund





## SOUTHERN INDIAN HEALTH COUNCIL, INC.

4058 Willows Road • Alpine, CA 91901-1620  
Mailing: P.O. Box 2128 • Alpine, CA 91903-2128  
(619) 445-1188 • FAX (619) 445-4131

October 24, 2016

Via E-Mail: [consultation@ihs.gov](mailto:consultation@ihs.gov)

Mary Smith  
Principal Deputy Director  
Indian Health Service  
5600 Fishers Lane  
Mail Stop: 08E86  
Rockville, MD 20857

### **RE: Request to Extend Comment Period on Proposed IHS Realignment**

Dear Ms. Smith.

On behalf of Southern Indian Health Council, Inc. (SIHC) I, on behalf of each of the seven Federally recognized Tribes represented by Southern Indian Health Council, Inc., write to request that the comment period be extended an additional 60 days to allow for a thoughtful response. Accordingly, SIHC requests that implementation of the proposal be delayed until meaningful Tribal Consultation has occurred with adequate notification. We ask this in light of the fact that much of the realignment as described by IHS is in direct response to the gaps in the delivery of the care in the Great Plains area. While we emphatically support addressing all the care provision issues experienced by the Great Plains nations, we wish to make sure that any realignment takes all regions into consideration; particularly those that have been performing well as well the implications to Self-Governance health consortium clinics, such as SIHC. We believe accountability at the level closest to the region will provide the best result and as such we should look to institute best practices in each region utilizing a structure at IHS headquarters that supports this effort. We ask for this extension for the following reasons:

1. This proposal fails to adhere to Presidential Executive Order 13175 as well as the Department of Health and Human Services (HHS) and the IHS Tribal Consultation Policies; and
2. Thirty (30) Days is not enough time to provide IHS with thoughtful, meaningful, input on the proposal; and
3. Missing and vague information in the proposal and subsequent Dear Tribal Leader Letter dated October 12<sup>th</sup> – which collectively indicates a clear lack of strategy for implementation and a need for more in-depth analysis.

Executive Order 13175 requires agencies to engage in widespread Tribal consultation through timely written notice before moving forward with new policies that have Tribal implications:

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# SOUTHERN INDIAN HEALTH COUNCIL, INC.

between the Federal Government and Indian [T]ribes, or on the distribution of power and responsibilities between the Federal Government and Indian [T]ribes.<sup>1</sup>

In IHS' Dear Tribal Leader Letter, dated October 5<sup>th</sup>, the stated purpose of the realignment is to provide greater Headquarters oversight, to clarify day-to-day functions and to create more transparent lines of accountability. In addition, IHS stated that they plan to make management processes changes to improve IHS area procurement planning and budget monitoring. Making fundamental changes to the way the Headquarters office operates has a direct effect on Tribes and will no doubt affect the relationship between the Federal Government and Tribes. Therefore this proposal has clear Tribal implications and formal Tribal consultation, as required by Executive Order 13175 and HHS' and IHS' own Tribal consultation policies, must occur.

Meaningful Tribal Consultation also means that there must be adequate notice to Tribes and provide enough time for thoughtful discussion and input. Thirty (30) days is not enough time to provide notice to Tribes about the substantive content of IHS' proposal, nor is it adequate time to decipher all of the potential consequences of IHS' proposal. For example, the Dear Tribal Leader Letter assures Tribes that this realignment will not impact Tribal shares, yet the cost of these administrative changes, in particular the formation of entirely new departments, must be accounted for somewhere. Clearly, an in-depth analysis is needed before Tribes can adequately analyze the information and provide thoughtful comments. While we appreciate that IHS has conducted an in-person session on the proposal, limiting consultation to one session is not within the spirit of meaningful consultation and does not respect the government-to-government relationship between Tribes and the Federal Government.

Of particular concern is the manner in which this proposal was presented to Tribes. On a conference call held September 29<sup>th</sup>, IHS provided a brief overview of the new Headquarters structure. It was unclear from the presentation exactly what the impact is for all regions (regardless of service delivery method) with regard to the development of new offices and divisions and shifting responsibilities. In requesting the extension for comments, our Tribal Nations wish to better understand the true impact of these changes and partner with IHS to ensure that the desired outcomes for all Tribal citizens are achieved. The presentation of additional new offices and divisions and shifted responsibilities has not been adequately outlined for Tribes to consider nor does it do enough to explain what the true impact the proposed IHS Headquarters realignment will have on the delivery of services to Tribes.

Southern Indian Health Council, Inc. has particular concerns regarding functionality, impact on a Self-Governance facility, as well as the impact on the staff and programming at IHS. To reiterate, quality and accessibility to healthcare is at the core of all SIHC efforts. However, what works within one setting, especially where the Areas are set-up differently, is very different than what works in another Area. In order to be most responsive and adherent to not only the "letter" of the intention behind IHS, but also the "spirit", the extension is requested to not only allow for meaningful Consultation, but also to allow meaningful thought and purpose behind a re-alignment or re-organization of programs.

We appreciate IHS' effort to be responsive to the quality of care crisis and the prioritization of workforce development, but this proposal does not match the partnership and momentum Tribes, IHS and the Obama Administration have built over the last eight (8) years. We hope that you

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# SOUTHERN INDIAN HEALTH COUNCIL, INC.

consider our request, provide additional time for consultation, and delay implementation until Tribes have developed a strategic vision and thoughtful feedback to bring IHS care to industry standards.

If you have any questions or wish to discuss these comments further, please contact SIHC's Chief Executive Officer, Carolina Manzano, at (619) 445-1188 or via email at [cmanzano@sihc.org](mailto:cmanzano@sihc.org). Thank you.

Sincerely,

/Gwendolyn Parada/

Gwendolyn Parada  
Chairwoman, Southern Indian Health Council, Inc.

cc: Carolina Manzano, Chief Executive Officer, Southern Indian Health Council, Inc.



**OFFICE OF THE GOVERNOR**

The Chickasaw Nation

Post Office Box 1548 • Ada, Oklahoma 74821

(580) 436-2603 • Fax (580) 436-4287

<http://www.chickasaw.net>

BILL ANOATUBBY  
GOVERNOR

October 25, 2016

Ms. Elizabeth Fowler  
Deputy Director for Management Operations  
Indian Health Service  
5600 Fishers Lane  
Mail Stop: 08E53  
Rockville, MD 20857

Dear Ms. Fowler:

On behalf of the Chickasaw Nation, we are pleased to offer comments and recommendations on the Indian Health Service Headquarters Realignment. Our comments are included with this letter.

If you have any questions, please contact Dr. Judy Goforth Parker, secretary of the Chickasaw Nation Department of Health, at (580) 436-3980 or at [judy.parker@chickasaw.net](mailto:judy.parker@chickasaw.net).

Sincerely,

/Bill Anaotubby/

Bill Anoatubby, Governor  
The Chickasaw Nation

BJA: sms

Enclosure

## **COMMENTS ON INDIAN HEALTH SERVICE HEADQUARTERS REALIGNMENT**

Thank you for this opportunity to provide comments and recommendations on the Indian Health Service (IHS) Headquarters Realignment. The Chickasaw Nation appreciates the agency's review and response to a systematic lack of oversight for ensuring compliance with various standards and requirements and attempt to achieve improvements in the agency's performance by better aligning the agency's structure and processes.

Although we appreciate the agency engaging tribes on these organizational changes, we are disappointed to be only included at the end of the process, rather than at the conceptualization stage. We certainly believe these decisions meet the level of a critical event that will have substantive impact on tribal governments as described in the Tribal Consultation Policy.

### **Chickasaw Nation Comments and Recommendations:**

- It appears the organizational changes proposed for headquarters operations will bring positive changes, clarify roles/responsibilities, bring consistency and accountability and new emphasis on quality, workforce and hands-on involvement of the chief medical officer, as is common in local tribal health infrastructure.
- The associate director for intergovernmental affairs and the offices within intergovernmental affairs:
  - The Office of Tribal Self Governance (OTSG), formed in the mid-1990s, has remained in the office of the director over strong advocacy of the tribes. On April 10, 1997, then director Trujillo specifically concurred with this position, stating that because OTSG implements the Self-Governance Project in a true government-to-government basis, "...the Director, OTSG reports directly to the Director, IHS. As such, the Director, OTSG, has full authority to carry out the responsibilities of the OTSG."
  - The office of direct service tribes, which has emerged as a sister-office in the agency, is required by section 1663 of the Indian Healthcare Improvement Act to be included in the office of the director of the IHS.
  - Because these two offices are the most direct means of contact with tribal governments, we strongly recommend that they remain in the office of the director.
  - Although the deputy director of intergovernmental affairs was created several years ago and had line-authority over the OTSG and Office of Direct Service and Contracting Tribes (ODSCT), this position has not had any added value for either the tribes or the agency.
  - It is our recommendation that in the interest of utilizing resources in the most useful way and to avoid keeping an unnecessary administrative/bureaucratic layer between the OTSG and ODSCT and the office of the director, that an associate director for intergovernmental affairs not be created.



**COMMENTS ON INDIAN HEALTH SERVICE  
HEADQUARTERS REALIGNMENT  
(Continued, Page 2)**

- The office of urban Indian health is not an office with government-to-government responsibilities to tribes, but rather coordinates sub-awards to non-profit urban entities to deliver important and critical health care services in urban areas. As such, we recommend that the office be located under the associate director for field operations.
- While we understand telemedicine to be a very useful tool in delivering healthcare services, it is a means to provide care, not a type of care. We are unclear why it is a stand-alone office under the Chief Medical Officer (CMO), when each of the disciplines may employ telemedicine as it is determined to be a feasible means of delivery. Setting up a stand-alone office may create more silos/barriers (additional approvers) in the organization to employ this tool, rather than instead gaining the emphasis on innovative methods of service delivery that is desired.
- It is unclear why office of program evaluation is located under the associate director of analysis, rather than under quality. If the effectiveness of programs (in addition to quality/compliance) is important to the agency, it would seem important to ensure that program evaluation is employed readily as a means to continuously improve operations either under the associate director for quality, or the CMO. For instance, office of improving patient care is under the associate director for quality, which has components that can be viewed as an evaluation model that perhaps should be replicated in other programs.
- There has been an increasing need over the last many years to place a high priority on information technology. This need is not expected to diminish, but rather to increase as value-based payments for healthcare services are increasingly employed across many payors for healthcare (both public and private). IT will need to continue to be a high priority and focus to provide the data upon which to make good justification for appropriation increases as well. Finally, it provides data upon which to make informed decisions about strategically how best to move the needle forward on improving health status of Indians, what portions of the system are high performing and where improvement is needed. Since our system (Resource Patient Management System (RPMS)) is proprietary, we simply cannot afford to let down at all on keeping it as modernized as possible and responsive to these increasing needs. At a minimum, major investments and perhaps replacement of RPMS is critical in the years to come. It must be aligned, elevated and have clear purpose and direction to support the overall health system. We, therefore, recommend that the associate director of analysis/evaluation become instead the Chief Information Officer (CIO), with health information technology, office of epidemiology, office of statistics, and office of research and analysis reporting to the CIO.

**COMMENTS ON INDIAN HEALTH SERVICE  
HEADQUARTERS REALIGNMENT  
(Continued, Page 3)**

- Finally, because the Indian health care system, both federally operated and tribally operated programs, rely so heavily on third-party revenues to support the recurring level of healthcare programs being provided, we recommend that an office of revenue enhancement or something similar be included under the chief operating officer. IHS, as a general rule, simply does not maximize collections, where every additional dollar has the potential to improve and expand health care services. We strongly recommend this become an emphasis, to bring in all available revenues to improve quality and quantity of services provided to American Indians/Alaska Natives.

Thank you again for allowing the Chickasaw Nation to provide input on the proposed IHS realignment. We look forward to continue working with you and your staff in our partnership to provide access to quality care for all of our tribal citizens.



# GILA RIVER INDIAN COMMUNITY

*Executive Office of the Governor & Lieutenant Governor*

*"Putting Our People First"*

*Stephen Roe Lewis*  
Governor



*Monica Lynn Antone*  
Lieutenant Governor

October 26, 2016

Mary Smith  
Principal Deputy Director  
Indian Health Service  
5600 Fishers Lane  
Mail Stop: 08E86  
Rockville, MD 20857

EXECUTIVE SECRETARIAT  
INDIAN HEALTH SERVICE  
2016 OCT 27 AM 11:00

## **RE: Request to Extend Comment Period on Proposed IHS Realignment**

Dear Ms. Smith.

On behalf of the Gila River Indian Community (the "Community"), I request that the comment period be extended an additional 6 months to allow for a thoughtful response. Accordingly, I request that implementation of the proposal be delayed until meaningful Tribal Consultation has occurred with adequate notification. I ask this in light of the fact that much of the realignment as described by IHS is in direct response to the gaps in the delivery of the care in the Great Plains area. While I emphatically support addressing all the care provision issues experienced by the Great Plains nations, I wish to make sure that any realignment takes all regions into consideration; particularly those that have been performing well. I believe accountability at the level closest to the region will provide the best result and as such I should look to institute best practices in each region utilizing a structure at IHS headquarters that supports this effort. I ask for this extension for the following reasons:

1. This proposal fails to adhere to Presidential Executive Order 13175 as well as the Department of Health and Human Services (HHS) and the IHS Tribal Consultation Policies; and
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In IHS’ Dear Tribal Leader Letter, dated October 5<sup>th</sup>, the stated purpose of the realignment is to provide greater Headquarters oversight, to clarify day-to-day functions and to create more transparent lines of accountability. In addition, IHS stated that they plan to make management processes changes to improve IHS area procurement planning and budget monitoring. Making fundamental changes to the way the Headquarters office operates has a direct effect on Tribes and will no doubt affect the relationship between the Federal Government and Tribes. Therefore this proposal has clear Tribal implications and formal Tribal consultation, as required by Executive Order 13175 and HHS’ and IHS’ own Tribal consultation policies, must occur.

Meaningful Tribal Consultation also means that there must be adequate notice to Tribes and provide enough time for thoughtful discussion and input. Thirty (30) days is not enough time to provide notice to Tribes about the substantive content of IHS’ proposal, nor is it adequate time to decipher all of the potential consequences of IHS’ proposal. For example, the Dear Tribal Leader Letter assures Tribes that this realignment will not impact Tribal shares, yet the cost of these administrative changes, in particular the formation of entirely new departments, must be accounted for somewhere. Clearly, an in-depth analysis is needed before Tribes can adequately analyze the information and provide thoughtful comments. While I appreciate that IHS has conducted an in-person session on the proposal, limiting consultation to one session is not within the spirit of meaningful consultation and does not respect the government-to-government relationship between Tribes and the Federal Government.

Of particular concern is the manner in which this proposal was presented to Tribes. On a conference call held September 29<sup>th</sup>, IHS provided a brief overview of the new Headquarters structure. It was unclear from the presentation exactly what the impact is for all regions (regardless of service delivery method) with regard to the development of new offices and divisions and shifting responsibilities. In requesting the extension for comments, the Community wishes to better understand the true impact of these changes and partner with IHS to ensure that the desired outcomes for all Tribal citizens are achieved. The presentation of additional new offices and divisions and shifted responsibilities has not been adequately outlined for Tribes to consider nor does it do enough to explain what the true impact the proposed IHS Headquarters realignment will have on the delivery of services to Tribes.

I appreciate IHS’ effort to be responsive to the quality of care crisis and the prioritization of workforce development, but this proposal does not match the partnership and momentum Tribes, IHS and the Obama Administration have built over the last eight (8) years. We hope that you consider our request, provide additional time for consultation, and delay implementation until Tribes have developed a strategic vision and thoughtful feedback to bring IHS care to industry standards.

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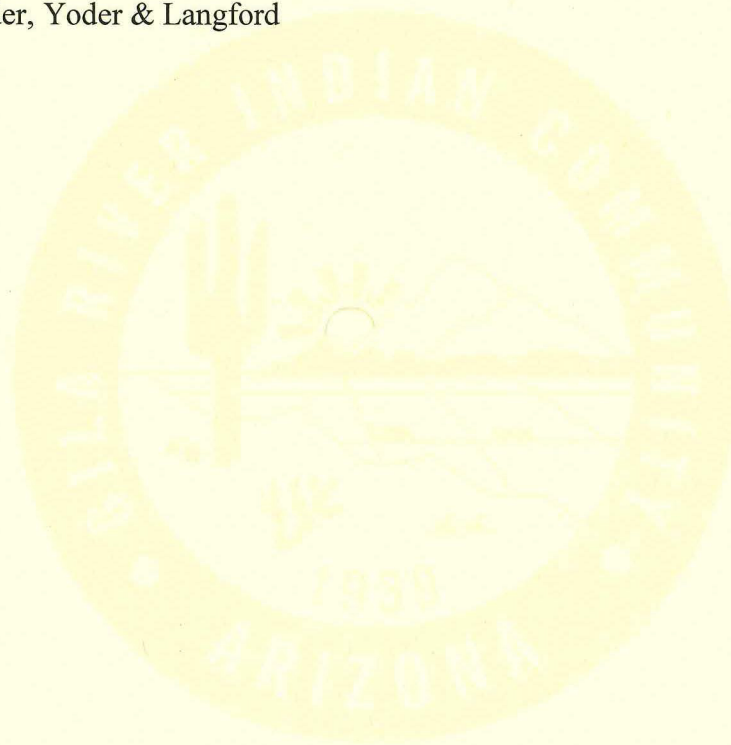
<sup>1</sup> Executive Order 13175, Sec. 2, 65 Fed. Reg. 67249 (November 9, 2000).

Sincerely,

/Stephen R. Lewis/

Stephen R. Lewis, Governor  
Gila River Indian Community

cc: Carol Schurz, Chair, Health and Social Standing Committee  
Carolyn Williams, Health and Social Standing Committee  
Joey Whitman, Health and Social Standing Committee  
Sandra Nasewytewa, Health and Social Standing Committee  
Lisa Shelde, Health and Social Standing Committee  
Myron Schurz, President, GRHC  
Ginger Fligger, CEO, GRHC  
Robert Yoder, Yoder & Langford





Sent electronically [mary.smith@ihs.gov](mailto:mary.smith@ihs.gov);  
[denise.turk@ihs.gov](mailto:denise.turk@ihs.gov)

October 31, 2016

Mary Smith  
Principal Deputy Director  
Indian Health Service  
Department of Health and Human Services  
5600 Fishers Lane  
Mail Stop: 08E86  
Rockville, MD 20857

**Re: Support for Proposed Indian Health Service Realignment Strategy**

Dear Ms. Smith:

On behalf of the Jamestown S'Klallam Tribe, I write to endorse the Indian Health Service (IHS) Realignment Strategy that was proposed in the *Dear Tribal Leader Letter* dated October 5, 2016 and presented at the Tribal Self-Governance Advisory Committee Quarterly Meeting on October 27, 2016. We believe that the Reorganizational Plan is well-thought out in terms of staff roles and lines of authority and provides clarity and transparency regarding the inner workings of the Agency.

Although the Agency is charged with raising the health status of American Indian/Alaska Natives to the highest level through the provision of quality healthcare, there were a number of concerns raised by the Office of the Inspector General and Government Accountability Office Reports that noted a lack of systematic oversight for ensuring compliance with Agency-wide standards and requirements. We understand that you believe these proposed changes will address these concerns by clearly outlining the administrative and programmatic functions of IHS Senior Leadership, strengthening quality infrastructure and creating an Associate Director for Healthcare Workforce Development who will be responsible for building a pathway for an adequately sized professional workforce. We support the Agency's effort to respond to the quality of care crisis and the prioritization of workforce development and understand your position that time is of the essence to move this agenda forward. However, in the future we would strongly advise the Agency to adhere to its Consultation Policy and the requirement for Tribal engagement on matters that substantially affect Tribal interests.

While the proposed changes do not resolve all of the healthcare challenges due to the lack of adequate resources, we believe this realignment proposal is a step in the right direction on the path forward. If you have any questions and/or concerns, please don't hesitate to contact me at 206-369-6699 or via email at [rallen@jamestowntribe.org](mailto:rallen@jamestowntribe.org).

Sincerely,

/W. Ron Allen/

W. Ron Allen, Tribal Chairman/CEO

Cc: National Indian Health Board  
National Congress of American Indians

*Nicholas F. Garcia*  
Governor



*Everett P. Herrera*  
Lt. Governor

P.O. Box 70  
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November 1, 2016

Elizabeth Fowler,  
Deputy Director for Management Operations,  
Indian Health Service  
3600 Fishers Lane  
Mail Stop:08E53  
Rockville, MD 20857

Email: [consultation@ihs.gov](mailto:consultation@ihs.gov)

Attn: Headquarters Realignment

Dear Ms. Fowler,

The Pueblo de Cochiti will provide comments, recommendations, questions and observations to your October 5, 2016 letter asking tribal leaders on input to the proposed realignment of the IHS Headquarters functions. The OIG and the GAO has identified deficiencies in management and compliance issues at all levels of the Agency. These comments are being made in good faith after a cursory review of the various changes and updates made in previous years.

The IHS agency is not what it was 5 and 10 years ago. The compacting and contracting under PL 93-638 has allowed tribes to assume much of the administrative, clinical and operational functions and services of IHS. Based on whatever percentage of IHS remains under IHS federal control should be reflected in the basic design and responsibility of drafting the reorganization functions of Headquarters. In addition, an identification by percentage and funding of all inherently federal Residual functions should be the starting point of your reorganization planning.

There appears to be some duplication of functions within the various offices in their descriptions of services, some services have remained the same since the original functions were described, and some services have not been provided ie: Indians Children's Program, due to no staffing and monitoring of those offices.



There are numerous mentions of national workload reports, evaluations, inventories and priority tools and instruments. Where are these 'evaluation of clinical, preventive and public health of community based programs' or application of 'program standards, evaluation of community and area wide services provided through grants and contracts with AI/AN tribes and organizations and direct services provided'? Is there a depository or electronic inventory of these reports and evaluations? In addition, there is a huge need on national and area workload reports, epidemiological profiles, morbidity and mortality trends, facility reports and reports to be made to Congress under various laws. These reports have not been made available to tribes, IHS, Congress and various other governmental entities.

Those functions that are inherently administrative in nature and from the Office of the Director, Legislative Affairs, Public Affairs, Personnel, Budgets, Contracting, Grants and Acquisition and inherently Federal should be operated based on residual responsibilities and appropriate percent currently under federal management and control. These Offices should be reporting to Congress, HHS and legislative inquiries.

The OIT, Division of Health information and informatics, Project Management and Budget, DITO, DIS and support are major functions needed by Tribes who have contracted PFSAs. The descriptions noted in these divisions are not universally offered nor completed in all areas and services not uniform to all tribes. This is a critical component for those tribes who remain with the RPMS system for their clinical, administrative, GPRA, Revenue cycle billing and collecting, and workload data. All the Offices/Divisions mention cross cutting issues, technology improvements, enterprise project management and other IT functions, however a listing and updated capabilities need to be promulgated to tribal IT users. How many tribes remain or left their shares with IT associated services? Is there a report or compilation of what IT services have been provided and what cross cutting issues have been addressed? Is there a website to review such issues and changes?

All the functions described under Associate Director of Quality are written well and needed. Are these written for IHS operated facilities only? These functions are central to all clinical operations however such services described have not been publicly documented, used for training, placed on best practices listing, lessons learned website or reported. It would be nice to see the documentation of 'monitoring of quality improvement and assurance metrics for healthcare delivery processes and outcomes including the standardization of healthcare delivery protocols and policies'.

All the offices and Divisions describe monitoring and evaluation of services within the various disciplines. Is there Headquarters reports, evaluation and data of services provided by Headquarters staff for tribes and other agencies to view for productivity and transparency? Are there reports submitted to HHS from IHS? Who is monitoring the Headquarters staff? What metrics are being used to evaluate Headquarter offices?



How are communications sent up and down the chain of command from Service Units to Areas to Headquarters? It would be a recommendation that Area staff review the Headquarters functions and provide input, in writing, with input from Service Unit staff. Your letter indicates a need promote fiscal accountability and transparency down to the Area and Service Unit level and staff at these levels need to provide input on what plans will be created to meet this directive.

Thank you for soliciting our comments from the community levels and thank you for your advocacy in IHS funding. If you have any questions call Iris Reano at 505-465-3100.

Respectfully Submitted,

/Nicholas F. Garcia/

Nicholas F. Garcia, Governor  
Pueblo de Cochiti





# Choctaw Nation of Oklahoma

PO Box 1210 • Durant, Oklahoma 74702-1210 • (580) 924-8280

Gary Batton  
Chief

Jack Austin, Jr  
Assistant Chief

November 2, 2016

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

RE: Comments on Headquarters Realignment

Dear Principal Deputy Director Smith,

This letter is in response to your Dear Tribal Leader Letter dated October 5, 2016, requesting Tribal Consultation on a draft realignment of the Indian Health Service (IHS) Headquarters Office. Overall, the Nation views this first interaction as a positive first step to better articulate roles and responsibilities. However, we offer the following comments to consider regarding how the structure and functional statements can be improved, in our view, to facilitate achieving IHS leadership's desired results.

1. **Improve interdepartmental relations and regulatory review.** Moving the responsibilities of the Division of Regulatory Affairs (DRA) to the Executive Secretariat does not convey the importance for IHS to work with partner agencies and departments to improve access and quality of care and account for the uniqueness of the Indian Health system. Regulation review and comment has ultimately become primarily a Tribal task. Major sets of regulations, such as those for Medicare Access and CHIP Reauthorization Act (MACRA)/ Merit Incentive Payment System are moving forward without Tribal Consultation, and we are highly concerned that Tribal comments/recommendations will not be included, resulting in negative effects on workload and reimbursement rates to IHS and Tribal facilities. These functions should be strengthened by identifying them separately from the correspondence-related activities of the Executive Secretariat, and specifically include activities that review and coordinate with other agencies prior to and during the promulgation process to develop and finalize rules that advance, and do not create barriers to Indian Health operations.
2. **Retain the Intergovernmental Affairs (IA) Group in the Office of the Director.** The offices that current report to the Deputy Director have long histories and many reasons that they report directly to the IHS Director. In particular, their placement is representative of, and sends a strong message of support for, the government-to-government relationship. Because these two offices are those with the most direct contact with Tribal governments, we strongly recommend that they remain in the Office of the Director. Additionally, the draft functional statement does not include a description for IA, nor does it reflect the proposed reporting structure for the Office of Tribal Self-Governance (OTSG) and Office of Direct Service and Contracting Tribes (ODSCT).

*Choctaws – growing as one with pride, hope and success*

Tribes have consistently advocated that these offices remain in the Office of the Director. OTSG, formed in the mid 1990's, has remained in the Office of the Director with strong support of the Tribes. On April 10, 1997, then Director Trujillo specifically concurred with this position, stating that because OTSG implements the Self-Governance Project in a true government-to-government basis, "...the Director, OTSG reports directly to the Director, IHS. As such, the Director, OTSG, has full authority to carry out the responsibilities of the OTSG." Additionally, Tribes successfully advocated to legislative mandate the creation of ODSCT. As a result, ODSCT, which has emerged as a sister-Office in the agency, is required by section 1663 of the Indian Healthcare Improvement Act to be included in the Office of the Director of the IHS.

3. **Integrate Telemedicine throughout the disciplines under the Chief Medical Officer (CMO).** While we understand Telemedicine to be a very useful tool in delivering health care services, it is a means to deliver care, not a type of care. While we support placing a priority on innovative delivery models, it is unclear why it is a stand-alone office under the CMO, when each of the disciplines may employ telemedicine as it is determined to be an efficient and effective means of delivery. Setting up a stand-alone office may create more barriers in the organization to employ this tool, rather than capitalizing on this innovative method of service delivery. The functional statement for Telemedicine also appears to be missing from the draft.
4. **Streamline Office Program Evaluation under the Associate Director of Quality.** It is unclear why "Office of Program Evaluation" is located under the Associate Director of Analysis, rather than under Quality. If the effectiveness of programs (in addition to quality/compliance) is a high priority of the agency, it would seem important to ensure that program evaluation is employed readily as a means to continuously improve operations either under the Associate Director for Quality, or the CMO. For instance, "Office of Improving Patient Care" is under the Associate Director for Quality, which has components that can be viewed as an evaluation model that perhaps should be replicated in other programs and operations.
5. **Revise the Realignment to reflect the importance of Information Technology.** There has been an increasing need over the last several years to place a high priority on Information Technology (IT). This need is not expected to diminish, but rather to increase as value-based payments for healthcare services are increasingly employed across many payors for healthcare (both public and private). IT will need to continue to be a high priority and focus to provide the data upon which to make good justification for appropriation increases as well. Finally, it provides data upon which to make informed decisions about strategically how best to move the needle forward on improving the health status of Indians, what portions of the system are high/low performing, and where improvement is needed. Since our system (RPMS) requires ongoing development and support from IHS, we simply cannot afford to rest, rather we must keep it as modernized as possible and responsive to these increasing needs. At a minimum, major investments and perhaps replacement of RPMS are critical considerations in the years to come. It must be aligned, elevated and have clear purpose and direction to support the overall health system, including becoming part of the leadership team and freedom to work cooperatively across the organization. We therefore recommend that the "Associate Director of Analysis/Evaluation" become instead the Chief Information Officer (CIO), with Health Information Technology, Office of Epidemiology, Office of Statistics, and Office of Research and Analysis reporting to the CIO.
6. **Create an Office to emphasize priority on Revenue Enhancement.** The Indian health system cannot rely solely on additional IHS appropriations to meet the ever increasing need in



Indian Country. Tribes operating their own health programs have quickly learned that the best opportunity to increase resources available for quality improvement systems and expansion of health services is through emphasizing revenue enhancement processes. These processes include benefits coordination and aggressive third party payor enrollment, as well as building enterprenurial billing and collection strategies. Efforts to create additional revenue have tangible results by increasing access to direct and specialty care and improving quality of care in Tribal health programs. As such, we recommend national leadership for a revenue enhancement office be placed under the Chief Operations Officer.

7. **Expand the services and functions assigned to the Associate Director of Health Care Workforce Development.** The proposed changes to elevate the workforce challenges faced by IHS reflect a high priority need for the Indian Health System. However, the corresponding functions did not change in the functional statement. IHS should take this opportunity to better articulate current and new activities the office will administer to support the agency's goal to increase workforce development. Many of these initiatives have already been described in writing and verbally, and should be included in the functional statements.
8. **Update the Headquarters Programs, Services, Functions, and Activities (PSFA) Handbook.** These proposed changes undoubtedly create the need to update the PSFA Handbook and to identify Tribal Shares and inherent federal functions. The PSFA Handbook has not been updated since 2000, and without a recent update, its usefulness to Tribes, particularly new contracting and compacting Tribes, is significantly diminished.

Thank you for the opportunity to comment and provide recommendations to the proposed Realignment of the IHS Headquarters, and we look forward to continued discussion about the future initiatives of IHS. If you have any questions or wish to discuss these comments further, please contact me at (580)924-8280, extension 2240 or via email at [mpeercey@choctawnation.com](mailto:mpeercey@choctawnation.com).

Sincerely,

/Mickey Peercy/

Mickey Peercy, LCSW  
Executive Director of Self Governance



# THE NAVAJO NATION

RUSSELL BEGAYE **PRESIDENT**  
JONATHAN NEZ **VICE PRESIDENT**

November 3, 2016

Mary Smith, Principal Deputy Director  
Indian Health Service  
Mail Stop: 08N34-A  
5600 Fishers Lane  
Rockville, MD 20857  
VIA EMAIL: [consultation@ihs.gov](mailto:consultation@ihs.gov)

**Subject: Headquarters Realignment**

Dear Ms. Smith:

On behalf of the Navajo Nation, I appreciate the process to consult between the Tribal Leaders and the Indian Health Services (I.H.S.) on the Headquarters Realignment.

I would like to offer support of the overall Headquarters Realignment as a strategy to improve I.H.S.' performance. The proposed updated draft organizational chart and draft Functional Statements – I.H.S. Headquarters Realignment (October 2015) presents clearer lines of senior staff leadership and oversight responsibilities. The organizational chart depicts the connections to the offices and functions for which they have responsibility and well accompanied with the functional statements. Thank you for assuring the Headquarters budget as reflected in the Headquarters Tribal Shares table is not impacted by the realignment and consequently does not change because of the realignment.

Due to the 30 day open comment period, I would like to state we may have questions specific on details of the Headquarters Realignment, or unforeseen adverse impacts of the realignment and trust you will provide clarification, when appropriate. For additional information please contact Ramona Antone Nez, Acting Executive Director, Navajo Department of Health at (928) 871-6350 or email at [ramona.nez@nndoh.org](mailto:ramona.nez@nndoh.org).

Respectfully,

**THE NAVAJO NATION**

/Russell Begaye/

Russell Begaye, *President*



Submitted via email [consultation@ihs.gov](mailto:consultation@ihs.gov)

Mary Smith, Principal Deputy Director  
Indian Health Service  
Office of the Director  
5600 Fishers Lane  
Mail Stop: 08E53  
Rockville, MD 20857

RE: Comments on IHS Headquarters Realignment

Dear Principal Deputy Director Smith,

I write on behalf of the Alaska Native Tribal Health Consortium (ANTHC) to offer comments in response to your "Dear Tribal Leader" letter dated October 5, 2016, requesting Tribal Consultation on a draft realignment of the Indian Health Service (IHS) Headquarters Office.

ANTHC is a statewide tribal health organization that serves all 229 tribes and more than 150,000 Alaska Natives and American Indians (AN/AIs) in Alaska. Along with our partners, Southcentral Foundation, we co-manage the Alaska Native Medical Center, the tertiary care hospital for all AN/AI people in Alaska. ANTHC also provides a wide range of statewide public health, community health, environmental health and other programs and services for AN/AI people and their communities.

**Improve interdepartmental relations and regulatory review.** Moving the responsibilities of the Division of Regulatory Affairs (DRA) to the Executive Secretariat does not convey the importance for IHS to work with partner agencies and departments to improve access and quality of care and account for the unique structure of the Indian Health system. Regulation review and comment has ultimately become primarily a Tribal task. Major sets of regulations, such as those for Medicare Access and CHIP Reauthorization Act (MACRA)/ Merit Incentive Payment System are moving forward without Tribal Consultation, and we are highly concerned that Tribal comments/recommendations are not included, resulting in negative effects on workload and reimbursement rates to IHS and Tribal facilities. These functions should be strengthened by identifying them separately from the correspondence-related activities of the Executive Secretariat, and specifically include activities that review and coordinate with other agencies prior to and during the promulgation process to develop/finalize rules that advance, and do not create barriers to Indian Health operations.

**Under the Associate Director of Intergovernmental Affairs, retain the Intergovernmental Affairs (IA) Group in the Office of the Director.** The offices that currently report to the Deputy Director have long histories and many reasons that they report directly to the IHS Director. In particular, their placement is representative of, and sends a strong message of

Alaska Native Tribal Health Consortium  
4000 Ambassador Drive, Anchorage, Alaska 99508  
Main: (907) 729-1900 | Fax: (907) 729-1901 | [anthc.org](http://anthc.org)

support for, the government-to-government relationship. Because these two offices are those with the most direct contact with Tribal governments, we strongly recommend that they remain in the Office of the Director. Additionally, the draft functional statement does not include a description for IA, nor does it reflect the proposed reporting structure for the Office of Tribal Self-Governance (OTSG) and Office of Direct Service and Contracting Tribes (ODSCT).

Tribes have consistently advocated that these offices remain in the Office of the Director. OTSG, formed in the mid 1990's, has remained in the Office of the Director with strong support of the Tribes. On April 10, 1997, then Director Trujillo specifically concurred with this position, stating that because OTSG implements the Self-Governance Project in a true government-to-government basis, "...the Director, OTSG reports directly to the Director, IHS. As such, the Director, OTSG, has full authority to carry out the responsibilities of the OTSG." Additionally, Tribes successfully mandated the creation of ODSCT in statute. As a result, ODSCT has emerged as a sister-Office in the agency and is required by section 1663 of the Indian Healthcare Improvement Act to be included in the Office of the Director of the IHS.

**Update the Headquarters Programs, Services, Functions, and Activities (PSFA) Handbook.**

These proposed changes undoubtedly create the need to update the PSFA Handbook and to identify Tribal Shares and inherent federal functions. The PSFA Handbook has not been updated since 2000, and without a recent update, its usefulness to Tribes, particularly new contracting and compacting Tribes, is significantly diminished.

Thank you for your consideration of our recommendations. Please do not hesitate to contact me at 907-729-1908 or via email [gmoses@anthc.org](mailto:gmoses@anthc.org) with questions, or if I can provide any additional information.

Sincerely,

/Gerald Moses/

Gerald Moses  
Senior Director of Intergovernmental Affairs



# IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education  
P.O. Box 1734, McAlester, OK 74501

Telephone (918) 302-0252 ~ Facsimile (918) 423-7639 ~ Website: [www.tribalselfgov.org](http://www.tribalselfgov.org)

Sent electronically to [consultation@ihs.gov](mailto:consultation@ihs.gov)

November 4, 2016

Mary Smith, Principal Deputy Director  
Indian Health Service  
Office of the Director  
5600 Fishers Lane  
Mail Stop: 08E53  
Rockville, MD 20857

## **RE: Comments on Headquarters Realignment**

Dear Principal Deputy Director Smith,

On behalf of the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC), this letter is in response to your *Dear Tribal Leader Letter* dated October 5, 2016, requesting Tribal Consultation on a draft realignment of the IHS Headquarters Office. Overall, the Nation views this first iteration as a positive first step to better articulate roles and responsibilities. However, we offer the following comments to consider regarding how the structure and functional statements can be improved, in our view, to facilitate achieving IHS leadership's desired results.

- 1. Improve interdepartmental relations and regulatory review.** Moving the responsibilities of the Division of Regulatory Affairs (DRA) to the Executive Secretariat does not convey the importance for IHS to work with partner agencies and departments to improve access and quality of care and account for the uniqueness of the Indian Health system. Regulation review and comment have ultimately become primarily a Tribal task. Major sets of regulations, such as those for Medicare Access and CHIP Reauthorization Act (MACRA)/ Merit Incentive Payment System are moving forward without Tribal Consultation, and we are highly concerned that Tribal comments/recommendations are not included, resulting in negative effects on workload and reimbursement rates to IHS and Tribal facilities. These functions should be strengthened by identifying them separately from the correspondence-related activities of the Executive Secretariat, and specifically include activities that review and coordinate with other agencies prior to and during the promulgation process to develop/finalize rules that advance, and do not create barriers to Indian Health operations.
- 2. Retain the Intergovernmental Affairs (IA) Group in the Office of the Director.** The offices that currently report to the Deputy Director have long histories and many reasons that they report directly to the IHS Director. In particular, their placement is representative of, and sends a strong message of support for, the government-to-government relationship. Because the Office of Tribal Self-Governance (OTSG) and Office of Direct Service and Contracting Tribes (ODSCT) are those with the most direct contact with Tribal governments, we strongly recommend that they remain in the Office of the Director, with the IA leadership reporting directly to the Director. Additionally, the draft functional statement does not include a description for IA, nor does it reflect the proposed reporting structure for the OTSG and ODSCT.

Tribes have consistently advocated that these offices remain in the Office of the Director. OTSG, formed in the mid 1990's, has remained in the Office of the Director with strong support of the Tribes. On April 10, 1997, then Director Trujillo specifically concurred with this position, stating that because OTSG implements the Self-Governance Project in a true government-to-government basis, "...the Director, OTSG reports directly to the Director, IHS. As such, the Director, OTSG, has full authority to carry out the responsibilities of the OTSG." Additionally, Tribes successfully advocated to legislatively mandate the creation of ODSCT. As a result, ODSCT, which has emerged as a sister-office in the agency, is required by section 1663 of the Indian Healthcare Improvement Act to be included in the Office of the Director of the IHS.

3. **Integrate telemedicine throughout the disciplines under the Chief Medical Officer (CMO).** While we understand telemedicine to be a very useful tool in delivering health care services, it is a means to deliver care, not a type of care. While we support placing a priority on innovative delivery models, it is unclear why it is a stand-alone office under the CMO, when each of the disciplines may employ telemedicine as it is determined to be an efficient and effective means of delivery. Setting up a stand-alone office may create more barriers in the organization to employ this tool, rather than capitalizing on this innovative method of service delivery. The functional statement for Telemedicine also appears to be missing from the draft.
4. **Streamline Office Program Evaluation under the Associate Director of Quality.** It is unclear why the "Office of Program Evaluation" is located under the Associate Director of Analysis, rather than under Quality. If the effectiveness of programs (in addition to quality/compliance) is a high priority of the agency, it would seem important to ensure that program evaluation is employed readily as a means to continuously improve operations either under the Associate Director for Quality, or the CMO. For instance, the "Office of Improving Patient Care" is under the Associate Director for Quality, which has components that can be viewed as an evaluation model that perhaps should be replicated in other programs and operations.
5. **Revise the Realignment to reflect the importance of Information Technology (IT).** There has been an increasing need over the last many years to place a high priority on IT. This need is not expected to diminish, but rather to increase as value-based payments for healthcare services are increasingly employed across many payors for healthcare (both public and private). IT will need to continue to be a high priority and focus to provide the data upon which to make good justification for appropriation increases as well. Finally, it provides data upon which to make informed decisions about strategically how best to move the needle forward on improving health status of American Indians and Alaska Natives (AI/AN), what portions of the system are high performing, and where improvement is needed. Since our system, Reporting and Patient Management System (RPMS), requires ongoing development and support from IHS, we simply cannot afford to rest, rather we must keep it as modernized as possible and responsive to these increasing needs. At a minimum, major investments and perhaps replacement of RPMS are critical considerations in the years to come. It must be aligned, elevated and have clear purpose and direction to support the overall health system, including becoming part of the leadership team and freedom to work cooperatively across the

- organization. We therefore recommend that the “Associate Director of Analysis/Evaluation” become instead the Chief Information Officer (CIO), with the Office of Health Information Technology, Office of Epidemiology, Office of Statistics, and Office of Research and Analysis reporting to the CIO.
6. **Create an Office to emphasize priority on Revenue Enhancement.** The Indian health system cannot rely solely on additional IHS appropriations to meet the ever increasing need in Indian Country. Tribes operating their own health programs have quickly learned that the best opportunity to increase resources available for quality improvement systems and expansion of health services is through emphasizing revenue enhancement processes. These processes include benefits coordination and aggressive enrollment, as well as building entrepreneurial billing and collection strategies. Efforts to create additional revenue have tangible results by increasing access to direct and specialty care and improving quality of care in Tribal health programs. As such, we recommend national leadership for a revenue enhancement office be placed under the Chief Operations Officer.
  7. **Expand the services and functions assigned to the Associate Director of Health Care Workforce Development.** The proposed changes to elevate the workforce challenges faced by IHS reflect a high priority need for the Indian Health System. However, the corresponding functions did not change in the functional statement. IHS should take this opportunity to better articulate current and new activities the office will administer to support the agency’s goal to increase workforce development. Many of these initiatives have already been described in writing and verbally, and should be included in the functional statements.
  8. **Update the Headquarters Programs, Services, Functions, and Activities (PSFA) Handbook.** These proposed changes undoubtedly create the need to update the PSFA Handbook and to identify Tribal Shares and inherent federal functions. The PSFA Handbook has not been updated since 2000, and without a recent update, its usefulness to Tribes, particularly new contracting and compacting Tribes, is significantly diminished.
  9. **Describe where the funding will be provided for newly created offices and functions.** Although we are able to cross-walk many of the offices, functions and positions from the previous organization to the proposed structure, TSGAC requests additional information about the functions and funding for newly created offices, such as the Associate Director of Workforce Improvement.
  10. **Communicate the results of Tribal comments and evaluation results of the new structure.** TSGAC requests follow up communication at the conclusion of the comment period including all comments received and plans to address the feedback provided. Additionally, we request a formal evaluation of the organizational changes at the six and twelve month marks. The future evaluations should occur in formal consultation with Tribes with the purpose to evaluate whether the Realignment fulfills the initial intent.

In summary, we appreciate and specifically note this statement in your October 5, 2016 letter, “Let me assure you that the Headquarters budget as reflected on the Headquarters Tribal Shares tables is not impacted by this realignment and consequently does not change because of the realignment.” TSGAC also appreciates the opportunity you afforded leadership during the

recent October Quarterly meeting and suggest that IHS consider hosting a similar webinar to more detailed information to Tribes and allow for an additional question and answer session.

Thank you for the opportunity to comment and provide recommendations on the proposed Realignment. We hope that you include the above recommendations and look forward to your response to the joint request for an extended comment period made on October 17, 2016. As always, if you have any questions or wish to discuss these comments further, please contact me at (860) 862-6192 or via email at [lmalerba@moheganmail.com](mailto:lmalerba@moheganmail.com).

Sincerely,

/Chief Lynn Malerba/

Chief Lynn Malerba, Mohegan Tribe of Connecticut  
Chairwoman, IHS TSGAC

cc: Jennifer Cooper, Acting Director, Office of Tribal Self-Governance, IHS  
TSGAC Members and Technical Workgroup



## **Buckley, Michael W. (IHS/HQ)**

---

**From:** Francys Crevier <FCrevier@ncuih.org>  
**Sent:** Friday, November 04, 2016 9:42 PM  
**To:** IHS - Consultation; Confer with Urban Programs  
**Subject:** NCUIH IHS Realignment  
**Attachments:** 2016\_1104\_IHS Realignment.pdf

Dear Principal Deputy Director Smith,

Please see our attached comments regarding the IHS Realignment. Thank you.



**Francys Crevier, J.D.**  
*Policy Analyst and Congressional Relations Liaison*  
924 Pennsylvania Ave SE  
Washington, DC 20003  
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# National Council of Urban Indian Health



Submitted via: [consultation@ihs.gov](mailto:consultation@ihs.gov); [urbanconfer@ihs.gov](mailto:urbanconfer@ihs.gov)

November 4, 2016

Principal Deputy Director Mary Smith  
Indian Health Service  
Attention: IHS Draft Quality Framework  
5600 Fishers Lane  
Mail Stop: 08E86  
Rockville, Maryland 20857

**RE: Comments on Headquarters Realignment**

Dear Principal Deputy Director Smith:

On behalf of National Council of Urban Indian Health (NCUIH), this letter is in response to your Dear Urban Indian Organization Leader Letter dated October 5, 2016, requesting Urban Confer on a draft realignment of the IHS Headquarters Office.

The National Council of Urban Indian Health was founded 18 years ago to represent the interests of Urban Indian Health Programs (UIHPs) before Congress and Federal agencies, and to influence policies impacting the health conditions experienced by urban American Indians and Alaska Natives (AI/AN). The National Council of Urban Indian Health is a 501(c)(3), membership-based organization devoted to support the development of quality, accessible, and culturally sensitive health care programs for AI/AN living in urban communities. NCUIH fulfills its mission by serving as a resource center providing advocacy, education, training, and leadership for urban Indian health care providers. NCUIH strives for healthy American Indians and Alaska Natives living in urban settings, which comprise over 70% of the AI/AN population, supported by quality, accessible health care centers and governed by leaders in the Indian community. NCUIH represents urban Indian Health Programs receiving grants under Title V of IHCA and the American Indian and Alaska Natives they serve.

## ***Recommendations***

NCUIH generally believes that there are many great changes in the structure that are common sense, however, we provide the following comments for improvement. We appreciate your expedited work to ensure that our people are cared for, and we offer you these comments in the same spirit.

### **I. Regulatory Affairs**

Regulations and legislation being in the same department can often lead to more synergy and better results. We believe that the regulation duties would be more effective in the Legislative Affairs department. We also ask that activities that they review and coordinate with other agencies prior to and during the promulgation process to develop/finalize rules that advance, and do not create barriers to Indian Health operations.

### **II. Retain the Intergovernmental Affairs (IA) Group in the Office of the Director.**

As there is a government-to-government trust relationship with Tribes as well as a fiduciary relationship with Tribal members, the Office of Intergovernmental Affairs should be in the Office of the Director to be in touch with the needs of the people and the Tribes. There is also a description missing from the functional statement as well as the office of Telemedicine, which makes it impossible to analyze its function.

### **III. Revenue Generation Office**

It is widely known that IHS is severely underfunded. While the limited funds is mostly due to lack of congressional budgeting, it is also caused by incorrect billing and underutilization of resources. We recommend not only training to capture better billing practices, but also provide revenue enhancing resources.

### **IV. Transparency in Progress**

NCUIH believes that in order for IHS to improve their relationship with Tribes and Tribal members, IHS should be open and transparent about all consultations and confer sessions. Providing stakeholders with the feedback submitted to IHS and routine updates regarding changes would be vital to creating a more positive relationship.

## *Conclusion*

NCUIH believes that the presentation IHS gave at the Tribal Self-Governance meeting in October was very helpful in understanding the thought process behind the changes, and recommends providing a similar presentation nationally, with opportunity for Tribes and Tribal members to comment.

We hope that you include the above recommendations and look forward to your response to the joint request for an extended comment period made on October 17, 2016. Please contact Francys Crevier, Policy Analyst and Congressional Relations Liaison at [FCrevier@ncuih.org](mailto:FCrevier@ncuih.org), if there are any additional questions or comments on the issues addressed in these comments.

Sincerely,

/Ashley Tuomi/

Ashley Tuomi  
President  
National Council of Urban Indian Health

**From:** [Cook, Michael \(IHS/NAS/STR\)](#)  
**To:** [IHS - Consultation](#)  
**Subject:** Request to Extend Comment Period on Proposed IHS Realignment  
**Date:** Friday, November 04, 2016 4:49:46 PM

---

On behalf of the Saint Regis Mohawk Tribe (SRMT) I present the following comments:

SRMT is a Title V IHS compacted Tribal Nation.

We request that the comment period be extended to allow for meaningful consultation to occur with the Tribal Nations.

The proposal fails to adhere to Presidential Executive Order 13175 as well as the Department of Health and Human Services (HHS) and the IHS Tribal Consultation policies. Making fundamental changes to the way Headquarters office operates has a direct effect on Tribes and will no doubt affect the relationship between the Federal Government and Tribes.

30 days comment period does not allow for adequate time to provide IHS with thoughtful, meaningful, input.

The dear Tribal Leader has missing and vague information which collectively indicates a clear lack of a thought-out strategy for implementation and need for more in-depth analysis.

The realignment as described by IHS is in direct response to the gaps in the delivery of the care in the Great Plains Area. We support addressing all the care provision issues experienced by the Great Plains nations we wish to make sure that any alignment takes all areas into consideration; particularly those that have been performing well.

Here in the Nashville area we have already experienced an impact; losing services of our Chief Medical Office, Dental Officer and ALN.

We expect consideration of our request, provide additional time for consultation and delay implementation until Tribes have developed a strategic vision and thoughtful feedback to bring IHS care to industry standards.

Niáwen:kowa, *(Thank You)*

Michael Cook

Director of Health

Saint Regis Mohawk Tribe



November 6, 2016

**Mary Smith, Principal Deputy Director**  
**Indian Health Service, Department of Health and Human Services**  
**5600 Fishers Lane**  
**Mail Stop: 08E86**  
**Rockville, MD 20857**

**Aaron A. Payment, MPA**

**Office of the  
Tribal Chairperson**

523 Ashmun Street

Sault Ste. Marie

Michigan

49783

**Phone**

906.635.6050

**Fax**

906-632-6829

**Email**

[aaronpayment@saulttribe.net](mailto:aaronpayment@saulttribe.net)

**FaceBook**

'Aaron Payment'

**Re: Support for Proposed Indian Health Service Realignment Strategy**

**Dear Ms. Smith:**

On behalf of the Sault Ste. Marie Tribe of Chippewa Indians, I write to strongly support the Indian Health Service (IHS) Realignment Strategy that was proposed in the *Dear Tribal Leader Letter* dated October 5, 2016. The Reorganizational Plan is well-thought out in terms of staff roles and lines of authority and provides clarity and transparency regarding the inner workings of the Agency. I do not see any point in delaying implementation after the initial 30 days. I am concerned with any delay that prevents implementation beyond the Obama Administration.

In particular, tribal leaders have been asking for years for a reorganization to ensure accountability. While testifying during Senate Indian Affairs Committee meetings in the past, I have witnessed US Senators complain and ask for a restructure. I laud you Ms. Smith for taking an honest assessment of the structure and aligning the reporting and lines of authority. The new structure as you have proposed, make it clear who is responsible when quality of care issues are not addressed or when budget requests fall short of the needs as identified by tribal leaders and advisory groups like the HHS STAC, Tribal Self-Governance and Direct Services Advisories, etc.

I believe this realignment proposal is a necessary step in the right direction on the path forward. If you have any questions and/or concerns, please don't hesitate to contact me at **906-635-6050** or via email at **aaronpayment@saulttribe.net**.

**Respectfully,**

/Aaron A. Payment/

**Aaron A. Payment**

**Cc: National Indian Health Board**  
**National Congress of American Indians**



# USET

SOVEREIGNTY PROTECTION FUND

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Submitted via: [consultation@ihs.gov](mailto:consultation@ihs.gov)

November 7, 2016

Ms. Mary Smith  
Principal Deputy Director  
Indian Health Service  
5600 Fishers Lane  
Rockville, MD 20857

**Re: USET SPF Comments on the Indian Health Service Realignment and Request for Area Listening Session to Review Impacts**

Dear Ms. Smith,

The United South and Eastern Tribes Sovereignty Protection Fund (USET SPF) is writing to provide the Indian Health Service (IHS) with the following comments in response to the October 5, 2016 "Dear Tribal Leader" Letter (DTLL) regarding the IHS Realignment Plans for Fiscal Year 2017. As stated in our initial letter to the IHS on October 4, 2016, USET SPF is supportive of initiatives which aim to increase the level of efficiency and transparency at IHS. However, we remain concerned with the level of Tribal consultation and the expediency with which IHS wishes to implement the Realignment. We are disappointed that the IHS chose not to extend the consultation period to give Tribal Nations sufficient time to review and discuss the impacts that such Realignment may have at the Area and Tribal Nation level. USET SPF maintains that true and meaningful consultation is the path to building a stronger and more efficient health care delivery system. The consultation efforts that IHS has conducted to date have failed to provide the level of detail necessary for Tribal Nations to effectively position themselves in support or opposition to the realignment efforts.

USET SPF is a non-profit, inter-tribal organization representing 26 federally recognized Tribal Nations from Texas across to Florida and up to Maine<sup>1</sup>. Both individually, as well as collectively through USET SPF, our member Tribal Nations work to improve health care services for American Indians. Our member Tribal

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<sup>1</sup> USET SPF member Tribal Nations include: Alabama-Coushatta Tribe of Texas (TX), Aroostook Band of Micmac Indians (ME), Catawba Indian Nation (SC), Cayuga Nation (NY), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

Nations operate in the Nashville Area of the IHS, which contains 36 IHS and Tribal health care facilities. Our

Questions remain regarding the need and impacts of the Realignment implementation and the nationalization of standards, seemingly in response to regionally-specific issues. Although we appreciate the detail provided within the functional statements, there is still concern with how centralization of certain functions, policy, and reporting changes will impact functions and services at the Area level. The Realignment proposes more than just organizational chart changes. How do policy changes to Procurement and Contracting impact the Area Office or to Area Tribal Nations? Will changes impede on Area progress? Additional detail on how proposed changes (i.e. programs, services, functions and activities [PSFAs] of new offices, policies and reporting requirements) impact existing Area infrastructure would have offered necessary transparency and a more complete picture of the Realignment.

Collectively, USET SPF member Tribal Nations and the Nashville Area Office have worked hard to establish the strong and high functioning Area Office we have today. Changing or centralizing functions performed by the Area has the potential to cause delays, loss of staff, and disruption in a trusted relationship between the Area Office and Tribal Nations. USET SPF Tribal Nations have not been adequately briefed on the Realignment's impact to this deep bond and as expressed above, we are disappointed IHS chose not to extend Tribal consultation an additional 30 days. USET SPF reiterates its initial request that draft policies and PSFAs for newly established offices and/or functions be shared with Tribal Nations immediately for review and comment. Additionally, as expressed to you during our discussion at the USET SPF Annual Meeting on October 25, 2016, we respectfully request that Area listening sessions be conducted between all parties so that Tribal Nations and Area Office personnel are aware and understand all changes being proposed.

USET SPF appreciates the opportunity to provide comments on the IHS proposed Realignment for Fiscal Year 2017. We remain a willing partner in the IHS' efforts to increase access to quality health services for AI/AN people in a transparent manner. We look forward to further collaboration and meaningful consultation with IHS on these important matters. Should you have questions or require additional information, please do not hesitate to contact Ms. Liz Malerba, USET Director of Policy and Legislative Affairs, at (202) 624-3550 or by e-mail at [lmalerba@usetinc.org](mailto:lmalerba@usetinc.org).

Sincerely,

/Kirk Francis/

Kirk Francis  
President

/Kitcki Carroll/

Kitcki Carroll  
Executive Director