Mayor
John K. Handeland

Manager
Glenn Steckman

Clerk
Bryant Hammond

Nome City Council
Jerald Brown
Doug Johnson
Mark Johnson
Adam Martinson
Scot Henderson
M. Sigvanna Tapqaq

102 Division St. ▪ P.O. Box 281
Nome, Alaska 99762
Phone (907) 443-6663
Fax (907) 443-5345

NOME CITY COUNCIL
BOARD OF EQUALIZATION
WEDNESDAY, MAY 4, 2022 @ 5:30 PM
CITY COUNCIL CHAMBERS IN CITY HALL

PLEASE NOTE*: The Board of Equalization will start on May 4, but will continue to May 5 & 6 only if necessary.*

I. ROLL CALL

II. HEARING OF APPELLANTS

III. ADJOURNMENT

17.20.050 Appeals.
(a) Any alleged error in valuation not adjusted by the assessor to the taxpayer's satisfaction may be appealed to the board of equalization in accordance with the procedures set forth in Alaska Statutes.

17.20.060 Board of equalization.
The city council shall sit as a board of equalization for the purpose of hearing any appeal from determinations of the assessor. Except as otherwise provided in this chapter the board shall be governed in its proceedings by the general rules of city council business regarding quorum and voting requirements, and by the general rules of administrative law applicable in the state of Alaska. (Ord. O-93-6-6 § 1 (part), 1994)

17.20.070 Hearing.
(a) The appellant shall bear the burden of proof of an alleged error in an exemption determination. The only grounds for adjustment is proof based on facts which are stated in a valid written appeal timely filed or proved at the hearing.

From: Bryant Hammond
To: Kristine Kienberger; Brad Soske; Jeremy Jacobson
Subject: FW: 001.023.09 Tax Assessment Appeal
Date: Monday, April 25, 2022 5:15:39 AM

Please print and put in the folder

From: Bill Tweet <cessna23cb@hotmail.com>
Sent: Sunday, April 24, 2022 8:00 PM
To: Bryant Hammond <BHammond@nomealaska.org>
Subject: 001.023.09 Tax Assessment Appeal

04/24/2022

To whom it may concern,

I am writing to appeal the 2022 property assessment of our rental property, parcel number 001.023.09, Lot 9A, Block 74A, 1006 East 4th Avenue. The owner of record is Misty Leccese (Tweet).

The 2022 assessment shows a total value of $122,900, with improvements making up $84,400 of that. This represents an overall increase of 10%, and an increase in the improvements of 15%. I contend that the assessment should be no higher than the 2020 assessment of $111,900, of which $73,400 was improvements.

I base my assertion on the following:

1. I have made no significant improvements to the property since the last assessment.
2. The 2020 assessment was already a similarly significant increase over previous assessments.
3. This property is used as a rental, and the common council has recognized that the lack of affordable rentals is a problem in Nome.
4. Increasing the assessment will force us to raise rent to our tenants.
5. This increase will be compounded by increased fuel cost.
6. The increased fuel costs will result in increased sales tax revenue for the city.
7. Raising property assessments disincentivizes investment in improvements to properties.
8. Raising property assessments increases costs and disincentivizes investments in rental properties.
9. The common council has considered tax incentives on new rental units. This is a tacit admission that the current tax structure is harmful to property owners.
10. Enacting tax incentives for new rental construction favors new constructors over long-time landlords.
11. Assessment based taxes are inequitable, as people pay vastly different amounts for the exact same services.
12. The current tax regime places the burden of proof on the property owner, while clearly it belongs upon the city.

13. The appeal is arduous and many people simply will not have the time or energy to appeal.

While I recognize that a full-scale tax system overhaul is beyond the scope of this appeal, I ask that the assessment be kept at the 2020 level.

Thank you,

Bill Tweet
For Misty Leccese Tweet

From: Bryant Hammond
To: Kristine Kienberger; Brad Soske; Jeremy Jacobson
Subject: FW: 001.052.05 Assessment Appeal 2022
Date: Monday, April 25, 2022 5:15:18 AM

Please print and put in the folder

From: Bill Tweet <cessna23cb@hotmail.com>
Sent: Sunday, April 24, 2022 8:02 PM
To: Bryant Hammond <BHammond@nomealaska.org>
Subject: 001.052.05 Assessment Appeal 2022

04/24/2022

To whom it may concern,

I am writing to appeal the 2022 assessment of my home. The property in question is tax parcel 001.052.05, with a legal description of Block 12, Lot 21, and a physical address of 910 East Front Street. The owners of record are Misty and William Tweet.

I would like to preface my appeal by stating that I do not dispute that property values are increasing, I dispute the magnitude of the increase, as well as the City of Nome's current tax regime.

For background, my wife and I purchased this property in November, 2019. At that time, the assessed value to the improvements to the property of $193,500. The assessed value of the property and it's improvements weighed heavily on our decision to purchase the property. By April, 2020, the assessed value of the improvements had increased to $232,200. This represents an increase of 20%. This increase was based on public records of the purchase price of the property, and failed to take into account any external motivations of either the buyer or the seller. I began to appeal the increase, however, conversations with the assessor proved fruitless, and in the interest of time, I dropped that appeal. In retrospect, that was a mistake.

While I fully understand that the city reassesses the property values regularly, I was shocked to see a similar percentage increase only two years later. In March, 2022, the improvement value had increased to $267,000. This represents a further increase of 15% since 2020 (or a 38% increase since purchasing in November, 2019). I wish all my investments would perform similarly. I recognize that property values have increased, however I find it absurd to think that the value of the improvements (which have had only minimal maintenance, and those required by the purchase appraisal) have truly increased by 38% in less than 2.5 years.

In my 2020 appeal, I detailed to the assessor several facts regarding the condition of the improvements, but these facts clearly fell on deaf ears. In the interest of time, I will simply state that the building had extensive deferred maintenance, as well as a very dated interior

and below average “quality of construction” (as stated by the appraiser).

While I assume that property values in Nome have generally risen by 15% (based on the increase in assessment), I request that the assessment of this property remain at 2020 levels for the following reasons:

1. No significant improvements nor repairs have been made to the property, other than those required by original appraisal, which was used as supporting evidence for the 2020 increase
2. The property is a duplex, and while the owners have absorbed the previous tax increase, we will be forced to pass the additional cost on to the tenants, further exacerbating the high cost of rentals in Nome.
3. While it is common practice to tax property based on assessment, the very model is not flawed, but broken. Under this scheme, property owners are taxed not on how they value a property, but how buyers of homes with certain similar features (regardless of the condition of the property) might value it.
4. As noted earlier, the existing assessment when we purchased the property was a factor in our purchase. It could be argued that we relied, to our detriment that the value would increase at a more normal rate, and not increase at a rate of 1.3% per *month.* While this would not likely hold up in court, this tax scheme opens the city up for nuisance litigation
5. The burden of proof is placed on the property owner, who then has to argue his or her case against a real estate professional who specializes in such cases. If the city wishes to increase assessments, logic and ethics clearly dictate that the burden of proof should fall upon the city.
6. The appeal process is arduous and time consuming. Once again, it should be up to the city and the assessor to prove that each property has increased not only in market value, but in value to the property owner.
7. Increasing property assessments disincentivize investment in properties and the community in general
8. While the city faces increased costs, due to increased fuel and inflation, so do the individuals and property owners. If the city wishes to increase assessments across the board, they should match that by an equal mill rate reduction.
9. The current tax system is inherently inequitable, forcing citizens to pay vastly different amounts for the same services.

While I hope that these justifications will cause you to reconsider the increase in this particular assessment, I truly hope that it will spur the city to revisit their overall tax scheme.

Thank you,

Bill Tweet

CITY OF NOME
ADMINSTRATIVE REVIEW AND APPEAL FORM

Appeal #: 13

This form is for you to appeal the assessed valuation on your property. Complete Sections 1, 2 and 3. Retain a copy for your records, and return or mail the original copy to the City Clerk's Office. Appeals must be returned or postmarked no later than the date indicated on the Assessment Notice. The Assessor will contact you regarding your appeal.

****

RECEIVED
APR 18 2022
CITY OF NOME
CLERKS DEPARTMENT

1) I appeal the value of tax parcel #: 001-411-23

Property legal description: Block 57, Lot 44PTN Mineral Survey _____, Other _____

Print Owner's Name: JOHN BOCKMAN

Owner's Mailing Address: PO Box 519, Day Phone: (907) 443-2212

NOME, AK 99762, Evening Phone: ( ) _____-_____

Address to which all correspondence should be mailed (if different than above): _____

****

2)

Assessor's Value	Land:	Bldg:	Total:	Purchase Date:
	$22,600	$302,600	$325,200	2018
Owner's Estimate of Value	NOT APPEALING AT THIS TIME	CORRECT GARAGE & DECK ASSESSMENT AMOUNTS		

Owner's reason for estimate of value (including inventory corrections, sales of comparable properties, and property income statements, if appropriate). The Appellant bears the burden of proof. Grounds for adjustment of assessment are proof of unequal, excessive, improper, or under-valuation based on facts that are stated in a valid written appeal or proven at the appeal hearing.

SEE ATTACHED

(PLEASE ATTACH STATEMENT IF YOU NEED MORE SPACE)

****

3) I hereby affirm that the foregoing information is true and correct, that I have read and understand the guidelines above, and that I am the owner or owner's authorized agent of the property described above.

John Bockman — **Signature of owner or authorized agent**

4/17/2022 — Date signed

_____ — Print Name (if different form item # 1)

SUBSCRIBED and SWORN to before me this 18th day of April, 2022

NOTARY PUBLIC in and for the STATE of ALASKA: Bradley D Soske 211214011

Commission Expires: with office

Seal:

BRADLEY D. SOSKE
Limited Governmental Notary Public
State of Alaska
My Commission Expires with Office

Appeal#: 13

4)

Assessor's Decision	From:	Land:	Building:	Total:
	To:			

Assessor's Reason for Decision: _____

(PLEASE ATTACH STATEMENT IF YOU NEED MORE SPACE)

Date Rec'd	Decision made by	Date	Approved by	Date	Date mailed

5) **Appellant's Response**:

☐ **I ACCEPT** the assessor's decision in Block 4 above and hereby withdraw my appeal.

☐ **I DO NOT ACCEPT** the assessor's decision and desire to have my appeal presented to the Board of Equalization.

Signature of owner or authorized agent	Date	Printed Name

6)

BOARD OF EQUALIZATION DECISION	LAND:	BUILDING:	TOTAL:

Date Received	Date Heard	Certified (Chairman or Clerk of Board)	Date	Date Mailed

2022 BOARD OF EQUALIZATION DATE: MAY 4, 5, & 6 2022

THE FINAL DAY TO APPEAL (April 25, 2022) IS 30 DAYS AFTER THE POSTMARK OF YOUR ASSESSMENT NOTICE (*March 25, 2022*)

Grounds for Adjustment of Property Assessment – Tax Year 2022

The following may be property tax assessment errors to correct, and if not, the tax assessments are excessive based on the cost approach and or purchase (sales) approach to determine the value of property. The property tax assessment amounts I referenced below are from the "Tax Year 2021" property information sheet or the city property form #44-005.

1. Detached garage is assessed at $17,147.
   - In city property form #44-005, under additions and deductions, the garage is written as:

     Grg 259 21.90 5,672

     If I understand this correctly it means:

     Garage 259 sq ft x $21.90 per sq ft = $5,672

   - In the "Tax Year 2021" property information sheet, the garage is revalued at:

     259 ft x $110.00 per sq ft = $28,578 with a
     60% reduction = $17,147 or $66 per sq ft

   I presume as the garage ages, with no renovations, would decrease in value and result in a lower property tax assessment. Thus, the most recent revalue of the garage would be incorrect ($28,578/$17,147). If not, the garage property tax assessment of $17,147 is excessive because:

   - The garage was built in 1956/1957, is uninsulated, no connections to water/sewer or electric, and has not been renovated.
   - The average cost in Alaska to build a garage is $46.46 to $59.74 per sq ft (Promatcher website)
   - A similar structure available for purchase at Outsiders in Nome, 907-443-2108, is priced at $16,950 or $71 per sq ft. A 240 sq ft structure that is uninsulated, and no connections to water/sewer or electric. (Purchase comparison as sales comparison is unavailable).
   - Finally, no one would be willing to pay more for an older structure than it will cost to build or buy a new similar structure.

2. Deck assessed at $11,095.
   - In the "Tax Year 2021" property information sheet, the deck is noted as being 42 sq ft and assessed at $11,095 or $264.16 per sq ft. If this is correct, this assessment is excessive because:

     - The cost to build the deck was approximately $4,180 or $69.66 per sq ft. The labor costs were estimated as my records were incomplete.

     - Second, the average cost to build a deck in Alaska is $20.25 to $20.91 per sq ft (Promatcher website). This sq ft amount does not distinguish between urban and rural Alaska.

     - See similar properties with a deck, whether recently built or seasoned, where the property assessment taxes are much lower:
       Blk 57 Lot 33 Building value $254,700 deck built about the same time (2/3 bed)
       Blk 57 Lot 18a Building value $272,200 deck large (3/4 bed)
       Blk 57 Lot 54A Building value $178,600 deck built about 5/10 yrs (2/3 bed)
       Compared to my property
       Blk 57 Lot 44ptn Building value $302,60 deck small (1 bed)

Alaska Home Decks Costs & Prices - ProMatcher Cost Report

Find Costs & Prices: Enter Zip Go

Click Here To Get Quotes

Alaska Home Decks Costs & Prices

We have collected data statewide to help calculate the average cost of home decks in Alaska. The following are average costs and prices reported back to us:

Cost of Building a Deck in Alaska
$20.58 per square foot (pressure treated pine)
(Range: $20.25 - $20.91)

Free Estimates from Local Pros

Cost of Staining a Deck in Alaska
$2.49 per square foot (Range: $1.99 - $2.99)

Free Estimates from Local Pros

Cost of Arbor, Pergola or Trellis Construction in Alaska
$3,351.94 for 10'x12' pergola (pressure-treated pine)
(Range: $3,159.45 - $3,544.43)

Free Estimates from Local Pros

Get Matched & Get Quotes From Deck Contractors

Select a Service to Get Started

- **Deck or Porch - Build or Replace**
- **Deck or Porch - Repair**
- **Deck or Porch - Clean, Seal, Stain or Waterproof**
- **Deck or Porch - Enclose or Cover**
- **Pergola, Arbor or Trellis - Install or Build**

Find Costs & Prices in Your City

Anchorage Home Decks Cost
Fairbanks Home Decks Cost
Juneau Home Decks Cost
Kodiak Home Decks Cost

Find costs and prices in another state:

Alabama
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
District of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin
Wyoming

Alaska Home Additions Costs & Prices - ProMatcher Cost Report

Find Costs & Prices: Enter Zip Go

Click Here To Get Quotes

Alaska Home Additions Costs & Prices

We have collected data statewide to help calculate the average cost of home additions in Alaska. The following are average costs and prices reported back to us:

Cost of Building a Home Addition in Alaska
$146.04 per square foot for standard grade construction (Range: $112.84 - $179.24)

Free Estimates from Local Pros

Cost of Building a Garage Addition in Alaska
$53.10 per square foot (custom designed, standard grade) (Range: $46.46 - $59.74)

Free Estimates from Local Pros

Cost of Building a Sunroom in Alaska
$123.46 per square foot (three-season room) (Range: $102.22 - $144.70)

Free Estimates from Local Pros

Cost of Dormer Addition in Alaska
$4,148.44 for single-window gable dormer (Range: $3,929.40 - $4,367.48)

Free Estimates from Local Pros

Cost of Building a Closet in Alaska
$2,002.72 for standard bedroom closet (4 ft reach-in) (Range: $1,912.26 - $2,093.18)

Free Estimates from Local Pros

Get Matched & Get Quotes From Home Addition Contractors

Select a Service to Get Started

- Addition to House - Build
- Garage - Build
- Sunroom - Build
- Dormer - Addition
- Remodeling - One or More Rooms
- Closet - Build

Find Costs & Prices in Your City

Anchorage Home Additions Cost
Fairbanks Home Additions Cost
Juneau Home Additions Cost
Kodiak Home Additions Cost

Find costs and prices in another state:

Alabama
Arizona
Arkansas
California
Colorado
Connecticut
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah

Tor Sparks
BOX 1743
Nome, AK 99762

City of Nome
P.O. BOX 281
Nome AK 99762

RECEIVED
APR 21 2022
CITY OF NOME
CLERKS DEPARTMENT

City of Nome
P.O. Box 281
Nome, AK 99762

Mr. Hammond,

I am appealing the City's assessment for 2022 property taxes on my E. 6th Avenue lots and home (unfinished). The City has assessed Lot 12, Block 113 (Parcel Number 001.011.04A) at $38,500. I think the value is too high when considering there is no water or sewer and all I have done is place some gravel on the lot. The adjacent lot and house (Lot 11, Block 113-Parcel Number 001.011.04) is appraised at $302,400. For a home that is less than 800 square feet, not completed and no water and sewer, I think this value is high as well.

Feel free to reach out to me to discuss.

Sincerely,

Thomas Sparks
P.O. Box 1343
Nome, AK 99762
907-443-5485 home
907-434-1476 cell

2022 ASSESSMENT NOTICE

SPARKS S THOMAS SPARKS G SHARON
PO BOX 1343
NOME, AK 99762

This is NOT a Tax Bill.
It is a notification of the value of property pursuant to Alaska Statute 29.45.170, owned by you or in your control as of January 1, 2022 and subject to City property tax. Your bill will be determined by the mill rate, which is set by the City Council at their regular meeting on the fourth Monday of May 2022.

Property Address	Parcel Number	Date Of Mailing	Appeal Deadline
E 6TH AVE	001.011.04	3/25/2022	4/24/2022

Legal Description

Lot Size: 7000 SF; Lot: 11; BLK: 113; Subdivision: NOME TOWNSITE; District: Nome - 201

Current Assessment

	Land	Improvement	Total Assessment
Assessment	$38,500	$263,900	$302,400
Exemptions			$0
Taxable Value	$38,500	$263,900	**$302,400**

For tax year 2022 the first one-half installment of the tax is due on or before August 1 and will be delinquent on August 2. The second half installment of the tax is due on or before October 31 and will be delinquent on November 1. Payment must be received by the City of Nome on or prior to the due date to be considered timely. If the first installment is not paid in full by the due date, the unpaid balance of that installment becomes delinquent and penalty, interest and costs accrue. A penalty of 8% on the unpaid balance of the tax installment will be added to the delinquent balance. Interest at 8% per annum shall accrue on the unpaid balance of delinquent taxes from the due date until paid in full.

A person whose name appears as the owner of record on the assessment notice or his agent or assigns may appeal to the Board of Equalization for relief from an alleged error in the above stated valuation. Written appeals must be submitted to and received at the City Clerk's Office within thirty (30) days after the date of this mailing. The final date for appeal is thirty (30) days after postmark of this notice. (NCO 17.20.050; AS 29.45.190). The Board of Equalization will meet May 4, 5, & 6 as needed.

Please submit your written appeal to the City Clerk's Office at City Hall or send to PO Box 281 Nome AK 99762 or send via email to bhammond@nomealaska.org. Please Contact the Clerk's Office with any questions.

City of Nome
PO Box 281 Nome, AK 99762
Phone #: (907) 443-6663 Fax#: (907) 443-5345

2022 ASSESSMENT NOTICE

SPARKS S THOMAS SPARKS G SHARON
PO BOX 1343
NOME, AK 99762

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It is a notification of the value of property pursuant to Alaska Statute 29.45.170, owned by you or in your control as of January 1, 2022 and subject to City property tax. Your bill will be determined by the mill rate, which is set by the City Council at their regular meeting on the fourth Monday of May 2022.

Property Address	Parcel Number	Date Of Mailing	Appeal Deadline
E 6TH AVE	001.011.04A	3/25/2022	4/24/2022

Legal Description

Lot Size: 7000 ; Lot: 12; BLK: 113; Subdivision: NOME TOWNSITE; District: Nome - 201

Current Assessment

	Land	Improvement	Total Assessment
Assessment	$38,500	$3,000	$41,500
Exemptions			$0
Taxable Value	$38,500	$3,000	**$41,500**

For tax year 2022 the first one-half installment of the tax is due on or before August 1 and will be delinquent on August 2. The second half installment of the tax is due on or before October 31 and will be delinquent on November 1. Payment must be received by the City of Nome on or prior to the due date to be considered timely. If the first installment is not paid in full by the due date, the unpaid balance of that installment becomes delinquent and penalty, interest and costs accrue. A penalty of 8% on the unpaid balance of the tax installment will be added to the delinquent balance. Interest at 8% per annum shall accrue on the unpaid balance of delinquent taxes from the due date until paid in full.

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City of Nome
PO Box 281 Nome, AK 99762
Phone #: (907) 443-6663 Fax#: (907) 443-5345

CITY OF NOME
ADMINSTRATIVE REVIEW AND APPEAL FORM

RECEIVED
Appeal #:
APR 14 2022
CITY OF NOME
CLERK'S DEPARTMENT

This form is for you to appeal the assessed valuation on your property. Complete Sections 1, 2 and 3. Retain a copy for your records, and return or mail the original copy to the City Clerk's Office. Appeals must be returned or postmarked no later than the date indicated on the Assessment Notice. The Assessor will contact you regarding your appeal.

****

1) I appeal the value of tax parcel #: 198.2.183A

Property legal description: Block____, Lot 2B, Mineral Survey_____, Other _____

Print Owner's Name: Geoff Hubert

Owner's Mailing Address: PO Box 489, Day Phone: ( ) 304-1145

Nome Ak 99762, Evening Phone: ( ) ____-____

Address to which all correspondence should be mailed (if different than above): _____

****

2)

Assessor's Value	Land:	Bldg:	Total:	Purchase Date:
	26,700	475,000	502,200	
Owner's Estimate of Value	26,700	319,600	346,300	

Owner's reason for estimate of value (including inventory corrections, sales of comparable properties, and property income statements, if appropriate). The Appellant bears the burden of proof. Grounds for adjustment of assessment are proof of unequal, excessive, improper, or under-valuation based on facts that are stated in a valid written appeal or proven at the appeal hearing.

I had a appraisal completed on my property 4-16-2021, the appraised value is significantly lower then the city assessed value. I'm trying to figure out how my property has increased $150,000 in value over the last two years, seems a little steep. I would like to see the formula for coming up with these numbers. Nothing has significantly changed in the last two years other then i installed vinyl siding on two sides of my home. I can remove the siding when the snow melts if it lowers the value 150k

(PLEASE ATTACH STATEMENT IF YOU NEED MORE SPACE)

****

3) I hereby affirm that the foregoing information is true and correct, that I have read and understand the guidelines above, and that I am the owner or owner's authorized agent of the property described above.

Signature of owner or authorized agent — Date signed: 4-14-2022 — Print Name (if different form item # 1)

SUBSCRIBED and SWORN to before me this 14th day of April, 2022

NOTARY PUBLIC in and for the STATE of ALASKA:

Commission Expires: 11/19/2023

Seal:

BRYANT HAMMOND
Notary Public
State of Alaska
My Commission Expires Nov 19, 2023

Appeal#:

4)

Assessor's Decision	From:	Land:	Building:	Total:
	To:			

Assessor's Reason for Decision: _____

(PLEASE ATTACH STATEMENT IF YOU NEED MORE SPACE)

Date Rec'd | Decision made by | Date | Approved by | Date | Date mailed

5) Appellant's Response:

☐ I ACCEPT the assessor's decision in Block 4 above and hereby withdraw my appeal.

☐ I DO NOT ACCEPT the assessor's decision and desire to have my appeal presented to the Board of Equalization.

Signature of owner or authorized agent | Date | Printed Name

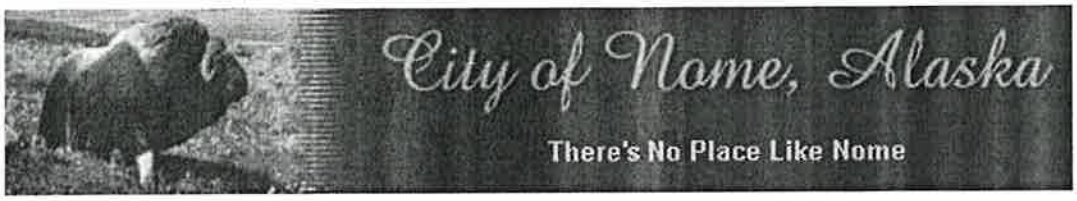
6)

BOARD OF EQUALIZATION DECISION	LAND:	BUILDING:	TOTAL:

Date Received | Date Heard | Certified (Chairman or Clerk of Board) | Date | Date Mailed

2022 BOARD OF EQUALIZATION DATE: MAY 4, 5, & 6 2022

THE FINAL DAY TO APPEAL (April 25, 2022) IS 30 DAYS AFTER THE POSTMARK OF YOUR ASSESSMENT NOTICE (*March 25, 2022*)



Search Details

Account #:	Street:	Legal Description:
198.2.183A	323 LESTER BENCH RD. B	Block Lot 2B

Owner's Name and Address:

HUBERT, GEOFFREY A.

Subdivision:	FLAT CREEK	Plat Number:	96-12
Mineral Survey #:			
Description:			
Comments:			
Tax Year:	2021	Mill Rate:	12
Land Value:	26700	Improvements Value:	319600
Lot Size:	21682	Building Size:	600
Water & Sewer:	no	Date Built:	1996
Zoning:	RESIDENTIAL		

Exemption: Percent Exempt: 0

Taxable value: 346300

FIGURES GOOD AS OF JUNE 18, 2021.

Call City Clerk's Office for Payoff of Taxes - (907) 443-6663

NOTICE: The above figures are taken from the most recent postings available. Current year tax is the calendar year 2021.

When payment is applied to an account in delinquent status, it will pay delinquent years first in the following order: cost; penalty; interest; principal.

Print Close

CITY OF NOME
ADMINSTRATIVE REVIEW AND APPEAL FORM

Appeal #: 23

This form is for you to appeal the assessed valuation on your property. Complete Sections 1, 2 and 3. Retain a copy for your records, and return or mail the original copy to the City Clerk's Office. Appeals must be returned or postmarked no later than the date indicated on the Assessment Notice. The Assessor will contact you regarding your appeal.

****

RECEIVED
APR 21 2022
CITY OF NOME
CLERK'S DEPARTMENT

1) I appeal the value of tax parcel #: 0 0 1 . 2 2 1 . 0 5 A

Property legal description: Block 91, Lot 3&4, Mineral Survey _____, Other _____

Print Owner's Name: Norton Sound Health Corporation

Owner's Mailing Address: PO Box 966, Day Phone: ( ) 443-3337

Nome, AK 99762, Evening Phone: ( ) _____-_____

Address to which all correspondence should be mailed (if different than above): _____

Please also email all information to: dpardee@nshcorp.org

****

2)

Assessor's Value	Land:	Bldg:	Total:	Purchase Date:
	$69,300	$828,800	$898,100	
Owner's Estimate of Value	$0.00	$0.00	exempt	

Owner's reason for estimate of value (including inventory corrections, sales of comparable properties, and property income statements, if appropriate). The Appellant bears the burden of proof. Grounds for adjustment of assessment are proof of unequal, excessive, improper, or under-valuation based on facts that are stated in a valid written appeal or proven at the appeal hearing.

Appeal based on AS 29.45.030 (a)(3), Hospital, Charitable Activities and Federal Law. Assessment is improper.

See attached

(PLEASE ATTACH STATEMENT IF YOU NEED MORE SPACE)

****

3) I hereby affirm that the foregoing information is true and correct, that I have read and understand the guidelines above, and that I am the owner or owner's authorized agent of the property described above.

Angie Gom — **Signature of owner or authorized agent**

4/20/22 — Date signed

Angie Gom — Print Name (if different form item # 1)

SUBSCRIBED and SWORN to before me this 20 day of April, 2022

NOTARY PUBLIC in and for the STATE of ALASKA: Meredith Ahmasuk

Commission Expires: 2026, Jan 5.

Seal:

STATE OF ALASKA
NOTARY PUBLIC
Meredith Ahmasuk
My Commission Expires Jan 5, 2026

Appeal#: 23

4)

Assessor's Decision	From:	Land:	Building:	Total:
	To:			

Assessor's Reason for Decision: _____

(PLEASE ATTACH STATEMENT IF YOU NEED MORE SPACE)

Date Rec'd | Decision made by | Date | Approved by | Date | Date mailed

5) **Appellant's Response**:

☐ **I ACCEPT** the assessor's decision in Block 4 above and hereby withdraw my appeal.

☒ **I DO NOT ACCEPT** the assessor's decision and desire to have my appeal presented to the Board of Equalization.

Signature of owner or authorized agent | 4/19/2022 Date | Geoffrey D. Strommer Printed Name

6)

BOARD OF EQUALIZATION DECISION	LAND:	BUILDING:	TOTAL:

Date Received | Date Heard | Certified (Chairman or Clerk of Board) | Date | Date Mailed

2022 BOARD OF EQUALIZATION DATE: MAY 4, 5, & 6 2022

THE FINAL DAY TO APPEAL (April 25, 2022) IS 30 DAYS AFTER THE POSTMARK OF YOUR ASSESSMENT NOTICE (*March 25, 2022*)

Attachment to Administrative Review and Appeal Form
Block 91, Lots 3 & 4, 117 101-201 W. 5th Avenue ("7 Plex")

I. Property Use Description

1. General Scope of Activities on Hospital-Owned Properties.

The Norton Sound Health Corporation (NSHC) is a tribally owned and operated, independent, not-for-profit healthcare organization founded in 1970 to meet the healthcare needs of the Inupiat, Siberian Yup'ik, and Yup'ik people of the Bering Strait region. NSHC is governed by a 22-member board of directors who represent all communities and areas of the Bering Strait region, a 44,000 square-mile section of Northwestern Alaska. The NSHC service area encompasses these 44,000 square miles. NSHC is the only regional health system serving Northwestern Alaska.

The NSHC healthcare system includes a tribally owned regional hospital which is operated pursuant to an Indian Self-Determination and Education Assistance Act (ISDEAA) agreement. NSHC operates health facilities and provides health care services to Alaska Natives and other beneficiaries pursuant to the Alaska Tribal Health Compact (ATHC), a multi-tribe self-governance compact with the Indian Health Service (IHS) under Title V of the ISDEAA, 25 U.S.C. § 5381, et seq., and funding agreements (FAs), which include program funding amounts that are negotiated for each fiscal year between the IHS and NSHC to fund the programs, functions, services, and activities (PFSAs) that NSHC performs on behalf of IHS. IHS funds the administration of the PFSAs, including the operation of the hospital facilities in Nome, that NSHC has contracted to perform on behalf of IHS.[1]

NSHC is an "instrumentality" of the United States in providing healthcare services under Title V of the ISDEAA. Healthcare services are federal PFSAs provided under the ISDEAA pursuant to the federal trust responsibility to Indians for health care.[2]

The ISDEAA deems tribes and tribal organizations carrying out ISDEAA agreements to be federal executive agencies for purposes of coverage under the Federal Tort Claims Act (FTCA) and access to federal sources of supply.[3] NSHC employees, like employees of other tribal entities operating agreements with IHS under the ISDEAA, are similarly equally covered by the FTCA and are "federal employees" for these purposes.[4] The ISDEAA also authorizes tribal contractors and compactors to perform personal services otherwise performed by federal employees in determining eligibility for IHS services and benefits, the amounts of such services and benefits, and how such services and benefits should be provided.[5] In addition, tribal

[1] 25 U.S.C. § 5325; 25 U.S.C. § 5396(a) (mandatory application of § 5325 to Title V agreements).

[2] 25 U.S.C. § 1602.

[3] 25 U.S.C. §§ 450f(d) and 450j(k).

[4] *See* 25 U.S.C. §§ 5321(d) and 5396(a); *M.J. ex rel. Beebe v. United States*, 721 F.3d 1079, 1084 (9th Cir. 2013).

[5] 25 USC § 450j(g).

facilities operated under the ISDEAA are interpreted by the Centers for Medicare and Medicaid Services as IHS facilities for purposes of the 100 percent Federal Medical Assistance Percentage under Section 1905 of the Social Security Act.[6]

The ATHC expressly provides that ATHC co-signers, such as NSHC, "are deemed by statute to be part of the Public Health Service (PHS), and the employees of the Tribes and Co-Signers are deemed by statute to be part of or employed by the Public Health Service, for purposes of coverage under the [FTCA]," while performing PFSAs under the ATHC's compact and as described in its Funding Agreement.[7] The current NSHC Funding Agreement expressly provides that "support services required to support the provision of health services," including human resources activities, administration and board support, performance management, financial functions, and the provision of staff housing, are part of the scope of work,[8] as is the training of community health aides;[9] emergency medical services training for staff and community members throughout the region;[10] and the provision of lodging for patients, family members of patients, and their escorts.[11]

2. Specific Use of 7-Plex.

This building houses doctors and nurses who are working at the hospital. Doctors are on a one-month on, one-month off rotation. Doctors and nurses are on call 24 hours for emergencies and must be within a few minutes of the hospital. The building is located conveniently, within walking distance, to the in-patient hospital facility. There are no efficient or feasible short-term rentals in the Nome area. The housing is offered to the doctors for free and has been a necessary incentive to attract qualified medical personnel to work in the remote area of Nome, Alaska. Similarly, nurses are hired on a contract basis from all over the United States due to a shortage in Alaska for qualified medical personnel. Again, the housing is provided free to these contract nurses and is a necessary incentive to attract qualified nursing staff. The provision of housing to medical personnel is also required by the NSHC funding agreement.

Ninety-eight percent (98%) of the occupancy of this building is medical staff as described above. The other two percent (2%) is temporary housing for new hires of the hospital system. New hires are provided housing here, rent-free, for 30 days. This is to allow them time to find permanent housing. Sometimes new hires stay on somewhat longer than 30 days, and are charged nominal rent during that stay-over period. NSHC does not generate a profit from this temporary rental to new-hires. (See attached FYE 2021 Housing Financial Report).

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[6] 42 U.S.C. § 1396(d).

[7] *See* ATHC Article V Sec. 3(a).

[8] Funding Agreement Between Certain Alaska Native Tribes Served By The Norton Sound Health Corporation And The Secretary Of Human Health And Human Services Of The United States of America Fiscal Years 2018-2020 § 3.5.

[9] *Id.* §§ 3.4.4, 3.4.5.

[10] *Id.* § 3.4.7.

[11] *Id.* at § 3.2.14.

II. NSHC Enjoys the Sovereign Immunity of its Member Tribes and is Immune from Suits to Collect Taxes

Tribal healthcare entities like NSHC performing self-determination contracts under the ISDEAA for health services enjoy sovereign immunity,[12] including those operating off-reservation.[13] "Indian tribes have long been recognized as possessing the common-law immunity from suit traditionally enjoyed by sovereign powers."[14] "As a matter of federal law, an Indian tribe is subject to suit only where Congress has authorized the suit or the tribe has waived its immunity."[15] "[T]ribal immunity is a matter of federal law and is not subject to diminution by the States."[16] Tribal immunity extends to tribal governing bodies and to tribal agencies or entities that act as an "arm of the tribe."[17] Lastly, "[i]t is settled that a waiver of [tribal] sovereign immunity cannot be implied but must be unequivocally expressed."[18]

In *Barron v. Alaska Native Tribal Health Consortium*, the U.S. District Court for the District of Alaska held a tribal health consortium organization enjoyed sovereign immunity where the organization was formed by Alaska Native tribes; its creation was authorized pursuant to the ISDEAA; it received federal funding to conduct activities that benefitted tribal members; the structure of its board placed control over its ownership and management in representatives of the Alaska Native tribes; its purpose of entering into self-determination and self-governance agreements was "core to the notion of sovereignty"; and it received federal funding "to carry out governmental functions critical to Alaska Native tribes," i.e., healthcare services.[19] Like the entity in *Barron*, and as more fully discussed below, NSHC shares these same attributes.

Tribal immunity extends to suits to collect unpaid taxes. This is because, as the U.S. Supreme Court noted in *Oklahoma Tax Commission v. Citizen Band Potawatomi Indian Tribe of Oklahoma*, "[a]lthough Congress has occasionally authorized limited classes of suits against Indian tribes, *it has never authorized suits to enforce tax assessments*."[20]

In *Matter of 1981–85 Delinquent Property Taxes Owed to the City of Nome, Alaska*, the Supreme Court of Alaska held that the Indian Reorganization Act (IRA) barred a city from foreclosing on lands held by groups of Alaska Natives organized under Section 16 of the IRA on the basis of non-payment of local property taxes.[21] In that case, the city sought to foreclose on two tracts owed by the Alaska Native group which were "purchased in part with funds from a federal grant under the [ISDEAA]."[22] In that case, the Court found the IRA was "intended to promote tribal self-government and conserve Indian lands and resources," and that had any doubt

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[12] *Manzano v. S. Indian Health Council, Inc.*, No. 20-cv-02130-BAS-BGS, 2021 WL 2826072, at *1 (S.D. Cal. July 7, 2021) (non-profit healthcare corporation formed by membership of seven tribes entitled to sovereign immunity).
[13] *See Pink v. Modoc Indian Health Proj., Inc.*, 157 F.3d 1185, 1189 (9th Cir. 1998) (nonprofit corporation created and controlled by two tribes entitled to sovereign immunity).
[14] *Santa Clara Pueblo v. Martinez*, 436 U.S. 49, 58 (1978).
[15] *Kiowa Tribe of Okla.* v. *Mfg. Techs., Inc.*, 523 U.S. 751, 754 (1998) (citations omitted).
[16] *Id.* at 756 (citations omitted).
[17] *Cook v. AVI Casino Enters., Inc.*, 548 F.3d 718, 725 (9th Cir. 2008).
[18] *Santa Clara Pueblo*, 436 U.S. at 58 (citation omitted) (internal quotation omitted).
[19] 373 F.Supp.3d 1232, 1239–40 (D. Alaska 2019).
[20] 498 U.S. 505, 510 (1991) (emphasis added).
[21] 780 P.2d 363 (Alaska 1989).
[22] *Id.* at 364.

remained, the Court "would rest on the settled principle that, in Indian law, all ambiguities must be resolved in favor of the Indians."[23]

In the U.S. Circuit Court of Appeals for the Ninth Circuit, where NSHC is located, courts look to the following factors to determine whether a tribal entity functions as an "arm of the tribe" and is therefore entitled to share in the tribe's sovereign immunity: "(1) the method of creation of the economic entities; (2) their purpose; (3) their structure, ownership, and management, including the amount of control the tribe has over the entities; (4) the tribe's intent with respect to the sharing of its sovereign immunity; and (5) the financial relationship between the tribe and the entities."[24] In *White v. University of California*, the Ninth Circuit upheld the district court's application of this test to hold that a tribal repatriation committee formed by twelve tribes was entitled to sovereign immunity because it was created by resolution of each of the tribes; comprised solely of tribal members appointed by each tribe; funded exclusively by the tribes; and its purpose, "to recover remains and educate the public, [was] 'core to the notion of sovereignty.'"[25] And in *Pink v. Modoc Indian Health Project, Inc.*, the court held that a subsidiary tribal entity established and controlled by several tribes to provide health care services was protected by sovereign immunity.[26]

1. NSHC's method of creation supports immunity.

NSHC was incorporated on November 27, 1970 under the Alaska Non-Profit Corporation Act. Article VII of the NSHC Articles of Incorporation names three individuals representing the Alaska Native villages of Shaktoolik, Gambell, and Teller to the initial Board of Directors, and Article VIII shows the same three Village representatives as the initial incorporators. The formation and governance of NSHC was thereby tied directly to the member Villages. Article I and Article III of the Articles of Incorporation also provide that NSHC shall be "non-profit in nature," weighing in favor of treating it as an arm of the tribes. It is clear that NSHC's member

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[23] *Id.* at 367 (citation omitted).

[24] *White v. Univ. of Cal.*, 765 F.3d at 1025 (2014) (citation omitted). Although not included in the Ninth Circuit's "arm of the tribe" test, an additional factor is examined by the Tenth Circuit: "the policies underlying tribal sovereign immunity and its connection to tribal economic development, and whether those policies are served by granting immunity to the economic entities." *Breakthrough Mgmt. Grp., Inc. v. Chukchansi Gold Casino and Resort*, 629 F.3d 1173, 1187 (2010).
Here, a grant of immunity to NSHC furthers the policies underlying tribal sovereign immunity. The doctrine of tribal sovereign immunity exists in order to avoid "interference with tribal autonomy and self-government," *Santa Clara Pueblo*, 436 U.S. at 59, and "infringe[ment] on the right of the Indians to govern themselves." *Williams v. Lee*, 358 U.S. 217, 223 (1959). Like the doctrine of tribal sovereign immunity, the fundamental policy underlying the ISDEAA is to enhance tribal autonomy and control in the provision of services to tribal communities. *See, e.g.*, 25 U.S.C. § 5302(a) (declaring that policy of ISDEAA is to assure "maximum Indian participation in the direction of educational as well as other Federal services to Indian communities so as to render such services more responsive to the needs and desires of those communities"). NSHC has taken on the entire federal responsibility for health care services for its member tribes. The essential federal-tribal nature of the ISDEAA program and the fact ISDEAA programs are funded by the federal resources that would have been spent on programs serving those tribes shows that NSHC is completely financially dependent on the tribes' right to ISDEAA funding, and has stepped into the tribes' shoes and operates as the "health arm" of its member tribes. Because NSHC has stepped into the shoes of its member tribes as the "health arm" of those tribes in order to enter a government-to-government relationship with the United States, NSHC's immunity from suit protects the tribal autonomy of NSHC's member governments.

[25] *White*, 765 F.3d at 1025.

[26] 157 F.3d at 1188–89.

tribes have delegated their governmental, rather than commercial, responsibility to provide health care to NSHC, which is not a for-profit venture but a vehicle for providing government health services.

2. NSHC's purpose to provide governmental health care supports immunity.

NSHC's Bylaws, adopted in 1977 and revised in 1978–79, expressly establish the Corporations purposes as follows:

1. To establish and maintain facilities, including but not limited to hospital and clinics, for the care of people suffering from injury, illness or disability requiring medical and hospital services and utilizing both inpatient and outpatient facilities and services, such care to be given regardless of the person's race, color, creed, age, sex, nationality or ability to pay.
2. To participate, so far as the circumstances may warrant, in any activity to promote the general health of the principal area.
3. To carry on educational programs, including the training of healing arts personnel, relating to rendering care to the sick and the promotion of health and the maintenance of high health care standards.
4. To advance general community understanding of, confidence in and proper use of the total program of health services.
5. To carry out the foregoing purposes [through the receipt and disbursement of funds and assets].

Each of these purposes reflects the delegation from the member tribes of their respective governmental health care responsibilities to NSHC. Indeed, the purpose of NSHC is to "step into the shoes" of the federal government to carry out, through the ISDEAA, the United States' responsibility to provide health care for Alaska Native and American Indian people.[27]

3. The tribal governments' close ownership, and management and control of NSHC support immunity.

NSHC is structured such that NSHC's member tribes directly control the governance of NSHC. Article IV of the Bylaws established a Board of Directors of 22 elected directors. Each of the 16 member villages elects one representative to the Board of Directors, and the Nome Eskimo Community elects two directors. The Nome City Council may elect one director, and the Board of Directors, among themselves, elects three additional directors representing Nome. Article V provides that the NSHC officers, including the Chairman, are elected from among the Board of Directors.

To this point, in 1980, the United States Department of the Interior unequivocally determined, based on the member tribal organizations' direct control of NSHC, that NSHC is an arm of the member tribes.[28]

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[27] *See* 25 U.S.C. § 5302.

[28] Status of Norton Sound Health Corporation As A Tribal Organization Pursuant to P.L. 93-638.

In his Memorandum, Alaska Regional Solicitor Dennis J. Hopewell informed the BIA Area Director, Juneau Area Office that "[NSHC] is not only considered the 'health arm' of the Bering Straits Native Corporation . . . which is a recognized Indian tribe . . . but the Norton Sound Health Corporation is controlled, sanctioned and chartered by other tribal governing bodies." Hopewell considered the NSHC Bylaws to be conclusive evidence of NSHC's direct control by its member tribal entities, stating "[s]ince the Bylaws for the [NSHC] also spell out that '[t]he management of the property, funds, affairs and business of this Corporation shall be vested in a Board of Directors consisting of ...' the members listed above, there can be no doubt that the corporation is controlled by tribal governing bodies." Hopewell found that NSHC "in addition to being controlled by, is also sanctioned and chartered by such tribal governing bodies," and "[t]his representation also shows that the operation and management of [NSHC] includes the maximum participation of Indians in all phases of its activities."

4. The tribal governments intended that NSHC share in their tribal sovereign immunity.

In 1975, Congress signed the ISDEAA (Pub. L. No. 93-638) into law. In 1978 and 1979, NSHC's member Alaska Native Villages each executed resolutions authorizing NSHC to enter contracts and grants with the United States on their behalf.[29] In 1994, the member Villages executed additional resolutions, which provide the current authority for NSHC to enter into the compact and funding agreements.[30]

Each resolution acknowledged that Congress enacted the ISDEAA as a "far reaching Indian Self-Determination Policy" that "grants Alaska Native villages the *sovereign right to designate tribal organizations which shall have the authority to provide services through contracts or grants with the Federal Government* under Public Law 93-638 for the provision of Government services to Native peoples."[31] The resolutions further note that NSHC "has village representation and traditionally provided information both to and from the village on health related matters" and that NSHC "is controlled and operated by a Board of Directors appointed by the tribal governments" of its member communities.[32]

In recognition of the foregoing, the resolutions authorize NSHC "to apply for, negotiate, appeal from adverse decisions, and secure contracts and grants with the Indian Health Service of the Department of Health, Education and Welfare for health care and related programs serving Native people" in the region.[33] The resolutions further authorize NSHC and its Board of Directors "to act on behalf of this village on health and related services" and "to accept funding for health and related service projects for this village from all funding agencies private and public."[34] The United States Supreme Court has noted that "[t]he common law sovereign immunity possessed by the Tribe is a necessary corollary to Indian sovereignty and self-governance."[35] The resolutions' provisions that NSHC would "act on behalf" of the villages as

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[29] A representative resolution from the Native Village of Elim is attached [hereafter Elim Resolution].
[30] A representative resolution from the Native Village of Diomede is attached.
[31] *See, e.g.,* Elim Resolution at 1 (emphasis added).
[32] *Ibid.*
[33] *Ibid.*
[34] *Ibid.*
[35] *Three Affiliated Tribes of Fort Berthold Reservation v. Wold Eng'g*, 476 U.S. 877,

their health arm and delegation of governmental duties to NSHC reflects their intent that NSHC would share in the "corollary" privilege of immunity from suit in carrying out those functions.

5. NSHC is wholly financially dependent on the member tribes' assignment of their right to contract with IHS to provide health services to their members.

Under the ATHC, all Alaska tribes participate in the delivery of health care services to their members and other beneficiaries in accordance with the principles of tribal self-governance. The Compact allowed NSHC, on behalf of its member tribes, to enter into a government-to-government relationship with the United States. Since 1994, NSHC has participated each year with other co-signers and the IHS in the negotiation of annual funding agreements and amendments to the ATHC.

The funding agreement (FA) NSHC negotiates annually with IHS on behalf of the member tribes includes a broad scope of work covering a wide variety of health care services, from hospital and clinic services to long-term care, from dental services to lodging for patients.[36] In fact, while NSHC is the *signatory* to the funding agreement, the *parties* to the FA are the HHS Secretary and NSHC's member villages themselves. The 2018 Funding Agreement, titled, "Funding Agreement Between Certain Alaska Native Tribes Served by the Norton Sound Health Corporation and the Secretary Of Health And Human Services Of The United States Of America," states:

> This Funding Agreement is entered into by and between certain Alaska Native Tribes in the Bering Straits region of the Norton Sound Service Unit, as identified on the signature page herein, and the Secretary of the Department of Health and Human Services. These Tribes have authorized the Norton Sound Health Corporation to sign this Funding Agreement for them and to be responsible for and carry out the terms of this Funding Agreement.[37]

Section 2.1 of the 2018 FA "obligates NSHC to be responsible for and to provide health PSFAs identified in Section 3 [Tribal Programs and Budget], utilizing the resources transferred under this FA and other funds as they may become available to NSHC." Section 5.2 provides these resources represent the entirety of the member Tribes' entitlement to these funds: "NSHC will be paid 100 percent of Headquarters and Area Tribal Shares in its initial lump sum payment, as negotiated in this FA." Section 4 of the 2018 FA describes the total FY 2018 funding made available to NSHC from funds that would otherwise be allocated to NSHC's member tribes. Without the Compact and Funding Agreements, through which NSHC performs governmental functions for their member villages, NSHC would be unable to function. Accordingly, the financial relationship between NSHC and the tribal entities supports NSHC's immunity.[38]

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890 (1986) (emphasis added).

[36] Funding Agreement Between Certain Alaska Native Tribes Served By The Norton Sound Health Corporation And The Secretary Of Health And Human Services Of The United States Of America Fiscal Years 2018-2020 §§ 3.2, 3.4.1, and 3.2.14.

[37] *Id.* at 1.

[38] *See White*, 765 F.3d at 1025 (fact that entity was funded solely by the tribe supported determination that entity was an "arm of the tribe" entitled to immunity).

In substance and in form, NSHC serves as an arm of its member tribes. NSHC is dependent on the authorization and support of its member tribal governments to operate, and it fills a critically under-resourced governmental function–far different from a private, for-profit economic venture or other state-incorporated non-profits that may operate in the public sector but are not fulfilling government functions. NSHC shares in the sovereign immunity of its member tribes, and this immunity from suit extends to suits to collect unpaid taxes. This sovereign immunity operates unless specifically and unequivocally waived, and NSHC has not waived its immunity.

III. The City's Taxation is Preempted by Federal Law

Alaska Statute 29.45.030(a)(8) exempts from tax, "property of a political subdivision, agency, corporation, or other entity of the United States to the extent required by federal law…" The city of Nome's tax on all real property owned by NSHC is preempted by federal law.

In *United States v. New Mexico*, the U.S. Supreme Court announced a rule to apply generally to determine immunity from state and local taxation under the supremacy doctrine:

> [T]ax immunity is appropriate in only one circumstance; when the levy falls on the United States itself, or on an agency or *instrumentality* so closely connected to the Government that the two cannot realistically be viewed as separate entities, *at least insofar as the activity being taxed is concerned.*[39]

Under the implied federal preemption doctrine, space that is used to carry out federal programs and that is subject to comprehensive and pervasive federal oversight is exempt from state or local taxation.[40]

In *Ketchikan Gateway Borough v. Ketchikan Indian Corporation*, the Alaska Supreme Court upheld application of the implied federal preemption doctrine to exempt from borough taxes "*all space in a building that contains a tribally operated clinic.*"[41] In that case, the tribally operated clinic was funded by the IHS and operated on land conveyed by the United States.[42] The only space held not to be exempt from taxation was "space not committed to use by the clinic," because it was "uncertain how the uncommitted space would be used" and it "appear[ed] that at least for near-term purposes it [would] either be leased to others or used for other [i.e., non-clinic-related] programs of [the Indian corporation]."[43]

This property is integral to the provision of healthcare under NSHC's ISDEAA agreement. As programs and services that support the healthcare operations are included under the scope of work as defined in NSHC's Funding Agreement, all areas used for human resources, administration and board support, performance management, training, medical personnel

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[39] 455 U.S. 720, 735 (1982) (emphasis added).
[40] *Ketchikan Gateway Borough v. Ketchikan Indian Corp.*, 75 P.3d 1042, 1048 (Alaska 2003).
[41] *Id.* at 1044 (emphasis added).
[42] *Ibid.*
[43] *Id.* at 1049; 1048 n.27.

housing, patient housing, and financial function are integral to NSHC's healthcare operations under the ISDEAA.

The Alaska Supreme Court, in *Ketchikan Gateway Borough,* acknowledged that federal law preempts state taxation where the activity is subject to comprehensive and pervasive federal oversight.[44]

The federal and tribal interests in the instant case are clear and strong. Provision of Indian health care services is comprehensively and pervasively regulated; this is manifest both in the ISDEAA and in the Indian Health Care Improvement Act (IHCIA). Congress expressed its intention in the ISDEAA that those operating under self-determination contracts receive the same amount of funding as would the federal government if one of its departments was still providing the services in question. NSHC is subject to comprehensive and pervasive oversight by virtue of its operation under the ISDEAA. Accordingly, the city's tax is preempted.[45]

Although tribes step into the shoes of the IHS when carrying out programs and providing services under the ISDEAA, the ultimate responsibility for those programs and services remains with IHS, which therefore retains a pervasive oversight role. Participation in the self-governance program requires a rigorous planning process and demonstration of financial stability and financial management capability for three (3) years.[46] ISDEAA contractors are subject to annual audits, with penalties for noncompliance with applicable cost principles.[47] And every ISDEAA agreement must, by law, include a provision allowing the Secretary to reassume operation of a program, and the associated funding, if the agency finds gross mismanagement or imminent danger to public health.[48] The regulations at 25 C.F.R. Part 900 and 42 C.F.R. Part 137 elaborate these and other limitations. As noted above, nothing in the ISDEAA abrogates or weakens the trust responsibility to tribes and individual Indians,[49] and IHS consequently retains comprehensive and pervasive oversight.

In *Ketchikan Gateway Borough*, the Alaska Supreme Court noted that while the rule of strict construction requires that "[t]axpayer exemptions are strictly construed against the taxpayer and in favor of the taxing authority . . . . where the question is whether federal law requires the exemption of tribal interests from taxation, ambiguities in federal law should be resolved *in favor of the tribe*."[50]

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[44] *Id.* at 1048.
[45] *Ketchikan Gateway Borough*, 75 P.3d at 1048.
[46] 25 U.S.C. § 5383(c)(1)(C).
[47] *Id.* § 5386(c).
[48] *Id.* § 5387(a)(2).
[49] *E.g.*, *id.* § 5332(2); *id.* § 5329(c), Model Agreement § (d)(1) ("The United States reaffirms the trust responsibility of the United States" to the contracting tribe); *id.* § 5395(b) ("Nothing in this chapter shall be construed to diminish in any way the trust responsibility of the United States to Indian tribes and individual Indians . . .").
[50] *Id.* at 1045 (citing *Cotton Petroleum Corp. v. New Mexico*, 490 U.S. 163, 177 (1989)).

IV. Alaska Law Exempts All Hospital Property from Taxation

1. The Subject Property Constitutes a "Hospital."

The Alaska Constitution provides that: "All, or any portion of, property used exclusively for non-profit religious, charitable, cemetery, or educational purposes, as defined by law, shall be exempt from taxation."[51] Pursuant to this provision, Alaska Statute (AS) 29.45.030(a)(3) provides that "property used exclusively for nonprofit religious, charitable, cemetery, hospital, or educational purposes" is exempt from general taxation.

The meaning of "hospital" is generally understood to include the structures operated as part of a hospital complex in addition to the limited area at which care is directly provided to patients.[52] In this opinion, the Alaska A.G. cites the Alaska Hospital and Medical Facilities Survey and Construction Act ("Construction Act") for the definition of "hospital", although the issue at hand did not directly implicate the Construction Act. The Alaska A.G found as follows:

> 'hospital' includes a public health center and general, tuberculosis, mental, chronic disease, and other type of hospital, and related facilities, including laboratory, outpatient department, nurses' homes, and training facilities, and central services facilities operated in connection with a hospital, but does not include a hospital furnishing primarily domiciliary care.[53]

Accordingly, the housing structure is by definition a "hospital" for purposes of AS 29.45.030(a)(3).

2. The Subject Property is Exclusively Used for NSHC's Exempt Purposes.

Constitutional or statutory provisions exempting real property used exclusively for hospital purposes have been interpreted by multiple courts, including in Alaska, to include hospital-owned residential facilities maintained for members of its staff or patients as tax exempt.

Interpreting constitutional and statutory provisions that exempted real property used exclusively for hospital purposes from taxation to include any facility reasonably necessary to accomplish a hospital purpose, the court in *Cedars of Lebanon Hospital v County of Los Angeles* 35 Cal.2d 729, 221 P.2d 31 (Cal. 1950), held that hospital-owned buildings used to house hospital staff were exempt. Resident physicians, interns, nurses, student nurses, supervisory and maintenance personnel, and other employees lived in various buildings that several hospitals maintained for their staffs. Describing a building immediately adjacent to one of the hospitals, which housed nurses who paid nominal rent as typical of the quarters at issue, the court pointed out that housing employees on or near hospital property was necessary to cope with emergency situations requiring extra personnel and to otherwise conduct an efficient operation.

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[51] Alaska Const. art. IX, § 4.

[52] AK Office of Attorney General Opinion, 1981 WL 38838 (Alaska A.G.) (1981) (hereinafter "A.G. Opinion").

[53] A.G. Opinion (citing AS 18.20.210(3)).

On two occasions, Alaska courts have distinguished the *Cedars of Lebanon* ruling because of factual differences. In *Harmon v. North Pacific Union Conference Association of Seventh Day Adventists*, 462 P.2d 432 (Alaska 1969), the *Cedars* case was found to be inapplicable because the *Harmon* matter involved a specific statutory exemption for the residences of clergy, and not a question of use of property by a hospital.[54] In *Greater Anchorage Area Borough v. Sisters of Charity of the House of Providence*, 553 P.2d 467 (Alaska 1976), the issue concerned office buildings owned by the hospital and being used for the private practice of medical providers and which were not being used by the hospital. The court found *Cedars* to be inapplicable to situations where the property is being leased out for private use.[55] Those distinctions do not apply in the instant case. The doctors and nurses occupying the NSHC residential facilities work at the hospital and are not renting or using the space for their own private practice. In fact, the *Sisters of Charity* court explicitly stated:

> This case does not raise the question of whether a hospital is entitled to an exemption for office space it must provide in order to secure doctor's services necessary to the functioning of the hospital. See *Baker v. Michigan State Tax Commission*, 43 Mich.App. 513, 204 N.W.2d 538 (1972).[56]

In the following cases, the courts held or recognized that under constitutional or statutory provisions exempting from taxation real property used exclusively for charitable purposes, hospital property used as a residence for its personnel was exempt from property taxes, where it was reasonably incidental to those purposes.

The court in *Bethesda General Hospital v State Tax Commission* 396 S.W.2d 631 (Mo. 1965) held that a hospital's residential properties, which housed key personnel, were exempt from taxation, under constitutional and statutory provisions exempting property used exclusively for charitable purposes, reasoning that the properties' residential use was incidental to the hospital's main charitable purpose. Among other property that the hospital owned in its immediate vicinity were homes rented to maintenance personnel, the chief laboratory technician, and resident physicians and other medical staff, all of whom were on call 24 hours and necessary to the efficient operation of the hospital. The court noted that since all of those employees were essential to the hospital's operation, they would have been housed in the hospital if it were physically possible. Pointing out that there was no contention that the hospital's purpose was not charitable, the court stated, "We rule that the use by these employees of the properties as residences provided them by respondent is not the dominant purpose, but is merely incidental to respondent's said main charitable purpose."[57]

In *Aultman Hospital Ass'n v Evatt*, 140 Ohio St. 114, 42 N.E.2d 646 (1942), the court awarded a property tax exemption, under a statute excepting property used exclusively for charitable purposes, to a hospital-owned building used entirely as living quarters for the

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[54] *Id.* at 438.

[55] *Sisters of Charity*, 553 P.2d at 470.

[56] *Id.* at 471 n.12.

[57] *Bethesda*, 396 S.W.2d at 635.

hospital's student nurses, concluding that the residence was incidental to the hospital. Noting that the institution had been organized as a nonprofit corporation taking in those who were unable to pay free of charge, and that its revenues had never met expenses, the court deemed it charitable and its hospital's site exempt from taxation. Reasoning that the property did not cease to be used exclusively for charitable purposes when, as occurred in many hospitals, nurses slept on the premises, the court pointed out that in this case, the hospital acquired property to house student nurses within its vicinity when quarters for them could no longer be rented in that section of the city. The court concluded that property acquired and used for that specific purpose became a necessary part of the hospital, observing that the nurses were engaged in caring for patients, which was essential in carrying on the hospital's work.

In *Hartford Hospital v Hartford*, 160 Conn. 370, 279 A.2d 561 (1971), the court held that a hospital-owned apartment building, in which members of its staff lived, was entitled to a tax exemption under statutes exempting real property used exclusively for carrying out hospital purposes, reasoning that for the hospital to properly perform its services, it needed to provide housing for a large number of its personnel in close proximity to the buildings used for the care of patients. Interns, resident physicians, and a janitor rented the 12 apartments in the building located near the hospital. Determining that the legislature intended to distinguish between the uses of property, not between rental and nonrental, the court concluded that although the hospital charged rent for occupancy, the exclusiveness of the use was not impaired.

The court in *Long Branch v Monmouth Medical Center*, 138 N.J. Super. 524, 351 A.2d 756 (1976), *aff'd* 373 A.2d 651 (1977), construed a statute that exempted real property devoted exclusively to hospital purposes from taxation to include facilities on hospital property reasonably necessary to accomplish a hospital purpose, and held that a hospital-owned apartment building used to house members of its staff was exempt. Among business, professional, and educational properties operated as part of its complex, the hospital maintained a 70-unit apartment building for resident physicians, interns, and nurses. Subsidizing the rent to attract qualified personnel to its staff, the hospital operated the apartments at a loss. Reasoning that the landlord-tenant relationship between the parties was secondary to the purpose of providing nearby housing, the court concluded that the apartment building was an integral part of the hospital's efficient operation.

Where hospital personnel's use of hospital-owned property as a residence has been declared necessary for accomplishment of the hospital's purposes, it has also been granted tax exemption under provisions that exempt property occupied and used for charitable purposes. The court in *Oakwood Hospital Corp. v Michigan State Tax Commission*, 374 Mich. 524, 132 N.W.2d 634 (Mich. 1965), reasoned that hospital-owned housing maintained for interns and resident physicians was necessary to the hospital's operation, and held it to be tax exempt, under a statute excepting real estate that a charitable institution owned and occupied solely for the purposes for which it was incorporated, or used for hospital or public health purposes. In response to a housing shortage in its vicinity, and to provide nearby residences for staff physicians and interns, a nonprofit hospital, which had been incorporated to provide health care, built six houses. The hospital charged nominal rent for their occupancy, considering the availability of the physicians and interns at all times and on short notice as essential to its operation and its accreditation. In the hospital's appeal of the properties' tax assessment, the

local authority did not dispute that the hospital was exempt, but rather argued that the houses were separate from the hospital building and used only for residential purposes. Disagreeing, the court stated that the entire facility was to be considered together to determine whether all of it, in combination or divisibly, served a hospital purpose. The court reasoned that the housing was incidental to the hospital operation, noting that interns and residents were difficult to attract unless housing was furnished, that the proximity of the residences was necessary for the immediate availability of doctors, and that other housing near the hospital was practically unavailable.

Based upon all of the aforementioned rulings, when property has been held tax exempt, factors that have been noted include: its necessity as an incentive to attract and retain qualified staff; the availability of comparable housing; the relation of its occupants to the hospital's operation; and its proximity, so as to facilitate the availability of personnel in an emergency and access for patients. All of these factors are present in the instant case, including:

1. Medical housing is integrated into the medical care provided by NSHC due to its proximity for 24-hour on-call, and month to month rotations of medical personnel.
2. NSHC must provide housing to medical personnel in order to attract and retain qualified nurses and doctors to the remote area of Nome. Primarily all medical personnel are hired from locations outside of the Nome area.
3. NSHC must provide temporary housing to medical personnel because they are hired from outside of Nome and serve month-on, month-off work rotations and there is inadequate temporary housing in the geographic area.
4. NSHC's funding agreement requires it to provide housing for medical personnel.

The use of this property by NSHC is distinguishable from uses that merely promote the charitable activity. *See, e.g., Evangelical Covenant Church of America v. City of Nome,* 394 P.2d 882 (Alaska 1964) (revenue from church's operation of radio station supported the charitable purposes but was not itself the direct and primary purpose of the church). NSHC occupies and operates these properties as an integral part of its operation, without which it could not provide medical care. This is use which is directly for the charitable purposes for which NSHC was incorporated and is not use for the primary purpose of production of income. *Matanuska-Susitna Borough v. King's Lake Camp,* 439 P.2d 441, 445 (Alaska 1968) (distinguishing *Evangelical Covenant Church*, income from participant camp fees were "incidental to and reasonably necessary for the carrying out of the primary charitable purposes of the camp"). NSHC cannot accomplish the charitable purposes for which it was organized without this property and is, in fact, legally obligated to provide this housing. As the Alaska court stated in *Sisters of Charity,* exemption is warranted when the property must be provided and utilized for purposes necessary to the functioning of the hospital. 553 P.2d at 471 n.12.

3. Assessor's Reliance on the "Vitally Necessary" Standard is Misplaced and Misconstrued.

The assessor appears to rely upon the case of *City of Nome v. Catholic Bishop of Northern Alaska*, 707 P.2d 870 (Alaska 1985), to deny tax exemptions to these properties. The

Catholic Bishop case entailed an interpretation of AS 29.53.020(a)(3) (repealed and replaced by AS 29.45.030(a)(3)) with respect to use of certain church properties. The assessor suggests that the standard for determining whether property is "exclusively used" for exempt purposes is set forth in *Catholic Bishop* as whether the use of the property is "vitally necessary" to the hospital's exempt purposes. This is a misinterpretation of *Catholic Bishop* and is not the applicable standard.

The *Catholic Bishop* court stated that the standard for interpreting "exclusive use" is whether the use is "direct and primary" to the exempt purposes:

> We have interpreted "exclusive use" in accord with our rule of strict construction. In *Harmon v. North Pacific Union Conference Association of Seventh Day Adventists,* 462 P.2d 432 (Alaska 1969), we decided that "[e]ven when the uses of a piece of property are highly related to the primarily exempted activity, the exemption will not apply when the statute requires 'exclusive' use." 462 P.2d at 437. All uses of the property must be for the "direct and primary" exempt purpose. *Evangelical Covenant Church v. City of Nome,* 394 P.2d 882, 883 (Alaska 1964) (citing Annot., 154 A.L.R. 895, 898 (1945)). *See Matanuska-Susitna Borough v. King's Lake Camp,* 439 P.2d 441, 445 (Alaska 1968).[58]

The "vitally necessary" test was first referenced in *Harmon* for purposes of interpreting a different statutory exemption from the instant case, the religious parsonage exemption under AS 29.10.336 (now AS 29.45.030(b)). The church in *Harmon* sought to exempt buildings used for the residences of church administrators, teachers, and visiting church staff members. The buildings were also used for counseling and church social gatherings. The court stated that it must strictly construe whether property is used "exclusively for religious purposes" based on the legislative intent to narrowly define the type of residence which qualifies for exemption.[59]

Similarly, in *Catholic Bishop*, the court addressed the same parsonage exemption under AS 29.53.020(b)(1) (now AS 29.45.030(b)(1)). The court stated that it recognizes a narrow exception to the exclusive-use standard when evaluating the parsonage allowance, as follows:

> Residences that are not exempt under AS 29.53.020(b)(1) may still be exempt if their use was directly incidental to and vitally necessary for the exempt use **of other church property**.[60]

In *Catholic Bishop,* three churches sought to exempt religious residences, administrative offices, sanctuaries, and property used for both religious educational and charitable purposes. They also sought to exempt properties used as support for exempt properties, and church property leased to other nonprofit organizations. With respect to the residence of a religious worker/volunteer, the court evaluated this as "other property" not specifically listed in the applicable statute (i.e., residence of bishop, pastor, priest, rabbi, minister), and applied the narrow "vitally necessary"

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[58] 707 P.2d. at 879.

[59] *Harmon*, 462 P.2d at 436.

[60] 707 P.2d at 880, 884-85 (emphasis added).

alternative standard to exclusive use. The *Catholic Bishop* court explained that the "vitally necessary" standard applies only to use of other [church] property and does not supplant the "direct and primary" exclusive-use standard for property used directly with the particular exempt activity.[61]

NSHC submits that the *Catholic Bishop* "vitally necessary" standard does not apply outside of interpreting the special definition of "exclusive religious use" for housing ministers, pastors, et al., under AS 29.45.030(b). Even if *Catholic Bishop* were found to be controlling in the instant matter, the case confirms that the test for determining "exclusive use" is whether the use is direct and primary to the exempt purposes.[62] NSHC's patient hostel and medical provider housing are "used directly" with its exempt activity of the hospital. The *Catholic Bishop* court acknowledges that residential accommodations which are "institutionally necessary" to the operation of a hospital are exempt.[63]

Since *Catholic Bishop,* Alaska courts have confirmed that "direct and primary" is the standard for evaluating exclusive use:

> Most of our charitable-purposes tax exemption cases revolve around the second part of the analysis: whether the property is being used exclusively for a charitable purpose. We have interpreted "exclusive use" to require that all uses of the property be for the "direct and primary" exempt purpose.[64]

The *Denά Nená Henash* court declined to use the "vitally necessary" standard when determining whether property used to house, in part, fundraising activities for non-exempt purposes was an "exclusive" charitable use.[65]

This is not a case of "other property" discrete from the hospital being used for ancillary purposes or purposes outside of the statutory definition of hospital use. This building is operated in connection with the hospital and, as such, meets the definition of "hospital." The property uses are institutionally necessary to the operation of the hospital and legally required for its operation. The properties are used directly for the charitable purposes for which NSHC was incorporated and not used for the primary purpose of production of income or some other ancillary or incidental purpose.

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[61] *Id.* at 880.

[62] *Id.* at 879.

[63] *Id.* at 880-881.

[64] *Fairbanks North Star Borough v. Denά Nená Henash*, 88 P.3d 124 (2004).

[65] *Id.* at 141.

Norton Sound Health Corp.
7-Plex 19516

	FY21
Rental Income	103,005.77
Expenses:	
Wages/Daily Security Checks	7,227.00
Heating Fuel	10,050.62
Utilities	12,657.60
Telephone	15,847.27
Corp Housing Allocation	
Prop Tax	10,304.40
Consulting & Purchased Svcs	
Supplies	3,751.81
Insurance	6,132.00
Equp Purchases	
Equip, Repairs & Maintenance	232,032.00
Freight	415.15
Total Expense	298,417.85
Excess Rev over (under) Expenses	(195,412.08)

Cost of Building (Purchased 2/15/11)

Community Health Needs Assessment Survey Report

Norton Sound Health Corporation

January 2021

For additional information regarding the Norton Sound Health Corporation Community Health Needs Assessment, contact Quality Improvement at (907) 443-4501.

In January 2019, NSHC started offering MRI services locally, with its new state-of-the-art MRI machine, the only one of its kind in Alaska and in the nation serving rural health needs. A staff neurologist was also hired. NSHC continued to offer tribal healing services and acupuncture services to compliment its pain management services.

NSHC continues to promote state-of-the-art facilities. Since 2017, NSHC has completed the construction of four new health clinics located in Savoonga, Gambell, Shaktoolik, and Little Diomede. The construction of two new health clinics are underway in St. Michael and Shishmaref, and a new clinic with staffing housing is under design for the village of Wales. NSHC has made village-based housing a priority to ensure the staff who work at the clinic have adequate housing available. New housing has been constructed in St. Michael, Savoonga, and Golovin to-date. The responsibility for the maintenance and oversight of the village-based facilities has also improved through NSHC's ability to establish 105(l) leases with the Indian Health Services.

Although significant improvements been made in health care delivery, five of the fifteen villages remain without water and sewer. One of NSHC's highest priorities is to continue to strengthen the region's best practice scores to remain eligible for water and sewer capital infrastructure funding. A sanitation engineer was hired in FY19 to manage and coordinate the region's water and sewer goals and objectives.

NSHC is excited to open its new Wellness and Training Center in June 2021; the new facility will include a sobering center with integrated wellness services to facilitate sobriety. The new training facility will provide expanded classroom space to train the organization's health aide workforce. It

Norton Sound Health Corporation is a model of how Indian Self-Determination is meant to work, with tribes taking responsibility for their own health and well-being.

BACKGROUND INFORMATION

In 1969, the Alaska Federation of Natives (AFN) sought a demonstration project to give Alaska Natives greater power in health care decisions. Norton Sound was selected for development of a model for community-based health care services as an alternative to regional, hospital-based care. Norton Sound Health Corporation (NSHC) was incorporated November 27, 1970. The first board had just three directors: William Takak of Shaktoolik, president; Winfred James of Gambell, treasurer; and Dorothy Isabell of Teller, secretary.

That first NSHC Board of Directors faced a formidable task: Bring health care services to a remote area with limited resources. At the time, northwest Alaskans had little access to health care, and getting medical treatment often meant traveling long distances to regional hospitals. One of the first initiatives NSHC launched was the health aide program, established in 1971. While health aides continue to be the backbone of the NSHC organization today, more than 40 years later, NSHC's services have expanded to include clinic travel clerks, village-based counselors, patient benefit coordinators, dental health therapists and nurse practitioners in all the villages served.

At its first meeting in November 1970, the NSHC Board of Directors established its highest goal: provide a "comprehensive and quality inpatient facility in Nome." That year, NSHC opened its first office in the basement of Maynard-McDougall Memorial Hospital in Nome, with a budget of $143,000. Six years later, NSHC purchased the hospital, and in 1978 Norton Sound Regional Hospital opened in Nome. It was quickly followed by Unalakleet' s sub-regional health clinic, staffed by a physician assistant and community health aides serving four villages.

In 1975, NSHC became the first Native health corporation to become independent of AFN and contract directly with the Indian Health Service. The following year, the board assumed responsibility for regional environmental health services through assignment of a federal Public Health Service sanitarian.

Over the years, NSHC's board focused on expanding patient care in the Bering Strait region of Alaska, adding basic services in 15 villages throughout the Norton Sound area as well as specialty clinics in Nome. In 2008, the Board of Directors opened The Patient Hostel, a 38-bed facility, located on the east side of Nome and positioned close to where the new facility would be constructed someday.

Another milestone was reached in 2009, when Indian Health Services awarded NSHC full funding to complete a new hospital building in Nome. Construction began in October 2009 and was completed in 2012. The first patients were seen at the new Norton Sound Regional Hospital and Quyanna Care Center in March 2013.

In October 2014, NSHC went live with its new electronic medical record, "Cerner" and completed the renovation for the Wales clinic and replaced the Shishmaref clinic. In 2015, NSHC initiated a village clinic improvement program and assumed oversight and responsibility for nearly all village clinics and hired housekeepers and maintenance workers to keep the clinics maintained in all the villages. The Nome outpatient clinic received a HRSA new access point grant and was integrated with the village primary health care services for the first time.

- We will assert and implement tribal self-governance to achieve our vision through effective leadership.
- We will hire and support our tribal members to deliver and manage our services.
- We will develop state of the art and efficient health care facilities throughout the region.
- We will be financially strong through aggressive, effective and efficient financial management.
- We will support and develop our youth to pursue higher education and health care careers to ensure there is future tribal leadership.

SCOPE OF THE STUDY

The purpose of the 2020 Norton Sound Health Corporation Community Health Needs Assessment is to collect data on specific information regarding community perception of the Use of Healthcare Services, Awareness of Services, Community Health, and Health Insurance. Additionally, data were collected regarding the demographics of survey responders. The data are presented in a format that can be useful to Norton Sound Health Corporation board of directors, administration, health care providers and community.

METHODOLOGY

A comprehensive survey was developed by the Quality Assurance/Performance Improvement Team "Aquutaq". The survey was loaded electronically into Microsoft Forms. It was distributed electronically via advertisement, QR code, email, public information, Facebook, community meetings and other avenues. Paper copies of the form were also mailed to all box holders in the region as well as made available at all clinics and within the Nome hospital site. The survey was also distributed at various Health Forums held within the region.

Data collection began in early 2019 and continued until early 2020 with a goal of at least 1000 responses. Processing of data and this report was delayed due to reallocation of staff during the pandemic and completed in 2021. The survey was closed for responses in January 2020, after 1004 responses had been received, (32.4% of households in the region). The data was entered into a Microsoft Forms/ Microsoft Excel database and are presented in the Survey Results section of this report. At the time of survey closure, data was first prepared and shared with the NSHC Board of Directors, final report was completed on January 26, 2021.

Language other than English spoken at home, percent of persons age 5 years+, 2015-2019	31.0%	16.1%
Computer and Internet Use		
Households with a computer, percent, 2015-2019	90.7%	94.1%
Households with a broadband Internet subscription, percent, 2015-2019	74.1%	85.5%
Education		
High school graduate or higher, percent of persons age 25 years+, 2015-2019	84.6%	92.8%
Bachelor's degree or higher, percent of persons age 25 years+, 2015-2019	16.1%	29.6%
Health		
With a disability, under age 65 years, percent, 2015-2019	6.8%	8.9%
Persons without health insurance, under age 65 years, percent	18.4%	13.9%
Economy		
In civilian labor force, total, percent of population age 16 years+, 2015-2019	64.8%	65.5%
In civilian labor force, female, percent of population age 16 years+, 2015-2019	66.8%	63.1%
Total accommodation and food services sales, 2012 ($1,000)(c)	14,821	2,221,335
Total health care and social assistance receipts/revenue, 2012 ($1,000)(c)	D	6,375,483
Total manufacturers shipments, 2012 ($1,000)(c)	D	D
Total merchant wholesaler sales, 2012 ($1,000)(c)	D	5,216,303
Total retail sales, 2012 ($1,000)(c)	78,672	10,474,275
Total retail sales per capita, 2012(c)	$7,935	$14,320
Transportation		
Mean travel time to work (minutes), workers age 16 years+, 2015-2019	6.7	19.1
Income & Poverty		
Median household income (in 2019 dollars), 2015-2019	$61,048	$77,640
Per capita income in past 12 months (in 2019 dollars), 2015-2019	$23,581	$36,787
Persons in poverty, percent	20.7%	10.1%
BUSINESSES		
Businesses		
Total employer establishments, 2018	168	21,293
Total employment, 2018	2,119	261,053
Total annual payroll, 2018 ($1,000)	121,975	15,732,010
Total employment, percent change, 2017-2018	-2.9%	-0.4%
Total nonemployer establishments, 2018	551	57,391

BEHAVIORAL RISK FACTOR DATA

Alaska Behavioral Risk Factor Surveillance System

2018 Nome Region

Risk Fact	Nome (%)	Alaska (%)
Health Status: General Health Excellent/Very Good	41.7	51.3
Health Status: Poor physical health	18.0	16.4
Health Status: Frequent mental distress	18.8	11.3
Thoughts of Suicide in past 12 months (2013)	5.0	4.2
Ever told had depressive disorder	15.4	21.2
HTN: Ever told HTN (2017)	25.7	29.9
CVD: Ever told heart attack	3.7	4.4
CVD: Diagnosis of Angina or Coronary Heart Disease	1	2.8
COPD	4.6	5.3
Cancer: Any type	4.2	7.8
Weight Status: Severely Obese (BM>40)	10.3	7.8
Weight Status: Obese (BMI 30-39.9)	26.5	31.2
Weight Status: Overweight	28.1	35.1
Weight Status: Underweight	0.6	1.8
Seen a provider in the last 12 months	56.0	69.3
Access: No Health Care Coverage	6.1	9.1
Follow Subsistence Lifestyle (2017)	79.7	30.2
Rent Home	20.3	27.2
Believe currently get enough physical activity (2015)	59.7	46.9
Activity Time: Adequate Aerobic Physical Activity (at least 150 minutes per week) (2017)	86.9	56.7
Activity Time: Adequate Aerobic Physical Activity (at least 300 minutes per week) (2017)	69.9	36.2
Received Food Assistance from Community Program(s) (2013)	14.7	7
Received Food Assistance from Government Program(s) (2013)	34.9	15.6
Less than 3 vegetables and 2 fruits per day	81.5	93.8
Sweetened carbonated beverages 1+ per day (2017)	27.5	13.2
Sweetened non-carbonated beverages 1+ per day (2017)	45.4	12.1
Cigarette Smoking: Current Smoker Everyday (2018)	30.3	17.1
Cigarette Smoking: Former Smoking (2018)	27.7	28.3
Cigarette Smoking: Never Smoked (2018)	42.1	54.6
Tobacco Use (not including e-cig) (2018)	63.4	25.2
Current Marijuana Use (2018)	44.6	17.3
Current Alcohol Use (2018)	34.9	58.6
Binge Drinking (2018)	13.4	16.4
Before age 18, lived with problem drinker/alcoholic/drugs/rx med (2015)	47.4	32.3
Seat Belt Use: always use a seatbelt (2018)	73.1	83.0
Hurt by intimate partner last 5 years (2017)	15.2	6.6

NOME CA MAPP: BRFSS DATA: 2015-2018: MIXED

3. What is your age range?

Age	Number	Percentage
18-25	100	9.96%
26-35	260	25.90%
36-45	163	16.24%
46-55	164	16.33%
56-65	197	19.62%
66-75	79	7.87%
76-85	21	2.09%
86+	1	0.10%
Unanswered/Prefer not to say	19	1.89%
Total	**1004**	**100.0%**

4. Are you an IHS beneficiary?

Response	Count	Percentages
Yes	660	65.74%
No	286	28.49%
Unanswered/Prefer not to say	58	5.78%
Total	**800**	**100%**

5. How many people, including yourself, live in your household?

Number	Count	Percentage
1	141	14.04%
2	196	19.52%
3	167	16.63%
4	150	14.94%
5	118	11.75%
6	75	7.47%
7	61	6.08%
8	38	3.78%
9	16	1.59%
10+	30	3%
Unanswered/ Prefer not to say	12	1.2%
Total	**1004**	**100%**

Grand Total	1004	100.00%

10. Do you have plumbed septic/sewer in your home?

Response	Count	Percentages
No	203	20.22%
Yes	789	78.59%
Unanswered/Prefer not to say	12	1.20%
Grand Total	**1004**	**100.00%**

11. What is the best way for NSHC to communicate with you? (Preferential choice ranking, only first preference listed below)

Response	Count	Percentage
Email	112	11.16%
Mail	90	8.96%
Phone	156	25%
Text Message	366	36.45%
Other Media	11	1.1%
Unanswered/Prefer not to say	296	29.48%
Total	**1004**	**100%**

12. What type(s) of health care coverage do you have? (Multiple responses allowed).

Response	Count	Percentage
Indian Health Services (IHS)	507	33.82%
Employer Sponsored	494	32.96%
Medicaid	259	17.28%
Medicare	111	7.40%
No coverage	38	3.78%
VA/Military	20	1.33%
Health Savings Account	9	0.60%
Other	38	3.78%
Unanswered/Prefer not to say	11	1.01%
Total	1004	100%

3. If you ever choose not to use NSHC facilities, why not?
(multiple responses allowed)

Response	Count	Percentage
n/a, I ONLY use NSHC	336	27.77%
Service I needed was unavailable	213	17.60%
Lack of privacy/confidentiality	83	6.86%
Costs too much money	77	6.36%
No appointment available in a timely manner	77	6.36%
Did not trust the provider	63	5.21%
Unsure if service I need is available	62	5.12%
Not treated with respect	52	4.30%
Do not like provider	50	4.13%
Appointments do not fit my schedule	46	3.80%
My insurance would not cover my care	30	2.48%
Provider is my co-worker/relative	26	2.15%
Other – free text response	66	5.45%
Unanswered/Prefer not to say	191	19.02%

4. In the past 12 months, was there a time when you or someone living in your home needed medical care from NSHC but were not seen?

Response	Count	Percentages
Yes	202	20%
No	731	73%
Other	39	4%
Unanswered/Prefer not to say	32	3%
Total	**788**	**100%**

5. If you answered "yes" above, what service were you not able to use:

Response	Count
Nome Hospital	20
Nome Clinic	45
Village Clinic	80
BHS Nome	11
BHS Village	4
Other	41

7. In the past 12 months, check all of the health care providers you or anyone living your home has seen: (multiple responses allowed)

Provider	Count
General practice provider (MD, DO, PA, NP)	646
Dentist/DHAT	488
Optometrist (Eye doctor)	420
Health Aide	394
Audiologist (hearing)	276
Pediatrician	212
Physical Therapist	179
Behavioral Health Clinician/Therapist	164
ENT Specialist (ear, nose, throat specialist)	156
Obstetrician/Gynecologist (female reproductive specialist)	134
Tribal Healer	128
Orthopedist (bone/joint specialist)	93
Cardiologist (heart specialist)	89
Dietitian	73
Neurologist (brain/nerve specialist)	72
Urologist (kidney/bladder/male reproductive specialist)	69
Surgeon	68
Diabetes Specialist	66
Psychiatrist	61
Rheumatologist (arthritis specialist)	42
Dermatologist (skin specialist)	35
Oncologist (cancer specialist)	34
Chiropractor	33
Social Worker	31
Tobacco Counselor	31
Pulmonologist (lung specialist)	30
Infant Learning Program	30
Podiatrist (foot/ankle specialist)	23
Allergy Specialist	23
Substance Abuse Counselor	15
Other (Free text)	44

10. Have you or anyone in your household been affected by these community issues:

	% Yes
Elder abuse	5.87%
Child Abuse	7.39%
Domestic Violence	17.54%
Drug Abuse	17.87%
Alcohol Abuse	29.63%
Tobacco Use	44.82%
Chronic Disease	22.83%
Obesity	28.12%
Heart Disease	19.98%
Diabetes	22.05%
Stroke	13.74%
Cancer	26.08%
Teen Pregnancy	10.23%
Sexually Transmitted Infections	17.16%
Suicide	23.58%
Lack of Access to Healthcare	19.41%
Lack of Access to Medications	15.47%
Lack of Quality childcare	19.41%
Lack of Quality Schooling	14.67%
Lack of Quality Housing	31.62%
Lack of Strong Family Support	14.51%
Lack of Safety	11.89%
Lack of Good Jobs	34.26%
Lack of Food due to expense	28.37%
Lack of healthy food available	36.08%
Lack of Native/Traditional foods	24.80%
Lack of Indoor Exercise Facilities	37.66%
Lack of Outdoor Recreational Spaces (parks, walking paths, etc)	24.85%
Lack of Running Water/Sewer	22.20%
Lack of Sobering Center	20.82%
Lack of Homeless Shelter	19.11%
Lack of Law Enforcement	30.87%

Performance Improvement Goals Summary

Over the next three years, NSHC will strive to:

1) Improve Communication with Patients by asking the patient what their preferred method of communication is and utilizing it to provide meaningful feedback to patients.

2) Improve Access to Care for Patient by ensuring the NSHC Primary Care System has both appointments available for patients to accommodate same-day access to care when needed.

3) Improve Notification and Reminders to Patients about scheduled appointments.

4) Improve customer service by training staff on phone etiquette and by improving the switchboard operator experience.

5) Improve the quality of patient care by performing audits of patients who present to NSHC's outpatient clinics for care on a frequent basis; reports will be made to the HRSA quality committee to ensure there is accountability.

6) Continue the initiatives of the Population Health Department to ensure patients are receiving coordinated care and referrals for prevention tests and receiving care that meets clinical standards for disease states.

7) Continue to strengthen the nurse call line by listening to consumer feedback; share success stories when possible.

8) Ensure patient privacy and confidentiality is preserved at all times by providing training to all staff at regular intervals.

9) Continue to focus on Tobacco cessation counseling and prevention activities, substance abuse treatment programs, and suicide prevention activities.

10) Improve access to healthy foods region-wide by collaborating with village leadership.

11) Increase access to indoor workout space region-wide by working with local leaders to develop partnerships for solutions.

12) Continue to develop and expand NSHC's in-home support program to provide personal care attendant services (PCA Program) and to offer end-of-life care for family's in the region at all locations.

13) Continue to provide patient transport services in all locations and to deliver prescription medications.

FUNDING AGREEMENT
BETWEEN CERTAIN ALASKA NATIVE TRIBES
SERVED BY THE
NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
OF THE
UNITED STATES OF AMERICA
FISCAL YEARS 2018-2020

This Funding Agreement is entered into by and between certain Alaska Native Tribes in the Bering Straits region of the Norton Sound Service Unit, as identified on the signature page herein, and the Secretary of the Department of Health and Human Services. These Tribes have authorized the Norton Sound Health Corporation to sign this Funding Agreement for them and to be responsible for and carry out the terms of this Funding Agreement.

Section 1 – Obligations of the IHS.

1.1 Generally. Under the authority of Section 325 of P.L. 105-83, and P.L. 93-638 as amended, non-residual programs, services, functions and activities (PSFAs) of the Alaska Area Office and the Alaska Native Medical Center (ANMC) have been transferred to tribal management.

Delivery of PSFAs shall be consistent with each Co-Signer's Funding Agreement (FA). The Indian Health Service (IHS) shall remain responsible for performing all federal residual PSFAs. The IHS shall remain responsible for negotiating assurances with the Alaska Native Tribal Health Consortium (ANTHC) and Southcentral Foundation (SCF) on behalf of Alaska Natives and American Indians to the effect that Co-Signers continue to receive non-residual PSFAs from the ANMC and Area Office and provided by ANTHC and SCF at a minimum at the level that such PSFAs were provided by the IHS as of October 1, 1997, to the extent permitted by Section 325 of P.L. 105-83. To the extent authorized by federal law, the IHS will respond to written Co-Signer concerns about the extent with which such assurances have not been complied and take appropriate action. IHS shall further be responsible for performing its special trust responsibilities and legal obligations as provided in the Indian Health Care Improvement Act, the Indian Self-Determination and Education Assistance Act, and other applicable provisions of federal law.

This FA obligates the IHS to provide funding and services identified herein and as provided in the Alaska Tribal Health Compact (ATHC) between the Norton Sound Health Corporation (NSHC) and certain other Co-Signers thereof and the United States in Fiscal Years 2018-2020.

The "Memorandum of Agreement Describing the Continuing Services of the IHS, Alaska Area Native Health Service" among the Co-Signers and the Alaska Area Native Health Service

(AANHS) reflects the understanding of the parties regarding services to be provided by the AANHS to Co-Signers. This document, attached as Appendix C, is hereby incorporated by reference.[1]

In addition, although funds are provided from Headquarters and Area Office in support of this ATHC, the IHS will agree to continue to make available to NSHC PSFAs from both Area Office and Headquarters unless 100 percent of the tribal shares for these PSFAs have been specifically included in this FA. In cases where a portion of tribal shares has been transferred, there may be some diminishment in the level of PSFAs provided by IHS. Furthermore, the IHS will reorganize both Headquarters and the Area Office to continue to provide the remaining PSFAs which have not been included in this FA, in the most effective and efficient manner possible, provided that the decisions about the array and level of PSFAs to be offered by the IHS shall be made in consultation with Alaska Tribes. The IHS PSFAs not negotiated into or listed in Appendix A are the responsibility of the IHS.

Unless funds are specifically provided from Headquarters, Headquarters retains all PSFAs and NSHC will not be denied access to, or services from, Headquarters. Specifically, NSHC will receive the following services from IHS Headquarters:

1.1.1 Information Services. IHS will provide the full range of Office of Information Technology (OIT) national support to ANTHC and ANMC OIT will provide specified services directly to NSHC. In addition, OIT will provide support to ANTHC to assist it to carry out its responsibility to provide day-to-day technical support, user support, distribution of software and files and other typical information technology support to Co-Signers as defined in the Assurances Appendix to the ANTHC FA. Upon request of ANTHC, after good faith efforts to resolve NSHC's technical issue, OIT's support of NSHC will include technical support needed on-site by NSHC. A list of the services due under this paragraph, with identification of the method of delivery, is shown below.

Office of Information Technology Provides:	Directly to ANTHC	Directly to Co-Signer	Indirectly to Cosigner through ANTHC
National Database Services			
100% Data Center Services	X		
Process Data exports into National Database		X	
Evaluate, correct, convert site data for National Database		X	
Telecommunications Management Services			
100% Telecommunications Management Services	X		
Maintain IHS to Alaska connection		X	
Email transfer and global address listing		X	
SMTP Gateway		X	
Intranet and Internet Access (to available bandwidth)		X	
Antivirus Software			X

[1] All references to Appendix A and Appendix C in this FA are to the Appendix for the applicable fiscal year.

Office of Information Technology Provides:	Directly to ANTHC	Directly to Co-Signer	Indirectly to Cosigner through ANTHC
Software Development and Maintenance			
100% Software Development and Maintenance	X		
Use of IHS contract vehicles		X	
RPMS Integrated Commercial-Off-The-Shelf packages (Average Wholesale Prices, CPT, ICD-9, Immunization Algorithm) licenses (This does not include licenses for stand-alone or interfaced commercial software.)			X
RPMS Package Support/Installation			X
System Support and Training			
100% System Support and Training	X		
Nationally Available OIT Training instruction (as available)		X	
Alaska On-site training instruction (four annual classes)			X
Hardware and Operating System Support			X
Cache Upgrade (initial installations)			X
National Patient File (2000) conversion			X
Envoy (WebMD) installation			X
Additional Services - Fee for Service	X	X	X

1.1.2 Access to Training and Technical Assistance. To the extent funds are identified by the IHS, NSHC shall have access to training, continuing education, and technical assistance in the manner and to the same extent NSHC would have received such services if it were not a Self-Governance Co-Signer.

1.1.3 Intellectual Property. In the course of administering federal contracts, grants, subgrants, and other agreements, IHS acquired various copyrights and licenses, including licenses pursuant to 45 CFR § 74.36 and 45 CFR § 92.34, in works which the IHS possessed, reproduced, published and otherwise used and allowed others to possess, reproduce, publish, and otherwise use. To carry out the PSFAs assumed by NSHC under this and previous FAs and contracts NSHC has the delegated authority and permission from IHS to use and allow others to reproduce, publish, and otherwise make use of these works to the same extent as IHS, consistent with the copyrights or licenses acquired by IHS in such works.

1.1.4 HIPAA Compliance. IHS retains the responsibility for complying with the Health Insurance Portability and Accountability Act of 1996 for retained IHS health care component activities.

1.2 Historical PSFAs. NSHC has historically received certain PSFAs from ANMC and AANHS. Responsibility for these PSFAs has been transferred to ANTHC by ANMC and AANHS prior to the transfer of management to ANTHC and SCF, NSHC attached to its FY 2002 FA Addendum I entitled "Memorialization of Historical Level of PSFAs provided by ANMC and AANHS." The PSFAs listed in this addendum are taken from NSHC's FY 1999 Annual FA. The addendum was attached to the FY 2002 FA only for the purpose of identifying historical levels of PSFAs received by the NSHC from ANMC and AANHS, and is specifically not made part of this

FA.

1.3 Community Health Aide Program Certification. The IHS retains the responsibility, pursuant to Section 119 of the Indian Health Care Improvement Act, as amended, to maintain the IHS Community Health Aide Program Certification Board (CHAPCB), which was established by and is under the direct control and supervision of IHS, to accredit training for and to certify community health aides, which includes community health aides/practitioners, dental health aides, and behavioral health aides/practitioners.

Section 2 – Obligations of the Co-Signer.

2.1 Generally. This FA obligates NSHC to be responsible for and to provide health PSFAs identified in Section 3 [Tribal Programs and Budget], utilizing the resources transferred under this FA and other funds as they may become available to NSHC. This FA further authorizes NSHC to consolidate and redesign PSFAs as provided in the Act and the ATHC. Whether providing, purchasing, or authorizing health care services described in the Compact and this Funding Agreement, in accordance with Section 2901(b) of Pub. L. 111-148, the Affordable Care Act, and as otherwise provided in law, NSHC shall be the payer of last resort. NSHC is committed to and will strive to provide quality health services and will strive to meet standards NSHC believes to be appropriate and applicable to the delivery of those health services.

2.2 Tribal Facilities and Locations. NSHC operates the programs described in this FA out of more than one facility or location. These include, but are not limited to the facilities and locations listed in Appendix B, which will be submitted prior to the effective date of this FA, and will be incorporated by reference herein. The Area Division of Planning Evaluation and Health Statistics shall compile from this Appendix a list of all health facilities identified in the Appendix and forward that list annually to the Headquarters' Office of Program Statistics, which shall include each of these facilities and locations in the annual list it must provide to the Centers for Medicare and Medicaid Services (CMS) (formerly Health Care Financing Administration) pursuant to the Memorandum of Agreement between the Health Care Financing Administration and the IHS (December 19, 1996).

Section 3 – Tribal Programs and Budget.

The NSHC agrees to be responsible for the health PSFAs identified below in accordance with the ATHC and this FA, including administration of the Norton Sound Service Unit of the IHS, a tribally operated Service Unit of the IHS. NSHC provides and facilitates a range of services directly, and in cooperation with ANMC, ANTHC, SCF and other Co-signers, through field clinics, referrals to ANMC, and other arrangements with tribal health organizations. Any PSFA described in this section 3 [Tribal Programs and Budget] may be performed by any organizational unit of NSHC at NSHC's discretion. For the purposes of this FA, the NSHC's General Budget Categories consolidate related health PSFAs as listed below.

3.1 Executive Leadership. NSHC through its Board of Directors and administration provides policy and administrative/executive/legal direction and oversight for all PSFAs in this FA. Board members, officers, General Counsel, and staff represent NSHC on the local, regional,

state and national committees and boards to provide for advocacy, negotiations, coordination, consultation, development of new programs and information activities.

3.2 Hospital and Clinic Services. NSHC is committed to providing quality patient care achieved through maintaining qualified staff, physical plant, and adequate supply of medical provisions. Under a comprehensive health care delivery plan NSHC provides the following direct patient care services:

3.2.1 Acute patient care swing-bed;

3.2.2 Twenty-four hour emergency services, including those associated with being a Level IV trauma center;

3.2.3 Ambulatory care services, including after-hour nursing phone triage service;

3.2.4 Medevac/air ambulance services;

3.2.5 Referral/transport system from the villages and/or Nome to and from the next higher level of care (e.g. travel coordination and authorization, patient transport vehicle, medivac transport and patient transportation, including adult escort, health professional and other escort as NSHC deems appropriate and emergency or non-emergency air transportation where ground transportation is not feasible and transportation by private vehicle where no other means is available, including specially-equipped vehicle and ambulance) subject to available funding. NSHC may provide the above described patient transportation services in accordance with Section 213 of the Indian Health Care Improvement Act as amended at 25 U.S.C. § 1621*l*;

3.2.6 Specialty clinic support;

3.2.7 Sexual Assault Response Team (SART), including forensic exams and counseling of victims;

3.2.8 Comprehensive health care nursing services for the elderly, disabled and others needing long term health care services as defined by Section 205(a)(4) of the Indian Health Care Improvement Act, as amended, and in accordance with Section 205(c) of such Act. Such services will include but not be limited to the nursing facility services of Quyanna Care Center;

3.2.9 Emergency and minor surgery within the expected capability of Medical Practitioners;

3.2.10 Services associated with training medical students, residents, physician assistant students, nursing students, and allied health provider students from accredited institutions, under supervision of appropriate staff;

3.2.10.1 Physician coverage for services provided in the hospital and villages in person and through daily contact by telephone and/or video telemedicine equipment as needed with the physician assistants and/or Community Health Aides/Practitioners in the villages, and for teleradiology services;

3.2.11 Comprehensive, well person, emergency, acute and chronic care and preventive services at the subregional/community health centers and surrounding village clinics. These services include, but are not limited to, Early Periodic Screening, Diagnosis and Treatment (EPSDT), immunizations, maternal and child health services including family planning, prenatal care and case management of care provided to children and other high-risk individuals; urgent care services 24 hours a day; and specialty clinics, dental services, optometry services, diagnostic imaging services, laboratory services, and telemedicine, telehealth, telepharmacy, teleradiology, telepsychiatry services, dialysis, and mammography, colonoscopy and other cancer screenings, and cancer

treatment;

3.2.12 Diabetes prevention program, including community exercise and activity programs, such as "Summercise" programs, community health fairs, and water aerobics. As authorized under Section 204(d) of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621c, NSHC provides dialysis services and is committed to and shall provide quality dialysis services that will at all times meet standards applicable to such services;

3.2.13 Ancillary services will be maintained at levels sufficient to support medical diagnosis, including but not limited to physical therapy, smoking cessation, respiratory therapy, diagnostic imaging, laboratory, pharmacy, social services, nutrition services, and point of care testing;

3.2.14 Provide lodging for patients, family members of patients, and/or their escorts, including but not limited to housing at the patient hostel, and elder housing;

3.2.15 Coordination with, support of, and assistance to tribal and non-profit entities with their provision of health and social services; and

3.2.16 Provides training and continuing education for NSHC employees and NSHC beneficiaries, and, subject to availability of funding, provides limited financial support for NSHC beneficiaries to assist them to be prepared to pursue health related careers. NSHC also provides a nursing educational program.

3.3 Behavioral Health Services. Provides behavioral health services including, but not limited to:

3.3.1 Substance Abuse Services. Provide services to reduce and prevent substance abuse and associated problems through in/outpatient services, prevention/education, referral services, transitional/residential care services, outreach services, and community involvement, diagnostic and primary alcoholism and drug abuse treatment services, including individual assessment and referrals, individual and group counseling, detoxification services, case management, and substance abuse education classes and Alcoholics Anonymous and/or Narcotics Anonymous meeting sponsorship.

3.3.2 Mental Health Service. Provides professional and paraprofessional staff that travel within the Norton Sound Service Unit, and provides family, child, adolescent and community mental health programs. As needed, a psychiatrist provides mental health services in the hospital. Services include but are not limited to assessment and diagnostic services, individual and group therapy, crisis intervention services, suicide prevention and psychological testing, and telebehavioral health.

3.3.3 Village Based Counseling Program. Provides supportive counseling to identified clients, including abused children, children with behavioral health problems, families in crisis, adults and adolescents with substance abuse and/or mental health issues, and the chronically mentally ill. This program works in conjunction with the substance abuse and mental health program and includes the services of behavioral health aides.

3.3.4 Rainbow Services. Provides services to clients with developmental disabilities. The program assists clients to remain in their homes and communities by developing skills to increase self-control and participation in the community. When this is not possible, the

program assists families to find appropriate treatment and services outside the home for the client.

3.3.5 Transitional Living Services. Provides transitional living services, including residential programs, to assist clients in maintaining sobriety while attending outpatient substance abuse treatment, and after completion of treatment until the client is ready to return to his/her home community.

3.3.6 Fetal Alcohol Spectrum Disorder Prevention Services. Provides education and assistance regarding Fetal Alcohol Spectrum Disorder, targeting pregnant women with substance abuse issues to educate them about the effects of substance abuse on children and families.

3.3.7 Children's Services. Provides intensive outpatient behavioral health services to high risk clients with severe emotional problems ages 9-20 and their families. The program aims to help youth succeed at school, home and in the community while eliminating the need to send them elsewhere. Children's services also may include a full array of behavioral health prevention, early intervention, and treatment programs, including recreational and activity programs and residential and day camps. Providing culturally relevant services involving the community in the treatment process.

3.4 Other Health Services. Provides other health services, including but not limited to:

3.4.1 Dental Services. Provides services at the hospital and in field clinics to raise dental health and lower the incidence of dental disease. The field dental program offers visits to all the villages. Dental services may include dental health aide and dental health aide therapist, training, supervision, and services under the Standards and Procedures approved by the IHS Community Health Aide Program Certification Board.

3.4.2 Audiology. Audiology Services will be delivered, both at the hospital and through field clinics throughout the Norton Sound Service Unit.

3.4.3 Optometry Services. Optometry Services will be provided consistent with the needs of the patients, both in Nome and through field clinics throughout the region.

3.4.4 Village Health Services. Provides training, supervision and services of Community Health Aides/Practitioners (CHA/Ps) and the Clinic Travel Clerks who act as support staff to the village clinics. The Community Health Aide Program will be carried out under the Standards and Procedures approved by the IHS Community Health Aide Program Certification Board.

3.4.5 Health Aide Training. Provides Community Health Aide Program training to trainees from throughout Alaska.

3.4.6 Traditional and Alternative Medicine. Provides traditional healing-services in coordination with existing western medicine services; and alternative healing practices only upon a referral from a provider credentialed in accord with the standards cited in Section 8 of this FA.

These services will be provided in accordance with Section 831 of the Indian Health Care Improvement Act, amended at 25 U.S.C. § 1680u.

3.4.7 Emergency Medical Services. NSHC will maintain Emergency Medical Services (EMS) to lower the incidence of death and disability by providing air ambulance services. The NSHC departments also provide various levels of EMS and injury prevention training for staff and community members throughout the region. NSHC participates in EMS delivery in cooperative with community fire departments, other emergency response, and rescue services throughout the region.

3.4.8 Maternal and Child Health Program. Provides:

3.4.8.1 Prematernal home care for village women awaiting delivery in Norton Sound Regional Hospital;
3.4.8.2 Prenatal, family planning and newborn patient education; and
3.4.8.3 Assistance in risk screening and coordination of prenatal care.

3.4.9 Office of Environmental Health. Provides inspections of the hospital and clinics; technical assistance, training and research to help protect the public from illness and injury related to problems with water, waste, food, air, pests, safety, hazardous waste sites and bioterrorism. Technical assistance is provided to local, state and federal officials as necessary to assist with funding processes and the development of local environmental programs. Training is provided to regional water/wastewater operators and utility managers as needed to ensure safe operation and management of environmental systems.

3.4.10 Public Health Nursing. Provides public health nursing services, including but not limited to consultation to CHA/Ps in the villages, child health and developmental screening, prenatal care, EPSDT, school screenings, immunizations, and tuberculosis and other infectious disease screening and monitoring.

3.4.11 Research and Prevention. Participate in research activities to determine whether genetic factors predispose Alaska Natives to disease.

3.4.12 Home Care and Other Community Based Services. Through a combination of western methods and traditional modalities, provides home care and other community based services, which includes but is not limited to assistance with activities of daily living such as bathing, dressing, laundry, light housekeeping, cooking, vital signs, and medication reminders. These services are provided to all individuals throughout the Bering Straits region who are unable to perform their activities of daily living on their own, or when the families are unable to meet their needs. Home and Community Based Services also provides palliative care and other end-of-life services, such as hospice care, respite, chore, nutrition, transportation, and other supportive services including various senior programs and activities. Such services may also include Assisted Living Services. NSHC will provide home and community based services, hospice and assisted living in accordance with the requirements at § 205 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621d.

3.4.13 Nutrition Services for Women, Young Children, and Infants. Provides supplemental foods, and nutritional education, counseling and other services to women, infants and young children who are at nutritional risk.

3.4.14 Infant and Young Child Developmental Program. Provides services that promote growth and development of infants and young children. Children who qualify for services may have been born prematurely, have delays in their development, or have a diagnosed disability such as Down's syndrome or cerebral palsy. Other child development and family services include, but are not limited to, health-oriented education; socialization; health screening; growth and nutritional assessment; individualized culturally-appropriate child development services; family services; and family involvement.

3.4.15 Injury Prevention Services. Provides services to lower the incidence of death and disability, including but not limited to, the provision of safety information, equipment, and training.

3.4.16 HIV Services. Provides testing, referrals, data collection, and training end education.

3.4.17 Purchased/Referred Care Services. Purchases services, which are not otherwise available or accessible to eligible beneficiaries, on a contractual or open-market basis within funds available. NSHC agrees to be bound by 42 C.F.R. Part 136, subpart I, in the administration and provision of Purchased/Referred Care (PRC) services carried out under this Agreement. Accordingly, NSHC has opted to pay at Medicare Like Rates for PRC in accordance with that subpart of the regulations.

3.4.18 Morgue. Provides morgue services in each village.

3.5 Support Services. Support services required to support the provision of health services, including, but not limited, to plant operations, biomedical services, housekeeping and linen/laundry services, security (for patients and staff), human resources, information systems, administration and board support, corporate planner, grant management, compliance officer and performance improvement, material management (procurement, receiving, processing and distribution), central sterile supply, infection control/employee health, and financial, including business office functions, coding and medical records, planning and implementation of an electronic health records system, patient benefits coordinator, and the provision of staff housing.

3.6 Capital Projects. Provides technical assistance, planning, design, engineering, management and general contracting for construction, maintenance and operation of all facilities used by NSHC, including both federal facilities and those leased or owned by NSHC. This program also provides technical assistance and construction related services to other tribes and tribal organizations inside and outside NSHC's service area.

3.7 Village Built Clinic (VBC) Lease Program. Provides funds to eligible entities to

support the rental of CHA/P clinic space. NSHC will operate this program directly with all VBC lessees, who so elect, including the provision of support services and technical assistance. NSHC will ensure that each lessee is in compliance with the standards referenced in the VBC lease.

3.8 Public Health and Epidemiology. Directly and/or through ANTHC, including its Epidemiology Center,[2] NSHC carries out public health, epidemiology and health research functions. These activities include, but are not limited to: collecting and receiving personally identifiable health information for the purpose of

3.8.1 preventing or controlling disease, injury, or disability;

3.8.2 reporting disease, injury, and vital events such as birth and death; and

3.8.3 the conduct of public health and epidemiological investigations, surveillance, and interventions, including the maintenance of disease and injury registries.

3.9 Other Programs/Services Funded.

3.9.1 Generally. This FA includes programs, functions, services and activities resulting from tribal redesign, or consolidation, reallocation or redirection of funds, including its own funds or funds from other sources, provided that such consolidation, redesign, or reallocation or redirection of funds results in carrying out programs, functions, services and activities that may be included in the FA pursuant to section 505 of Title V and Article III, Section 6 [Consolidation with Other Programs] of the ATHC. This includes any other new health care programs, including, but not limited to, those identified in the Indian Health Care Improvement Act funded during the fiscal years.

3.9.2 Non-IHS Funding. NSHC will complement and supplement the PSFAs described throughout Section 3 [Tribal Programs and Budget] with funding from sources other than the IHS through this Funding Agreement, subject to the availability of such other funding sources. Consistent with Article III, Section 5 [Reallocation], 6 [Merging with Other Programs], and 7 [Program Income] of the ATHC, non-IHS funds will be added to or merged with funds provided by the IHS through this FA.

3.10 FTCA. The Federal Tort Claims Act applies to NSHC's PSFAs under this FA as provided in Section 516(a) of Title V (which incorporates Section 102(d) of Title I of the Act and Section 314 of P.L. 101-512). The extent of Federal Tort Claims Act coverage is described more particularly in 25 C.F.R. Sections §§ 900-180-900.210.

Section 4 – Amounts Available During the Term of the FA

4.1 The following amounts shall be available to NSHC pursuant to the ATHC and Title V of the Act and are subject to reductions only in accordance with Section 508(d) of Title V and Section 106 of Title I of the Act.[3]

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[2] The ANTHC Epidemiology Center was previously operated by the Alaska Native Health Board.

[3] A breakout of these funds is shown in Appendix A, which cites the source document used to determine the amount. These amounts are subject to change under the Act and as provided in this FA. For other fiscal

Recurring Base: Inclusive of all recurring funding, including recurring contract support funds and Village Built Clinic Funds of $425,417.[4]	$48,467,747
Non-recurring funds: inclusive of all non-recurring contract support funds and such other funding which may be added to the contract.[5]	$13,954,404
Subtotal: (This amount is subject to amendments in accordance with Section 14 [Amendment or Modification of this FA])[6]	$62,422,151
Area "Tribal" share to include funding identified from the Area Office and identified in Appendix A to this Agreement.[7]	$1,031,630
Headquarters-tribal share: "Tribal Size Adjustment Pool," including all funds identified in Appendix A. The amount identified is exclusive of funds for which distribution amount has not been determined. The final amount due shall be determined as set forth in this FA or Appendix A.[8]	$731,037
Headquarters-Tribal share: "Program Formula Pool" – to include all funds identified in Appendix A, and such additional funds which the IHS may make available on a program formula basis during the year based on the programs accepted for this allocation in Appendix A.	$0

years to which this FA may be applicable, the replacement Appendix A will be negotiated between IHS and NSHC for the respective year and amended to this FA and incorporated by reference, accordingly.

4 A breakout of these recurring costs is found in Appendix A, fully incorporated herein and citing the actual documents used to determine the amount. *See* Footnote 3.

5 These non-recurring funds include contract support costs and routine Maintenance and Improvement funds available at the beginning of the fiscal year. *See* Footnote 3.

6 The Radiologist Consultation funds in the amount of $195,131 and Biomed funds in the amount of $67,102 are not included in this amount (neither of these amounts include any adjustments for mandatory increases). These recurring funds and any mandatories associated with them are in the ANTHC FA and will be negotiated annually as a flow-thru from the ANTHC, in accordance with the interpretation of Section 325 of P.L. 105-83 by the IHS.

7 Funds from the Alaska Area were distributed according to methods agreed upon in a caucus open to all Alaska Tribes and tribal organizations. The specific methodology is identified in Appendix A.

8 Headquarters tribal shares were allocated according to the following process, which was adopted in a caucus open to all Alaska tribal organizations: The Alaska Area Tribal shares of Headquarters was first defined using the national IHS recommended methodology. The total Alaska Area Tribal shares was then reallocated to each Co-Signer according to the agreed upon Alaska Area methodology, which is identified specifically for each line in Appendix A.

Subtotal – Tribal Shares[9]	$1,762,667
TOTAL ATHC FUNDING	**$64,184,818**

These amounts are subject to additions for other reimbursements, and for new funds received during the term of this Agreement including amounts that have historically been distributed as non-recurring funds under the Act. Any amounts remaining unspent under the prior FA, after adjustments and services, as of the previous fiscal year, shall be included and spent under this FA.

Of the amount shown above for non-recurring program funds, $1,211,108 are for Routine Maintenance and Improvement (M&I); the Routine M&I amount paid as a part of the lump sum due NSHC was determined by multiplying the FY 2017 Routine M&I amount paid to the Co-Signer by 90%. The final Routine M&I amounts paid in FYs 2018-2020 will be based on the final 2018-2020 Routine M&I allocations. If the final Routine M&I amounts, as determined by the final FYs 2018-2020 Routine M&I allocations, is less than the 90% calculation, NSHC will return the difference to the IHS. See also Appendix A, footnote to line 19 on page 6.

Of the amount shown above for Headquarters Tribal Share "Program Formula," $141,878 are for Equipment Replacement, the Equipment Replacement amount paid as part of the lump sum due NSHC was determined by multiplying the FY 2017 Equipment Replacement amount paid to NSHC by 90%. The final Equipment Replacement amounts paid in FYs 2018-2020 will be based on the final FYs 2018-2020 Equipment Replacement allocations. If the final Equipment Replacement amounts, as determined by the final FYs 2018-2020 Equipment Replacement allocations, is less than the 90% calculation, NSHC will return the difference to the IHS. See also Appendix A, footnote to line 22 on page 6.

The Recurring Base amount shown above includes $291,158 that NSHC received, recurring in FY 2006 for Congressionally earmarked alcohol funds. Such funds are subject to "Adjustments Due to Congressional Actions" as described herein in Section 6 as well as any conditions on those funds that may be described in the FYs 2018-2020 Interior Appropriations Acts (Act) or Congressional Reports. After each Act is passed into law, such conditions, including Congressionally-directed reporting requirements, will be added by amendment not requiring NSHC's signature as described in Section 14 [Amendment or Modification of this FA].

The parties agree Section 505(b)(2) of Title V provides, among other things, that grants administered by the Department of Health and Human Services through the IHS may be added to NSHC's FA after award of such grants. In accordance with this provision of Title V and its implementing regulations, the Secretary will add NSHC's diabetes grants and any other statutorily mandated grant(s) administered by the Department through the IHS to this FA after such grant(s) have been awarded. Grant funds will be paid to NSHC as a lump sum advance payment through the PMS grants payment system as soon as practicable after award of the grant. NSHC will use interest

[9] The subtotal of Tribal shares does not include certain Headquarters for which the amount or availability has not been determined. This amount will be adjusted to make available all Tribal shares for which NSHC is eligible. IHS will pay mandatory increases on some Headquarters Tribal shares, subject to appropriations.

earned on such funds to enhance the purposes of the grant including allowable administrative costs. NSHC will comply with all terms and conditions of the grant award, including reporting requirements, and will not reallocate grant funds nor redesign the grant program, except as provided in the implementing regulations or the terms of the grant.

4.2 Contract Support Costs. Contract support costs (CSC) will be paid in accordance with 25 U.S.C. § 5325 and § 5388(c). The parties agree that, according to the best data available as of the date of execution of this agreement, the amount to be paid under FY 2018, which represents the parties' estimate of the Tribe's full CSC requirement pursuant to 25 U.S.C. § 5325, is $16,798,500, including $4,197,082 for direct CSC and $12,601,418 for indirect or indirect-like CSC.[10] This estimate shall be recalculated as necessary as additional data becomes available including information regarding the direct cost base, pass throughs and exclusions, and the indirect cost rates to reflect the full CSC required under 25 U.S.C. § 5325. The parties will cooperate in updating the relevant data to make any agreed upon adjustments. In the event the parties disagree on the CSC amounts estimated and paid pursuant to this paragraph and the Tribe's full CSC requirement under the ISDEAA, the parties may pursue any remedies available to them under the ISDEAA, the Compact, and the Contract Disputes Act, 41 U.S.C. §7101 et seq.

4.3 Base Budgets.

4.3.1 Categories and Base Year. At the end of the first period of the base budget option, the IHS and Co-Signers agreed to extend the three year (FY1998-FY2000) base budgets implemented for the ATHC for an additional two years (FY2001-FY2002). IHS and NSHC have subsequently agreed to additional extensions through FY 2009. The IHS and Co-Signers have agreed to further extend the base budget period at the Co-Signer's option. The following categories are subject to base budgeting for the base year period and the period, as noted below.

Category of Funding	Base Period for Base Funding	Extended through:
Headquarters TSA amounts[11]	FY 97	FY 2020
Equipment Replacement Funding	Not Included	N/A
Area Tribal Share	Not Included	N/A

4.3.2 Adjustments. Adjustments to base funding shall be permitted in direct proportion to changes in appropriated amounts (by sub-activity), as provided under Section 6.1 of this FA titled "Adjustments, Due to Congressional Actions." Adjustments shall also be permitted for the addition of new Co-Signers to the ATHC and when current Co-Signers add or retrocede PSFAs,

10 For other fiscal years to which this FA is applicable, the CSC estimates will be negotiated between the IHS and NSHC for the respective year and amended to this FA in Appendix A.

11 ATHC base budgets for TSA amounts shall be considered as a whole (entire ATHC amount) and shall be subject to adjustment of the internal allocation subject to ATHC agreements.

as provided in Section 14.4 [Due to Addition of New Programs].[12] Adjustments also shall be permitted when Co-Signer chooses to restrict or un-restrict previously "restricted" or "un-restricted" categories, provided that restrictions shall be changed only during annual negotiations. NSHC shall also be eligible for funding for new service increases, mandatories, specific Congressional appropriation for population growth, health services priority system, contract support costs and other increases in resources on the same basis as all other Tribes. Adjustments for changes required when a Tribe joins or withdraws from a Tribal consortium shall also be permitted, as provided under Section 10.3 [Withdrawal Procedures] of this FA. Co-Signers shall also remain eligible for the distribution of additional Tribal shares for Assessments, Workers Compensation, Emergency Reserve, Management Initiatives, and other PSFAs from Headquarters.

Section 5 – Methods of Payment.

5.1 Payment Schedule. Except as provided in subsection 5.2 [Availability of Tribal Shares], 5.3 [Buyback/Withholding], and 5.4 [Periodic Payments] of this Section, all funds identified in Section 4 [Amounts Available During the Term of the FA] of this FA shall be paid to NSHC, in accordance with Article II, Section 4(a) [Payment Schedule] of the ATHC; payment to NSHC to be made as follows: One annual lump sum payment to be made in advance.

5.2 Availability of Tribal Shares. NSHC will be paid 100 percent of Headquarters and Area Tribal Shares in its initial lump sum payment, as negotiated in this FA, for each year under the term of this FA.

5.3 Buyback/Withholding. NSHC may carry out its responsibility to provide certain PSFAs included in this FA by using services or other resources of the Federal government under Article V, Section 22 [Purchases from the IHS] of the ATHC, as permitted by law. Except as provided herein, the cost of such services and the terms under which they may be available to NSHC are set forth in the Buyback/Withhold Agreement between the IHS and NSHC, which is attached as Appendix D to this FA and incorporated by reference herein. The administrative surcharge provided for in Section 2.2.4 of the Buyback/Withhold Agreement for FY 2018 shall be .285 percent. During the term of this FA, the Administrative surcharge rates will be negotiated annually. Notwithstanding Section 5 of the Buyback/Withhold Agreement, upon the request of the IHS or any Co-Signer, such FA will be negotiated for future fiscal years annually during negotiation of this FA.

5.4 Periodic Payments. Payment of funds otherwise due to NSHC under this FA, which are added or identified after the initial payment is made, shall be made promptly upon request of NSHC by check or wire transfer.

Section 6 – Adjustments.

[12] This includes addition of new facilities when the addition of these facilities includes an increase in equipment funds identified for the new facilities.

6.1 Due to Congressional Actions. The parties to this FA recognize that the total amount of the funding in this FA is subject to adjustment due to Congressional action in appropriations Acts or other law affecting availability of funds to the IHS and the Department of Health and Human Services. Upon enactment of any such Act or law, the amount of funding provided to NSHC in this FA shall be adjusted as necessary, after NSHC has been notified of such pending action and subject to any rights which NSHC may have under this FA, the ATHC, or the law.

6.2 Proposals by Authorizing Tribes. Should any authorizing Tribe assume responsibility for PSFAs (or portions thereof) under a contract or annual FA pursuant to the Act, adjustment to funding amounts under this FA will be negotiated.

Section 7 – Records.

7.1 Incorporation of the Privacy Act. Pursuant to Section 506(d)(1) of Title V, records acquired, generated or maintained by NSHC shall not be treated as Federal records under chapter 5 of title 5 of the United States Code, except that:

7.1.1 Patient medical, financial records and personnel records may be disclosed only in accordance with 5 U.S.C § 552a(b); and

7.1.2 Medical records generated by NSHC shall be eligible for storage in Federal Records Centers at NSHC's option in accordance with Section 105(o) of Title I.

7.2 Confidentiality Standards. NSHC will seek to comply with the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including, but not limited to, privacy, security, transactions, and code set regulations, codified at 45 CFR Parts 160, 162, and 164. If a record is not subject to HIPAA, NSHC will maintain the confidentiality of its records in accordance with policies and procedures adopted by its Governing Body, which will be consistent with the purposes and guidelines of HIPAA and the Federal Privacy Act of 1974.

7.3 Quality Assurance Records. NSHC operates a medical quality assurance program and treats the records of such program as confidential and privileged in accordance with section 805 of the Indian Health Care Improvement Act as amended at 25 U.S.C. § 1674.

Section 8 – Program Rules.

NSHC in carrying out the PSFAs in this FA agrees to comply only with those guidelines, manuals, and policy directives that are listed below: Joint Commission (formerly known as JCAHO) standards, as applicable, and Community Health Aide/Practitioner certification standards.

Except as specifically set forth in this Section, pursuant to Section 517(e) of Title V, NSHC does not agree to be subject to any agency circular, policy, manual, guidance or rule adopted by the IHS, except for the eligibility provisions of Section 105(g) and the regulations promulgated under Section 517 of Title V, unless otherwise waived.

Section 9 - Real Property Reporting Requirements

9.1 Leases. The IHS must report on its federally leased facilities. NSHC agrees to notify the AANHS of changes of occupancy, size, use, and general condition of Village Built Clinic (VBC) leased facilities in locations where NSHC has bought back services from the IHS. IHS will annually, or upon renegotiation, provide to NSHC a copy of each VBC lease. No increase in the amount due to the lessor pursuant to a lease will be negotiated by IHS without advance notice to NSHC. In administering these leases, the IHS will work with NSHC to ensure that each lease is in compliance with the standards referenced in the VBC lease.

9.2 Maintenance and Improvement Funds. NSHC agrees to use maintenance and improvement funds received through this FA in accordance with the appropriation language for Indian Health Facilities in the Department of Interior and Related Agencies Appropriation Act for FYs 2018-2020 or any comparable Act of Congress that contains the subject appropriation and in accordance with 41 U.S.C. § 12 to the extent applicable.

Section 10 – Services to Non-Beneficiaries.

Section 813 of the Indian Health Care Improvement Act, as amended, 25 U.S.C. 1680c, (Section 813), authorizes the governing body of a Tribal Organization carrying out health services of the IHS under the Indian Self-Determination and Education Assistance Act to determine whether health services should be provided under the Tribal Organization's FA with the IHS "to individuals who are not eligible for such health services under any other subsection of this section or under any other provision of law", 25 U.S.C. 1680c(c). The NSHC Board of Directors has made such determination consistent with Section 813, and provides for its findings in Resolution No. 2010-16. Resolution No. 2010-16 is attached as Appendix E and incorporated by reference herein. NSHC may provide services under this FA to "non-beneficiaries" as described in Resolution No. 2010-16. In addition services may be provided to U.S. Public Health Service Commissioned Corps Officers and their dependents.

Section 11 – Retrocession and Discontinuance.

11.1 Retrocession. The retrocession provisions of Section 506(f) of the Act are herein adopted, except that the effective date from a retrocession request of the ATHC and FA, in whole or in part, shall be one year from the date of the request by an authorizing Tribe or Village, except as provided below. Retrocession may be effective with less then one years notice, providing the Tribe or Village requesting retrocession, NSHC and the IHS agree to an effective date of less than one year from the date of retrocession request.

11.2 Discontinuance. NSHC may discontinue its participation in the ATHC after written notice to each authorizing Tribe or Village and the IHS. Notice must be provided one year in advance of the effective date of the request except that the effective date of a request may be less than one year upon approval of all authorizing Tribes and Villages and the IHS.

11.3 Withdrawal Procedures.

11.3.1 Process. Unless prohibited by law and in accordance with § 506(g) of Title V, an Indian tribe may fully or partially withdraw from a participating inter-tribal consortium or tribal organization its share of any program, function, service or activity (or portions thereof) included in the ATHC or FA, and any such withdrawal will become effective within the time frame specified in the resolution which authorized transfer to the participating inter-tribal consortium or tribal organization, provided that in the absence of a specific time frame being set forth in the resolution, such withdrawal shall become effective on -

11.3.1.1 The earlier of

11.3.1.1.1 One year after the date of submission of such request; or

11.3.1.1.2 The date on which the FA expires, or

11.3.1.2 Such date as may be mutually agreed upon by the Secretary, the withdrawing Indian tribe, and the participating tribal organization or inter-tribal consortium that has signed the ATHC or FA on behalf of the withdrawing Indian tribe, inter-tribal consortium, or tribal organization.

11.3.2 Distribution of Funds. In accordance with Sections 503(b) and 506(g) of the Act, when a tribe proposing to enter into a contract under Title I or a compact and FA under Title V fully or partially withdraws from a participating tribal organization, the withdrawing Tribe shall, upon written request, be entitled to be paid its tribal share of funds supporting those PSFAs (or portions thereof) which it will be carrying out under its own contract or compact and FA, and such funds shall be removed from the FA of the tribal organization and awarded to the Tribe upon approval of a Title I contract or compact and FA. The IHS shall retain any funds removed, but not awarded in a Title I contract or compact and FA.

Section 12 – Memorandum of Agreement with Member Village.

Funds provided under this FA may be allocated to and expended by an Alaska Native Village ("Village") which is party to this FA in accordance with the terms of the ATHC, this FA and a Memorandum of Agreement (MOA) approved by NSHC and the Village. The Federal Tort Claims Act shall apply to PSFAs carried out by the Village under such MOA and to the Village and its employees to the same extent as if they had been carried out directly by NSHC. Such an MOA may include provisions for the assignment of federal employees under IPA assignment or Commissioned Corps detail. Such assignment shall be subject to the approval of the AANHS Director. NSHC shall be responsible for assuring compliance by the Village with the ATHC, this FA and the MOA.

Section 13 – Consolidation of Contract and Previous Annual FAs.

The contracts listed below and all previous Annual FAs shall be amended or terminated, as appropriate to transfer applicable contract funds into this FA for services, materials and activities, programs, functions and facilities provided to the Tribes represented by NSHC: Title I, P.L. 93-638 Contract #243-89-0011, as modified.

Section 14 – Amendment or Modification of this FA.

14.1 Form of Amendments. Except as otherwise provided by this FA, the ATHC, or by law, any modifications of this FA shall be in the form of a written amendment and shall require written consent of each of the signatory Tribes, acting directly or through NSHC as authorized by resolution, the NSHC, and the United States. Participation or written consent of Tribes and Co-Signers not subject to the terms of this FA shall not be required.

14.2 Funding Increases.

14.2.1 Written consent of NSHC shall only be required for issuing amendments for those funds which:

14.2.1.1 require a change to Section 3 [Tribal Programs and Budget];

14.2.1.2 require a specific commitment by NSHC (*e.g.*, Maintenance & Improvement projects and prior fiscal year Sanitation Facility Construction projects); or

14.2.1.3 reduce funding other than changes in Congressional appropriations pursuant to Section 6.1 [Adjustments Due to Congressional Actions].

14.2.2 Amendments not requiring written consent may include, but are not limited to:

14.2.2.1 Program/Area/HQ Mandatories;

14.2.2.2 Program/Area/HQ End-of-Year Distributions;

14.2.2.3 CHEF, subject to the condition that if a case initially qualifying for reimbursement is paid (in whole or in part) by an alternate resource or cancels for any reason, NSHC will return the unused amount to the IHS CHEF account;

14.2.2.4 PRC Deferred Services;

14.2.2.5 Routine Maintenance & Improvement; or

14.2.2.6 Collections and reimbursements.

14.2.3 Amendments reflecting payment of these funds shall be provided to NSHC after any such funds are added to the FA. NSHC retains the right to reject the addition of such funds to the FA and return the funds to the IHS.

14.3 Services from IHS. Should NSHC determine that it wishes the IHS to provide PSFAs included in this FA for which funding has been identified but not provided, the parties shall negotiate an amendment to the FA to reflect the transfer of responsibilities from NSHC back to the IHS and the pro-rata share of funding for that program, services, function or activity shall be retained by the IHS. Unless otherwise negotiated, IHS will not transfer centrally paid expenses including but not limited to Workers Compensation to any ATHC Co-Signer.

14.4 Due to the Addition of New Programs. Should NSHC determine that it wishes to provide a program, service, function or activity of the IHS not included in this FA, NSHC shall submit a proposal to the IHS to provide such program, service, function or activity. The parties agree to negotiate such a proposal and, should the parties fail to reach agreement, NSHC may submit a final offer in accordance with the Title V procedures set forth in Sections 507(b)-(d) of Title V. A

proposal submitted pursuant to this section shall be treated as a request for amendment to the FA and, once approved by the IHS, the Alaska Area Office shall prepare within 30 days an amendment to this FA and the amendment shall be executed through the Area Office and added to the FA.

14.5 Due to Availability of Additional Funding. NSHC shall be eligible for any increases in funding or funding for Medicaid, Medicare, maintenance and improvement, other reimbursements and new programs for which it would have been eligible had it been administering programs under a self-determination contract, rather than under the ATHC and this FA, and for any other funds that are not restricted by appropriations language for which any Alaska Tribe or tribal organizations may be eligible, including any new funds appropriated for IHS Headquarters and funds passed to Alaska Area as recurring or non recurring funds, and this FA shall be amended to provide for timely payment of such new funds to NSHC. Such amendment shall be originated and prepared within 30 days by the Alaska Area Office and executed through the Area Office in consultation with the Co-Signer.

14.6 Other Adjustments. Upon written authorization by NSHC and agreed to by the IHS, the IHS may reallocate funds retained by the IHS, which are obligated to NSHC, for the purpose of reimbursing the IHS for services or equipment provided to NSHC to assist NSHC in carrying out the terms of the ATHC and this FA.

14.7 General Procedures for Amending or Modifying this FA. Amendments or modifications proposed by NSHC shall be submitted in writing to the IHS Alaska Area Director with a copy to the Office of Tribal Self Governance at IHS. Except as provided with respect to the incorporation of a provision of Title I under Article V, Section 21 [Applicability of Title I Provisions] of the ATHC, or as provided above in paragraphs .1, .2, .3 and .4 of this Section 14 [Amendment or Modification of this FA], a request to amend or modify this FA submitted by NSHC shall be processed in accordance with Sections 507(b)-(d) of Title V and all provisions of those identified sub-sections are incorporated herein for this purpose.

Section 15 – Third Party Recoveries.

Any funds recovered by NSHC through the filing, litigating, or settling a claim against a third party to require that third party to pay for services previously provided to IHS-eligible beneficiaries by NSHC, or for such services previously provided by the IHS in a PSFA now operated by NSHC, shall be the property of the Co-Signer and shall be considered program income to be utilized by NSHC as provided in Article III, Section 7 [Program Income] of the ATHC. Any prospective recovery of funds for such services shall likewise be considered program income to be utilized pursuant to Article III, Section 7 [Program Income] of the ATHC.

Section 16 – Severability.

This FA shall not be considered invalid, void or voidable if any section or provision of this FA is found to be invalid, unlawful or unenforceable by a court of competent jurisdiction. Should such a court make such a finding, the parties will seek agreement to amend, revise or delete any such

invalid, unlawful or unenforceable section or provision, in accordance with the provisions of the ATHC.

Section 17 – Memorializing Disputes.

The parties to this FA may have failed to reach agreement on certain matters which remain unresolved and in dispute. Such matters may be addressed through the process set forth in Sections 507(b)-(d) of Title V, or, at the option of NSHC, may be set forth in Addendum II to this FA, which shall be identified as "Memorialization of Matters Remaining in Dispute." This attachment shall not be considered a part of this FA but is attached for the purpose of recording matters in dispute for future reference, discussion and resolution as appropriate. The NSHC does not waive any remedy it may have under the law with regard to these issues and any others not listed herein.

Section 18 – Title I Provisions Applicable to This FA. As authorized in 25 U.S.C. § 5396(b), NSHC exercises its option to include the following provisions of Title I of the Act as part of this FA, and these provisions shall have the force and effect as if they were set out in full in Title V of the Act.

18.1. 25 U.S.C. § 5304(e) (definition of "Indian Tribe");
18.2. 25 U.S.C. § 5322(b) (related to grants for health facility construction and planning, training and evaluation);
18.3. 25 U.S.C. § 5322(d)(1) (related to duty of IHS to provide technical assistance);
18.4. 25 U.S.C. § 5324(a)(1) (exemption from Federal procurement and other contracting laws and regulations);
18.5. 25 U.S.C. § 5328(b), (conflicting provisions of law);
18.6. 25 U.S.C. § 5329(c), section 1(b)(8)(F) (screener identification);
18.7. 25 U.S.C. § 5329(c), section 1(b)(9) (availability of funds);
18.8. 25 U.S.C. § 5329(c), section 1(d)(1)(B) (construction of contract);
18.9. 25 U.S.C. § 5329(c), section 1(d)(2) (good faith).

Section 19 – Exemption from Licensing Fees.

In accordance with Section 124 of the IHCIA, as amended at 25 U.S.C. 1616q, employees of the NSHC health programs shall be exempt from payment of licensing, registration, and any other fees imposed by a federal agency to the same extent that officers of the Public Health Service commissioned corps and other employees of the Indian Health Service are exempt from such fees.

Section 20 – Licensure.

Licensed NSHC health professionals will be licensed in accordance with section 221 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621t.

Section 21 – Purchase of Health Coverage.

NSHC may use federal funds for purchase of health care coverage in accordance with section

402 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1642.

Section 22 – Medicare & Medicaid Reimbursements.

22.1 Medicare & Medicaid. NSHC has elected to directly collect Medicare and Medicaid payments as provided in 25 U.S.C. § 1641, as amended. NSHC is obligated and entitled to directly collect and retain reimbursement for Medicare and Medicaid and any other third party payers for services provided under this Agreement in accordance with section 401 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1641 and section 206 of such Act, 25 U.S.C. § 1621e, as amended.

22.2 Recovery Right. NSHC has the right to recover reimbursement from certain third parties of the reasonable charges for health services in accordance with section 206 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621e.

Section 23 – Federal Insurance. IHS will assist NSHC to obtain information about the coverage, rights and benefits available for its employees under chapters 87 and 89 of title 5, United States Code, the cost of such coverage, rights and benefits (including any options in coverage, rights and benefits that may be available), and the procedures by which NSHC may exercise its rights under Section 409 of the IHCIA, as amended, to have access to such Federal insurance for its employees.

Section 24 – Environmental and Cultural Resources. The National Environmental Policy Act (NEPA), National Historic Preservation Act (NHPA), and related provisions of law require the IHS to review and approve actions resulting in the use or commitment of IHS funds or that affect IHS property, and which may significantly impact the environment or cultural resources. Unless NSHC has assumed these responsibilities under a construction project agreement in accordance with Section 509 of Title V and 42 C.F.R. § 137.285-312, the IHS must carry out these responsibilities and has elected to utilize Appendix H. Where NSHC plans to undertake an action, as described in Appendix H, on IHS owned real property or utilizing IHS funds received through this Funding Agreement, and NSHC has not assumed these responsibilities, NSHC will provide the IHS with a Project Summary Document (see Appendix F) and a completed Environmental Information and Documentation Form (see Appendix G) so that the IHS can accomplish these requirements, and issue a Determination Document (Categorical Exclusion (CATEX) or Finding of No Significant Impact (FONSI)), as soon as possible. All documentation shall be submitted to the IHS as early as possible in the planning phase of the project to prevent delays in the action. No irreversible action can be taken by NSHC until the IHS completes its compliance responsibilities and so advises NSHC with a Determination Document. Pending resource availability, the IHS is available for education and consultation on NEPA, NHPA, and related provisions of law on an as needed basis.

Section 25 – Effective Date and Duration.

This Funding Agreement becomes effective on October 1, 2017, and will remain in effect through the 2020 Federal Fiscal Year or until a subsequent agreement is negotiated and becomes effective pursuant to Article II, Section 12 [Subsequent Funding Agreements] of the ATHC.

United States of America
Secretary of Department of Health and Human Services

By: _____
Director, Indian Health Service

Date: 6-14-2019

Norton Sound Health Corporation On Behalf of Itself and Certain Alaska Native Tribes, Identified in Exhibit A of the Compact.

By: _____
Angie Gorn
President/CEO

JUN 14 2019

Date: _____

FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

Amendment Effective October 1, 2018

In accordance with Section 14.1 of the Norton Sound Health Corporation (NSHC) FYs 2018-2020 Multi-Year Funding Agreement (MFA), NSHC's MFA is hereby amended as follows:

1. Section 3.2.9 is amended as follows: "Emergency surgery, and minor and other outpatient day surgery, within the scope of qualified ~~expected capability of~~ Medical Practitioners;"

2. Section 3.3.4 is amended to change the title from "Rainbow Services" to "Developmental Disability Program."

3. Appendix B, the list of facilities in which Norton Sound is carrying out health services, is amended as follows:

   In the portion pertaining to "Nome and all Villages," change the Facility Name to add the underlined language: "staff housing owned/rented including "Lawyer's apts," St. Michael Triplex, Golovin 2-bedroom home, and Savoogna duplexes".

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

By: Angie Gorn
Angie Gorn, President/CEO

6/4/2019
Date

United States of America
Secretary of
Department of Health and Human Services

By:
Director, Indian Health Service

8/2/2019
Date

FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

In accordance with Section 14.1 of the FYs 2018-2020 Funding Agreement made and entered into by Norton Sound Health Corporation (NSHC) and the Secretary of the Department of Health and Human Services of the United States of America, effective October 1, 2017, the Funding Agreement, as amended, is hereby further amended as follows:

1. **Appendices.** The following appendices are incorporated by reference and attached:

   - Appendix A (Financial Summary Agreement) FY 2021
   - Appendix B (Facility List) FY 2021

2. **Effective Date**. This amendment is effective October 1, 2020.

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

Angie Gorn 4/30/2021

By: _____ _____
Angie Gorn, President/CEO Date

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S Digitally signed by Evangelyn L. Dotomain -S Date: 2022.03.11 16:22:11 -09'00' _____
Alaska Area Director, Indian Health Service Date

Norton Sound Health Corporation

Appendix A - Financial Summary Tribal Shares Funding Agreement - FY 2021

Tribal Share Summary Norton Sound Health Corporation	FY 2021 Negotiated Amount	NSHC Restricted	Total Due NSHC	Initial Lump Sum Payment
Area TS Amount	$1,094,886	$45,473	$1,049,412	$1,049,412
	0		0	0
Subtotal Area TS Amount	$1,094,886	$45,473	$1,049,412	$1,049,412
Headquarters TSA Amount	$828,953	$93,107	$735,846	$735,846
Headquarters Other Program Formula (OEHE)	$48,412	$48,412	$0	$0
Subtotal Headquarters TS amounts	$877,365	$141,519	$735,846	$735,846
Total Tribal Shares	$1,972,250	$186,992	$1,785,258	$1,785,258

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Driving Variables Norton Sound Health Corporation	FY 2021
Population (2010 Census AN/AI population)	7749
Tribes (Federally Recognized Tribes)	20
Recurring Base - FY 2013 (less VBC)	$34,794,479
Percentage of Total Area TS (of all Alaska Tribes)	8.12295%
Percentage of ATHC (of all Title V Alaska Tribes)	8.22359%
Number of MOA employees	3
Number of IPA employees	0

Individually Restricted Items Norton Sound Health Corporation	FY 2021
Area Office (Individual Restricted Only)	
Supply Service Center	YES
Emergency Medical Services	NO
Village Clinic Leasing Management	YES
Headquarters (ATHC Restricted Only)	
ACOG	YES
OIT - Negotiated Alaska Plan	YES
Clinical Sup. Ctr. (Inc. CME Cert.)	YES

Appendix A - Financial Summary for Funding Agreement-Area Tribal Shares
Norton Sound Health Corporation

Line #	FY 2021 Budget Activity/Service	Total Area Budget	Residual Amount	ATHC restricted		Total AO Tribal Shares	NSHC AK Dist.	NSHC Retained	NSHC Total TS Due
				Trans. Fed.	ANTHC				
		(Column 1)	*(Column 2)*	*(Column 3)*	*(Column 4)*	*(Column 5)*	*(Column 6)*	*(Column 7)*	*(Column 8)*
1	TRIBAL SHARE FUNDS	$11,900,108	$0		$0	$11,900,108	$966,640		$966,640
2									
3	AREA OFFICE PFSAs (excluding OEHE)								
4	Area Office PFSA's	$4,193,809	$2,442,960	$681,500	$1,069,349	$0	$0		$0
5	Lease Costs-	$1,657,267	$185,820	$193,220	$1,278,227	$0	$0		$0
5a	Space Costs- negotiations	$19,000	$0	$19,000					
6	Area Director's Reserve	$100,000	$0	$100,000	$0	$0	$0		$0
7	Headquarters Assessments	$488,590	$54,720	$230,202	$203,668	$0	$0		$0
8	Human Resources	$849,441	$210,962	$356,311	$282,168	$0	$0		$0
9	Human Resources (ANMC) funds	$0	$0	$0	$0	$0	$0		$0
10	Area PFSA transferred to ANTHC	$3,028,546	$0	$0	$3,028,546	$0	$0		$0
11	CHC Reserve	$1,555,064	$0	$0	$1,555,064	$0	$0		$0
12	Area Managed Care	$723,423	$0	$0	$723,423	$0	$0		$0
13	ANHB (inc. tobacco funds)	$389,983	$0	$0	$389,983	$0	$0		$0
14	Supply Service Center	$853,749	$0	$0	$335,598	$518,151	$42,089	$42,089	$0
15	Epidemiologists	$196,885	$0	$0	$0	$196,885	$15,993		$15,993
16	EMS program at ANMC	$195,140	$0		$0	$195,140	$15,851	*$0*	$15,851
17	Centers for Disease Control	$282,902	$0	$0	$282,902	$0	$0		$0
18	Subtotal Area PFSAs (ex. OEHE)	$14,533,798	$2,894,462	$1,580,233	$9,148,927	$910,176	$73,933	$42,089	$31,844
19									
20	OFFICE OF ENVIRONMENTAL HEALTH AND DESIGN								
21	Office of Envir. Hlth and Eng.-.(EH	$5,961,749	$244,466		$5,127,476	$589,807	$47,910		$47,910
22	Real Property/Realty (FSA)	$148,888	$92,682		$14,547	$41,659	$3,384	$3,384	$0
23	Health Facilities/Main./ Spec. Pro	$1,368,036	$114,204		$1,216,669	$37,163	$3,019		$3,019
24	Subtotal OEHE	$7,478,673	$451,352	$0	$6,358,692	$668,629	$54,312	$3,384	$50,928
25	**TOTAL AREA OFFICE**	$33,912,579	$3,345,814	$1,580,233	$15,507,619	$13,478,914	$1,094,886	$45,473	$1,049,412

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General Notes on Alaska Area Office Tribal Shares

Column 1 - Includes all FY17 changes allocated to TS, Residual, & Transitional as of FY17. In FY 2019 TS changes will be added as received.

Column 2 - Residual includes no changes in residual functions. Based on FY2018 Area approved residual budgets.
Remaining funds at 9/30 distributed (Non-Recurring) to all Alaska Area health programs based on recurring base.

Column 3 - Transitional funds agreed by co-signers to remain at Area Office. Based on FY2018 approved transitional budget.

Column 4 - Restricted by all co-signers & transferred to the ANTHC to provide "Area PSFAs" .

Column 5 - Includes Area TS for all Alaska Tribes, including Title I & Title V. FY19 mandatories to be added if received.

Column 6 - Available Tribal shares for Co-Signer (amounts for ANTHC include pass-through to awardees with shares captured by Sec. 325).
Distributed by the approved ATHC methodology of - 30% # of Tribes / 35% 2010 Census Pop. / 35% 2013 Rec. Base (less VBC).
All Area TS for Services line items will be recurring, Area TS for Facilities will be non recurring.

Column 7 - Items restricted by individual co-signer to pay for continued services from ANTHC. (Restricted amounts are added to ANTHC FA.)

Column 8 - The agreed upon amount due (col. 6 - col. 7) to the co-signer after all retained shares are withheld.

Line 1 - All TS funds for non-OEHE Area Office PSFAs except where co-signers have individually decided to retain certain PSFAs at the ANTHC or AANHS.

Line 5 - Lease on Inuit Building.

Line 5a - $20,000 (less sequester) from transitional funding held by IHS to rent space for annual negotiations. Funds transferred to ANTHC upon confirmation of space availa

Line 7 - Centrally paid expenses, including personnel & finance support for Area positions, costs & funds for departmental assessments.

Line 8 - Area Human Resources functions (previously Office of Personnel & Training).

Line 9 - Funding originally from ANMC - have all been returned to SCF/ANTHC as IPA/MOAs were reduced.

Line 10 - Includes funding for Area PSFAs transferred to ANTHC under Section 325.

Line 11 - Funds to ANTHC to support the statewide Contract Health Services reserve program.

Line 12 - Funds to ANTHC to support specialized services in Barrow, NSHC, & BBAHC & certain statewide laboratory contracts.

Line 13 - ANHB funds from Loc 77 including previous tobacco prevention funding.

Line 14 - Supply Service Center individually withheld amounts retained for ANTHC for all co-signers except YKHC, Seldovia, & Eklutna.

Line 15 - Funds distributed to support the Epidemiology Center distributed to co-signers for individual payment to ANTHC.

Line 16 - Funds for EMS training. Retained by IHS for transfer to ANTHC for Maniilaq, BBAHC, & Chugachmiut for EMS training at ANMC.

Line 18 - Does not include funds from surcharge, assessments, or other services purchased through Area Office.

Line 22 - Funds retained for ANTHC for all co-signers except YKHC, SCF, & KIC.

Line 24 - Does not include NR SFC funds for Health Facilities design and construction oversight.

Appendix A - Financial Summary for Annual Funding Agreement - Headquarters Tribal Shares
Norton Sound Health Corporation

Sub Act.	Line Item	Account	TSA	PF	BB	National FY 2021 TSA Pool	Chickaloon inc in All AK	Knik in All AK	All Alaska	ATHC Eligible Shares Total ATHC TS	NSHC Eligible shares	Co - Signer 0% Retained	0 Due
						Column 1				*Column 2*	*Column 3*	*Column 4*	*Column 5*
Hospitals and Clinics													
	101	Emergency Fund		x		$3,956,016			$462,063	462,063	End of year funds to be dist. on AK TSA formula.		
	104	Inter-Agency Agreements				$0			$138,380	138,380	$11,380	$0	$11,380
	105	Management Initiatives		x		$2,049,512			$239,383	239,383	End of year funds to be dist. on AK. TSA formula.		
	106	A.C.O.G. Contract	x			$98,592			11,209	11,209	$922	$922	$0
	107	H.P./D.P. Initiatives	x			$3,484,867			200,844	200,844	$16,517	$0	$16,517
	110	N.E.C.I.	x			$1,107,951			124,173	124,173	$10,211	$0	$10,211
	111	Nurse Initiatives	x			$1,287,656			140,892	140,892	$11,586	$0	$11,586
	112	Nursing Co-steps	x			$648,528			72,677	72,677	$5,977	$0	$5,977
	113	Chief Clinical Consultant	x			$277,340			31,086	31,086	$2,556	$0	$2,556
	115	Emer. Medical Svcs	x			$465,222			41,980	41,980	$3,452	$0	$3,452
	117	Traditional Advocacy Prog.	x			$100,578			11,272	11,272	$927	$0	$927
	118	Research Projects	x			$1,283,252			143,088	143,088	$11,767	$0	$11,767
	119	A.A.I.P. Contract	x			$26,731			2,994	2,994	$246	$0	$246
	120	Clinical Support Center-Phoenix	x			$1,744,883			204,917	204,917	$16,852	$2,549	$14,302
	121	Co-steps Non-physicians	x			$81,839			9,159	9,159	$753	$0	$753
	123	Physician Residency	x			$277,416			31,093	31,093	$2,557	$0	$2,557
	124	Recruitment/Retention	x			$2,057,393			230,592	230,592	$18,963	$0	$18,963
	125	U.S.U.H.S., etc.	x			$3,071,317			344,246	344,246	$28,309	$0	$28,309
	126	DIR Support Fund	x			$24,915,898			2,762,946	2,762,946	$227,213	$63,165	$164,048
	127	Evaluation	x			$1,063,992			119,272	119,272	$9,808	$0	$9,808
	128	National Indian Health Board	x			$459,114			51,111	51,111	$4,203	$0	$4,203
	129	Albq./HQ Administration	x			$892,404			112,813	112,813	$9,277	$0	$9,277
	130	Nutrition Training Center	x			$345,053			41,806	41,806	$3,438	$0	$3,438
	131	Diabetes Program- Albq./HQ	x			$1,295,589			151,342	151,342	$12,446	$0	$12,446
	132	Cancer Prevention- Albq./HQ	x			$716,968			84,278	84,278	$6,931	$0	$6,931
	133	Health Records	x			$136,277			12,043	12,043	$990	$0	$990
	134	AIDS Program	x			$422,971			78,823	78,823	$6,482	$0	$6,482
	135	Handicapped Children	x			$346,083			40,775	40,775	$3,353	$0	$3,353
	137	National OIT Sup.- Albq./HQ	x			$8,292,508			925,939	925,939	$76,145	$21,168	$54,977
	154	Prescription Drug Monitoring	x			$1,002,361			$115,171	115,171	$9,471	$0	$9,471
Dental Health													
	201	IHS Dental Program	x			$2,505,120			$300,609	300,609	$24,721	$0	$24,721
	202	IHS Dental Program- Program formula		x		$5,269,192					$0	$0	$0
Mental Health													
	301	MH/SS Tech. Asst.	x			$1,542,507			$174,272	174,272	$14,331	$0	$14,331
	302	C.M.I. Grants	x			$628,310			$70,130	70,130	$5,767	$0	$5,767
	303	National Conference	x			$107,552			$11,990	11,990	$986	$0	$986
Alcohol/Sub. Abuse													
	401	Clinical Advocacy	x			$3,148,617			$516,623	516,623	$42,485	$0	$42,485
	402	Collaborative Initiatives	x			$848,033			$48,451	48,451	$3,984	$0	$3,984

Appendix A - Financial Summary for Annual Funding Agreement - Headquarters Tribal Shares
Norton Sound Health Corporation

Sub Act.	Line Item	Account	TSA	PF	BB	National FY 2021 TSA Pool	Chickaloon inc in All AK	Knik in All AK	All Alaska	ATHC Eligible Shares Total ATHC TS	ATHC Eligible Shares NSHC Eligible shares	Co - Signer 0% Retained	Co - Signer 0 Due
						Column 1				*Column 2*	*Column 3*	*Column 4*	*Column 5*
Contract Health Care													
	501	Fiscal Immediary		x						$0	$0	$0	$0
	504	C.H.S. Reserve & Undistrib.	x			$3,377,832			$361,250	361,250	$29,708	$0	$29,708
Public Health Nursing													
	601	Preventive Health Initiatives	x			$951,210			$103,180	103,180	$8,485	$0	$8,485
	602	Preventive H. Init. - Prog. Formula		x							$0	$0	$0
Health Education													
	701	IHS Health Education Program	x			$1,133,793			$127,796	127,796	$10,509	$0	$10,509
CHR													
	801	IHS CHR Program	x			$2,412,266			$267,854	267,854	$22,027	$0	$22,027
Direct Operations													
	1301	Direct Operations	x			$13,847,784			$1,557,559	1,557,559	$128,087	$0	$128,087
	1301a	Direct Operations- OIT	x			$2,716,551			$305,550	305,550	$25,127	$5,302	$19,825
	1302	Direct Ops Dental	x			$0			$0	-	$0	$0	$0
Facilities and Environmental Health Services													
	2401	Sanitation Fac. Construction Sup.		x		$6,761,916				$325,101	$0	$0	$0
	2402	Environmental Health Ser. Support		x		$5,114,837				$197,905	$25,264	$25,264	$0
	2403	Facilities & Property Support		x		$24,019,205				$221,409	$17,947	$17,947	$0
	2404	Facilities Engineering Support		x						$0	$0	$0	$0
	2405	Engineering Services Support		x						$51,699	$5,201	$5,201	$0
TOTAL TSA AMOUNT						$89,122,358	$0	$0	$10,080,185	10,080,185	$828,953	$93,107	$735,846
TOTAL PROGRAM FORMULA AMOUNT						$47,170,678				$1,497,560	48,412	$48,412	$0
TOTAL HEADQUARTERS TRIBAL SHARE						$136,293,036				$11,577,745	$877,365	$141,519	$735,846

Column 1 - All numbers are based on HQ PFSAs for FY20 Table #4 dated 1/13/20 & FY21 Table 4F dated 7/16/20 (facilities)
Column 2 - All numbers are based on HQ PFSAs for FY20 Table #4 dated 1/13/20 & FY21 Table 4F dated 7/16/20 (facilities)

Column 3 - Individual Co-Signer share of column 2.
Column 4 - Co-Signer amounts left with (retained by) IHS to provide service- If service is not available IHS shall pay to each Co-Signer amount provided.
Column 5 - This column (col. 3 - col. 4) is the HQ. TS funds due to Co-Signer, calculated by Alaska TSA formula.
All Headquarters Tribal Shares shall be recurring except for Facilities (lines 2401 -2405) and funds in lines 101 and 105.
Line 101 - Any funds remaining will be distributed non recurring on 9/30 (from HQ by TSA formula) and to each Co-Signer on ATHC distribution method.
Line 105 - Any funds remaining will be distributed non recurring on 9/30 (from HQ by TSA formula) and to each Co-Signer on ATHC distribution method.
Line 106 - All Alaska Co-Signers restricted all funds to continued advanced OB training opportunities for all Alaska Area physicians.
Line 120 -Alaska Co-Signers restricted a total of $31,000 dollars for the clinical support center for CME certification and "IHS Provider" magazine.
Line 124 - BBAHC, EAT, Chugachmiut, Eyak, and Maniilaq retrocede 50% of line 124 to IHS in exchange for use of recruitment website ihs.gov/jobs.
Line 126, 137 -DIR withheld were computed at 27.8% of each Co-Signer on ATHC proposal. See Section 1 of the Funding Agreement.
Line 0154 New line for Prescription Drug monitoring. Full share included in co-signers TS.
Line 201 - Dental Program - approximately $800,000 transferred to line 1302 in Direct Ops Dental. No impact on TS.
Line 1301a - DIR Withheld was computed at 21.1% of each Co-Signer share based on continuing agreements with Dir. DIR.
Linr 1302 - Direct Ops Dental is now in line 201
Lines 2401-2405 - Funds available for OEHE support functions (from table 4f) provided based on national formula at tribal option.

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Name of Tribe/Tribal Org. **Norton Sound Health Corporation** **58G950016**

Contract/Compact Period **October 1, 2020 through September 30, 2021**

	Initial Negotiated Annual Funding Agreement						
	Budget Activity	Program/Service Unit Base		Area Tribal Share	Headquarter Tribal Share	Contract (Reductions)	Net Annual Payment Obligation
		Recurring	Non-Recurring	0.081229506		IPA/MOA	
		(1)	(2)	(3)	(4)	(5)	1+2+3+4+5=(6)
1	Hospitals & Clinics	$23,213,352		$275,437	$424,929	($224,613)	$23,689,105
2	Dental	$2,533,887		$17,016	$24,721	$0	$2,575,624
3	Mental Health	$765,746		$104,878	$21,085		$891,708
4	Alcohol & Substance Abuse	$1,174,320		$69,541	$46,469		$1,290,330
5	Public Health Nursing	$1,063,687		$9,956	$8,485		$1,082,128
6	Health Education	$117,928		$20,402	$10,509		$148,840
7	Community Health Representativ	$329,970		$7,517	$22,027		$359,515
8	Immunization (AK only)	$10,316		$28,276	$0	$0	$38,592
9	Direct Operations	$40,186		$347,386	$147,913		$535,484
10							
11							
12	Self-Governance				$0		$0
13	Other, Services (Annual)						
14	TOTAL, Services (Annual)	$29,249,392	$0	$880,409	$706,138	($224,613)	$30,611,327
15	Purchased/Referred Care	$13,412,656		$118,066	$29,708		$13,560,429
16	Operational Cost for Tribal Clinics					0	$0
17	Environmental Health Support	$661,707		$47,910			$709,617
18	Facilities Support	$1,828,331		$3,028			$1,831,359
19	OEHE Support				$0		$0
20	Maintenance & Improvement		$1,462,821		$0		$1,462,821
21	Sanitation Facilities - Housing				$0		$0
22	Sanitation Facilities - Regular				$0		$0
23	Equipment		$180,666				$180,666
24	TOTAL, Facilities	$2,490,038	$1,643,487	$50,937	$0	$0	$4,184,463
25	Current year CSC Direct	$4,630,788					$4,630,788
26	Current year CSC Indirect		$12,264,014				$12,264,014
27							
28	Other (*See* Remarks)						$0
29	TOTAL, CSC	$4,630,788	$12,264,014	$0	$0	$0	$16,894,802
30	Quarters						$0
31	Contract Health Services (Prior Year)						$0
32	Indian Health Facilities (Prior Year)						$0
33	Others						
34	TOTAL, Other	$0	$0	$0	$0	$0	$0
35					$0		$0
36	**GRAND TOTAL, AFA**	**$49,782,874**	**$13,907,501**	**$1,049,412**	**$735,846**	**($224,613)**	**$65,251,021**

Footnotes:

The FA program funding amount in column 1 and 2 are as of FA 12 dated 7/31/2020

The FA funding also includes all funds from Diomede ISDA TI agreement transferred in FY15.

Line 20 and 23 - Routine M&I and Equipment funding is estimated at 90% of prior FY amount for lump sum payment -subject to adjustn with Sec. 4 of the FA.

d Health Corporation

Norton Sound Health Corporation
Withhold Calculation

The Co-Signer will "withhold" 100% of all estimated costs for IPA/MOA, SSC, VBC, **No**

surcharge **0.285%** **(Yes or No)**

The Co-Signer will "withhold" the minimum initial amount for IPA, etc., and "buyback" services. **Yes**

0.285% **(Yes or No)**

Service	Annual Amount (1)	(2)	(3)	Total Annual Estimated Costs	Est. Monthly Payment	Initial Auth. Withhold
	(1)	(2)	(3)	1+2+3=(4)	(4)/12=(5)	*see* Footnotes
H & C						
IPA/MOA Personnel Costs	$566,729	18,731	$1,615	$587,076	$48,923	$195,692
VBC	$0		$0	$0	$0	$0
Other	$86,516		$247	$86,763	$7,230	$28,921
SUBTOTAL H & C	$653,245	$18,731	$1,862	$673,838	$56,153	$224,613
DENTAL						
IPA/MOA personnel costs			$0	$0	$0	$0
Supply Service Center		$0	$0	$0	$0	$0
All other costs-			$0	$0	$0	$0
SUBTOTAL DENTAL	$0	$0	$0	$0	$0	$0
IMMUNIZATION						
IPA/MOA personnel costs			$0	$0	$0	$0
Supply Service Center		$0	$0	$0	$0	$0
Village Clinic Leases			$0	$0	$0	$0
All other costs-			$0	$0	$0	$0
SUBTOTAL IMMUNIZATION	$0	$0	$0	$0	$0	$0
T-CLINIC						
VBC Increases			$0	$0	$0	$0
		$0	$0	$0	$0	$0
			$0	$0	$0	$0
SUBTOTAL T-CLINIC	$0	$0	$0	$0	$0	$0
Withhold Total	$653,245	$18,731	$1,862	$673,838	$56,153	$224,613

Footnotes:

Column 2 - IPA/MOA Centrally Paid Expenses are estimated at $588 for each IPA and $6,243.81 for each MOA.

Column 2 - IPA/MOA Centrally Paid Expenses are estimated at $588 for each IPA and $5,293.74 for each MOA.

Employee Dispute Pool Costs are no longer charged in advance (*see* Section 2.3.2.3 of Buyback Agreement).

Column 3 - Surcharge for all Co-Signers using buyback is .285%

This sheet not to be included in Appendix A - Provided to assist in completing Section 4 of the FA then disca

Norton Sound Health Corporation	
Recurring base	$49,782,874
Non Recurring base	$13,907,501
Subtotal recurring and non recurrir	$63,690,375
Area tribal Share	$1,049,412
HDQ TSA Tribal Share	$735,846
HDQ program formula tribal share	**$0**
Subtotal tribal shares	$1,785,258
TOTAL Funding Agreement	$65,475,634

non recurring includes M & I $1,462,821

FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

Amendment Effective December 30, 2018

In accordance with Section 14.1 of the Norton Sound Health Corporation (NSHC) FYs 2018-2020 Multi-Year Funding Agreement (MFA), as amended, the NSHC and IHS agree to the following revision:

Appendix B (as previously amended) is hereby further amended and restated by the version of Appendix B attached.

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

Angie Gorn 12/9/20

By: _____ _____
Angie Gorn, President/CEO Date

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S Digitally signed by Evangelyn L. Dotomain -S Date: 2021.01.05 14:53:56 -09'00' _____
Director, Indian Health Service Date

Norton Sound Health Corporation Funding Agreement - Appendix B
Fiscal Years 2018-2020

This non-exhaustive list of Tribal Facilities and Locations identifies the sites where Norton Sound Health Corporation owns, leases, occupies, or otherwise used real property to carry out its responsibilities under the Alaska Tribal Health Compact and its Funding Agreement. Each description of facilities and locations is intended to include surrounding and adjacent grounds.

Additionally, the cross references to specific PSFAs are not intended to limit the scope of PSFAS that may be performed at a facility or for which a facility may be used; rather, cross references are intended as an example of the type of PSFA that may be performed at the facility or of the manner in which a facility may be utilized. Cross references are not exhaustive and may not be construed to be exclusory of other PSFAs that may be performed at a facility or of the uses of the facility.

LOCATION	FACILITY NAME	TRIBAL PROGRAMS (including but not limited to)
Nome	Norton Sound Regional Hospital-Main Campus (Replacement Facility)	Section 3.1; Sections 3.2.1-3.2.7; Sections 3.2.9-3.2.13; Section 3.2.15; Section 3.2.16; Section 3.3.6; Sections 3.4.1-3.4.4; Sections 3.4.6-3.4.8; Sections 3.4.11-3.4.14; Section 3.5; Section 3.6; Section 3.7; Section 3.8.
Nome	Quyanna Care Center	Section 3.2.8
Nome	Hostel	Section 3.2.14
Nome	BIA EMT Training Center/Drug and Alcohol Rehabilitation Center	Section 3.2.13; Sections 3.3.1-3.3.3, 3.3.5-3.3.7; Section 3.4.6, 3.4.12
Nome	Kusgi House	Section 3.3.5, 3.3.6
Nome 607 Division Street	NSHC Behavioral Health Clinic	Section 3.3.1-3.3.3, 3.3.5-3.3.7; Section 3.4.10; Section 3.8
Nome	Health Aide Training	Section 3.4.5
Brevig Mission	Brevig Mission Clinic	Section 3.2.5, 3.2.10, 3.2.11; Section 3.3.1-3.3.3; Section 3.4.1-3.4.4, 3.4.12; Section 3.7; Section 3.8
Diomede	Diomede Clinic	Section 3.2.5, 3.2.10, 3.2.11; Section 3.3.1-3.3.3; Section 3.4.1-3.4.4, 3.4.12; Section 3.7; Section 3.8

All Villages	Village-Based Counselor Office Space	Section 3.3
All Villages	Village Based Morgues	Section 3.4.17

AMENDMENT TO
FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

In accordance with Section 14.1 of the FY's 2018-2020 Funding Agreement made and entered into by Norton Sound Health Corporation and the Secretary of the Department of Health and Human Services of the United States of America, effective October 1, 2017, the funding agreement, as amended, is hereby further amended as follows:

1. **Appendices.** The following appendices are incorporated by reference and attached:

   - Appendix C – FY 2020 Continuing Services Agreement

2. **Effective Date**. This amendment is effective October 1, 2019.

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

By: Angie Gorn
Angie Gorn, President/CEO

3/29/21
Date

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S
Digitally signed by Evangelyn L. Dotomain -S
Date: 2021.04.27 16:07:52 -08'00'
Director, Indian Health Service

Date

MEMORANDUM OF AGREEMENT DESCRIBING THE CONTINUING SERVICES OF THE INDIAN HEALTH SERVICE, ALASKA AREA NATIVE HEALTH SERVICE TO NORTON SOUND HEALTH CORPORATION FOR FY 2020

I. INTRODUCTION

This agreement provides for the continuation by the Indian Health Service (IHS) of certain services from the Alaska Area Office for the benefit of Norton Sound Health Corporation under its Funding Agreement (FA) under the Alaska Tribal Health Compact (ATHC) Self-Governance Compact.

This agreement is limited to the programs, services, functions, and activities (PSFAs) performed by the residual and transitional federal staff of the Alaska Area Office.

This agreement should be interpreted in conjunction with Norton Sound Health Corporation's FA and Appendix A to that FA, which may provide for additional detail on "restrictions" of funds at the Area or Headquarters level to ensure that specific services are continued to the individual Co-Signer.

In FY 2020, funding for these continuing services and activities will be from the funds, which have been designated as residual and from funds, which have been designated in support of temporary transitional federal PSFAs. In addition funding to purchase specific services, i.e., use of IPA/MOA assignees and Village Built Clinic leases, may be provided through reimbursement by Norton Sound Health Corporation to the IHS.

II. DEFINITIONS

The following definitions are in common usage in the Alaska Area:

A. ATHC Tribal Restricted Share - Used in Alaska to refer to those retained Tribal shares all compacting Tribes jointly initially agreed to leave in the Area Office in support of Alaska Area state wide PSFAs. Pursuant to Section 325 of PL 105-83, these shares now are in the Alaska Native Tribal Health Consortium (ANTHC) FA or are used for transitional federal PSFAs.

B. Buyback - The process by which Co-Signers use cash to purchase Area services from the Area Office. Requires accurate description and pricing of service, and mechanism for Area to invoice and receive payment.

C. Co-Signer Restricted Shares - Used in Alaska to refer to "retained Tribal shares" that have been left at the Area Office or Headquarters on an individual basis by a Co-Signer to allow the Area, Headquarters or ANTHC to provide specific services to the Co-Signer. Pursuant to Section 325 of PL 105-83, these Area shares now are in the ANTHC FA or are used for transitional federal PSFAs.

D. Residual - The resources necessary to support the PSFAs required for the United

A. OFFICE OF THE DIRECTOR

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Director	Provides overall executive direction and support on behalf of the Secretary.	R	1
Deputy Director, Chief Medical Officer	Provides public health advocacy; clinical consultation (CMO); legally required certification of health aide credentials and oversight of CHAP certification process; consultation in CHAP/Rural Health program management.	R	1
Executive Officer	Serves as principal advisor to the Director on overall management policies and procedures.	R	1
Attorney	Provides Region X attorney support and consultation.	R	1
EEO	Provides EEO support. 1		
Support Staff	Secretarial, clerical and administrative support to inherent and transitional federal functions at all levels of the Area Office.	R T	3 1
Planning, Evaluation & Statistics	Prepare statistical reports and publications in support of planning, evaluation and resource allocation requirements.	R	2
	Total		10

The Office will provide the specific PSFAs defined below:

1. Executive direction on behalf of the Secretary to the remaining inherently federal functions.
2. Advocacy at national level on behalf of the Tribes of Alaska including: legislative, policy, resource allocation, and appropriation advocacy.
3. Policy formulation and interpretation; supervision of non-IPA/MOA federal employees; negotiate, execute and administer compacts and FAs; resource allocation.
4. Public health coordination with Tribal, state and federal governments.
5. Provide legal advice and consultation on behalf of the Secretary.
6. Provides representation on the Executive Committee and Planning Committee of the Alaska Federal Health Care Partnership (AFHCP). Through the government-to-government relationship with Tribes and Tribal organizations, provides the mechanism for Tribal membership on the AFHCP.
7. Eligibility determinations assistance.
8. Equal Employment Opportunity program management in support of federal employment rights.
9. Oversight of certification of Community Health Aides as outlined by law and the *IHS Community Health Aide Program Certification Board Standards and Procedures.*
10. Consultation and technical assistance to Tribes and Tribal organizations staff and programs including
    a. Program review or evaluation at the request of the Area Director or the invitation of Tribal programs;
    b. Submission of electronic health record data to IHS National Data Warehouse; and
    c. Maintain current Area statistics to provide statistical analysis in support of resource needs and allocations.

1 The EEO function is provided under an intra-agency agreement among the IHS Alaska, California and Portland Area Offices.

B. OFFICE OF ACQUISITION AND PROPERTY MANAGEMENT [2]

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Federal Contracting ,, Personal Property, and FOIA Coordinatio n	Responsible for federal acquisitions to support the Alaska Area Office, including the federal credit card program. Maintains the federal personal property inventory. Provides or coordinates various administrative services for the Alaska Area Office.	R	1
	Total		1

The Office will provide the specific PSFAs defined below:

1. Negotiate, award and administer federal acquisitions.
2. Maintain or develop Alaska Area Interagency and Cooperative Agreements in close partnership with appropriate IHS or other federal, state or Tribal entity(s).
3. Coordinate various administration functions including Freedom of Information Act requests and IHS delegations and directives.
4. Maintain the federal personal property management inventory, including excess and disposal.
5. Provide technical assistance to Tribally managed facilities on procurement issues as requested regarding procurement issues and acquired federal excess property.
6. Maintain the federal credit card program.

2 Residual (1) FTE moved to Office of Tribal Programs in support of Title 1 contracts and audit resolution.

a. Overall direction of resources and related environmental surveillance for statewide public health impacts.

b. Continue to carry out functions related to serving as one of the health and medical representatives to the Alaska Federal Emergency Response Group.

c. Provide management and verification of tribal input data in the IHS Environmental Health Services data system known as the Web-based Environmental Health Reporting System (WebEHRS).

d. Provide safety assurance, compliance and reporting relating to federal workers, and professional programmatic support for staff.

e. In the event of a national disaster situation as defined in the Federal Response Plan, IHS is the lead agency for emergency response related to water and sewer damage assessment and mitigation.

3. **Health Facilities:** PSFAs include:

a. Perform budget allocation;

b. Support and approve project or resource allocations derived through a priority system developed through the Maintenance & Improvement Resource Allocation Committee (MIRAC) and ANTHC process consistent with IHS national project eligibility criteria. Verify data submittals and manage IHS facilities databases in conformance with IHS national project and health facilities space eligibility criteria.

c. Respond to Congressional inquiries;

d. Review Project Justification Document/Program Of Requirements (PJD/POR) documents prepared by others;

e. Review and approve national priority systems applications, including Tribal Equipment Funds and Dental Facilities Funds;

f. Maintenance of Alaska portion of the IHS Healthcare Facilities Data System (HFDS) including the Facilities Maintenance and Improvement/Equipment database for federally and Tribally owned health facilities;

g. Support for new health facility construction project funds distribution and project development;

h. Stewardship responsibility for oversight of environmental cleanup of federally owned real property;

i. Approve workload statistics;

j. Advocate statewide and nationally for the DEHE program and facilitates its implementation.

4. **Realty:** PSFAs include:

a. Monitor and manage real property assets in accordance with Executive Order 13327, "Federal Real Property Asset Management" and existing authority under law or by executive order for real property, capital improvements, square footage, use or disposal.

b. Maintain the IHS Real Property Inventory by updating the asset book values with costs relating to acquisition of real property, capital improvements, square footage, use or disposal.

c. Verify construction project closeout documentation for capital improvements made to federal facilities prior to adjusting the real property subsidiary ledger.

d. Perform annual review of real property.

e. Warranted Lease Contracting Officer authorized to lease Village Built Clinics

Co-Signers and contractors to maintain accurate records of funding allocations, reconciliations and cash management issues.

8. Reconciliation, billing and amendment management related to contractor and compactor use of federal resources including but not limited to IPA/MOA employees and the Village Built Clinic lease program. Reconciliation includes transaction verification of buyback services with corrections and reports.

9. Support withhold and buyback management including payment for continuing government contracts for goods and services, permanent change of station moves, etc.

10. Monthly general ledger reconciliation including cash management related to Prompt Pay Act, Treasury, cash and others.

11. Process reimbursement requests including Beneficiary Medical Program (BMP), Interagency Payment and Collections (IPAC), quarters collections, CHEF and others. Make deposits and transfers of such reimbursements to Co-Signers no less often than monthly.

12. Assist Tribes during annual Budget Formulation for the second succeeding year's annual budget, including preparation for the National Budget Formulation meeting.

E. OFFICE OF HUMAN RESOURCES

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Civil Service Staffing, Classification & Employee/ Labor Relations	Advertise and recruit for federal, direct and IPA/MOA replacements; process personnel and pay actions; provide job information; maintain official records; rate applicants, appoint new employees, and provide HR consultation; Title 38 and Physician's Comparability Allowance, Market Pay & Locality Pay maintenance; process Reduction in Force and counseling; provides transportation services and relocation assistance for federal employees and consultation re: Tribal direct hires as requested; administers Workers' Compensation program; grievances, discipline/adverse actions; Merit Systems Protection Board, appeals and agency representation; performance management; retirements; payroll; benefits; outside activities; ethics program; suitability adjudication; manage Federal Employee Assistance program and Family Medical Leave and Family Friendly Acts consultation; conducts desk audits; applies Classification Standards and consultation. Initiate and assure completion of suitability investigations as needed on federal employees and personal services contractors.	R T	2 0
	Total		2

Under the direction of the IHS Western Region Human Resources Director, the Office of Human Resources will provide the specific PSFAs defined below for the current approximately 340 federal employees employed either directly or through Civil Service IPAs (58) or Commissioned Corps MOAs (254):

1. Advertise and recruit for direct federal employees. Replacement IPA positions may be filled with a current IPA already on board (such as by reassignment) or a new or replacement MOA. Process Reductions In Force (RIF). Provide counseling on RIF.

2. Maintain official personnel files (electronic and paper) and records for Civil Service employees.

F. COMMISSIONED CORPS PERSONNEL[4]

P/S/F/A	MAJOR FUNCTIONS	Buyback	Staffing (FTE)
Commissioned Corps Personnel	Orient and assist officers and their families to include: recruitment support, liaison between areas, TRICARE advice, wage verifications, grievances, leave programs, COERs and COSTEP. As necessary, Corps-specific personnel discipline advice to CEOs and HR staff of 638 awardees with MOA assignees and supervisors of MOAs.	B	2
	Total		2

Under the direction of the IHS Division of Commissioned Personnel Support, the Commissioned Corps Personnel component will provide the specific PSFAs defined below for the approximately 259 USPHS Commissioned Officers in the Alaska Area:

1. Provide general orientation to new Commissioned Officers.
2. Counsel Commissioned Officers; provide Corps-specific discipline advice to appropriate Co-Signer managers.
3. Maintain unofficial files and records for Commissioned Officers.
4. Process required federal personnel actions for Commissioned Officers including orders for deployment.
5. Assist and consult with officers and their supervisors.

G. OFFICE OF TRIBAL PROGRAMS

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Director	Management of Area Title V responsibilities for Self-Governance and Title I review, approval and technical assistance. Managing CHEF submissions, and fund distribution; clerical and secretarial support.	T	1
Health Care (Management) Consultation	Title V compacts/FAs (including amendments and database management of same), cooperative agreements, and grants; negotiate and administer CSC funds.	T	3
Health Care [5] (Management) Consultation	Negotiate, manage, and execute Title I contracts. Review audit findings and work with Tribal contractors to resolve as needed.	R	1
	Total		5

The Office will provide the specific PSFAs defined below:

1. Provide or facilitate technical assistance to Tribes which may or may not lead to the preparation of proposal(s) to assume PSFAs for Title I contracting, Title V compacting and Tribal Management grants for Tribes and Tribal organizations
2. Evaluate P.L. 93-638 proposal(s) to determine acceptance, declination or rejection; if

4 During FY 2005 this PSFA was centralized under the Division of Commissioned Personnel Support at IHS Headquarters. Effective FY 2006, it is funded by assessing the locations that use Commissioned Officers. See, also, Appendix A.

5 Formally P/S/F/A: Federal Contracting Title I awards, (1) Residual FTE moved from the Office of Acquisition and Property Management; to support Title I contracts and audit resolution.

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S
Digitally signed by Evangelyn L. Dotomain -S
Date: 2021.04.27 16:06:22 -08'00'

Director
Alaska Area Native Health Service, IHS

Date: _____

Norton Sound Health Corporation
on Behalf of Itself and Certain Alaska Tribes,
Identified in Exhibit A to the Compact.

By: Angie Gorn

Angie Gorn, President/CEO
Norton Sound Health Corporation

Date: 10/30/2020

Appendix D
Buyback/Withhold Agreement
between
the Indian Health Service
and
Norton Sound Health Corporation

Section 1. Generally. Pursuant to Section 5.3 of the Funding Agreement between Certain Alaska Native Tribes Served by Norton Sound Health Corporation (hereinafter "NSHC") and the Secretary of the Department of Health and Human Services of the United States of America (hereinafter "Secretary"), NSHC has determined that it wishes to carry out its responsibility to provide certain programs, activities, functions or services (e.g. salaries of IPA/MOA employees, and Village Built Clinics Program) included in its Funding Agreement utilizing services, personnel or other resources of the Federal Government, (hereinafter "services") under Article V, section 22 of the Compact, as permitted by law. These services may include some that are expected to be used throughout the year and some incidental services to be identified by NSHC on an as needed basis, and provided by the Indian Health Service (hereinafter "IHS") when IHS has the capacity to do so. The cost of providing the purchased services to NSHC shall be determined under section 2 below. NSHC's purchase of services is contingent upon the availability of IHS resources to provide those services. In addition, services must be paid for in advance, in order to avoid violation of the Anti-Deficiency Act and are subject to full cost recovery in accord with 25 USC 458aaa-7(f) and 31 USC 9701.

Section 2. Determination of Cost.

2.1 Generally. NSHC may acquire services from the IHS by either providing for full year withhold (with appropriate reconciliation) under terms agreed upon in this funding agreement, in which case the administrative surcharge provided for under section 2.2.4 shall not apply. In the alternative, NSHC may acquire services by authorizing partial year withhold amounts, as provided for in section 2.2, in which case the payment schedule and administrative surcharge provided for in section 2.2.4 shall apply. Whether full or partial year withhold is authorized, the full costs of IPA/MOAs including those detailed in section 2.3, Determination of IPA/MOA Costs, shall be paid by NSHC.

2.2 Conditions for Partial Year Withhold and Buyback.

2.2.1 IPA/MOA.

2.2.1.1 Advance withhold. The funds for IPA/MOA salary and other costs detailed in section 2.3, "Determination of IPA/MOA Costs," will be paid as a lump sum in accord with Section 5(a) of the Funding Agreement, except that an amount equal to three monthly payments based on the initial mutually agreed upon estimate of the annual IPA/MOA salary costs and related surcharges, as provided in section 2.2.4, will be withheld and retained by the Indian Health Service pending final disbursement for the last three months of the fiscal year as provided in section 3.2.2.2.

services to NSHC.

2.3 Determination of IPA/MOA Costs.

2.3.1 List of Costs. It is agreed by the parties that the entire cost of IPA/MOA assignments, including costs associated with the initiation, maintenance, and termination of the assignments are the responsibility of NSHC. The IHS must be reimbursed for all such costs which include but are not limited to the following:

2.3.1.1 Permanent change of station costs including the cost of moving replacement IPAs from the lower forty-eight to Alaska and the cost of moving IPA employees who separate back to the lower forty-eight.

2.3.1.2 Recruitment, relocation and retention bonuses if such funds are necessary to attract or retain employees.

2.3.1.3 Severance pay for employees who are released by NSHC and separated without cause.

2.3.1.4 Payment of turnaround leave travel expenses. All individuals who are eligible for these expenses shall be identified in the IPA negotiated between the parties. The IHS will retain liability for existing IPAs. NSHC assumes the liability for new IPAs and upon renewal of an existing IPA.

2.3.1.5 Lump sum leave payments for employees who leave federal service. All leave accrued prior to the employee becoming employed by NSHC shall be identified in the IPA/MOA negotiated between the parties. The liability for accrued leave on existing, renewing, and new IPA/MOAs shall be the responsibility of NSHC.

2.3.1.6 Costs associated with settling or resolving employment related disputes, subject to the terms specified in section 2.3.2 below.

2.3.1.7 Centrally paid expenses, subject to the terms specified in section 2.3.3 below.

2.3.1.8 The cost of paying unemployment benefits assessed to the Area in FY 2002 and thereafter on behalf of an employee who was employed by NSHC under an IPA immediately prior to voluntary or involuntary separation from IHS regardless of the year in which unemployment benefits were paid. The NSHC is not responsible for unemployment costs that were assessed to the Area in Fiscal Years 2000 and 2001.

2.3.2 Costs Related to Employment Related Disputes.

2.3.2.1 Responsibilities of the IHS. The Indian Health Service shall be responsible for the payment of all costs of the IHS Office of Human Resources and any other section of the Indian Health Service, the Office of General Counsel, and the Department of

2.3.3 Costs Related to IPA/MOA Centrally Paid Expenses. Certain costs associated with IPA and MOA employees are paid centrally by Headquarters from Area funds. These include costs detailed in columns 6, 7, and 8 of the spreadsheet entitled "Allocation of Centrally Paid Expenses (Excluding FTS)," Corrected May 11, 1998, that was prepared by David Mather. These are costs associated with Commissioned Corps, Personnel and Payroll, and Balance of Human Resources. The Alaska Area Native Health Service may pay for or recover assessments from Headquarters to cover these identified costs by including in the monthly charge for each IPA or MOA the monthly cost to the IHS of such Centrally Paid Expenses. The cost charged NSHC for each IPA/MOA may not exceed the average cost per federal employee actually paid by IHS. For purposes of calculating the initial withhold amount and estimated monthly payments, the estimated average cost per month for each IPA or MOA is shown in Appendix A of the Funding Agreement.

2.4 Limitation on Obligations and Notice.

2.4.1 Obligations. IHS shall within 30 days provide notice to NSHC of the best available estimate of the costs that may be incurred under this Agreement of leases, contracts, salaries and related expenses and permanent change of station.

2.4.2 Content of Notices of Best Available Estimates and Costs. Notice of best available estimates under section 2.4.1 and full accounting of all costs due under section 3.3.1 shall include the amount, vendor and reason for obligation or expenditure, including the name of the employee, if any.

Section 3. Method of Payment.

3.1 Full Year Withhold. Payment for services being purchased from the IHS may be made by NSHC authorizing a withhold of the full year's initial mutually agreed upon estimate of the annual cost of each category of services NSHC proposes to purchase from the IHS. In such case, no monthly payments are due from NSHC. Upon periodic reconciliation, provided for under section 3.3.1, excess withheld funds will be paid by the IHS to NSHC and adjustments in the amount of withhold or payments needed to pay for all services NSHC has purchased, or proposes to purchase, will be made to the IHS by NSHC. *See* "Summary of Withhold/Buyback" page of Appendix A for calculation of the amount NSHC hereby authorizes for full year withhold, if any.

3.2 Purchases through Buyback under section 2.2.

3.2.1 Calculations.

3.2.1.1 Of Initial Estimated Monthly Payment. The initial estimated monthly payment is determined by estimating the annual cost of services to be purchased from IHS, including the surcharge on all services under section 2.2.4, and dividing by 12. *See* "Summary of Withhold/Buyback" page of Appendix A for calculation of the amount of the initial estimated monthly payment.

reconciliation is due any under recovery must be paid by NSHC.

3.3.2 For Administrative Surcharge.

3.3.2.1 Use and Rebate. The administrative surcharge shall be used exclusively for administration of the buyback provisions under this Buyback/Withholding Agreement. All income from the administrative surcharge will be accounted for separately and compared on an annual basis to the cost of administering buyback at the Area Office. This accounting and reconciliation shall be complete within 60 days of the end of the last day of the fiscal year. Any surplus in administrative surcharges shall be returned to the Co-Signers who participated in the buyback option on a pro rata basis depending on the amount of administrative surcharge paid.

3.3.3 Adjustment in Estimated Monthly Payment. In addition to adjustments in estimated payments that may occur under sections 3.3.1 and 3.3.2.1, the parties may at any time mutually agree, based on a change in circumstances, to change the estimated monthly payment due from NSHC.

3.4 Use of Other Funds Due NSHC to Avoid Default or Satisfy Obligations to IHS and other Remedies.

3.4.1 Avoiding Default. Default may be avoided to the extent funds are held by the IHS from other funds due to NSHC, which may be withheld to satisfy the amount of the payment, which would otherwise be in default or to satisfy amounts due IHS after reconciliation of costs and payments when an amount is due to IHS.

3.4.2 Recoupment. Any amount due to the IHS by reason of NSHC's failure to pay in full all amounts owing under the buyback provisions of the Funding Agreement for the immediately preceding fiscal year shall be recouped by the IHS from any funds due to NSHC under this funding agreement.

3.4.3 Full Year Withhold as Penalty for Default. Notwithstanding any other provision of this Buyback/Withholding Agreement, the IHS may require "full year withhold" as permitted herein as a condition of permitting a Co-Signer who was in arrears at the end of the immediately preceding fiscal year to buyback services from the IHS under the terms of this Agreement.

Section 4. Dispute Resolution. The parties shall endeavor to resolve any disputes concerning amounts due by NSHC under this Agreement in a manner agreeable to NSHC and to the IHS. In the event of a failure to reach agreement on the resolution of any such dispute, NSHC may, after providing written notice to the IHS, choose not to include the disputed amount in any subsequent payment due. Payment in such a manner shall not be considered as a resolution of the dispute. The parties shall thereafter attempt to resolve the dispute through Alternative Dispute Resolution following, as appropriate, the principles and processes set forth in Executive Order 12988 signed by President Clinton on February 5, 1996, and made effective as of May 5, 1996. NSHC shall have the option of resolving the dispute in accordance with Article

Funding Agreement Appendix E

P.O. BOX 966
NOME, ALASKA 99762
(907) 443-3311

NORTON SOUND HEALTH CORPORATION

Norton Sound Health Corporation

RESOLUTION # 2010-16
Services for Non-Eligible Individuals

WHEREAS, the Norton Sound Health Corporation (NSHC) is a tribal organization that is a Co-Signer of the Alaska Tribal Health Compact (ATHC) and has negotiated a Funding Agreement (FA) with the Indian Health Service (IHS) under Title V of the Self-Determination Education and Assistance Act (ISDEAA); and

WHEREAS, the ATHC authorizes Co-Signers to provide services to non-eligible individuals provided Section 813 of the Indian Health Care Improvement Act (IHCIA) is complied with (*See* ATHC Article III, Section 4), and Section 813, as amended at 25 U.S.C. § 1680c(c)(2), provides that a tribe or tribal organization which operates a health facility under an ISDEAA agreement may make its own determination whether to provide health services to persons not otherwise eligible (i.e. non-beneficiaries) to receive IHS-funded health services; and

WHEREAS, NSHC is authorized to determine whether it will provide health services under its IHS-funded programs to persons who are not eligible beneficiaries under federal law, provided that NSHC gives consideration to whether the provision of such services will result in a denial or diminution of health services to eligible beneficiaries; and

WHEREAS, NSHC has determined that the provision of health services on a fee-for-service basis to non-beneficiaries, in an amount not less than the actual costs of providing such services, will not result in a denial or diminution of health services to beneficiaries; and

NOW THEREFORE, BE IT RESOLVED, that NSHC has decided to extend all available health services under the ATHC and its FAs to non-beneficiaries on a fee-for-service basis; and

BE IT FURTHER RESOLVED, that whenever significant evidence is presented to NSHC Board of Directors that services to non-eligible, non-beneficiaries have resulted in a denial or diminution of health services to beneficiaries, NSHC may suspend the delivery of such services to non-beneficiaries.

DATED this 25 day of June, 2010.

CERTIFICATION

The above Resolution was passed at a regular meeting of the Norton Sound Health Corporation Executive Board held on this 25 day of June, 2010 at Nome, Alaska at which a quorum was present. 8 FOR, 0 AGAINST, 0 ABSTAIN.

Attest: _____ Attest: Berda Willson
Emily Hughes, Board Chair — Berda Willson, Board Secretary

"Serving the communities of: Brevig Mission, Council, Diomede, Elim, Gambell, Golovin, King Island, Koyuk, Mary's Igloo, Nome, St. Michael, Savoonga, Shaktoolik, Shishmaref, Solomon, Stebbins, Teller, Unalakleet, Wales, White Mountain"

Norton Sound Health Corporation

APPENDIX F

PROJECT SUMMARY DOCUMENT

requirements. Cite specific, code or JCAHO references by standard clause, chapter, paragraph, etc.]

III. DEFICIENCIES

The following deficiencies will be corrected as part of this project:

[List and describe only those facility deficiencies this project will address. The types of deficiencies include BEMAR, JCAHO, NFPA, HFPM, Public Law compliance items, ADA, etc.]

IV. COST ESTIMATE

Provide a budgetary cost estimate and the funding sources for the proposed project, including separate line items for design Architect/Engineer fees, project construction, construction contract administration fees, and project contingency.

V. PROJECT SCORE SHEET DOCUMENT (*only required for BEMAR competitive pool funds*)

Complete a project score sheet further detailing the scope, impact and benefits of this project. Provide the information required by the project score sheet.

VI. OTHER PROJECT ITEMS TO BE ADDRESSED

Supporting Documents: Drawings, Photos, Estimates, Etc.

Norton Sound Health Corporation

APPENDIX G

ENVIRONMENTAL INFORMATION AND DOCUMENTATION

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

6. Does the proposed action have significant adverse direct or indirect effects on park land, other public lands, or areas of recognized scenic or recreational value?	Yes or No. Explanation.
7. Does the proposed action include construction of a new municipal solid waste landfill at a new solid waste disposal site?	Yes or No. Explanation.
8. Will the proposed action create a need for additional capacity at solid waste disposal facilities?	Yes or No. Explanation.
9. Does the proposed action include construction of a new wastewater treatment facility that will discharge treated sewage effluent to the waters of the U.S.	Yes or No. Explanation.
10. Will the proposed action create a need for additional capacity at wastewater treatment facilities?	Yes or No. Explanation.
11. Will the proposed action create a need for additional capacity in the drinking water supply?	Yes or No. Explanation.
12. Are there other considerations about the proposed action that could adversely affect the environment and/or public health and safety?	Yes or No. Explanation.

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

19. Will the proposed action require major sedimentation and erosion control measures?	Yes or No. Explanation.
20. Will the proposed action violate a storm water permit or a wastewater discharge permit either for construction or on-going operations?	Yes or No. Explanation.
21. Safe Drinking Water Act: Will the proposed action impact an EPA designated sole source aquifer?	Yes or No. Explanation.
22. Wetlands and Water Resources (lakes, rivers, ponds, streams, etc.): Will the proposed action violate a Section 404 (Clean Water Act) permit for actions in a wetland and/or Section 10 (Rivers and Harbors Act) permit for actions in a stream or river?	Yes or No. Explanation.
23. Floodplains: a. Is the proposed action located in either a 100-year or, for critical actions, a 500-year floodplain? (If Flood Insurance Rate Maps do not exist for the project site, a floodplain survey or consultation may be required. Also may need to consider if the facility will require flood insurance).	Yes or No. Explanation.
b. Will the proposed action adversely impact flood flows in a floodplain or support development in a floodplain?	Yes or No. Explanation.

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

27. Does the proposed action involve the sale or transfer of real property, on which any hazardous substance was stored for one year or more, known to have been released, or disposed of? (Provide relevant documentation for any hazardous substance releases. See 40 CFR 373.2(b), 302.4, and 261.30 for reportable quantities.)	Yes or No. Explanation.
28. Does the proposed action involve the sale or transfer of real property, on which underground or above ground storage tanks are located?	Yes or No. Explanation.
29. Will the proposed action violate Tribal, local, state, or federal law on the use and storage of hazardous substances or the transportation, storage, and disposal of hazardous wastes or medical wastes? (Activities that may generate reportable quantities include air conditioning repair and service, pesticide application, motor pools, automobile repair, welding, landscaping, agricultural activities, print shops, hospitals, clinics, & medical centers. Repair, renovation, or demolition activities can generate waste that has asbestos-containing materials, asbestos, lead-based paint, PCBs, CFCs, etc.)	Yes or No. Explanation.

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

36. Wild and Scenic Rivers Act: Will the proposed action affect a wild, scenic, or recreational river area or create conditions inconsistent with the character of the river? (A consideration for activities that are in or near any wild and scenic waterway including construction of stream/river crossings, intake structures, outfalls, etc.)	Yes or No. Explanation.

I certify that to the best of my knowledge and ability the information presented above is true and correct. The record was examined to identify potential extraordinary or exceptional circumstances which would require further environmental review.

Review by:

Title Date Environmental Coordinator Date

Norton Sound Health Corporation

APPENDIX H

ACTIONS REQUIRING IHS ENVIRONMENTAL REVIEW AND DETERMINATION

[]	Pg 571 (K)(4): Those involving the use of technology where the possible effects are highly uncertain or involve unique or unknown risks and where such technology has not been assessed previously for environmental impact;
[]	Pg 571 (K)(5): Those which have adverse effects on unique geographic characteristics (e.g. historic, archeological, or cultural resources, park recreation or refuge lands, wilderness, areas, wild or scenic rivers, sole or principal drinking water aquifers, prime farmlands, wetlands, floodplains, coastal management zones, or ecological or critical areas including those listed on the Department of Interior National Register of National landmarks);
[]	Pg 571 (K)(6): Those which establish a precedent for future action or represent a decision in principle about future actions with potentially significant environmental effects;
[]	Pg 571 (K)(7): Those which have adverse effects on properties listed or eligible for listing on the National Register of Historic Places;
[]	Pg 571 (K)(8): Those which have adverse effects on species listed by the Federal Government as Endangered or Threatened Species, or which have adverse effects on any designated critical habitat for these species;
[]	Pg 571 (K)(9): Those which require assessment in accordance with Executive Order 11988 (Floodplain Management), or Executive Order 11990 (Protection of Wetlands), or the Fish and Wildlife Coordination Act; and
[]	Pg 572 (K)(10): Those which involve the use, transfer, or lease of real property which has been determined, after investigation in accordance with the provisions of CERCLA 120 (h), to have been used as a storage facility for hazardous waste for more than 1 year; and
[]	Pg 572 (K)(11): Construction projects which are significantly greater in scope or size than normally experienced for a particular category of action.

Any action NOT categorically excluded per Federal Register Vol. 58, No. 3, pg 569-572, dated January 6, 1993 attached hereto.	**The Environmental Review and Determination Process for this group of actions ranges from 60 to 180 days from the receipt by the IHS of the proposal package.**

* The time needed to complete Environmental Reviews is highly dependent on required consultations with other Federal and State Agencies. As an example, the NHPA Section 106 Process requires the State Historic Preservation Officer (SHPO) be allotted 30 days to review and comment on a proposed action (36 CFR Part 800.3(c)(4)). Furthermore, additional time beyond the 30 days may be required for consultation with SHPO to adequately review and determine the effects of the proposed action on existing historical resources. Coordination early in the planning phase of the project can help identify these potential issues and allow NSHC and IHS to resolve them early.

employed varies from Area to Area. Population, health indices, and facilities and services available from sources other than the IHS are evaluated to determine the methods IHS uses to provide services.

The IHS program consists of two major systems: (1) A Federal health care delivery system, administered by Federal employees, and (2) a tribal health delivery system, administered by tribes and tribal groups under grants, contracts or cooperative agreements. The categorical exclusions apply to IHS program actions whether carried out directly by the IHS, or funded or otherwise sponsored by the IHS. The IHS contracts, grants, and cooperative agreements are actions defined in NEPA and are subject to the IHS review procedures established to ensure NEPA compliance, including provisions covering extraordinary and exceptional circumstances. The NEPA compliance for the tribal health care delivery system is ensured through IHS administrative procedures for contracts, grants, and cooperative agreements.

The selection of IHS program actions to list as categorical exclusions has been determined, in part, by agency experience in complying with NEPA, during the past 10 years. Actions required to provide health care services will not have significant impact on the environment except when exceptional or extraordinary circumstances exist. The IHS has categorically excluded these actions, since enactment of NEPA; however, actions involving construction normally have required completion of an environmental review/assessment.

The IHS administers programs for the construction of domestic sanitation facilities (water, wastewater, and solid waste) for Indian homes and communities, construction of new or replacement health care facilities and staff quarters, and renovations to existing health care facilities and quarters units.

Environmental reviews/assessments of construction projects undertaken during the past 10 years have concluded that an EIS was not required for any of them. Approximately 2,300 sanitation facilities construction projects and fewer than 60 health care facilities/staff quarters construction projects have been approved during this time.

The type of program and procedures employed to administer the construction of sanitation facilities for Indian homes and communities, and the consistent determinations that these projects do not have a significant impact on the environment, are the basis for the decision to list most sanitation facilities projects as categorically excluded.

Factors considered in making this determination include:

1. Projects are undertaken to improve health and/or environment.

2. Projects are untaken at the request and with approval of the tribal governing body, which provides for discussion and evaluation of the project and its impacts.

3. Projects are normally constructed on tribally owned or individually owned tribal land within reservation boundaries.

4. Projects are constructed to comply with all current applicable environmental regulations and plans and specifications are submitted to State and Federal agencies as necessary for review and comment.

5. Projects are constructed to provide utilities (water, sewer, solid waste) either for existing American Indian or Alaska Native homes or for new homes constructed with Federal, tribal, State or other resources. New homes are constructed at sites and locations approved by the Tribal Governing Board. Utilities are not provided for future development or undeveloped parcels, and capacity provided is limited to that routinely provided by standard engineering practice for the current design population.

6. The IHS projects fall into the category of minor construction projects based on cost. During the last 10 years, 85 of the 2,300 projects exceeded $1 million, and the average estimated cost was $250,000.

7. Standard IHS procedures require documentation of an environmental review of each construction project to identify any exceptional or extraordinary circumstances and to ensure compliance with all environmental laws, regulations, and executive orders; e.g., those concerning floodplains, wetlands, endangered species, etc. This review is required early in the project planning process.

The categorical exclusion for construction of health care facilities and staff quarters has been limited to renovation or new construction at existing health care delivery sites, and construction or development of relatively small facilities at new locations. The procedures noted in item 7 above for sanitation facilities construction projects also apply to all health care facility and staff quarters construction projects. Most health care facility and staff quarters renovation projects can be classified as minor construction projects based on cost. Fewer than 200 major renovation projects have been undertaken and only a few were funded at a level exceeding $1 million.

Categorical Exclusions

A. Health Services

Direct delivery of medical, dental, nursing, and other related health services; e.g., patient care/counseling administered from hospitals, health centers, health stations, satellite clinics, and in private homes by IHS staff or contract providers to authorized recipients.

B. Research

Research activities that are consistent with the mission of IHS including: (a) Biological and behavioral studies conducted in laboratories, clinics, and the field; (b) studies on the development and delivery of prevention and treatment services and their administration and financing; and (c) evaluations of prevention and treatment.

C. Pesticides

Application of pesticides which are not classified for restricted use under provisions of the Federal Insecticide, Fungicide and Rodenticide Act when used for routine pest control purposes.

D. Contracts, Grants, and Cooperative Agreements

Contracts, grants, and cooperative agreements and continuations, supplements, extensions, and amendments of these documents for IHS programs or actions that are categorically excluded. (Includes Self-Determination Act contracts, Contract Health Care contracts, etc.)

E. Technical Assistance

Action involving the provision of technical assistance to American Indian and Alaska Native tribes and groups. other Federal agencies, State and local governments, and non-profit organizations are excluded. These actions include but are not limited to:

1. The provision of technical assistance to American Indian and Alaska Native tribes and groups for the purpose of developing management capabilities needed to enable eventual tribal assumption of health program operation;

2. The provision of technical assistance to American Indian and Alaska Native tribes and groups for the purpose of developing capabilities in the areas of epidemiology, disease reduction, injury prevention, environmental improvement, and the operation and maintenance of sanitation facilities; and

3. The assignment of IHS personnel to agencies/organizations for the purpose of providing technical expertise (e.g.,

Order 11990 (Protection of Wetlands), or the Fish and Wildlife Coordination Act; and

10. Those which involve the use, transfer, or lease of real property which has been determined, after investigation in accordance with the provisions of CERCLA 120 (h), to have been used as a storage facility for hazardous waste for more than 1 year; and

11. Construction projects which are significantly greater in scope or size than normally experienced for a particular category of action.

Dated: December 29, 1992.

Michael E. Lincoln,

Deputy Director.

[FR Doc. 93-172 Filed 1-5-93; 8:45 am]

BILLING CODE 4310-16-M

ADDENDUM I

MEMORIALIZATION OF HISTORICAL LEVEL OF PFSA'S PROVIDED BY ANMC AND AANHS TO THE NORTON SOUND HEALTH CORPORATION

The ANMC and the Alaska Area Native Health Services, Area Office, subject to available appropriations, has historically provided the following PFSAs to Norton Sound Health Corporation as of October 1, 1997 and continued to provide such services through December 31, 1998:

- Coordination and support for the NSHC dental clinic, including dental specialty referral services, and the annual Alaska dental chiefs meeting. Commissioned Corp recruitment assistance including transportation costs of the recruiter to and from Nome, any applicable documentation, award information for Commissioned Officer promotions, and career counseling for officers desiring long term affiliation with IHS.

- Specialty care field clinics, consultation to Norton Sound Health Corporation physicians, arrange contracts for reference laboratory services, routine reading of x-rays, medivacs support for neonatal emergencies patient travel support for NSHC patients returning home from treatment at the ANMC.

- Accepting all referrals of Alaskan Natives from the Norton Sound Regional Hospital.

- The ANMC EMS program provided specialized training such as ACLS, ATLS, PALS, including hypothermia, cold water drowning and frostbite.

- The NSHC Laboratory received the following services from ANMC: (a) pathologist consultation and visitation twice a year; (b) Anatomical tissue analysis and reporting; and (c) Access to TDY Services as needed and available.

- The ANMC provided consultation and informational support for the NSHC Social Services program, including JCAHO standards and other licensure issues.

- The ANMC provided support including screening, diagnosis, consultations, referrals, personnel training, information, network and recruitment assistance for the FAS program at NSHC and for its Maternal Child Health Program.

- The ANMC provided recruitment assistance to the Mental Health program as needed.

- STD/HIV testing, counseling, partner notification, education and consultation as requested by NSHC.

- Nutrition education and counseling services from the statewide Diabetes program based at ANMC.

- Environmental Health /Sanitation services including, but not limited to, appropriate village visits for environmental services, injury prevention, institutional services.

- Diabetes patients tracking and registration.

- Engineering services inclusive of maintenance and improvement for federal facilities and projects;

- Purchasing activities under GSA contracts;

- Office of Environmental Health Services and activities, health facilities support, real property support especially for village built clinics; projects for health facilities management, special projects and sanitations facilities.

- Administration and management of IPA/MOAs;

- Certain contract health services, not otherwise contracted under Title I;

- Region X legal consultation.

ADDENDUM II
NORTON SOUND HEALTH CORPORATION
MEMORIALIZATION OF MATTERS REMAINING IN DISPUTE

(1) Norton Sound Health Corporation (NSHC) does not agree with the IHS' position that Area Office tribal shares that were restricted by individual Co-Signer decision or by a consensus decision of all Co-Signers from FY 1995 through FY 2000 are not available for inclusion in FY 2002 because of Section 325, P.L. 105-83. NSHC believes it has the right to include such tribal shares in its FY 2002 funding agreements notwithstanding Section 325. NSHC reserves any remedies it may have under law.

ALASKA TRIBAL HEALTH COMPACT

BETWEEN

CERTAIN ALASKA NATIVE TRIBES

AND THE

UNITED STATES OF AMERICA

OCTOBER 1, 1994

—

AMENDED AND RESTATED

OCTOBER 1, 2017

ALASKA TRIBAL HEALTH COMPACT

OCTOBER 1, 1994

AMENDED AND RESTATED
OCTOBER 1, 2017

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ALASKA TRIBAL HEALTH COMPACT
BETWEEN
CERTAIN ALASKA NATIVE TRIBES
AND THE
UNITED STATES OF AMERICA
OCTOBER 1, 1994
AMENDED AND RESTATED
OCTOBER 1, 2010

This Compact of Self-Governance, which under Title III of Public Law No. 93-638, as amended, became effective October 1, 1994, was amended and restated effective October 1, 1995, October 1, 1996, October 1, 1997, October 1, 1998, October 1, 2000, and was further amended and restated in FY 2001, effective October 1, 2000, to conform with Public Law 106-260, Title V of the Indian Self-Determination and Education Assistance Act, as amended (hereinafter Title V), October 1, 2003, October 1, 2006, October 1, 2008, and October 1, 2010 is made and entered into by and between the Secretary of Health and Human Services of the United States of America, represented by the Director of the Indian Health Service, and certain Alaska Native Tribes recognized by the United States acting collectively, and the Alaska Native Tribal Health Consortium, as set forth in Exhibit A. This Compact is entered into under the Title V, which authorizes the Secretary to enter into Compacts and Funding Agreements with the governing bodies of participating Tribal governments. The Secretary has delegated the authority to enter into this Compact and funding agreements to the Director, Indian Health Service (hereinafter IHS). This Compact reflects the United States' special trust responsibility and legal obligations to Indians and Alaska Natives, as stated in 25 U.S.C. section 1602, and the unique tribal cooperation that has developed in Alaska to assure that all Alaska Natives have access to a comprehensive, integrated, and tribally-controlled health care delivery system. The parties are committed to ensuring that the essential statewide functions of the Alaska Native Medical Center in Anchorage remain intact, whether operated by the Indian Health Service, the Alaska Native Tribal Health Consortium or by Alaska Native Tribes recognized by the United States.

WITNESSETH:

WHEREAS, the Alaska Native people have governed themselves and lived in the area known as Alaska since time immemorial;

WHEREAS, federally recognized tribal governments in the State of Alaska

> . . . have the same governmental status as other federally acknowledged Indian tribes by virtue of their status as Indian tribes with a government-to-government relationship with the United States; are entitled to the same protection, immunities, privileges as other acknowledged tribes; have the right, subject to general principles of Federal Indian law, to exercise the same inherent and delegated authorities available to other tribes; and are subject to the same limitations imposed by law on other tribes;

(*Indian Entities Recognized and Eligible to Receive Services from the United States Bureau of Indian Affairs*, 58 Fed. Reg. 54364 (October 21, 1993));

WHEREAS, for the purposes of ensuring that all Alaska Natives and America Indians in Alaska can receive the services provided by the Federal Government through an Alaska Native provider, the Congress has defined the term, "Indian Tribe," to mean:

> . . . any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(Indian Self-Determination and Education Assistance Act, as amended, 25 U.S.C. § 450b(e));

WHEREAS, to prioritize between the entities eligible to authorize contracting under the Indian Self-Determination and Education Assistance Act, as amended, the Indian Health Service has established in the Alaska Area the following order of preference:

> If there is an Indian Reorganization Act (IRA) Council, and it provides governmental functions for the village, it will be recognized.
>
> If there is no IRA Council, or it does not provide governmental functions, then the traditional village council will be recognized.
>
> If there is no IRA Council and no traditional village council, then the village profit corporation will be recognized.
>
> If there is no IRA Council, no traditional village council, and no village profit corporation, then the regional profit corporation will be recognized for that particular village.

(*Alaska Area Guidelines for Tribal Clearances for Indian Self-Determination Contracts*, 46 Fed.

Reg. 27178);

WHEREAS, the United States of America has recognized certain entities in Alaska as American Indian Tribes for purposes of the Indian Self-Determination and Education Assistance Act (*See* 25 U.S.C. § 450b(e); *Indian Entities Recognized and Eligible To Receive Services from the United States Bureau of Indian Affairs*, 58 Fed. Reg. 54364 (October 21, 1993); and *Alaska Area Guidelines for Tribal Clearances for Indian Self-Determination Contracts*, 46 Fed. Reg. 27178, (hereinafter "the Tribes");

WHEREAS, certain Tribes of Alaska have formed and authorized certain Tribal Organizations and Inter-Tribal Consortia as defined in 25 U.S.C. § 450b(*l*) and section 501(a)(5) of Title V, for the purpose of providing health care to Alaska Natives and to contract with the Indian Health Service and other federal and non-tribal agencies for such purpose as well as to provide health care to the other residents of their respective service areas, as permitted by section 813 of the Indian Health Care Improvement Act, as amended, or other applicable law;

WHEREAS, the Congress has declared its commitment to the maintenance of the Federal Government's unique and continuing relationship with, and responsibility to, Alaska Native and American Indian Tribes and to the Alaska Native and American Indian people as a whole through the permanent establishment of a meaningful Indian self-governance policy, which will permit an orderly transition from the federal domination of programs for, and services to, Alaska Natives and American Indians to effective and meaningful participation by the Alaska Native and American Indian people in the planning, conduct, and administration of those programs and services; 25 U.S.C. § 458aaa(note);

WHEREAS, the Congress has declared its commitment to strengthening the government-to-government relationship and to supporting and assisting Alaska Native and American Indian Tribes in the orderly transition from the federal domination of programs and services to provide Alaska Native and American Indian Tribes with meaningful authority, control, funding and discretion to plan, conduct, redesign and administer programs, services, functions and activities (or portions thereof) that meet the needs of the individual tribal communities, 25 U.S.C. § 458aaa(note);

WHEREAS, Federal health services to maintain and improve the health of the Indians and Alaska Natives are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian and Alaska Native people, 25 U.S.C.§§ 1601(1), (2);

WHEREAS, in accordance with 25 U.S.C. § 1601(2) a major national goal of the United States is to provide resources, processes and structures that will enable Indians and Alaska Natives to obtain the quality and quantity of health care services and opportunities that will eradicate health disparities between Indians and Alaska Natives and the general population of the United States;

WHEREAS, the Congress has declared that it is the policy of the United States as stated in 25 U.S.C. § 1602, in fulfillment of its special trust responsibilities and legal obligations to the American Indian and Alaska Native people, to ensure the highest possible health status for Indians

and Alaska Natives and to provide all resources necessary to effect that policy; to raise the health status of Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives; and also the ensure maximum Indian and Alaska Native participation in the direction of health care services so as to render the person administering such services and the services themselves more responsive to the needs and desires of Indian and Alaska Native communities;

WHEREAS, for the purposes of this Compact,

"ANTHC" shall mean only the Alaska Native Tribal Health Consortium;

"Co-Signer" shall mean all Tribes and tribal organizations or Inter-Tribal Consortia, including the ANTHC, participating in the Compact;

"Signatory Tribe(s)" shall mean all Tribes participating in the Compact either directly or through a tribal organization or Inter-Tribal Consortium that has been authorized to participate by resolution;

"Tribal Co-Signer" shall mean only those Tribes, tribal organizations and Inter-Tribal Consortia authorized by resolution of a Tribe, as defined in 25 U.S.C. § 450b(*l*) and sections 501(a)(5) and (b) of Title V, to participate in the Compact and shall not include the ANTHC; and

WHEREAS, under authority from the Tribes, certain Tribal Organizations and Inter-Tribal Consortia in Alaska have provided health services for many years under self-determination contracts with the Indian Health Service and have been recognized by the Indian Health Service as tribally-operated service units;

WHEREAS, pursuant to section 325 of P.L. 105-83, the Alaska Native Tribal Health Consortium (herein "ANTHC"), a tribal organization and Inter-tribal Consortium, as defined in section 501(a)(5) of Title V, was organized and is controlled by the Alaska Native tribes and tribal organizations which are represented on its Board of Directors;

WHEREAS, Tribes, Tribal Organizations and Inter-Tribal Consortia throughout Alaska are reliant on the services to be provided by the ANTHC;

WHEREAS, participation by the ANTHC in the Alaska Tribal Health Compact promotes the commitment of Alaska Native Tribes, Tribal Organizations and Inter-Tribal Consortia to maintain the unique tribal cooperation that has developed in Alaska to assure that all Alaska Natives have access to a comprehensive, integrated, organized, tribally controlled health care delivery system in which Alaska tribal health providers participate in numerous joint activities including utilization review and provide their health services in a clinically integrated care setting in which individuals typically receive health care from more than one of these Alaska tribal providers;

WHEREAS, in furtherance of the federal policy of Alaska Native and American Indian tribal self-determination and self-governance, Congress has directed the Secretary of Health and Human Services (herein the "Secretary") to carry out the Tribal Self-Governance Program under Title V.;

WHEREAS, Congress, in Title V, has authorized the Secretary to negotiate and implement a Compact of Self-Governance and Funding Agreements with the governing bodies of participating Tribal governments of qualified Alaska Native and American Indian Tribes that have completed a planning activity;

WHEREAS, Congress has directed that the Funding Agreements, which the Secretary negotiates with Alaska Native and American Indian tribes, shall authorize the Co-Signers to plan, conduct, consolidate, administer, receive full tribal shares of funding, redesign programs, and reallocate funds for programs, services, functions and activities as provided in sections 505(b)(1) and, (b)(2) and 506 (e) of Title V;

WHEREAS, each Funding Agreement shall specify the programs, services, functions or activities to be performed or administered, the funds to be provided, and the responsibilities of the Co-Signer and the Secretary in accordance with section 505 of Title V;

WHEREAS, the Funding Agreement shall specify the authority of the Co-Signer to redesign or consolidate programs, functions, services and activities (or portions thereof) and to reallocate or redirect funds or modify budget allocations pursuant to section 506(e) of Title V;

WHEREAS, to the extent to which, funding is provided to a Co-Signer, as authorized by Alaska Native Tribes, pursuant to a Funding Agreement, such Co-Signer shall be responsible for administration of programs, services, functions and activities pursuant to the Agreement, consistent with section 505 of Title V;

WHEREAS, nothing in this Compact or associated Funding Agreements shall be construed to limit or reduce in any way the funding for any program, project or activity serving an Indian Tribe under Title V or any other applicable Federal law, pursuant to section 515(a) of Title V;

WHEREAS, in Title V, Congress has directed that the Funding Agreements, which the Secretary negotiates with Co-Signers shall contain certain provisions and, at the option of the Co-Signers, apply to certain programs, activities, functions and services of the Indian Health Service (including construction) as specified in sections 505, 507(a)(2)(A), and 509 of Title V;

WHEREAS, Congress has directed that, at the request of the governing body of qualifying Tribes and the ANTHC and under the terms of a Funding Agreement, the Secretary shall provide funding to the Tribes and the ANTHC to implement the Funding Agreement in accordance with section 508 of Title V;

WHEREAS, Congress has directed that the Secretary shall interpret federal laws and regulations in a manner that will facilitate the implementation of a Compact of Self-Governance and Funding Agreement authorized by section 512(a) of Title V;

WHEREAS, Congress has directed that the Secretary shall interpret federal laws and regulations in a manner that will facilitate the inclusion of activities, programs, services, and functions (or portions thereof) in Compacts of Self-Governance and Funding Agreements authorized by section 512(a) of Title V;

WHEREAS, it is the intent of certain Alaska Native Tribes to collectively enter into a single Compact with the Secretary. To carry out that intent, such Tribes (hereafter referred to as signatory Tribes) enter into this Compact either by individual signature or by means of a delegation of signature authority as authorized by resolution of the Tribal government. Such resolutions are attached as Exhibit "A".

WHEREAS, it is the intent of the signatory Tribes that this Compact will be carried out either by the Tribe itself, by tribal organizations or Inter-Tribal Consortia, as authorized by resolution of Tribe(s) as defined by 25 USC § 450b(e), section 501(b), and by the ANTHC under section 325 of P.L. 105-83. These Tribes, tribal organizations and Inter-Tribal Consortia, including the ANTHC, are bound by the terms of this Compact and are signing separately as Co-Signers.

WHEREAS, it is the intent of the parties that each Tribal Co-Signer Funding Agreement entered into under this Compact shall be executed by the Tribes, either by individual signature or by means of a delegation of signature authority as authorized by resolution of the Tribal government. Each such Funding Agreement also will be signed by a Tribal Co-Signer, designated by the Tribal governing body. The Tribal Co-Signer will carry out the terms of the Funding Agreement for the signatory Tribe(s) from which it has obtained a resolution of authority and be bound by its terms;

WHEREAS, the ANTHC may enter into this Compact and into Funding Agreements under this Compact as authorized by the Board of Directors of the Alaska Native Tribal Health Consortium; and

WHEREAS, for purposes of clarification, and to recognize the government to government relationship between the signatory Tribes and the Secretary, the parties agree that the signatory Tribes, by entering into this Compact, do not relinquish any aspects of Tribal sovereignty to the Co-Signers. The Tribal Co-Signers act only for and on behalf of the signatory Tribe(s) within the scope of the authority granted to them by tribal resolution or by law and the ANTHC has only the authority granted to it under section 325 of P.L. 105-83. Tribal Co-Signers and the ANTHC by carrying out the terms of this Compact and the associated Funding Agreements do not gain the status of a sovereign tribal government;

WHEREAS, the parties have determined that all of the provisions of this Compact are authorized by Title V or other provisions of federal law and the parties have executed this Compact in reliance on this representation;

NOW, THEREFORE, the Secretary, signatory Tribes and the Co-Signers do hereby agree to enter into, undertake, and be bound by this Compact in accordance with the foregoing principles.

ARTICLE I — AUTHORITY AND PURPOSE

Section 1 – Authority. This Compact of Self-Governance, which became effective October 1, 1994, was amended and restated effective October 1, 1995, October 1, 1996, October 1, 1997, October 1, 1998, and October 1, 2000, and was further amended and restated in FY 2001 effective October 1, 2000, to conform with Title V, October 1, 2003, October 1, 2006, October 1,

2008, and October 1, 2010 (hereinafter the "Compact"), is authorized by Title V of the Indian Self-Determination and Education Assistance Act, as amended, and is hereby entered into by the Secretary of the Department of Health and Human Services of the United States of America (hereinafter the "Secretary"), represented by the Director of the Indian Health Service, certain Alaska Native Tribes, as identified in Exhibit A, recognized by the United States, acting individually or collectively, and the Alaska Native Tribal Health Consortium (hereinafter the "ANTHC"). The Director of the Indian Health Service by signing this Compact commits the Secretary to the extent and within the scope of the Secretary's delegation of authority to enter into Compacts and Funding Agreements pursuant to Title V or as otherwise authorized.

Section 2 – Purpose. This Compact shall be liberally construed to achieve its purposes:

(a) This Compact is to carry out a Self-Governance Program authorized by Title V, and is intended to transfer to tribal governments, at a tribe's request, the power to decide how federal programs, services, functions and activities (or portions thereof) shall be funded and carried out. Title V is meant to strengthen the government-to-government relationship and to uphold the United States trust responsibility for each Indian Tribe. This Compact promotes the autonomy of the Tribes in Alaska in the realm of health care.

(b) This Compact is to enable the signatory Tribes and the Co-Signers to re-design health programs, activities, functions, and services of the Indian Health Service; to reallocate funds for programs, activities, functions, or services according to the priorities of the signatory Tribes and Co-Signers; to enhance the effectiveness and long-term financial stability of the Tribes and the Co-Signers; and to streamline the federal Indian Health Service bureaucracy.

(c) This Compact is to enable the United States to maintain and improve its unique and continuing relationship with, and special trust responsibilities and legal obligations, pursuant to 25 U.S.C. 1602 of the IHCIA, to the Tribes through tribal self-governance and to permit an orderly transition from federal domination of programs and services.

(d) This Compact and Funding Agreement shall transfer to signatory Tribes, acting individually or collectively, and the ANTHC the responsibility for the programs, activities, functions and services of the Indian Health Service included in the Funding Agreement. This Compact allows signatory Tribes, acting individually or collectively, and the ANTHC to exercise meaningful authority to plan, conduct, and administer those programs and services to meet the health care needs of the Alaska Native Tribes. In fulfilling its responsibilities under the Compact and consistent with 25 U.S.C. §§ 1602(5), (6), and the November 5, 2009 Memorandum for the Heads of Executive Departments and Agencies, the April 29, 1994, Memorandum from the President of the United States of America for the Heads of Executive Departments and Agencies, attached hereto as Exhibit B, Executive Order 13175 on Consultation and Coordination with Indian Tribal Governments, the September 23, 2004, Memorandum from the President of the United States of America for the Heads of Executive Departments and Agencies, and the Department of Health and Human Services Tribal Consultation Policy, the Secretary hereby pledges that the Indian Health Service will conduct all relations with the Tribes on a government-to-government basis.

ARTICLE II — TERMS, PROVISIONS AND CONDITIONS

Section 1 – Term and Resolutions.

(a) Term. The term of this Compact begins as to each Co-Signer on the effective date of the Co-Signer's first Funding Agreement and shall extend thereafter as to each Co-Signer throughout the period authorized by Title V of the Indian Self-Determination and Education Assistance Act, and any subsequent amendment thereto, provided the Co-Signer has a Funding Agreement in effect, and shall remain in effect for so long as is permitted by Federal law or until terminated by mutual written agreement, retrocession, or reassumption pursuant to section 504(d) of Title V.

(b) Resolutions from Signatory Tribes. Those Tribes which intend to participate in this Compact and the applicable Funding Agreement through delegation of signature authority as provided in this Compact must have issued a written resolution authorizing the Tribal Co-Signer, on their behalf, to enter into this Compact and Funding Agreement on or before the date the Compact and the applicable Funding Agreement is signed by the Tribal Co-Signer for that Tribe, provided that if a Tribal Co-Signer negotiates a Funding Agreement prior to obtaining an authorizing resolution from a Tribe, nothing herein shall be construed to limit or impair in any way a tribal government's sovereign right to decide whether or not to sign such a resolution.

(c) Resolution from the Board of the ANTHC. The ANTHC may participate in this Compact and the applicable Funding Agreement upon receipt of an authorizing resolution of the Board of Directors of the ANTHC, attached hereto as a part of Exhibit A.

Section 2 – Effective Date.

(a) Once this Compact and the Funding Agreements, attached hereto as Exhibit C, are approved and signed by the Co-Signers and the Secretary, they shall be effective as of October 1, 2008. Subsequent Funding Agreements will be effective on the date signed by the Secretary and Co-Signer or another date mutually agreed upon.

(b) During the term of this Compact any Co-Signer which has not previously negotiated a Funding Agreement may do so. All Funding Agreements shall be subject to, and all the activities thereunder shall be governed by, the terms of this Compact to the same extent as the initial Funding Agreements. New Funding Agreements will be effective on the date signed by the Secretary and Co-Signer or another date mutually agreed upon.

(c) Each Funding Agreement and subsequent Funding Agreement of a Co-Signer is deemed to be incorporated, as negotiated, by reference into this Compact, for the purposes only of that Co-Signer and the United States. In the event of inconsistency between the Compact and any subsequent Funding Agreement, the provisions of the Compact shall prevail.

Section 3 – Funding Amount. Subject only to the appropriation of funds by the Congress of the United States and in accordance with section 508 of Title V, the Secretary shall provide the total amounts specified in the Funding Agreements.

Section 4 – Payment.

(a) Payment Schedule. Payment shall be made expeditiously and shall include financial arrangements to cover funding during periods under continuing resolutions to the extent permitted by such resolutions. For each fiscal year covered by the Compact, the Secretary shall make available the funds specified for that fiscal year under the Funding Agreements by paying the respective total amount as provided for in each Funding Agreement in advance lump sum, as permitted by law, or such other payments as provided in the schedule set forth in each Funding Agreement. The first payment shall be made on or before ten calendar days after the date on which the Office of Management and Budget (hereinafter "OMB") apportions the appropriations for that fiscal year for the programs, activities, functions and services subject to the Compact. The Prompt Payment Act, Chapter 39 of Title 31, United States Code, shall apply to the payment of funds due under this Compact and to each Funding Agreement negotiated thereunder.

(b) Interest on Advances. Co-Signers receiving funds under applicable Funding Agreements pursuant to this Compact shall be permitted to retain interest earned on funds advanced pending disbursement as authorized by law. Interest earned on advances shall not diminish the amount of funds the Co-Signer is authorized to receive under its Funding Agreement in the year earned or in any subsequent fiscal year. All funds transferred under Funding Agreements pursuant to this Compact shall be managed using the prudent investment standard pursuant to section 508(h) of Title V.

Section 5 – Reports to Congress. In accordance with section 514 of Title V, the Secretary shall submit to the Senate Committee on Indian Affairs and the House Resources Committee a written report not later than January 1 of each year on the administration of Title V. Each report shall include a detailed analysis on the level of need being presently funded or unfunded for each signatory Tribe and Co-Signer. The contents of each report shall comply with section 514(b). In compiling the reports, the Secretary may not impose any reporting requirements on Co-Signers not otherwise provided in Title V. The Secretary shall provide each Co-Signer with a draft of each report required to be submitted to Congress under this provision for a thirty (30) day comment period prior to the submission of the report to Congress so that the Co-Signers may comment on the report. The Secretary shall include each Co-Signer's comments in the final report to Congress.

Section 6 – Audits

(a) Single Audit. Each Co-Signer that has executed a Funding Agreement pursuant to this Compact shall provide to the National External Audit Review Center (or its successor), which is the designee of the Secretary for the purposes of this section, an annual single organization-wide audit as prescribed by the Single Audit Act of 1984, as amended, 31 U.S.C. § 7501, *et seq*. A copy of this audit will be sent simultaneously to the Indian Health Service Area Office, the cognizant agency, and the Federal Audit Clearinghouse.

(b) Cost Principles. Each Co-Signer shall apply cost principles under the applicable OMB Circular, except as modified by section 106(k) of the Indian Self-Determination and Education Assistance Act, as amended, which section is hereby incorporated into this Compact, or by any exemptions subsequently granted by OMB. To the extent that OMB Circular A-87 or its successor, or other applicable circulars, permit agency pre-approval of allowable costs,

the agency hereby grants that pre-approval. The Secretary will assist the Co-Signers in obtaining such additional waivers from OMB as are requested by the Co-Signers. No other audit or accounting standards shall be required by the Secretary. Any claim by the Federal Government against any Co-Signer receiving funds under a Funding Agreement based on any audit under this section shall be subject to the provisions of section 106(f) of the Indian Self-Determination and Education Assistance Act, as amended.

Section 7 – Records. Each Co-Signer's practices relating to document disclosure and record-keeping associated with this Compact shall, in accordance with applicable law, be set forth in the respective Funding Agreement.

Section 8 – Property.

(a) In General. The provisions of section 512(c) and section 1(b)(8) of the Model Agreement set forth in section 108(c) of the Indian Self-Determination and Education Assistance Act, as amended, are hereby incorporated into this Compact.

(b) Property Management. Management of property under this Compact shall be in accordance with additional provisions included in each Co-Signer's Funding Agreement.

(c) Access to Property Subject to Destruction. Prior to the destruction of federal property which would otherwise be declared surplus or excess and which is located within the service area of a Co-Signer, the Secretary, if previously requested by the Co-Signer, shall provide notice of such proposed destruction to the Co-Signer. Such notice shall inform the Co-Signer of the name and address of the official responsible for determining whether such property will be destroyed or declared surplus or excess. If the Secretary is the responsible official, the Secretary will consider information provided by the Co-Signer regarding transfer of the property, rather than destruction, and, if not the responsible official, the Secretary will assist the Co-Signer in communicating information to the responsible official.

(d) Leases. Upon the request of a Co-Signer, the Secretary shall enter into a lease with the Co-Signer in accordance with section 105(*l*) of the Indian Self-Determination and Education Assistance Act, as amended.

Section 9 – Regulatory Authority. The Secretary and the Co-Signers agree to utilize the following procedures governing the establishment and application of program rules and regulations under this Compact:

(a) Program Rules. No Co-Signer is required to comply with any agency circular, policy, manual, guidance or rule adopted by the Indian Health Service other than those identified in this section or expressly incorporated by reference in the individual Co-Signer's Funding Agreement in carrying out the programs, services, activities and functions under the Compact, except for the eligibility provisions of section 105(g) of the Indian Self-Determination and Education Assistance Act, as amended, and regulations promulgated under section 517 of Title V.

(b) Federal Regulations.

(1) Applicable Federal Regulations. The Co-Signers, in carrying out the provisions of this Compact and applicable Funding Agreements, will be required to comply only with applicable federal regulations, which include regulations promulgated under section 517 of Title V unless waived as provided in section 512(b) of Title V.

(2) Waiver of Federal Regulations.

(A) The Secretary and the Co-Signer will seek to identify federal regulations promulgated pursuant to section 517 or under the authorities specified in section 512(b) of Title V which may require waiver in order to effectively carry out this Compact or any Funding Agreement.

(B) Waivers of regulations shall be submitted and addressed in accordance with the procedures set forth in section 512(b).

(c) Title I Section Incorporated by Reference. Section 105(a)(1) of the Indian Self-Determination and Education Assistance Act, as amended, 25 U.S.C. § 450j(a)(1), is hereby incorporated in this Compact and shall have the same force and effect as if it were set forth in full in Title V of the Act.

Section 10 – Disputes.

(a) All disputes between the Indian Health Service and any Co-Signer or between the Indian Health Service and all Co-Signers under this Compact shall be subject to Title V and the provisions of section 110 of the Indian Self-Determination and Education Assistance Act, as amended, and all remedies provided for therein shall be available to each Co-Signer of this Compact. Actions and proceedings to enforce the Co-Signer's rights and the Secretary's obligations under this Compact shall be subject to the Equal Access to Justice Act, Public Law 96-481, as amended, to the same extent as are actions and proceedings involving Public Law 93-638 contracts.

(b) In the alternative, the Indian Health Service and the Co-Signers may use the processes authorized and encouraged in the Administrative Dispute Resolution Act, 5 U.S.C. § 581 note, for more informal resolution of disputes arising under this Compact and associated Funding Agreements.

Section 11 – Retrocession and Withdrawal

(a) Retrocession. Section 506(f) of the Act is herein adopted. A Co-signer may retrocede, fully or partially, to the Secretary programs, services, functions, or activities (or portions thereof) included in the compact or funding agreement. Unless the Co-signer rescinds the request for retrocession, such retrocession will become effective within the timeframe specified by the parties in the compact or funding agreement. In the absence of such a specification, such retrocession shall become effective on

(1) the earlier of

(A) one year after the date of submission of such request; or

(B) the date on which the funding agreement expires; or

(2) such date as may be mutually agreed upon by the Secretary and the Co-signer.

(b) Withdrawal. Section 506(g) of the Act is herein adopted. Unless prohibited by law and in accordance with Section 506(g) of the Act, a Tribe may fully or partially withdraw from a participating inter-tribal consortium or tribal organization its share of any program, function, service, or activity (or portions thereof) included in a compact or funding agreement. The withdrawal shall become effective within the timeframe specified in the resolution which authorizes transfer to the participating tribal organization or inter-tribal consortium. In the absence of a specific timeframe set forth in the resolution, such withdrawal shall become effective on

(1) the earlier of

(A) one year after the date of submission of such request; or

(B) the date on which the funding agreement expires; or

(2) such date as may be mutually agreed upon by the Secretary, the withdrawing Indian tribe, and the participating tribal organization or inter-tribal consortium that has signed the compact or funding agreement on behalf of the withdrawing Indian tribe, inter-tribal consortium, or tribal organization.

Section 12 – Discontinuance. Co-signer may discontinue its participation in the Alaska Tribal Health Compact after written notice to each authorizing Tribe or Village and the IHS. Notice must be provided one year in advance of the effective date of the request except that the effective date of a request may be less than one year upon approval of all authorizing Tribes and Villages and the IHS.

Section 13 – Subsequent Funding Agreements.

(a) Negotiations for subsequent Funding Agreements, as provided for in Article VI, section 2, shall begin no later than 120 days in advance of the conclusion of the preceding Funding Agreement. Each Co-Signer is hereby assured that future funding of the Co-Signer's subsequent Funding Agreements shall only be reduced pursuant to the provisions of section 508(d) of Title V provided, however, that future funding for each Co-Signer's non-recurring funds and tribal shares shall be subject to adjustments in accordance with a yearly reallocation decision by the Co-Signers. The Secretary agrees to prepare and supply relevant information, and promptly to comply with the Co-Signers' requests for information reasonably needed to determine the funds that may be available for a subsequent Funding Agreement as provided for in Article VI, Section 2 of this Compact.

(b) If the parties are unable to conclude negotiation of a subsequent Funding Agreement, the terms of this Compact and the existing Funding Agreement shall, at the option of the Co-Signer, continue on in 30-day, 90-day or longer increments until a subsequent Funding Agreement is agreed to. As provided in section 505(e) of Title V, the terms of the subsequent Funding Agreement will become retroactive to the end of the term of the preceding Funding Agreement. Any increases in funding to which Tribes are entitled by law or which have been made available by Congress, or increases which Co-Signers subsequently negotiate, shall be included in each Co-Signer's subsequent Funding Agreement.

Section 14 – Health Status Reports. In accordance with section 507(a)(1), Co-Signers shall provide the Secretary a health status and service delivery report to the extent that relevant data is not otherwise available to the Secretary and specific funds for this purpose are provided to the Co-Signer in its Funding Agreement. Such reporting may impose only minimal burdens on the Co-Signer and shall be consistent with regulations promulgated under section 517 of Title V.

Section 15 – Secretarial Approval. For the term of the Compact, the provisions of 25 U.S.C. § 81 and 25 U.S.C. § 476 shall not apply to attorney and other professional contracts of signatory tribal governments of Alaska Native Tribes operating under the Compact pursuant to section 511(b) of Title V.

Section 16 – Transportation and Other Supply Sources.

(a) Use of Motor Vehicles. Subject to agreement of the General Services Administration, the Secretary hereby authorizes each Co-Signer to obtain Interagency Motor Pool vehicles and related services for performance of any programs, activities, functions and services under this Compact.

(b) Other Supply Sources. Federal supply sources (including lodging, airline transportation, and other means of transportation) shall be available to each Co-Signer in accordance with sections 508(e) and 516(a) of Title V.

Section 17 – Limitation of Costs. Each Co-Signer shall not be obligated to continue performance that requires an expenditure of funds in excess of funds awarded under the Funding Agreement. In accordance with section 508(k), if, at any time the Co-Signer has reason to believe that the total amount required for performance of a Funding Agreement, or a specific activity conducted under the Funding Agreement, would be greater than the amount of funds awarded under the Funding Agreement, the Co-Signer shall provide reasonable notice to the Indian Health Service and affected Tribes and tribal organizations. If the Indian Health Service does not take such action as may be necessary to increase the amount of funds awarded under the Funding Agreement, the Co-Signer may suspend performance of the Funding Agreement until such time as additional funds are transferred.

ARTICLE III — OBLIGATIONS OF EACH CO-SIGNER

Section 1 – Consolidation. Each Co-Signer will be responsible for performing the health programs, activities, functions and services as specified in Section 3 of this Article III and in their respective Funding Agreements, as provided for in Article VI, Section 2 of this Compact. To the extent a program, activity, function, or service included within a contract or grant entered into pursuant to sections 102 or 103 of the Indian Self-Determination and Education Assistance Act, as amended, is included within a Funding Agreement, that contract or grant shall be modified or terminated as appropriate. The parties' obligations shall be governed by this Compact and all funds previously obligated under contracts or grants (including carry-over funds) will be re-obligated to the Co-Signer under the applicable Funding Agreement. Such terminated contracts shall be identified by contract number in each Funding Agreement.

Section 2 – Amount of Funds. The total amount of funds covered by the consolidation and redesign provided for in Section 1 of this Article that the Secretary shall make available to the Co-Signers shall be determined in accordance with section 508(c) of Title V and shall be set forth in the respective Funding Agreements between the Secretary and each Co-Signer.

Section 3 – Compact Programs. The health programs, activities, functions and services will be the responsibility of each Co-Signer under this Compact and shall be identified in each Co-Signer's Funding Agreement.

Section 4 – Eligibility for Services. In determining eligibility for services, the Co-Signers shall comply with applicable eligibility provisions set forth in the Indian Health Care Improvement Act, as amended, applicable regulations, and other statutory law.

Section 5 – Reallocation, Redesign and Consolidation. In accordance with section 506(e) of Title V, a Co-Signer may redesign or consolidate programs, services, functions, and activities (or portions thereof) included in a Funding Agreement and reallocate or redirect funds for such programs, services, functions, and activities (or portions thereof) in any manner in which the Co-Signer deems to be in the best interest of the health and welfare of the Indian community being served, only if the redesign or consolidation does not have the effect of denying eligibility for services to population groups otherwise eligible to be served under applicable federal law.

Section 6 – Consolidation with Other Programs. Each Co-Signer may consolidate programs, services, functions, and activities and associated funds identified in its funding agreement with other programs, services, functions, and activities provided with its own funds or funds from other sources, provided that the programs, services, functions, and activities are allowable for inclusion in a funding agreement under Section 505 of Title V. When programs, services, functions, and activities are consolidated in a funding agreement by a Co-Signer in accordance with the terms of the Funding Agreement and Title V, the Co-signer and its employees carrying out those programs, services, functions, and activities may receive Federal Tort Claims Act coverage in accordance with the statutory provisions and regulations cited in the Compact. Whether the Federal Tort Claims Act applies in any particular case is decided on an individual case-by-case basis by the United States Department of Justice and subsequently by the Federal courts. In cases in which a Co-Signer consolidates programs, services, functions, and activities under this section, the Co-Signer shall not be required to separate dollars or programs, services, functions, and activities so long as the Co-Signer can provide sufficient data to permit an acceptable program and financial audit to be conducted.

Section 7 – Program Income, including Medicare/Medicaid. All Medicare, Medicaid or other program income earned by a Co-Signer shall be treated as additional supplemental funding to that negotiated in the Funding Agreement and the Co-Signer may retain all such income, including Medicare/Medicaid, and expend such funds in the current year or in future years, nor shall such funds result in any off-set or reduction in the negotiated amount of the Funding Agreement. Medicare/Medicaid collections of a Co-Signer under Title IV of Public Law 94-437, as amended, shall be used by the Co-Signer in accordance with any applicable statutory restrictions on the use of such funds.

Section 8 – Carry-over. Congressionally appropriated funds allocated in accordance with

a Funding Agreement under this Compact are "no year" funds and may be expended by the Co-Signer in accordance with its budget for the year for which the funds are appropriated or carried over and expended in any subsequent fiscal year, and such carry-over shall not diminish the amount of funds the Co-Signer is authorized to receive under its Funding Agreement for any such subsequent fiscal year.

Section 9 – Matching Funds. Funds may be used to meet matching and other cost participation requirements under any other federal or non-federal programs pursuant to section 512(d) of Title V.

ARTICLE IV — OBLIGATIONS OF THE UNITED STATES

Section 1 – Trust Responsibility. In accordance with sections 507(g) and 515(b) of Title V, nothing in this Compact waives, modifies, or diminishes in any way the trust responsibility of the United States with respect to the Alaska Native Tribes or individual Alaska Natives and American Indians which exists under treaty, executive orders, and acts of Congress.

Section 2 – Programs Retained.

(a) The Secretary hereby retains the responsibility for the programs, activities, functions and services with respect to the signatory Tribes that are not specifically assumed by the signatory Tribes, acting individually or collectively, or by the ANTHC through their applicable Funding Agreements and they shall continue to be entitled to the full benefit of those programs, activities, functions, and services retained by the Indian Health Service. In accordance with section 506(h), each Co-Signer shall be eligible for new programs, activities, functions and services of the Secretary and the Indian Health Service on the same basis as other Tribes and Tribal Organizations. The Indian Health Service, in consultation with the Tribes, may reorganize to sustain its ability to provide, in the most effective and efficient manner, all programs, activities, functions, and services that have not been included in the Funding Agreement.

(b) No later than 120 days prior to the end of each fiscal year, the Indian Health Service shall provide each signatory Tribe and Co-Signer with a written list of the retained programs, activities, functions, and services relevant to Native health care in Alaska for the upcoming fiscal year. To the fullest extent permitted by law, the Secretary shall provide any requesting signatory Tribe and Co-Signer access to, and copies of, all documents and other information relevant to any ongoing retained programs, activities, functions, or services, and shall cooperate with any evaluation which the Co-Signer or signatory Tribe may wish to conduct. The Secretary will cooperate with each Tribe and Co-Signer to facilitate the inclusion of programs, activities, functions and services in future Funding Agreements of those Tribes and Co-Signer.

Section 3 – Financial and Other Information.

(a) To assist the Tribes and Co-Signers in monitoring compliance with section 508(c) of the Indian Self-Determination and Education Assistance Act, as amended, the Secretary shall provide to Co-Signers:

(1) all monthly reports of obligations and allowances, including all reports from Central Office, Headquarters, the Office of Tribal Self-Governance and the Alaska Area Office, concerning funds provided to support programs, activities, functions and services provided by Tribes or Tribal Organizations under this Compact and funds retained by the Indian Health Service to support programs, activities, functions and services retained by the Indian Health Service; and

(2) prompt notice of any new programs, activities, functions and services for which the Tribes or Co-Signers are eligible, including the funding available for such programs, activities, functions and services.

(b) The Secretary shall prepare and promptly supply relevant financial information and comply with each Co-Signer's request for information needed to determine funds that may be available for a successor Funding Agreement.

Section 4 - Savings. If the programs, services, functions and activities carried out under Title V Funding Agreements and this Compact result in a reduction to the administrative or other responsibilities of the Secretary, with respect to the operation of Indian programs, and thereby result in saving that have not otherwise been included in the amount of tribal shares and other funds determined under section 508(c) of Title V, the Secretary shall make such savings available to the Co-Signers for the provision of additional services in accordance with section 507(f) of Title V.

ARTICLE V — OTHER PROVISIONS

Section 1 – Designated Officials/Agent.

(a) Parties. On or before the effective date of this Compact, both the Secretary and each Co-Signer shall provide a written designation of an individual as their representative/liaison. The Secretary shall direct all communications about the Compact, and relevant Funding Agreement to the Co-Signer's designee, except in the case where the Compact or Funding Agreement requires notice to the signatory Tribes, in which case notice shall also be sent to the Tribes. Reference herein to Co-Signers or the Secretary shall include the respective Designated Official thereof.

(b) Agent for Notice. If Co-Signers assign an agent to accept and distribute notices, those Co-Signers shall provide the name and address of the agent and a description of the limited powers and duties of the agent.

Section 2 – Indian Preference in Employment, Contracting and Sub-Contracting. The Co-Signers will comply with the Indian and Alaska Native preference provisions of sections 7(b) and 7(c) of the Indian Self-Determination and Education Assistance Act, as amended. The parties agree that any Co-Signer may comply with any Indian or Alaska Native preference established by their respective Tribes, including preference based on tribal affiliation.

Section 3 – Federal Tort Claims Act Coverage; Insurance.

(a) The Tribes and Co-Signers are deemed by statute to be part of the Public Health

Service (PHS), and the employees of the Tribes and Co-Signers are deemed by statute to be part of or employed by the Public Health Service, for purposes of coverage under the Federal Tort Claims Act, while performing programs, activities, functions or services under this Compact and described in the Co-Signer's Funding Agreement (including new and existing programs, services, functions and activities as provided under Article III, Section 5 or 6, or supported with income received in accordance with Article III, Section 7), including coverage for claims of medical malpractice, as is more fully described in 25 C.F.R. Part 900 Subpart M, attached hereto as Exhibit E, and incorporated by reference herein, and section 102(d) of the Indian Self-Determination and Education Assistance Act, as amended, as required by section 516(a).

(b) The above status of a Tribe or Co-Signer, or an employee's status as an employee of a Tribe or employee of a Co-Signer, is not affected by the source of the funds used by the Tribe or Co-Signer to carry out the programs, services, functions or activities or to pay the employee's salary and benefits as long as the employee does not receive any additional compensation for the performance of covered services from anyone other than the Tribe or Co-Signer.

(c) The Tribe's employee or the Co-Signer's employee may, while performing under this Compact and any applicable Co-Signer's Funding Agreement and as a condition of employment, be required by the Tribe or Co-Signer to provide services to non-Indian Health Service beneficiaries in order to meet the obligations under this Compact either in facilities of the Tribe or Co-Signer or in facilities other than those of the Tribe or Co-Signer.

(d) Funds provided under a Funding Agreement may be used to purchase such additional liability and other insurance as is prudent in the judgment of a Co-Signer performing under this Compact and Funding Agreement for its protection and the protection of its employees.

(e) Personal services contracts shall be covered under this provision to the extent provided under section 102(d) of the Indian Self-Determination and Education Assistance Act, as amended.

(f) Coverage shall also apply in accordance with Section 813(e) of the IHCIA, as amended.

Section 4 – Compact Modifications or Amendments.

(a) Any request for a modification of this Compact must be communicated in writing to all signatory Tribes and Co-Signers and to the Indian Health Service. To be effective any modifications of this Compact shall be in the form of a written amendment to the Compact, and shall require written consent of each of the signatory Tribes, acting directly or through an agent authorized by resolution, and the Secretary.

(b) This provision shall not apply to amendment of the Compact to include additional Tribes and/or Co-Signers. Such amendment shall only require the concurrence of the additional Tribe and/or Co-Signer, and the Secretary.

Section 5 – Construction. This Compact shall apply to funds included in the facilities category of Indian Health Service appropriations. A Co-signer may assume construction projects or programs in accordance with Titles I or V or P.L. 86-121. In doing so, the Co-Signer elects to comply with the regulations of the elected statutory provision.

Section 6 – Officials Not To Benefit. No member of or delegate to Congress shall be admitted to any share or part of any Compact executed pursuant to this Compact, or to any benefit that may arise there from; but this provision shall not be construed to extend to any contract under this Compact if made with a corporation for its general benefit.

Section 7 – Covenant Against Contingent Fees. The parties warrant that no person or selling agency has been employed or retained to solicit or secure any contract executed pursuant to this Compact upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial or selling agencies maintained by the contractor for the purpose of securing business.

Section 8 – Penalties. The parties agree that the criminal penalties set forth in 25 U.S.C. § 450d apply to all activities conducted pursuant to this Compact.

Section 9 – Use of Federal Employees. Section 104 of the Indian Self-Determination and Education Assistance Act, as amended, shall apply to this Compact and to any individuals assigned or detailed to any Co-Signer performing functions under this Compact or leaving federal employment to perform services under this Compact, including assignments either on detail or on leave without pay and with or without reimbursement by the Co-Signer for the travel and transportation expenses to or from the place of assignment and for the pay, or supplemental pay, or a part thereof, of the employee during assignment.

Section 10 – Extraordinary or Unforeseen Events. This Compact is intended to obligate each Co-Signer to carry out all usual and ordinary functions respecting the programs, activities, functions and services that it is undertaking to assume responsibility for under its Funding Agreement. In the event major unforeseen or extraordinary events occur, as jointly identified by each Co-Signer and the Secretary, with consequences beyond the control of the Co-Signer, that the Co-Signer shall have access to additional services and funding amounts for its Funding Agreement as described in its Funding Agreement. The parties will seek to ensure that funds available to the Co-Signer to deal with the unforeseen circumstance will not be less than would have been available to non-Compact Tribes or the Indian Health Service had they encountered a similar circumstance. Each Co-Signer's participation in the Indian Health Service Catastrophic Health Emergency Funds will be identified in the Co-Signer's Funding Agreement.

Section 11 – Mature Contractor Status upon Compact Termination. In accordance with section 506(g)(3) of Title V, should any signatory Tribe, tribal organization at the direction of a signatory Tribe or Tribes, or the ANTHC, elect to convert all or some of the programs operated under the Compact back to contract status under Public Law 93-638, as amended, such conversion shall not affect the Co-Signer's or the Tribe's status as having operated a mature contract within the meaning of section 4(h) of the Indian Self-Determination and Education Assistance Act, as amended. Such conversion would occur only at the end of the Compact term, on another date mutually acceptable to the Tribe, the Co-Signer and the Secretary, or as otherwise provided in this Compact, and will be implemented in a manner which avoids any interruption of services to

individual tribal members. If the Compact is terminated or a Tribe determines that it will retrocede any program, activity, function or service operated under the Compact, neither the Tribe nor the Co-Signer shall lose its mature contractor status under section 4(h) as provided above.

Section 12 – Startup Costs. In accordance with section 508(c) of Title V, startup costs may be separately negotiated by each Co-Signer and shall be included in each Co-Signer's Funding Agreement, if available. Startup costs are designed to compensate the Tribe for costs associated with implementing this Compact which the Co-Signer would not normally incur. Upon agreement to such costs on an annual basis, funds for such costs shall be included in the Funding Agreement, if available.

Section 13 – Limitation of Liability. Any liability to the United States or to any third party incurred by a Co-Signer arising out of its performance of or expenditure of funds under this Compact and each Co-Signer's Funding Agreement shall be the obligation only of that Co-Signer and shall not be the obligation of any Co-Signer of this Compact which did not participate in such performance or expenditure.

Section 14 – Contracting Rights. Nothing in this Compact or in any Funding Agreement shall be construed to preclude a Co-Signer from contracting with the Secretary to perform a program, activity, function, or service under Title I of P.L. 93-638, as amended, subject, however, to constraints against duplication pursuant to section 506(h) of Title V.

Section 15 – Sovereign Immunity. Nothing in this Compact or in any Funding Agreement shall be construed to affect the sovereign immunity, to the extent that it may exist, of any Tribe or Co-Signer.

Section 16 – Interpretation of Federal Law. In the implementation of this Compact, the Secretary, to the extent feasible, shall interpret all federal laws, executive orders, and regulations and this Compact in a manner that effectuates and facilitates the purposes of this Compact and achievement of the Co-Signers' health goals and objectives in accordance with section 512(a) of Title V.

Section 17 – Inadequacy of Program Funding. The parties to this Compact understand that the Indian Health Service budget is inadequate to fully meet the special responsibilities and legal obligations of the United States to assure the highest possible health status for American Indians and Alaska Natives and that, accordingly, the funds provided to the Co-Signers are inadequate to permit the Co-Signers to achieve this goal. The Secretary commits to advocate for increases in the Indian Health Service budget to further the ability of the Co-Signers to provide the full range of services that are the responsibility and obligation of the United States to make available to American Indian and Alaska Native people and to meet the goals of the Indian Health Care Improvement Act.

Section 18 – Effect on Non-Signatory Tribes.

(a) Nothing in this Compact or associated Funding Agreements shall be construed to limit or reduce in any way the service, contracts or funds that any Indian tribe, inter-tribal

consortium or tribal organization is eligible to receive. It is the intent of the parties to this Compact that the Compact will not have an adverse impact on any tribe choosing not to participate in this Compact directly or through a tribal organization.

(b) The Compact shall not be construed to limit or curtail the right of any Tribe to pursue a contract under Title I of the Indian Self-Determination and Education Assistance Act, as amended, individual participation in this Compact under Title V, or an independent compact under Title V.

Section 19 – Gaining Mature Contractor Status. Subject to Secretarial approval, a tribe that participates in this Compact by authorizing a tribal organization or inter-tribal consortium to be a Co-signer and receive funds on its behalf, which enters into a Memorandum of Agreement with the Co-Signer, for three years manages a program, activity, function or service identified in the Co-Signer's Funding Agreement and obtains three audits with no material unresolved audit exceptions, shall be deemed a mature contractor for all purposes, including entering into a Compact under section 503(c) of Title V. Nothing in this section precludes the right of a tribe to become a mature contractor under other provisions of law.

Section 20 – Severability. This Compact shall not be considered invalid, void or voidable if any section or provision of this Compact is found to be invalid, unlawful or unenforceable by a court of competent jurisdiction. Should such a court make such a finding, the parties will seek agreement to amend, revise or delete any such invalid, unlawful or unenforceable section or provision, in accordance with the provisions of this Compact.

Section 21 – Applicability of Title I Provisions. At the request of a Co-Signer, any provision of Title I, not already specified in section 516(a) of Title V, to the extent such provision does not conflict with a provision in Title V, shall be made a part of a Funding Agreement. The Secretary is obligated to include such provision at the option of the Co-Signer. If such provision is incorporated it shall have the same force and effect as if it were set out in full in Title V and in the Funding Agreement. Should the Co-Signer request such an incorporation sometime other than during the negotiation stage of the Funding Agreement, the Co-Signer will present the proposed incorporated Section to the Indian Health Service, OTSG, with a copy to the Alaska Area IHS Director. The Director of the Indian Health Service shall approve a written addendum to the Funding Agreement within 30 days after verifying that the provision is in Title I. In the case of any such provision, it shall be deemed incorporated in the Funding Agreement at the end of the 30 day period unless the Co-Signer receives a written notice from the Indian Health Service stating that the provision is not in Title I. In the event a Co-Signer requests such incorporation at the negotiation stage of this Compact or a Funding Agreement, such incorporation shall be deemed effective immediately and shall control the negotiation and resulting Compact and Funding Agreement.

Section 22 — Purchases from the Indian Health Service. With respect to functions transferred by the Indian Health Service to a Co-Signer under this Compact or an applicable Funding Agreement, the Indian Health Service shall provide goods and services to the Co-Signer, on a reimbursable basis, including payment in advance with subsequent adjustment. The reimbursements received from those goods and services, along with the funds received from the Co-Signer pursuant to this section, may be credited to the same or subsequent appropriation account which provided the funding, such amounts to remain available until expended.

ARTICLE VI — ATTACHMENTS

Section 1 – Approval of Compact. The resolutions of the Tribes approving this Compact for each Co-Signer are attached as part of Exhibit A. Additional resolutions for each Co-Signer may be filed with the Indian Health Service and included in Exhibit A up to the effective date of each Co-Signer's Funding Agreement. The resolution of the Board of Directors of the ANTHC is attached as part of Exhibit A.

Section 2 – Funding Agreements. Each Co-Signer's Funding Agreement shall be attached hereto as Exhibit C.

ARTICLE VII — COUNTERPART SIGNATURES

This Compact may be signed in counterparts.

CITY OF NOME
ADMINSTRATIVE REVIEW AND APPEAL FORM

Appeal #: 24

This form is for you to appeal the assessed valuation on your property. Complete Sections 1, 2 and 3. Retain a copy for your records, and return or mail the original copy to the City Clerk's Office. Appeals must be returned or postmarked no later than the date indicated on the Assessment Notice. The Assessor will contact you regarding your appeal.

RECEIVED
APR 21 2022
CITY OF NOME
CLERKS DEPARTMENT

1) I appeal the value of tax parcel #: 0 0 1 . 2 0 1 . 0 5

Property legal description: Block 127, Lot 7A, Mineral Survey _____, Other _____

Print Owner's Name: Norton Sound Health Corporation

Owner's Mailing Address: PO Box 966, Nome, AK 99762

Day Phone: ( ) 443-3337

Evening Phone: ( ) ____-____

Address to which all correspondence should be mailed (if different than above): _____

Please also email all information to: dpardee@nshcorp.org

2)

Assessor's Value	Land:	Bldg:	Total:	Purchase Date:
	$288,400	$1,204,600	$1,493,000	
Owner's Estimate of Value				

Owner's reason for estimate of value (including inventory corrections, sales of comparable properties, and property income statements, if appropriate). The Appellant bears the burden of proof. Grounds for adjustment of assessment are proof of unequal, excessive, improper, or under-valuation based on facts that are stated in a valid written appeal or proven at the appeal hearing.

Appeal based on AS 29.45.030 (a)(3), Hospital, Charitable Activities and Federal Law. Assessment is improper.

See attached

(PLEASE ATTACH STATEMENT IF YOU NEED MORE SPACE)

3) I hereby affirm that the foregoing information is true and correct, that I have read and understand the guidelines above, and that I am the owner or owner's authorized agent of the property described above.

Angie Gom — **Signature of owner or authorized agent**

4/20/22 — Date signed

Angie Gom — Print Name (if different form item # 1)

SUBSCRIBED and SWORN to before me this 20 day of April, 20 22

NOTARY PUBLIC in and for the STATE of ALASKA: Meredith Ahmasuk

Commission Expires: Jan. 5, 2026

Seal:

STATE OF ALASKA
NOTARY PUBLIC
Meredith Ahmasuk
My Commission Expires Jan 5, 2026

Appeal#: 24

****

4)

Assessor's Decision	From:	Land:	Building:	Total:
	To:			

Assessor's Reason for Decision: _____

(PLEASE ATTACH STATEMENT IF YOU NEED MORE SPACE)

Date Rec'd | Decision made by | Date | Approved by | Date | Date mailed

****

5) Appellant's Response:

☐ **I ACCEPT** the assessor's decision in Block 4 above and hereby withdraw my appeal.

☒ **I DO NOT ACCEPT** the assessor's decision and desire to have my appeal presented to the Board of Equalization.

Signature of owner or authorized agent | 4/19/2022 Date | Geoffrey D. Strommer Printed Name

****

6)

BOARD OF EQUALIZATION DECISION	LAND:	BUILDING:	TOTAL:

Date Received | Date Heard | Certified (Chairman or Clerk of Board) | Date | Date Mailed

2022 BOARD OF EQUALIZATION DATE: MAY 4, 5, & 6 2022

THE FINAL DAY TO APPEAL (April 25, 2022) IS 30 DAYS AFTER THE POSTMARK OF YOUR ASSESSMENT NOTICE (*March 25, 2022*)

Attachment to Administrative Review and Appeal Form
Block 127, Lot 7A, W. 6th Avenue ("West Campus")

I. Property Use Description

1. General Scope of Activities on Hospital-Owned Properties.

The Norton Sound Health Corporation (NSHC) is a tribally owned and operated, independent, not-for-profit healthcare organization founded in 1970 to meet the healthcare needs of the Inupiat, Siberian Yup'ik, and Yup'ik people of the Bering Strait region. NSHC is governed by a 22-member board of directors who represent all communities and areas of the Bering Strait region, a 44,000 square-mile section of Northwestern Alaska. The NSHC service area encompasses these 44,000 square miles. NSHC is the only regional health system serving Northwestern Alaska.

The NSHC healthcare system includes a tribally owned regional hospital which is operated pursuant to an Indian Self-Determination and Education Assistance Act (ISDEAA) agreement. NSHC operates health facilities and provides health care services to Alaska Natives and other beneficiaries pursuant to the Alaska Tribal Health Compact (ATHC), a multi-tribe self-governance compact with the Indian Health Service (IHS) under Title V of the ISDEAA, 25 U.S.C. § 5381, et seq., and funding agreements (FAs), which include program funding amounts that are negotiated for each fiscal year between the IHS and NSHC to fund the programs, functions, services, and activities (PFSAs) that NSHC performs on behalf of IHS. IHS funds the administration of the PFSAs, including the operation of the hospital facilities in Nome, that NSHC has contracted to perform on behalf of IHS.[1]

NSHC is an "instrumentality" of the United States in providing healthcare services under Title V of the ISDEAA. Healthcare services are federal PFSAs provided under the ISDEAA pursuant to the federal trust responsibility to Indians for health care.[2]

The ISDEAA deems tribes and tribal organizations carrying out ISDEAA agreements to be federal executive agencies for purposes of coverage under the Federal Tort Claims Act (FTCA) and access to federal sources of supply.[3] NSHC employees, like employees of other tribal entities operating agreements with IHS under the ISDEAA, are similarly equally covered by the FTCA and are "federal employees" for these purposes.[4] The ISDEAA also authorizes tribal contractors and compactors to perform personal services otherwise performed by federal employees in determining eligibility for IHS services and benefits, the amounts of such services and benefits, and how such services and benefits should be provided.[5] In addition, tribal

[1] 25 U.S.C. § 5325; 25 U.S.C. § 5396(a) (mandatory application of § 5325 to Title V agreements).

[2] 25 U.S.C. § 1602.

[3] 25 U.S.C. §§ 450f(d) and 450j(k).

[4] *See* 25 U.S.C. §§ 5321(d) and 5396(a); *M.J. ex rel. Beebe v. United States*, 721 F.3d 1079, 1084 (9th Cir. 2013).

[5] 25 USC § 450j(g).

facilities operated under the ISDEAA are interpreted by the Centers for Medicare and Medicaid Services as IHS facilities for purposes of the 100 percent Federal Medical Assistance Percentage under Section 1905 of the Social Security Act.[6]

The ATHC expressly provides that ATHC co-signers, such as NSHC, "are deemed by statute to be part of the Public Health Service (PHS), and the employees of the Tribes and Co-Signers are deemed by statute to be part of or employed by the Public Health Service, for purposes of coverage under the [FTCA]," while performing PFSAs under the ATHC's compact and as described in its Funding Agreement.[7] The current NSHC Funding Agreement expressly provides that "support services required to support the provision of health services," including human resources activities, administration and board support, performance management, financial functions, and the provision of staff housing, are part of the scope of work,[8] as is the training of community health aides;[9] emergency medical services training for staff and community members throughout the region;[10] and the provision of lodging for patients, family members of patients, and their escorts.[11]

2. Specific Use of West Campus

The buildings on this lot are utilized exclusively by NSHC. There are no unused portions of these buildings. The uses are as follows:

1. Storage of Essential Records and Equipment. Approximately one-half of one of the buildings is used to store, medical, HR, and finance records. There is no space within the actual hospital facility for storage—all space is devoted to the provision of care. Therefore, essential records are stored in this building. Physical personnel records are stored here until the employee dies. Federal law under the Employee Retirement Income Security Act of 1974 (ERISA) legally requires the hospital to maintain the physical personnel files for this period of time, which means the storage needs are ever-increasing. In addition, all of the accounting and finance records are stored here. These records must be maintained for a minimum of seven (7) years before they can be destroyed. Medical records which have not been digitized are stored here and must be safely and securely maintained under federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. In addition, some old medical equipment is stored in this part of the building.
2. Vehicle and Facility Maintenance. The other one-half of the building is utilized for maintenance purposes. Part of the area is a garage where the snow plow, sanding equipment, and other trucks are parked and maintained. The garage is also where all

[6] 42 U.S.C. § 1396(d).
[7] *See* ATHC Article V Sec. 3(a).
[8] Funding Agreement Between Certain Alaska Native Tribes Served By The Norton Sound Health Corporation And The Secretary Of Human Health And Human Services Of The United States of America Fiscal Years 2018-2020 § 3.5.
[9] *Id.* §§ 3.4.4, 3.4.5.
[10] *Id.* § 3.4.7.
[11] *Id.* at § 3.2.14.

hospital vehicle maintenance is done. Painting supplies for all the hospital facilities are kept here also.

3. Plant Operation Training. Training for plant operations is conducted at this building. This training is conducted periodically throughout the year.

II. NSHC Enjoys the Sovereign Immunity of its Member Tribes and is Immune from Suits to Collect Taxes

Tribal healthcare entities like NSHC performing self-determination contracts under the ISDEAA for health services enjoy sovereign immunity,[12] including those operating off-reservation.[13] "Indian tribes have long been recognized as possessing the common-law immunity from suit traditionally enjoyed by sovereign powers."[14] "As a matter of federal law, an Indian tribe is subject to suit only where Congress has authorized the suit or the tribe has waived its immunity."[15] "[T]ribal immunity is a matter of federal law and is not subject to diminution by the States."[16] Tribal immunity extends to tribal governing bodies and to tribal agencies or entities that act as an "arm of the tribe."[17] Lastly, "[i]t is settled that a waiver of [tribal] sovereign immunity cannot be implied but must be unequivocally expressed."[18]

In *Barron v. Alaska Native Tribal Health Consortium*, the U.S. District Court for the District of Alaska held a tribal health consortium organization enjoyed sovereign immunity where the organization was formed by Alaska Native tribes; its creation was authorized pursuant to the ISDEAA; it received federal funding to conduct activities that benefitted tribal members; the structure of its board placed control over its ownership and management in representatives of the Alaska Native tribes; its purpose of entering into self-determination and self-governance agreements was "core to the notion of sovereignty"; and it received federal funding "to carry out governmental functions critical to Alaska Native tribes," i.e., healthcare services.[19] Like the entity in *Barron*, and as more fully discussed below, NSHC shares these same attributes.

Tribal immunity extends to suits to collect unpaid taxes. This is because, as the U.S. Supreme Court noted in *Oklahoma Tax Commission v. Citizen Band Potawatomi Indian Tribe of Oklahoma*, "[a]lthough Congress has occasionally authorized limited classes of suits against Indian tribes, *it has never authorized suits to enforce tax assessments*."[20]

In *Matter of 1981–85 Delinquent Property Taxes Owed to the City of Nome, Alaska*, the Supreme Court of Alaska held that the Indian Reorganization Act (IRA) barred a city from foreclosing on lands held by groups of Alaska Natives organized under Section 16 of the IRA on

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[12] *Manzano v. S. Indian Health Council, Inc.*, No. 20-cv-02130-BAS-BGS, 2021 WL 2826072, at *1 (S.D. Cal. July 7, 2021) (non-profit healthcare corporation formed by membership of seven tribes entitled to sovereign immunity).
[13] *See Pink v. Modoc Indian Health Proj., Inc.*, 157 F.3d 1185, 1189 (9th Cir. 1998) (nonprofit corporation created and controlled by two tribes entitled to sovereign immunity).
[14] *Santa Clara Pueblo v. Martinez*, 436 U.S. 49, 58 (1978).
[15] *Kiowa Tribe of Okla.* v. *Mfg. Techs., Inc.*, 523 U.S. 751, 754 (1998) (citations omitted).
[16] *Id.* at 756 (citations omitted).
[17] *Cook v. AVI Casino Enters., Inc.*, 548 F.3d 718, 725 (9th Cir. 2008).
[18] *Santa Clara Pueblo*, 436 U.S. at 58 (citation omitted) (internal quotation omitted).
[19] 373 F.Supp.3d 1232, 1239–40 (D. Alaska 2019).
[20] 498 U.S. 505, 510 (1991) (emphasis added).

the basis of non-payment of local property taxes.[21] In that case, the city sought to foreclose on two tracts owed by the Alaska Native group which were "purchased in part with funds from a federal grant under the [ISDEAA]."[22] In that case, the Court found the IRA was "intended to promote tribal self-government and conserve Indian lands and resources," and that had any doubt remained, the Court "would rest on the settled principle that, in Indian law, all ambiguities must be resolved in favor of the Indians."[23]

In the U.S. Circuit Court of Appeals for the Ninth Circuit, where NSHC is located, courts look to the following factors to determine whether a tribal entity functions as an "arm of the tribe" and is therefore entitled to share in the tribe's sovereign immunity: "(1) the method of creation of the economic entities; (2) their purpose; (3) their structure, ownership, and management, including the amount of control the tribe has over the entities; (4) the tribe's intent with respect to the sharing of its sovereign immunity; and (5) the financial relationship between the tribe and the entities."[24] In *White v. University of California*, the Ninth Circuit upheld the district court's application of this test to hold that a tribal repatriation committee formed by twelve tribes was entitled to sovereign immunity because it was created by resolution of each of the tribes; comprised solely of tribal members appointed by each tribe; funded exclusively by the tribes; and its purpose, "to recover remains and educate the public, [was] 'core to the notion of sovereignty.'"[25] And in *Pink v. Modoc Indian Health Project, Inc.*, the court held that a subsidiary tribal entity established and controlled by several tribes to provide health care services was protected by sovereign immunity.[26]

1. NSHC's method of creation supports immunity.

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[21] 780 P.2d 363 (Alaska 1989).

[22] *Id.* at 364.

[23] *Id.* at 367 (citation omitted).

[24] *White v. Univ. of Cal.*, 765 F.3d at 1025 (2014) (citation omitted). Although not included in the Ninth Circuit's "arm of the tribe" test, an additional factor is examined by the Tenth Circuit: "the policies underlying tribal sovereign immunity and its connection to tribal economic development, and whether those policies are served by granting immunity to the economic entities." *Breakthrough Mgmt. Grp., Inc. v. Chukchansi Gold Casino and Resort*, 629 F.3d 1173, 1187 (2010).

Here, a grant of immunity to NSHC furthers the policies underlying tribal sovereign immunity. The doctrine of tribal sovereign immunity exists in order to avoid "interference with tribal autonomy and self-government," *Santa Clara Pueblo*, 436 U.S. at 59, and "infringe[ment] on the right of the Indians to govern themselves." *Williams v. Lee*, 358 U.S. 217, 223 (1959). Like the doctrine of tribal sovereign immunity, the fundamental policy underlying the ISDEAA is to enhance tribal autonomy and control in the provision of services to tribal communities. *See, e.g.*, 25 U.S.C. § 5302(a) (declaring that policy of ISDEAA is to assure "maximum Indian participation in the direction of educational as well as other Federal services to Indian communities so as to render such services more responsive to the needs and desires of those communities"). NSHC has taken on the entire federal responsibility for health care services for its member tribes. The essential federal-tribal nature of the ISDEAA program and the fact ISDEAA programs are funded by the federal resources that would have been spent on programs serving those tribes shows that NSHC is completely financially dependent on the tribes' right to ISDEAA funding, and has stepped into the tribes' shoes and operates as the "health arm" of its member tribes. Because NSHC has stepped into the shoes of its member tribes as the "health arm" of those tribes in order to enter a government-to-government relationship with the United States, NSHC's immunity from suit protects the tribal autonomy of NSHC's member governments.

[25] *White*, 765 F.3d at 1025.

[26] 157 F.3d at 1188–89.

NSHC was incorporated on November 27, 1970 under the Alaska Non-Profit Corporation Act. Article VII of the NSHC Articles of Incorporation names three individuals representing the Alaska Native villages of Shaktoolik, Gambell, and Teller to the initial Board of Directors, and Article VIII shows the same three Village representatives as the initial incorporators. The formation and governance of NSHC was thereby tied directly to the member Villages. Article I and Article III of the Articles of Incorporation also provide that NSHC shall be "non-profit in nature," weighing in favor of treating it as an arm of the tribes. It is clear that NSHC's member tribes have delegated their governmental, rather than commercial, responsibility to provide health care to NSHC, which is not a for-profit venture but a vehicle for providing government health services.

2. NSHC's purpose to provide governmental health care supports immunity.

NSHC's Bylaws, adopted in 1977 and revised in 1978–79, expressly establish the Corporations purposes as follows:

1. To establish and maintain facilities, including but not limited to hospital and clinics, for the care of people suffering from injury, illness or disability requiring medical and hospital services and utilizing both inpatient and outpatient facilities and services, such care to be given regardless of the person's race, color, creed, age, sex, nationality or ability to pay.
2. To participate, so far as the circumstances may warrant, in any activity to promote the general health of the principal area.
3. To carry on educational programs, including the training of healing arts personnel, relating to rendering care to the sick and the promotion of health and the maintenance of high health care standards.
4. To advance general community understanding of, confidence in and proper use of the total program of health services.
5. To carry out the foregoing purposes [through the receipt and disbursement of funds and assets].

Each of these purposes reflects the delegation from the member tribes of their respective governmental health care responsibilities to NSHC. Indeed, the purpose of NSHC is to "step into the shoes" of the federal government to carry out, through the ISDEAA, the United States' responsibility to provide health care for Alaska Native and American Indian people.[27]

3. The tribal governments' close ownership, and management and control of NSHC support immunity.

NSHC is structured such that NSHC's member tribes directly control the governance of NSHC. Article IV of the Bylaws established a Board of Directors of 22 elected directors. Each of the 16 member villages elects one representative to the Board of Directors, and the Nome Eskimo Community elects two directors. The Nome City Council may elect one director, and the Board of Directors, among themselves, elects three additional directors representing Nome.

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[27] *See* 25 U.S.C. § 5302.

Article V provides that the NSHC officers, including the Chairman, are elected from among the Board of Directors.

To this point, in 1980, the United States Department of the Interior unequivocally determined, based on the member tribal organizations' direct control of NSHC, that NSHC is an arm of the member tribes.[28]

In his Memorandum, Alaska Regional Solicitor Dennis J. Hopewell informed the BIA Area Director, Juneau Area Office that "[NSHC] is not only considered the 'health arm' of the Bering Straits Native Corporation . . . which is a recognized Indian tribe . . . but the Norton Sound Health Corporation is controlled, sanctioned and chartered by other tribal governing bodies." Hopewell considered the NSHC Bylaws to be conclusive evidence of NSHC's direct control by its member tribal entities, stating "[s]ince the Bylaws for the [NSHC] also spell out that '[t]he management of the property, funds, affairs and business of this Corporation shall be vested in a Board of Directors consisting of ...' the members listed above, there can be no doubt that the corporation is controlled by tribal governing bodies." Hopewell found that NSHC "in addition to being controlled by, is also sanctioned and chartered by such tribal governing bodies," and "[t]his representation also shows that the operation and management of [NSHC] includes the maximum participation of Indians in all phases of its activities."

4. The tribal governments intended that NSHC share in their tribal sovereign immunity.

In 1975, Congress signed the ISDEAA (Pub. L. No. 93-638) into law. In 1978 and 1979, NSHC's member Alaska Native Villages each executed resolutions authorizing NSHC to enter contracts and grants with the United States on their behalf.[29] In 1994, the member Villages executed additional resolutions, which provide the current authority for NSHC to enter into the compact and funding agreements.[30]

Each resolution acknowledged that Congress enacted the ISDEAA as a "far reaching Indian Self-Determination Policy" that "grants Alaska Native villages the *sovereign right to designate tribal organizations which shall have the authority to provide services through contracts or grants with the Federal Government* under Public Law 93-638 for the provision of Government services to Native peoples."[31] The resolutions further note that NSHC "has village representation and traditionally provided information both to and from the village on health related matters" and that NSHC "is controlled and operated by a Board of Directors appointed by the tribal governments" of its member communities.[32]

In recognition of the foregoing, the resolutions authorize NSHC "to apply for, negotiate, appeal from adverse decisions, and secure contracts and grants with the Indian Health Service of the Department of Health, Education and Welfare for health care and related programs serving

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[28] Status of Norton Sound Health Corporation As A Tribal Organization Pursuant to P.L. 93-638.
[29] A representative resolution from the Native Village of Elim is attached [hereafter Elim Resolution].
[30] A representative resolution from the Native Village of Diomede is attached.
[31] *See, e.g.,* Elim Resolution at 1 (emphasis added).
[32] *Ibid.*

Native people" in the region.[33] The resolutions further authorize NSHC and its Board of Directors "to act on behalf of this village on health and related services" and "to accept funding for health and related service projects for this village from all funding agencies private and public."[34] The United States Supreme Court has noted that "[t]he common law sovereign immunity possessed by the Tribe is a necessary corollary to Indian sovereignty and self-governance."[35] The resolutions' provisions that NSHC would "act on behalf" of the villages as their health arm and delegation of governmental duties to NSHC reflects their intent that NSHC would share in the "corollary" privilege of immunity from suit in carrying out those functions.

5. NSHC is wholly financially dependent on the member tribes' assignment of their right to contract with IHS to provide health services to their members.

Under the ATHC, all Alaska tribes participate in the delivery of health care services to their members and other beneficiaries in accordance with the principles of tribal self-governance. The Compact allowed NSHC, on behalf of its member tribes, to enter into a government-to-government relationship with the United States. Since 1994, NSHC has participated each year with other co-signers and the IHS in the negotiation of annual funding agreements and amendments to the ATHC.

The funding agreement (FA) NSHC negotiates annually with IHS on behalf of the member tribes includes a broad scope of work covering a wide variety of health care services, from hospital and clinic services to long-term care, from dental services to lodging for patients.[36] In fact, while NSHC is the *signatory* to the funding agreement, the *parties* to the FA are the HHS Secretary and NSHC's member villages themselves. The 2018 Funding Agreement, titled, "Funding Agreement Between Certain Alaska Native Tribes Served by the Norton Sound Health Corporation and the Secretary Of Health And Human Services Of The United States Of America," states:

> This Funding Agreement is entered into by and between certain Alaska Native Tribes in the Bering Straits region of the Norton Sound Service Unit, as identified on the signature page herein, and the Secretary of the Department of Health and Human Services. These Tribes have authorized the Norton Sound Health Corporation to sign this Funding Agreement for them and to be responsible for and carry out the terms of this Funding Agreement.[37]

Section 2.1 of the 2018 FA "obligates NSHC to be responsible for and to provide health PSFAs identified in Section 3 [Tribal Programs and Budget], utilizing the resources transferred under this FA and other funds as they may become available to NSHC." Section 5.2 provides these resources represent the entirety of the member Tribes' entitlement to these funds: "NSHC

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[33] *Ibid.*
[34] *Ibid.*
[35] *Three Affiliated Tribes of Fort Berthold Reservation v. Wold Eng'g*, 476 U.S. 877, 890 (1986) (emphasis added).
[36] Funding Agreement Between Certain Alaska Native Tribes Served By The Norton Sound Health Corporation And The Secretary Of Health And Human Services Of The United States Of America Fiscal Years 2018-2020 §§ 3.2, 3.4.1, and 3.2.14.
[37] *Id.* at 1.

will be paid 100 percent of Headquarters and Area Tribal Shares in its initial lump sum payment, as negotiated in this FA." Section 4 of the 2018 FA describes the total FY 2018 funding made available to NSHC from funds that would otherwise be allocated to NSHC's member tribes. Without the Compact and Funding Agreements, through which NSHC performs governmental functions for their member villages, NSHC would be unable to function. Accordingly, the financial relationship between NSHC and the tribal entities supports NSHC's immunity.[38]

In substance and in form, NSHC serves as an arm of its member tribes. NSHC is dependent on the authorization and support of its member tribal governments to operate, and it fills a critically under-resourced governmental function–far different from a private, for-profit economic venture or other state-incorporated non-profits that may operate in the public sector but are not fulfilling government functions. NSHC shares in the sovereign immunity of its member tribes, and this immunity from suit extends to suits to collect unpaid taxes. This sovereign immunity operates unless specifically and unequivocally waived, and NSHC has not waived its immunity.

III. The City's Taxation is Preempted by Federal Law

Alaska Statute 29.45.030(a)(8) exempts from tax, "property of a political subdivision, agency, corporation, or other entity of the United States to the extent required by federal law…" The city of Nome's tax on all real property owned by NSHC is preempted by federal law.

In *United States v. New Mexico*, the U.S. Supreme Court announced a rule to apply generally to determine immunity from state and local taxation under the supremacy doctrine:

> [T]ax immunity is appropriate in only one circumstance; when the levy falls on the United States itself, or on an agency or *instrumentality* so closely connected to the Government that the two cannot realistically be viewed as separate entities, *at least insofar as the activity being taxed is concerned.*[39]

Under the implied federal preemption doctrine, space that is used to carry out federal programs and that is subject to comprehensive and pervasive federal oversight is exempt from state or local taxation.[40]

In *Ketchikan Gateway Borough v. Ketchikan Indian Corporation*, the Alaska Supreme Court upheld application of the implied federal preemption doctrine to exempt from borough taxes "*all space in a building that contains a tribally operated clinic.*"[41] In that case, the tribally operated clinic was funded by the IHS and operated on land conveyed by the United States.[42] The only space held not to be exempt from taxation was "space not committed to use by the clinic," because it was "uncertain how the uncommitted space would be used" and it "appear[ed]

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[38] *See White*, 765 F.3d at 1025 (fact that entity was funded solely by the tribe supported determination that entity was an "arm of the tribe" entitled to immunity).
[39] 455 U.S. 720, 735 (1982) (emphasis added).
[40] *Ketchikan Gateway Borough v. Ketchikan Indian Corp.*, 75 P.3d 1042, 1048 (Alaska 2003).
[41] *Id.* at 1044 (emphasis added).
[42] *Ibid.*

that at least for near-term purposes it [would] either be leased to others or used for other [i.e., non-clinic-related] programs of [the Indian corporation]."[43]

This property is integral to the provision of healthcare under NSHC's ISDEAA agreement. As programs and services that support the healthcare operations are included under the scope of work as defined in NSHC's Funding Agreement, all areas used for human resources, administration and board support, performance management, training, medical personnel housing, patient housing, and financial function are integral to NSHC's healthcare operations under the ISDEAA.

The Alaska Supreme Court, in *Ketchikan Gateway Borough,* acknowledged that federal law preempts state taxation where the activity is subject to comprehensive and pervasive federal oversight.[44]

The federal and tribal interests in the instant case are clear and strong. Provision of Indian health care services is comprehensively and pervasively regulated; this is manifest both in the ISDEAA and in the Indian Health Care Improvement Act (IHCIA). Congress expressed its intention in the ISDEAA that those operating under self-determination contracts receive the same amount of funding as would the federal government if one of its departments was still providing the services in question. NSHC is subject to comprehensive and pervasive oversight by virtue of its operation under the ISDEAA. Accordingly, the city's tax is preempted.[45]

Although tribes step into the shoes of the IHS when carrying out programs and providing services under the ISDEAA, the ultimate responsibility for those programs and services remains with IHS, which therefore retains a pervasive oversight role. Participation in the self-governance program requires a rigorous planning process and demonstration of financial stability and financial management capability for three (3) years.[46] ISDEAA contractors are subject to annual audits, with penalties for noncompliance with applicable cost principles.[47] And every ISDEAA agreement must, by law, include a provision allowing the Secretary to reassume operation of a program, and the associated funding, if the agency finds gross mismanagement or imminent danger to public health.[48] The regulations at 25 C.F.R. Part 900 and 42 C.F.R. Part 137 elaborate these and other limitations. As noted above, nothing in the ISDEAA abrogates or weakens the trust responsibility to tribes and individual Indians,[49] and IHS consequently retains comprehensive and pervasive oversight.

In *Ketchikan Gateway Borough*, the Alaska Supreme Court noted that while the rule of strict construction requires that "[t]axpayer exemptions are strictly construed against the taxpayer and in favor of the taxing authority . . . . where the question is whether federal law requires the

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[43] *Id.* at 1049; 1048 n.27.
[44] *Id.* at 1048.
[45] *Ketchikan Gateway Borough*, 75 P.3d at 1048.
[46] 25 U.S.C. § 5383(c)(1)(C).
[47] *Id.* § 5386(c).
[48] *Id.* § 5387(a)(2).
[49] *E.g., id.* § 5332(2); *id.* § 5329(c), Model Agreement § (d)(1) ("The United States reaffirms the trust responsibility of the United States" to the contracting tribe); *id.* § 5395(b) ("Nothing in this chapter shall be construed to diminish in any way the trust responsibility of the United States to Indian tribes and individual Indians . . .").

exemption of tribal interests from taxation, ambiguities in federal law should be resolved *in favor of the tribe*."[50]

IV. Alaska Law Exempts All Hospital Property from Taxation

A. The Subject Property Constitutes a "Hospital."

The Alaska Constitution provides that: "All, or any portion of, property used exclusively for non-profit religious, charitable, cemetery, or educational purposes, as defined by law, shall be exempt from taxation."[51] Pursuant to this provision, Alaska Statute (AS) 29.45.030(a)(3) provides that "property used exclusively for nonprofit religious, charitable, cemetery, hospital, or educational purposes" is exempt from general taxation.

The meaning of "hospital" is generally understood to include the structures operated as part of a hospital complex in addition to the limited area at which care is directly provided to patients.[52] In this opinion, the Alaska A.G. cites the Alaska Hospital and Medical Facilities Survey and Construction Act ("Construction Act") for the definition of "hospital", although the issue at hand did not directly implicate the Construction Act. The Alaska A.G. found as follows:

> 'hospital' includes a public health center and general, tuberculosis, mental, chronic disease, and other type of hospital, and related facilities, including laboratory, outpatient department, nurses' homes, and training facilities, and **central services facilities operated in connection with a hospital,** but does not include a hospital furnishing primarily domiciliary care.[53]

By 'operated in connection with the hospital,' it is assumed that the primary purpose of the building is to further the hospital's operations.

B. The Subject Property is Exclusively Used for NSHC's Exempt Purposes.

The use of this property for essential record storage, hospital vehicles and maintenance, and operations training is the direct and primary purpose for which the hospital was incorporated. Alaska courts interpret "exclusive use" to require that all uses of the property be for the "direct and primary" exempt purpose.[54]

There are no cases in Alaska which address the precise facts in the instant case. However, courts in jurisdictions that have, like Alaska, an "exclusive use" standard for granting tax exemption and similarly hold that exclusive use refers to the primary purpose for which the property is being used have addressed the exemption for off-site buildings. In *Norwegian American Hospital, Inc. v. Department of Revenue,* 210 Ill. App. 3d 318, 569 N.E.2d 83 (1st

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[50] *Id.* at 1045 (citing *Cotton Petroleum Corp. v. New Mexico*, 490 U.S. 163, 177 (1989)).

[51] Alaska Const. art. IX, § 4.

[52] AK Office of Attorney General Opinion, 1981 WL 38838 (Alaska A.G.) (1981) (hereinafter "A.G. Opinion").

[53] A.G. Opinion (third emphasis added) (citing AS 18.20.210(3)).

[54] *Fairbanks North Star Borough v. Denά Nenά Henash*, 88 P.3d 124 (Alaska 2004).

Dist. 1991), the court evaluated what is meant by primary use. The court recognized that the use need not be absolutely indispensable for carrying out, as in this instance, patient care. If the party seeking the exemption can establish that the property is used primarily for purposes reasonably necessary for the accomplishment and fulfillment of the institution's objectives and administration, an exemption will be sustained.[55] The *Norwegian* court went on to say, "The hospital need not prove that the subject parcels involved activity that directly related to the healing of patients in order to receive tax exemptions for the properties."[56]

Storage of essential records, which the hospital has a legal obligation to maintain in a safe and secure manner, is necessary to the operation of the hospital. NSHC cannot provide health care unless it is operating in a legally compliant fashion. Since there is no physical space within the hospital to store essential records, it has no choice but to store them off site.

The same is true for maintenance and storage of vehicles and equipment essential to the operations of the hospital. It is incongruous to conclude that it is "not necessary," as the agent has in this case, to dedicate hospital-owned space to the storage and maintenance of equipment required to operate the hospital facility. The direct and primary purpose of this building is dedicated to the operation of the hospital. Without the functions and activities conducted in this building, the hospital could not legally and safely operate. The building's use is entirely integrated with the hospital. Its use is not ancillary or incidental.

Further, training facilities operated in connection the hospital are part of the hospital.[57] The use of this building to conduct operations training is integral to its function as a hospital.

This property was determined to be tax exempt in 2021. The uses and purposes have not changed in 2022. Thus, there is no compelling reason to change its tax-exempt status in 2022.

C. Assessor's Reliance on the "Vitally Necessary" Standard is Misplaced and Misconstrued.

The assessor appears to rely upon the case of *City of Nome v. Catholic Bishop of Northern Alaska,* 707 P.2d 870 (Alaska 1985) to deny tax exemptions to these properties. The *Catholic Bishop* case entailed an interpretation of AS 29.53.020(a)(3) (repealed and replaced by AS 29.45.030(a)(3)) with respect to use of certain church properties. The assessor suggests that the standard for determining whether property is "exclusively used" for exempt purposes is set forth in *Catholic Bishop* as whether the use of the property is "vitally necessary" to the hospital's exempt purposes. This is a misinterpretation of *Catholic Bishop* and is not the applicable standard.

The *Catholic Bishop* court stated that the standard for interpreting "exclusive use" is

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[55] *Norwegian*, 210 Ill. App. 3d at 322–23.

[56] *Id* at 324; *see also*, *Nw. Mem'l Found. v. Johnson*, 141 Ill. App. 3d 309, 490 N.E.2d 161 (1st Dist. 1986) (parking lot for employees and patients exempt from tax as necessary to fulfill the purposes of the hospital although not always in use).

[57] A.G. Opinion.

whether the use is "direct and primary" to the exempt purposes:

> We have interpreted "exclusive use" in accord with our rule of strict construction. In *Harmon v. North Pacific Union Conference Association of Seventh Day Adventists,* 462 P.2d 432 (Alaska 1969), we decided that "[e]ven when the uses of a piece of property are highly related to the primarily exempted activity, the exemption will not apply when the statute requires 'exclusive' use." 462 P.2d at 437. All uses of the property must be for the "direct and primary" exempt purpose. *Evangelical Covenant Church v. City of Nome,* 394 P.2d 882, 883 (Alaska 1964) (citing Annot., 154 A.L.R. 895, 898 (1945)). *See Matanuska-Susitna Borough v. King's Lake Camp,* 439 P.2d 441, 445 (Alaska 1968).[58]

The "vitally necessary" test was first referenced in *Harmon* for purposes of interpreting a different statutory exemption from the instant case, the religious parsonage exemption under AS 29.10.336 (now AS 29.45.030(b)). The church in *Harmon* sought to exempt buildings used for the residences of church administrators, teachers, and visiting church staff members. The buildings were also used for counseling and church social gatherings. The court stated that it must strictly construe whether property is used "exclusively for religious purposes" based on the legislative intent to narrowly define the type of residence which qualifies for exemption.[59]

Similarly, in *Catholic Bishop*, the court addressed the same parsonage exemption under AS 29.53.020(b)(1) (now AS 29.45.030(b)(1)). The court stated that it recognizes a narrow exception to the exclusive-use standard when evaluating the parsonage allowance, as follows:

> Residences that are not exempt under AS 29.53.020(b)(1) may still be exempt if their use was directly incidental to and vitally necessary for the exempt use **of other church property**.[60]

In *Catholic Bishop,* three churches sought to exempt religious residences, administrative offices, sanctuaries, and property used for both religious educational and charitable purposes. They also sought to exempt properties used as support for exempt properties, and church property leased to other nonprofit organizations. With respect to the residence of a religious worker/volunteer, the court evaluated this as "other property" not specifically listed in the applicable statute (i.e., residence of bishop, pastor, priest, rabbi, minister), and applied the narrow "vitally necessary" alternative standard to exclusive use. The *Catholic Bishop* court explained that the "vitally necessary" standard applies only to use of other [church] property and does not supplant the "direct and primary" exclusive-use standard for property used directly with the particular exempt activity.[61]

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[58] 707 P.2d. at 879.

[59] *Harmon*, 462 P.2d at 436.

[60] 707 P.2d at 884–85 (emphasis added).

[61] *Id.* at 880.

NSHC submits that the *Catholic Bishop* "vitally necessary" standard does not apply outside of interpreting the special definition of "exclusive religious use" for housing ministers, pastors, et al. under AS 29.45.030(b). Even if *Catholic Bishop* were found to be controlling in the instant matter, the case confirms that the test for determining "exclusive use" is whether the use is direct and primary to the exempt purposes.[62] NSHC's patient hostel and medical provider housing are "used directly" with its exempt activity of the hospital. The *Catholic Bishop* court acknowledges that residential accommodations which are "institutionally necessary" to the operation of a hospital are exempt.[63]

Since *Catholic Bishop,* Alaska courts have confirmed that "direct and primary" is the standard for evaluating exclusive use:

> Most of our charitable-purposes tax exemption cases revolve around the second part of the analysis: whether the property is being used exclusively for a charitable purpose. We have interpreted "exclusive use" to require that all uses of the property be for the "direct and primary" exempt purpose.[64]

The *Denά Nenά Henash* court declined to use the "vitally necessary" standard when determining whether property used to house, in part, fundraising activities for non-exempt purposes was an "exclusive" charitable use.[65]

This is not a case of "other property" discrete from the hospital being used for ancillary purposes or purposes outside of the statutory definition of hospital use. As described previously, the operation and use of this property is necessary to accomplishing its core charitable purposes and its legal obligations under the funding agreement.

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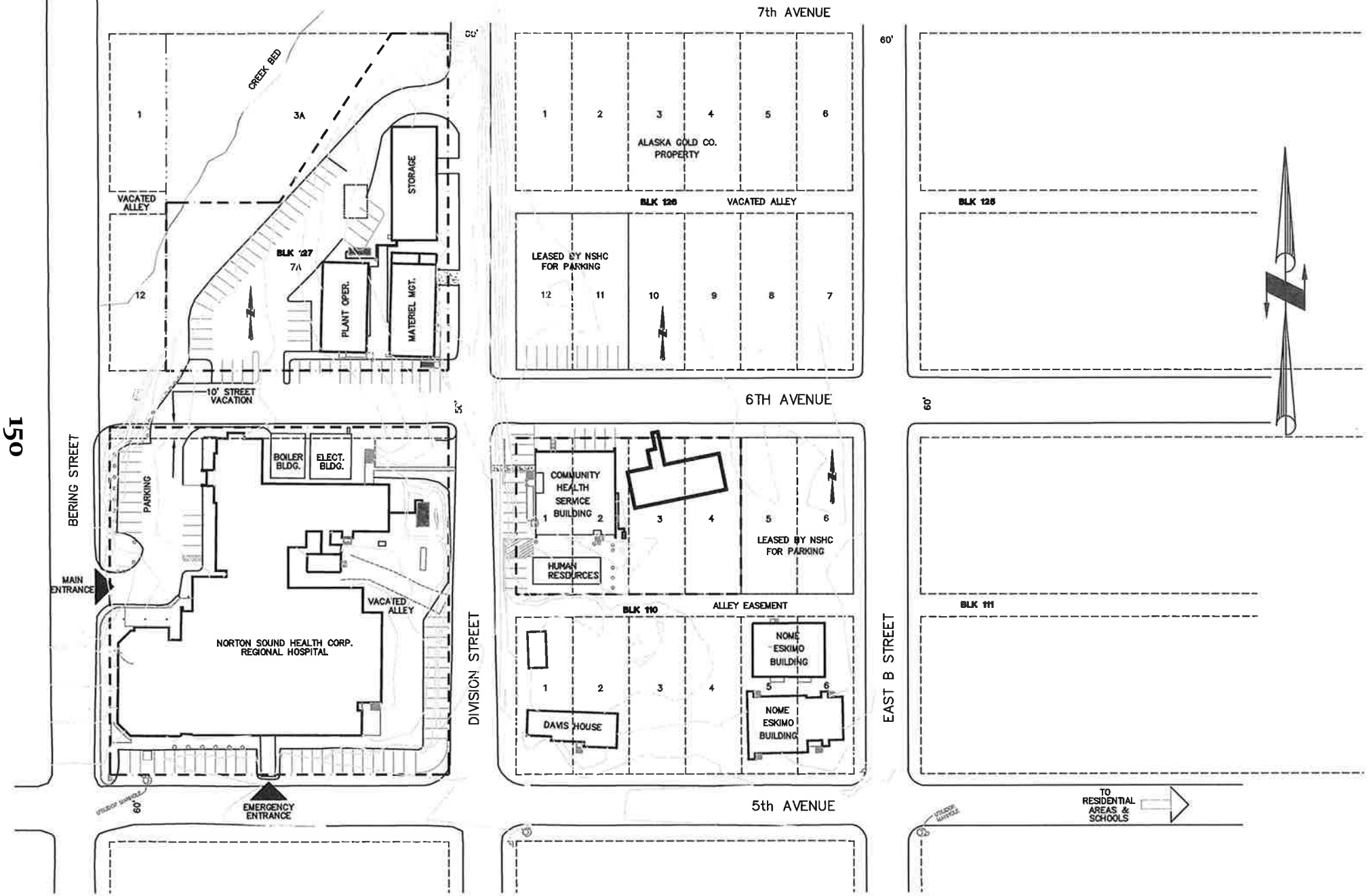
[62] *Id.* at 879.
[63] *Id* at 880–81.
[64] *Denά Nenά Henash*, 88 P.3d at 132.
[65] *Id* at 141.


7th AVENUE
6TH AVENUE
5th AVENUE
BERING STREET
DIVISION STREET
EAST B STREET
CREEK BED
VACATED ALLEY
BLK 127
7A
3A
STORAGE
PLANT OPER.
MATERIEL MGT.
10' STREET VACATION
ALASKA GOLD CO. PROPERTY
BLK 126
VACATED ALLEY
LEASED BY NSHC FOR PARKING
BLK 125
BOILER BLDG.
ELECT. BLDG.
PARKING
MAIN ENTRANCE
VACATED ALLEY
NORTON SOUND HEALTH CORP. REGIONAL HOSPITAL
EMERGENCY ENTRANCE
COMMUNITY HEALTH SERVICE BUILDING
HUMAN RESOURCES
LEASED BY NSHC FOR PARKING
BLK 110
ALLEY EASEMENT
NOME ESKIMO BUILDING
DAVIS HOUSE
NOME ESKIMO BUILDING
BLK 111
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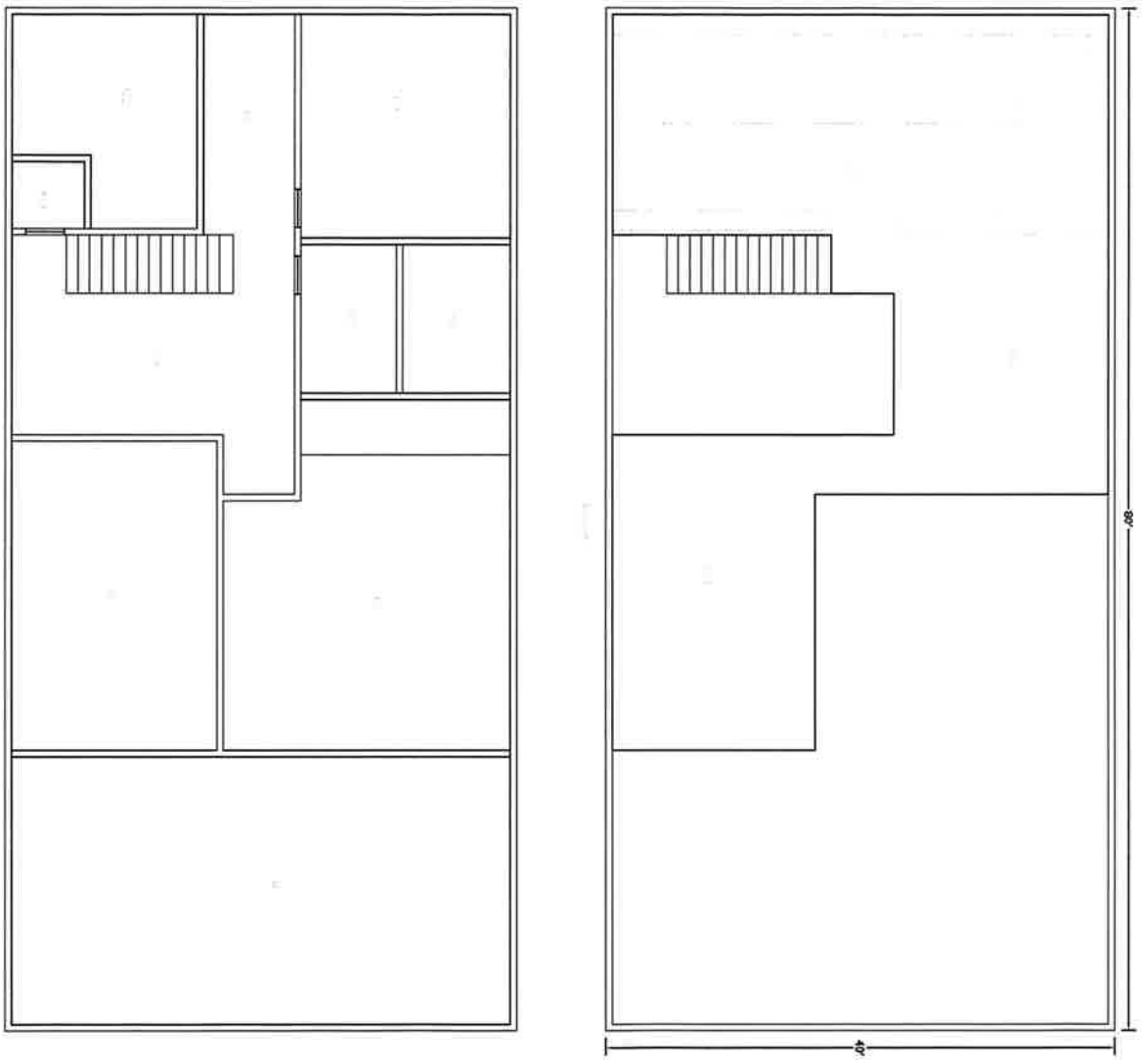

NOME, ALASKA
NSHC REGIONAL HOSPITAL
HOSPITAL SUPPORT BUILDINGS
MAINTENANCE FACILITY FLOORPLAN

DATE: 9 MARCH, 2010
SCALE: FOR ILLUSTRATION ONLY
DRAWN BY: CB

FILE NAME: MAINT, MAT, STOR BLDGS
LAYOUT NAME: MAINTENANCE
PROJ ENG:

ALASKA NATIVE
TRIBAL HEALTH CONSORTIUM

DIVISION OF ENVIRONMENTAL
HEALTH AND ENGINEERING
1901 SOUTH BRAGAW STREET, SUITE 200
ANCHORAGE, ALASKA, 99508-3440
(907) 729-3600

DATE	REVISIONS	INIT.

TOTAL SHEETS 3 SHEET A1

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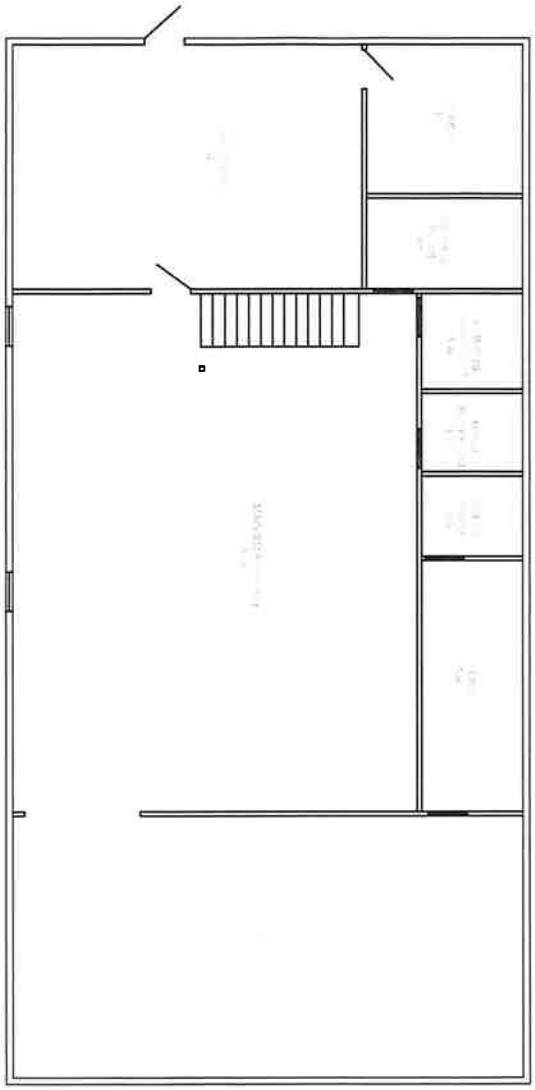

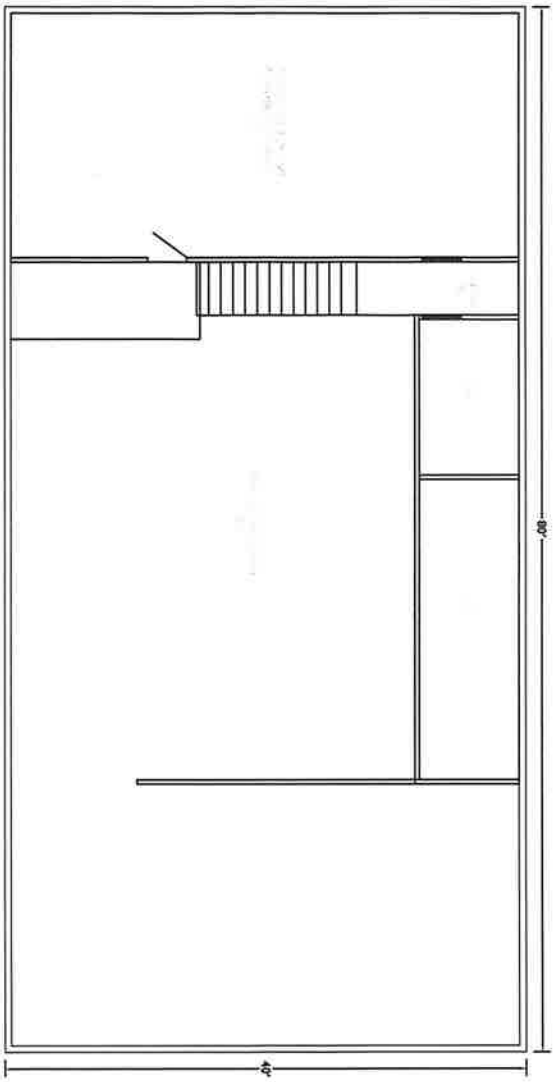

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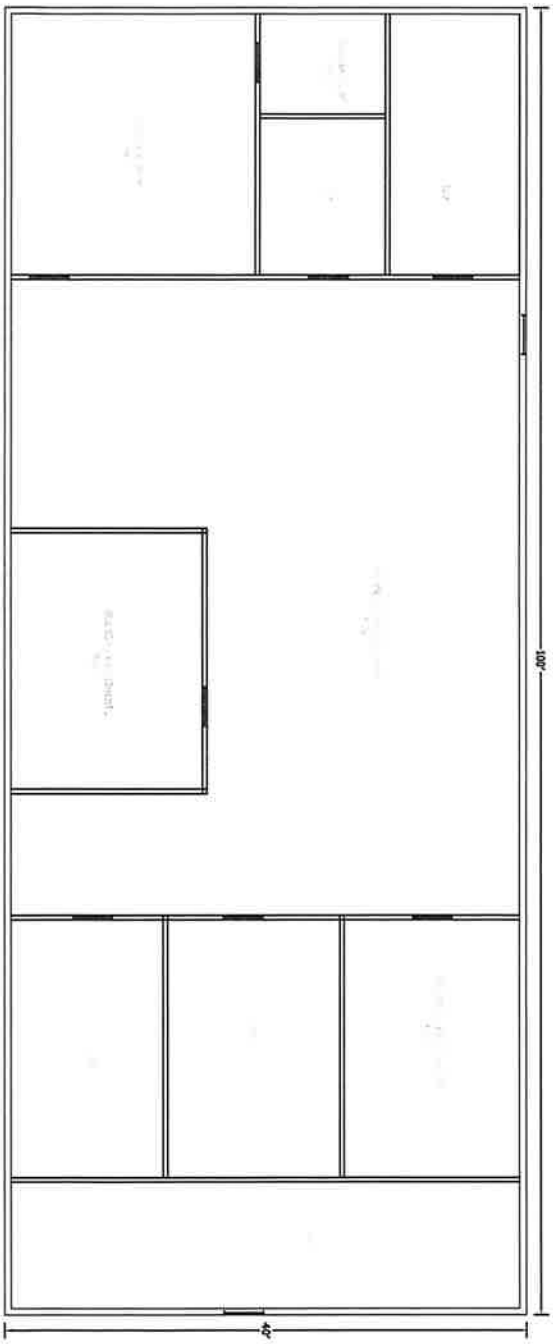


NOME, ALASKA
NSHC REGIONAL HOSPITAL
HOSPITAL SUPPORT BUILDINGS
STORAGE FACILITY FLOORPLAN

DATE: 9 MARCH, 2010
SCALE: FOR ILLUSTRATION ONLY
DRAWN BY: CB
FILE NAME: MAINT, MAT, STOR BLDGS
LAYOUT NAME: STORAGE
PROJ ENG:

ALASKA NATIVE
TRIBAL HEALTH CONSORTIUM

DIVISION OF ENVIRONMENTAL
HEALTH AND ENGINEERING
1901 SOUTH BRAGAW STREET, SUITE 200
ANCHORAGE, ALASKA, 99508-3440
(907) 729-3600

DATE	REVISIONS	INIT.

Community Health Needs Assessment Survey Report

Norton Sound Health Corporation

January 2021

For additional information regarding the Norton Sound Health Corporation Community Health Needs Assessment, contact Quality Improvement at (907) 443-4501.

EXECUTIVE SUMMARY

Norton Sound Regional Hospital

Norton Sound Health Corporation (NSHC) is a tribally owned and operated, independent, not-for profit health care organization, founded in 1970 to meet the health care needs of the Inupiat, Siberian Yup'ik and Yup'ik people of the Being Strait region. NSHC is governed by a 22-member board of directors who represent all communities and areas of the Bering Strait region, a 44,000 square-mile section of northwestern Alaska.

Norton Sound Health Corporation puts the patient first. This principle applies equally at the new Norton Sound Regional Hospital and at the 15 village clinics managed by NSHC.

Every day, NSHC's approximately 750 employees – about 62% of them Alaska Native – demonstrate their commitment to our mission: providing quality health services and promoting wellness within our people and environment. NSHC strives to train local people to deliver and manage its services. NSHC offers a 2-year Registered Nurse Program through the University of Alaska Anchorage, a Certified Nursing Assistant Course, and other local trainings in partnership with the local Nome Northwest Campus and the region's partners.

In 2019, Norton Sound Health Corporation was recognized as one of the nation's top clinically performing community health centers. HRSA named NSHC as a "gold tier" Health Center Quality Leader awardee, meaning that the organization is among the top 10% of health centers to achieve best overall clinical performance nationwide. NSHC improved on measures such as tobacco intervention, colorectal cancer screening, and childhood immunization status.

The organization also increased the level of medical and mental health care provided to patients. Significant steps have been taken by NSHC to ensure that whole-person care is being delivered; behavioral health services have been prioritized, and resources have been increased. Full-time psychiatry services were implemented to better meet the needs of our patients. In FY19, NSHC opened a drug rehabilitation program, known as the "day shelter", which utilizes the skills of recovery coaches to facilitate lifestyle changes. The resource and recovery program has resulted in guests securing jobs, housing, reducing emergency department visits, and achieving GED status. The day shelter is just one of the critical steps necessary to enhance the behavioral health continuum of care model.

The goal to increase access to care for all communities is being realized; village visits have doubled and more mid-level providers have been hired to provide higher level care in the village clinics, to provide relief to health aides, and to facilitate additional on-call coverage. A Population Health Department was implemented to coordinate prevention care and to ensure clinical standards of care are being met for patients. An In-home support program was also initiated, in which NSHC will administer the Personal Care Attendant (P.C.A) Program for the region with the goal to offer end-of-life care for families who need the services.

In January 2019, NSHC started offering MRI services locally, with its new state-of-the-art MRI machine, the only one of its kind in Alaska and in the nation serving rural health needs. A staff neurologist was also hired. NSHC continued to offer tribal healing services and acupuncture services to compliment its pain management services.

NSHC continues to promote state-of-the-art facilities. Since 2017, NSHC has completed the construction of four new health clinics located in Savoonga, Gambell, Shaktoolik, and Little Diomede. The construction of two new health clinics are underway in St. Michael and Shishmaref, and a new clinic with staffing housing is under design for the village of Wales. NSHC has made village-based housing a priority to ensure the staff who work at the clinic have adequate housing available. New housing has been constructed in St. Michael, Savoonga, and Golovin to-date. The responsibility for the maintenance and oversight of the village-based facilities has also improved through NSHC's ability to establish 105(l) leases with the Indian Health Services.

Although significant improvements been made in health care delivery, five of the fifteen villages remain without water and sewer. One of NSHC's highest priorities is to continue to strengthen the region's best practice scores to remain eligible for water and sewer capital infrastructure funding. A sanitation engineer was hired in FY19 to manage and coordinate the region's water and sewer goals and objectives.

NSHC is excited to open its new Wellness and Training Center in June 2021; the new facility will include a sobering center with integrated wellness services to facilitate sobriety. The new training facility will provide expanded classroom space to train the organization's health aide workforce. It

Norton Sound Health Corporation is a model of how Indian Self-Determination is meant to work, with tribes taking responsibility for their own health and well-being.

TABLE OF CONTENTS

BACKGROUND INFORMATION

In 1969, the Alaska Federation of Natives (AFN) sought a demonstration project to give Alaska Natives greater power in health care decisions. Norton Sound was selected for development of a model for community-based health care services as an alternative to regional, hospital-based care. Norton Sound Health Corporation (NSHC) was incorporated November 27, 1970. The first board had just three directors: William Takak of Shaktoolik, president; Winfred James of Gambell, treasurer; and Dorothy Isabell of Teller, secretary.

That first NSHC Board of Directors faced a formidable task: Bring health care services to a remote area with limited resources. At the time, northwest Alaskans had little access to health care, and getting medical treatment often meant traveling long distances to regional hospitals. One of the first initiatives NSHC launched was the health aide program, established in 1971. While health aides continue to be the backbone of the NSHC organization today, more than 40 years later, NSHC's services have expanded to include clinic travel clerks, village-based counselors, patient benefit coordinators, dental health therapists and nurse practitioners in all the villages served.

At its first meeting in November 1970, the NSHC Board of Directors established its highest goal: provide a "comprehensive and quality inpatient facility in Nome." That year, NSHC opened its first office in the basement of Maynard-McDougall Memorial Hospital in Nome, with a budget of $143,000. Six years later, NSHC purchased the hospital, and in 1978 Norton Sound Regional Hospital opened in Nome. It was quickly followed by Unalakleet' s sub-regional health clinic, staffed by a physician assistant and community health aides serving four villages.

In 1975, NSHC became the first Native health corporation to become independent of AFN and contract directly with the Indian Health Service. The following year, the board assumed responsibility for regional environmental health services through assignment of a federal Public Health Service sanitarian.

Over the years, NSHC's board focused on expanding patient care in the Bering Strait region of Alaska, adding basic services in 15 villages throughout the Norton Sound area as well as specialty clinics in Nome. In 2008, the Board of Directors opened The Patient Hostel, a 38-bed facility, located on the east side of Nome and positioned close to where the new facility would be constructed someday.

Another milestone was reached in 2009, when Indian Health Services awarded NSHC full funding to complete a new hospital building in Nome. Construction began in October 2009 and was completed in 2012. The first patients were seen at the new Norton Sound Regional Hospital and Quyanna Care Center in March 2013.

In October 2014, NSHC went live with its new electronic medical record, "Cerner" and completed the renovation for the Wales clinic and replaced the Shishmaref clinic. In 2015, NSHC initiated a village clinic improvement program and assumed oversight and responsibility for nearly all village clinics and hired housekeepers and maintenance workers to keep the clinics maintained in all the villages. The Nome outpatient clinic received a HRSA new access point grant and was integrated with the village primary health care services for the first time.

In 2016, NSHC began an ambitious mission to replace and/or update aging clinic facilities throughout the region. In 2017, saw NSHC's Nome Primary Care Center receive recognition as a Patient Centered Medical Home by the National Committee on Quality Assurance. New clinics were completed in the villages of Gambell, Savoonga, and Shaktoolik. Village-based housing projects were also completed in Savoonga and Golovin.

In 2018 an MRI was added to the NSHC hospital to further advanced our diagnostic capabilities and a new health clinic for the village of Shakoolik was opened.

In 2020, NSHC achieved its vision to complete construction for a new health clinic for the remote village of Little Diomede.

In 2021, NSHC expects to open the long- awaited Wellness and Training Center which will create the first sobering center in the region as well as add intensive outpatient mental health services to our comprehensive service wrap around services.

The COVID-19 pandemic saw Norton Sound Health Corporation face the challenge of the generations while minimizing morbidity and mortality, supporting communities in mitigation and suppression methods while retaining high quality preventative, chronic and emergency care.

NORTON SOUND HEALTH CORPORATION: MISSION, VISION, AND VALUES

Our purpose, core values and vision for the future are built on our commitment to providing the Native people of the Norton Sound region with the highest quality health care possible.

Our mission:
Providing quality health services and promoting wellness within our people and environment.

Our core values:

- Integrity
- Cultural sensitivity and respect for traditional values
- Always learning and improving
- Compassion
- Teamwork
- Pride

Our vision for the future:

- We will ensure that all patients receive quality and respectful health care.
- We will educate our patients and communities to be proactive in caring for themselves and promoting wellness.
- We will listen to, honor, and respect our elders, preserve their right to speak, and ensure they receive the best care in gratitude for their leadership.
- We will increase wellness efforts to reduce addictive behaviors and to raise the quality of life among our people and communities.
- We will advocate that our environment (air, land and water) will be clean, and our water and waste disposal systems are safe and affordable, in order to ensure our subsistence way of life.

- We will assert and implement tribal self-governance to achieve our vision through effective leadership.
- We will hire and support our tribal members to deliver and manage our services.
- We will develop state of the art and efficient health care facilities throughout the region.
- We will be financially strong through aggressive, effective and efficient financial management.
- We will support and develop our youth to pursue higher education and health care careers to ensure there is future tribal leadership.

SCOPE OF THE STUDY

The purpose of the 2020 Norton Sound Health Corporation Community Health Needs Assessment is to collect data on specific information regarding community perception of the Use of Healthcare Services, Awareness of Services, Community Health, and Health Insurance. Additionally, data were collected regarding the demographics of survey responders. The data are presented in a format that can be useful to Norton Sound Health Corporation board of directors, administration, health care providers and community.

METHODOLOGY

A comprehensive survey was developed by the Quality Assurance/Performance Improvement Team "Aquutaq". The survey was loaded electronically into Microsoft Forms. It was distributed electronically via advertisement, QR code, email, public information, Facebook, community meetings and other avenues. Paper copies of the form were also mailed to all box holders in the region as well as made available at all clinics and within the Nome hospital site. The survey was also distributed at various Health Forums held within the region.

Data collection began in early 2019 and continued until early 2020 with a goal of at least 1000 responses. Processing of data and this report was delayed due to reallocation of staff during the pandemic and completed in 2021. The survey was closed for responses in January 2020, after 1004 responses had been received, (32.4% of households in the region). The data was entered into a Microsoft Forms/ Microsoft Excel database and are presented in the Survey Results section of this report. At the time of survey closure, data was first prepared and shared with the NSHC Board of Directors, final report was completed on January 26, 2021.

Population Data

PEOPLE		
Population		
Population estimates, July 1, 2019, (V2019)	**10,004**	**731,545**
Population estimates base, April 1, 2010, (V2019)	9,492	710,249
Population, percent change - April 1, 2010 (estimates base) to July 1, 2019, (V2019)	5.4%	3.0%
Population, Census, April 1, 2010	9,492	710,231
Age and Sex		
Persons under 5 years, percent	10.0%	7.0%
Persons under 18 years, percent	34.6%	24.6%
Persons 65 years and over, percent	8.0%	12.5%
Female persons, percent	47.4%	47.9%
Race and Hispanic Origin		
White alone, percent	15.7%	65.3%
Black or African American alone, percent(a)	0.9%	3.7%
American Indian and Alaska Native alone, percent(a)	75.3%	15.6%
Asian alone, percent(a)	1.5%	6.5%
Native Hawaiian and Other Pacific Islander alone, percent(a)	0.2%	1.4%
Two or More Races, percent	6.5%	7.5%
Hispanic or Latino, percent(b)	2.9%	7.3%
White alone, not Hispanic or Latino, percent	14.9%	60.2%
Population Characteristics		
Veterans, 2015-2019	394	65,186
Foreign born persons, percent, 2015-2019	2.5%	7.8%
Housing		
Housing units, July 1, 2019, (V2019)	4,100	319,854
Owner-occupied housing unit rate, 2015-2019	60.5%	64.3%
Median value of owner-occupied housing units, 2015-2019	$154,600	$270,400
Median selected monthly owner costs -with a mortgage, 2015-2019	$1,470	$1,933
Median selected monthly owner costs -without a mortgage, 2015-2019	$469	$582
Median gross rent, 2015-2019	$1,287	$1,244
Building permits, 2019	6	1,680
Families & Living Arrangements		
Households, 2015-2019	2,844	253,346
Persons per household, 2015-2019	3.30	2.80
Living in same house 1 year ago, percent of persons age 1 year+, 2015-2019	84.1%	82.1%

Language other than English spoken at home, percent of persons age 5 years+, 2015-2019	31.0%	16.1%
Computer and Internet Use		
Households with a computer, percent, 2015-2019	90.7%	94.1%
Households with a broadband Internet subscription, percent, 2015-2019	74.1%	85.5%
Education		
High school graduate or higher, percent of persons age 25 years+, 2015-2019	84.6%	92.8%
Bachelor's degree or higher, percent of persons age 25 years+, 2015-2019	16.1%	29.6%
Health		
With a disability, under age 65 years, percent, 2015-2019	6.8%	8.9%
Persons without health insurance, under age 65 years, percent	18.4%	13.9%
Economy		
In civilian labor force, total, percent of population age 16 years+, 2015-2019	64.8%	65.5%
In civilian labor force, female, percent of population age 16 years+, 2015-2019	66.8%	63.1%
Total accommodation and food services sales, 2012 ($1,000)(c)	14,821	2,221,335
Total health care and social assistance receipts/revenue, 2012 ($1,000)(c)	D	6,375,483
Total manufacturers shipments, 2012 ($1,000)(c)	D	D
Total merchant wholesaler sales, 2012 ($1,000)(c)	D	5,216,303
Total retail sales, 2012 ($1,000)(c)	78,672	10,474,275
Total retail sales per capita, 2012(c)	$7,935	$14,320
Transportation		
Mean travel time to work (minutes), workers age 16 years+, 2015-2019	6.7	19.1
Income & Poverty		
Median household income (in 2019 dollars), 2015-2019	$61,048	$77,640
Per capita income in past 12 months (in 2019 dollars), 2015-2019	$23,581	$36,787
Persons in poverty, percent	20.7%	10.1%
BUSINESSES		
Businesses		
Total employer establishments, 2018	168	21,293
Total employment, 2018	2,119	261,053
Total annual payroll, 2018 ($1,000)	121,975	15,732,010
Total employment, percent change, 2017-2018	-2.9%	-0.4%
Total nonemployer establishments, 2018	551	57,391

All firms, 2012	676	68,032
Men-owned firms, 2012	380	35,402
Women-owned firms, 2012	212	22,141
Minority-owned firms, 2012	381	13,688
Nonminority-owned firms, 2012	264	51,147
Veteran-owned firms, 2012	61	7,953
Nonveteran-owned firms, 2012	578	56,091

GEOGRAPHY

Geography		
Population per square mile, 2010	0.4	1.2
Land area in square miles, 2010	22,961.76	570,640.95
FIPS Code	02180	02

About datasets used in this table

Value Notes

Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable.

The vintage year (e.g., V2019) refers to the final year of the series (2010 thru 2019). *Different vintage years of estimates are not comparable.*

Fact Notes

- (a)Includes persons reporting only one race
- (b)Hispanics may be of any race, so also are included in applicable race categories
- (c)Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

Value Flags

- -Either no or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest or upper interval of an open ended distribution.
- D- Suppressed to avoid disclosure of confidential information

QuickFacts data are derived from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area Health Insurance Estimates, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits.

Source: US Department of Commerce. US Census Bureau

http://quickfacts.census.gov/qfd/index.html

BEHAVIORAL RISK FACTOR DATA

Alaska Behavioral Risk Factor Surveillance System

2018 Nome Region

Risk Fact	Nome (%)	Alaska (%)
Health Status: General Health Excellent/Very Good	41.7	51.3
Health Status: Poor physical health	18.0	16.4
Health Status: Frequent mental distress	18.8	11.3
Thoughts of Suicide in past 12 months (2013)	5.0	4.2
Ever told had depressive disorder	15.4	21.2
HTN: Ever told HTN (2017)	25.7	29.9
CVD: Ever told heart attack	3.7	4.4
CVD: Diagnosis of Angina or Coronary Heart Disease	1	2.8
COPD	4.6	5.3
Cancer: Any type	4.2	7.8
Weight Status: Severely Obese (BM>40)	10.3	7.8
Weight Status: Obese (BMI 30-39.9)	26.5	31.2
Weight Status: Overweight	28.1	35.1
Weight Status: Underweight	0.6	1.8
Seen a provider in the last 12 months	56.0	69.3
Access: No Health Care Coverage	6.1	9.1
Follow Subsistence Lifestyle (2017)	79.7	30.2
Rent Home	20.3	27.2
Believe currently get enough physical activity (2015)	59.7	46.9
Activity Time: Adequate Aerobic Physical Activity (at least 150 minutes per week) (2017)	86.9	56.7
Activity Time: Adequate Aerobic Physical Activity (at least 300 minutes per week) (2017)	69.9	36.2
Received Food Assistance from Community Program(s) (2013)	14.7	7
Received Food Assistance from Government Program(s) (2013)	34.9	15.6
Less than 3 vegetables and 2 fruits per day	81.5	93.8
Sweetened carbonated beverages 1+ per day (2017)	27.5	13.2
Sweetened non-carbonated beverages 1+ per day (2017)	45.4	12.1
Cigarette Smoking: Current Smoker Everyday (2018)	30.3	17.1
Cigarette Smoking: Former Smoking (2018)	27.7	28.3
Cigarette Smoking: Never Smoked (2018)	42.1	54.6
Tobacco Use (not including e-cig) (2018)	63.4	25.2
Current Marijuana Use (2018)	44.6	17.3
Current Alcohol Use (2018)	34.9	58.6
Binge Drinking (2018)	13.4	16.4
Before age 18, lived with problem drinker/alcoholic/drugs/rx med (2015)	47.4	32.3
Seat Belt Use: always use a seatbelt (2018)	73.1	83.0
Hurt by intimate partner last 5 years (2017)	15.2	6.6

NOME CA MAPP: BRFSS DATA: 2015-2018: MIXED

COMMUNITY HEALTH NEEDS SURVEY RESULTS (as of 1/26/2021) (1004 households reporting)

Norton Sound Health Corporation

*NOTE SOME TOTALS MAY NOT EQUAL TO 100% DUE TO ROUNDING AND ALLOWANCE FOR MULTIPLE RESPONSES PER ITEM. ALSO NUMBER OF RESPONSES DIFFERS TO EACH ITEM ALLOWING FOR NON-RESPONDERS AND MULTIPLE RESPONSES TO SOME ITEMS.

Section A: Please tell us about yourself

1. What is your zip code?

Village	Zip Code	Number	Percentage
Nome, Golovin, Diomede	99762	481	47.91%
Brevig	99785	28	2.79%
Elim	99739	73	7.27%
Gambell	99742	55	5.48%
Koyuk	99753	25	2.49%
St. Michael	99659	15	1.49%
Savoonga	99769	31	3.09%
Shaktoolik	99771	17	1.69%
Shishmaref	99772	56	5.58%
Stebbins	99671	49	4.88%
Teller	99778	16	1.59%
Unalakleet	99684	96	9.56%
Wales	99783	9	0.90%
White Mountain	99784	29	2.89%
OTHER		11	1.10%
NO RESPONSE		13	1.29%
Total		**1004**	**100%**

2. What is your gender?

Gender	Number	Percentage
Male	295	29.38%
Female	679	67.63%
Transgender	2	0.20%
Other	1	0.10%
Prefer not to answer	27	2.69%
Total	**1004**	**100.0%**

3. What is your age range?

Age	Number	Percentage
18-25	100	9.96%
26-35	260	25.90%
36-45	163	16.24%
46-55	164	16.33%
56-65	197	19.62%
66-75	79	7.87%
76-85	21	2.09%
86+	1	0.10%
Unanswered/Prefer not to say	19	1.89%
Total	**1004**	**100.0%**

4. Are you an IHS beneficiary?

Response	Count	Percentages
Yes	660	65.74%
No	286	28.49%
Unanswered/Prefer not to say	58	5.78%
Total	**800**	**100%**

5. How many people, including yourself, live in your household?

Number	Count	Percentage
1	141	14.04%
2	196	19.52%
3	167	16.63%
4	150	14.94%
5	118	11.75%
6	75	7.47%
7	61	6.08%
8	38	3.78%
9	16	1.59%
10+	30	3%
Unanswered/ Prefer not to say	12	1.2%
Total	**1004**	**100%**

6. How many children under the age of 18 live in your household?

Number	Count	Percentage
0	425	42.37%
1	164	16.35%
2	160	15.95%
3	110	10.97%
4	61	6.08%
5	37	3.69%
6	18	1.79%
7	7	0.70%
8	1	0.10%
9+	2	0.20%
Unanswered/ Prefer not to say	19	1.89%
Total	**1004**	**100%**

7. What is your employment status?

Response	Count	Percentage
Work full-time	529	52.69%
Work part-time	129	12.85%
Retired	116	11.55%
Unemployed and looking for employment	103	10.26%
Not currently seeking employment	69	6.87%
Disabled	25	2.49%
Student	21	2.09%
Unanswered/Prefer not to say	12	1.20%
Total	**1004**	**100%**

8. Do you access the internet in your home?

Response	Count	Percentages
Yes	646	64.34%
No	343	34.16%
Unanswered/Prefer not to say	15	1.49%
Grand Total	**1004**	**100.00%**

9. Do you have plumbed drinking water in your home?

Response	Count	Percentages
No	180	17.93%
Yes	813	80.98%
Unanswered/Prefer not to say	11	1.10%

Grand Total	1004	100.00%

10. Do you have plumbed septic/sewer in your home?

Response	Count	Percentages
No	203	20.22%
Yes	789	78.59%
Unanswered/Prefer not to say	12	1.20%
Grand Total	**1004**	**100.00%**

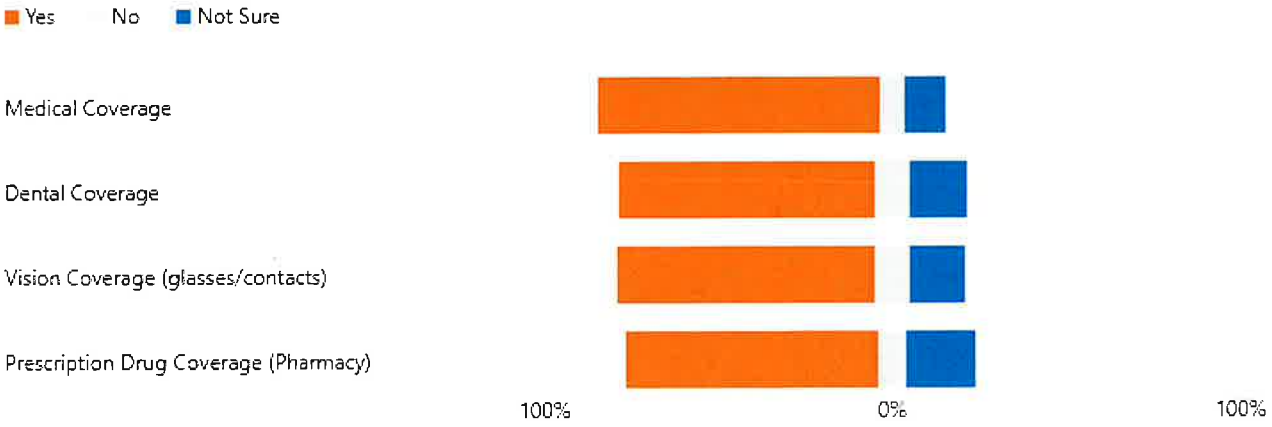
11. What is the best way for NSHC to communicate with you? (Preferential choice ranking, only first preference listed below)

Response	Count	Percentage
Email	112	11.16%
Mail	90	8.96%
Phone	156	25%
Text Message	366	36.45%
Other Media	11	1.1%
Unanswered/Prefer not to say	296	29.48%
Total	**1004**	**100%**

12. What type(s) of health care coverage do you have? (Multiple responses allowed).

Response	Count	Percentage
Indian Health Services (IHS)	507	33.82%
Employer Sponsored	494	32.96%
Medicaid	259	17.28%
Medicare	111	7.40%
No coverage	38	3.78%
VA/Military	20	1.33%
Health Savings Account	9	0.60%
Other	38	3.78%
Unanswered/Prefer not to say	11	1.01%
Total	1004	100%

13. What types of coverage do you have?



Section B: Tell us about your healthcare experience

1. Have you used any Norton Sound Health Corporation facilities?

Response	Count	Percentages
Yes	943	93.92%
No	38	3.78%
Unanswered/Prefer not to say	23	2.29
Total	**1004**	**100%**

2. Why do you choose to use NSHC facilities?
(multiple responses allowed)

Response	Count
Only clinic available	759
Has services I need	264
Needed medication refefilled	187
Emergency, no other choices	185
Provider listens to me	126
Provider knows me by name	119
Referred	92
Great experiences prior	89
Short waiting time	87
Hospital/Clinic reputation for quality	70
Required by my insurance	46
Recommended by family/friends	42
Cost of Care	35
n/a, I NEVER use NSHC facilities	18
Other, free text responses	17
VA/Military requirement	6

3. If you ever choose not to use NSHC facilities, why not?
(multiple responses allowed)

Response	Count	Percentage
n/a, I ONLY use NSHC	336	27.77%
Service I needed was unavailable	213	17.60%
Lack of privacy/confidentiality	83	6.86%
Costs too much money	77	6.36%
No appointment available in a timely manner	77	6.36%
Did not trust the provider	63	5.21%
Unsure if service I need is available	62	5.12%
Not treated with respect	52	4.30%
Do not like provider	50	4.13%
Appointments do not fit my schedule	46	3.80%
My insurance would not cover my care	30	2.48%
Provider is my co-worker/relative	26	2.15%
Other – free text response	66	5.45%
Unanswered/Prefer not to say	191	19.02%

4. In the past 12 months, was there a time when you or someone living in your home needed medical care from NSHC but were not seen?

Response	Count	Percentages
Yes	202	20%
No	731	73%
Other	39	4%
Unanswered/Prefer not to say	32	3%
Total	**788**	**100%**

5. If you answered "yes" above, what service were you not able to use:

Response	Count
Nome Hospital	20
Nome Clinic	45
Village Clinic	80
BHS Nome	11
BHS Village	4
Other	41

6. Check any of the reasons below that help explain why you were not seen. (multiple responses allowed)

Reason	Count
Clinic is too far away	3
Costs too much money	19
Did not trust the provider	21
Do not like provider (MD, DO, PA, NP, Health Aide)	14
Had no one to watch kids	6
Lack of privacy/confidentiality	21
Language barrier	0
My insurance would not cover	8
No appointment available in a timely manner	73
No appointments that fit my schedule	26
No transportation	14
Not treated with respect	25
Other	47
Provider is my co-worker/relative	7
Too afraid or nervous	7
Unsure if service I need is available	11
Service I needed was unavailable	40

7. In the past 12 months, check all of the health care providers you or anyone living your home has seen: (multiple responses allowed)

Provider	Count
General practice provider (MD, DO, PA, NP)	646
Dentist/DHAT	488
Optometrist (Eye doctor)	420
Health Aide	394
Audiologist (hearing)	276
Pediatrician	212
Physical Therapist	179
Behavioral Health Clinician/Therapist	164
ENT Specialist (ear, nose, throat specialist)	156
Obstetrician/Gynecologist (female reproductive specialist)	134
Tribal Healer	128
Orthopedist (bone/joint specialist)	93
Cardiologist (heart specialist)	89
Dietitian	73
Neurologist (brain/nerve specialist)	72
Urologist (kidney/bladder/male reproductive specialist)	69
Surgeon	68
Diabetes Specialist	66
Psychiatrist	61
Rheumatologist (arthritis specialist)	42
Dermatologist (skin specialist)	35
Oncologist (cancer specialist)	34
Chiropractor	33
Social Worker	31
Tobacco Counselor	31
Pulmonologist (lung specialist)	30
Infant Learning Program	30
Podiatrist (foot/ankle specialist)	23
Allergy Specialist	23
Substance Abuse Counselor	15
Other (Free text)	44

8. How long did you have to wait to see the specialist from the time you were referred or requested an appointment?

Column1	Count	Percentage
1 month	240	23.90%
2 months	102	10.16%
3 months	60	5.98%
4 months	24	2.39%
5 months	13	1.29%
6 moths or more	50	4.98%
Unanswered/choose not to respond	515	51.29%
Total	**1004**	**100%**

9. Please rate the following services Norton Sound Health Corporation offers and tell where you used that service most:

	Excellent	Good	Fair	Poor
Emergency Room	44.20%	43.30%	7.59%	4.91%
Inpatient (Acute Care)	16.57%	40.51%	35.54%	7.38%
QCC (Quyanna Care Center, Nursing Home)	31.76%	44.12%	20.00%	4.12%
Nome Primary Care	25.48%	52.71%	18.59%	3.22%
Village Clinic	32.13%	44.68%	20.91%	2.28%
Laboratory	33.28%	47.68%	17.50%	1.54%
Physical Therapy	33.04%	46.67%	17.39%	2.90%
Eye Care Clinic (Optometry)	42.48%	42.48%	12.07%	2.98%
Audiology	38.39%	47.16%	12.32%	2.13%
Dental	39.55%	42.93%	13.67%	3.86%
Behavioral Health	27.09%	44.15%	21.40%	7.36%
Case Management	22.87%	40.96%	23.55%	12.63%
CAMP Program	36.33%	39.45%	19.92%	4.30%
Tribal Healing	50.76%	36.64%	9.54%	3.05%
Infant Learning Program	34.68%	42.74%	18.55%	4.03%
Radiology/Diagnostic Imaging	39.64%	44.42%	13.44%	2.51%
EMS-Medevac Team	57.38%	32.07%	10.13%	0.42%
WIC Program	42.93%	41.46%	13.66%	1.95%
Environmental Health (OEH)	27.93%	45.95%	22.52%	3.60%
Respiratory Therapy	33.74%	51.53%	12.88%	1.84%
Medical Records/HIM	27.73%	45.48%	21.81%	4.98%
Billing Department	27.38%	38.39%	22.32%	11.90%
Human Resources Department	24.91%	37.37%	24.57%	13.15%
Patient Driver	39.21%	40.84%	14.15%	5.80%
Patient Advocate	33.69%	36.56%	19.71%	10.04%
Administration	29.52%	38.10%	21.59%	10.79%

10. Have you or anyone in your household been affected by these community issues:

	% Yes
Elder abuse	5.87%
Child Abuse	7.39%
Domestic Violence	17.54%
Drug Abuse	17.87%
Alcohol Abuse	29.63%
Tobacco Use	44.82%
Chronic Disease	22.83%
Obesity	28.12%
Heart Disease	19.98%
Diabetes	22.05%
Stroke	13.74%
Cancer	26.08%
Teen Pregnancy	10.23%
Sexually Transmitted Infections	17.16%
Suicide	23.58%
Lack of Access to Healthcare	19.41%
Lack of Access to Medications	15.47%
Lack of Quality childcare	19.41%
Lack of Quality Schooling	14.67%
Lack of Quality Housing	31.62%
Lack of Strong Family Support	14.51%
Lack of Safety	11.89%
Lack of Good Jobs	34.26%
Lack of Food due to expense	28.37%
Lack of healthy food available	36.08%
Lack of Native/Traditional foods	24.80%
Lack of Indoor Exercise Facilities	37.66%
Lack of Outdoor Recreational Spaces (parks, walking paths, etc)	24.85%
Lack of Running Water/Sewer	22.20%
Lack of Sobering Center	20.82%
Lack of Homeless Shelter	19.11%
Lack of Law Enforcement	30.87%

11. What would improve your access to care? (multiple responses allowed)

	Count
More providers/health aides	352
More specialty clinics	309
End of Life Care Program	126
Prescription deliver	127
Home visits by providers/health aides	164
Longer hours at the clinics	145
Telemedicine availability	67
Personal Care Attendants	152
Transportation to clinic or hospital	152
Assisted Living Center	171
Availability of Long Term Care	109
Financial Support for Out of Region	91
Other (free text)	

Nurse Call Line

12. Have you ever used the NSHC Nurse Call Line, and based on your experience, how would you rate it? (1 – Excellent, 5 - poor)

Row Labels	Count of ID	Sum of ID
No - but I've head of it	**103**	**18.35%**
1	28	6.47%
2	16	3.21%
3	38	5.12%
4	7	1.28%
5	14	2.28%
No - but I've heard of it	**3**	**1.08%**
1	3	1.08%
No - Never heard of it	**8**	**1.26%**
1	1	0.22%
2	2	0.53%
3	3	0.37%
5	2	0.13%
Yes, I have used the Nurse Call Line	**392**	**79.31%**
1	108	22.31%
2	75	14.64%
3	101	19.89%
4	46	9.87%
5	62	12.60%
Grand Total	**506**	**100.00%**

Performance Improvement Goals Summary

Over the next three years, NSHC will strive to:

1) Improve Communication with Patients by asking the patient what their preferred method of communication is and utilizing it to provide meaningful feedback to patients.

2) Improve Access to Care for Patient by ensuring the NSHC Primary Care System has both appointments available for patients to accommodate same-day access to care when needed.

3) Improve Notification and Reminders to Patients about scheduled appointments.

4) Improve customer service by training staff on phone etiquette and by improving the switchboard operator experience.

5) Improve the quality of patient care by performing audits of patients who present to NSHC's outpatient clinics for care on a frequent basis; reports will be made to the HRSA quality committee to ensure there is accountability.

6) Continue the initiatives of the Population Health Department to ensure patients are receiving coordinated care and referrals for prevention tests and receiving care that meets clinical standards for disease states.

7) Continue to strengthen the nurse call line by listening to consumer feedback; share success stories when possible.

8) Ensure patient privacy and confidentiality is preserved at all times by providing training to all staff at regular intervals.

9) Continue to focus on Tobacco cessation counseling and prevention activities, substance abuse treatment programs, and suicide prevention activities.

10) Improve access to healthy foods region-wide by collaborating with village leadership.

11) Increase access to indoor workout space region-wide by working with local leaders to develop partnerships for solutions.

12) Continue to develop and expand NSHC's in-home support program to provide personal care attendant services (PCA Program) and to offer end-of-life care for family's in the region at all locations.

13) Continue to provide patient transport services in all locations and to deliver prescription medications.

FUNDING AGREEMENT
BETWEEN CERTAIN ALASKA NATIVE TRIBES
SERVED BY THE
NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
OF THE
UNITED STATES OF AMERICA
FISCAL YEARS 2018-2020

This Funding Agreement is entered into by and between certain Alaska Native Tribes in the Bering Straits region of the Norton Sound Service Unit, as identified on the signature page herein, and the Secretary of the Department of Health and Human Services. These Tribes have authorized the Norton Sound Health Corporation to sign this Funding Agreement for them and to be responsible for and carry out the terms of this Funding Agreement.

Section 1 – Obligations of the IHS.

1.1 Generally. Under the authority of Section 325 of P.L. 105-83, and P.L. 93-638 as amended, non-residual programs, services, functions and activities (PSFAs) of the Alaska Area Office and the Alaska Native Medical Center (ANMC) have been transferred to tribal management.

Delivery of PSFAs shall be consistent with each Co-Signer's Funding Agreement (FA). The Indian Health Service (IHS) shall remain responsible for performing all federal residual PSFAs. The IHS shall remain responsible for negotiating assurances with the Alaska Native Tribal Health Consortium (ANTHC) and Southcentral Foundation (SCF) on behalf of Alaska Natives and American Indians to the effect that Co-Signers continue to receive non-residual PSFAs from the ANMC and Area Office and provided by ANTHC and SCF at a minimum at the level that such PSFAs were provided by the IHS as of October 1, 1997, to the extent permitted by Section 325 of P.L. 105-83. To the extent authorized by federal law, the IHS will respond to written Co-Signer concerns about the extent with which such assurances have not been complied and take appropriate action. IHS shall further be responsible for performing its special trust responsibilities and legal obligations as provided in the Indian Health Care Improvement Act, the Indian Self-Determination and Education Assistance Act, and other applicable provisions of federal law.

This FA obligates the IHS to provide funding and services identified herein and as provided in the Alaska Tribal Health Compact (ATHC) between the Norton Sound Health Corporation (NSHC) and certain other Co-Signers thereof and the United States in Fiscal Years 2018-2020.

The "Memorandum of Agreement Describing the Continuing Services of the IHS, Alaska Area Native Health Service" among the Co-Signers and the Alaska Area Native Health Service

(AANHS) reflects the understanding of the parties regarding services to be provided by the AANHS to Co-Signers. This document, attached as Appendix C, is hereby incorporated by reference.[1]

In addition, although funds are provided from Headquarters and Area Office in support of this ATHC, the IHS will agree to continue to make available to NSHC PSFAs from both Area Office and Headquarters unless 100 percent of the tribal shares for these PSFAs have been specifically included in this FA. In cases where a portion of tribal shares has been transferred, there may be some diminishment in the level of PSFAs provided by IHS. Furthermore, the IHS will reorganize both Headquarters and the Area Office to continue to provide the remaining PSFAs which have not been included in this FA, in the most effective and efficient manner possible, provided that the decisions about the array and level of PSFAs to be offered by the IHS shall be made in consultation with Alaska Tribes. The IHS PSFAs not negotiated into or listed in Appendix A are the responsibility of the IHS.

Unless funds are specifically provided from Headquarters, Headquarters retains all PSFAs and NSHC will not be denied access to, or services from, Headquarters. Specifically, NSHC will receive the following services from IHS Headquarters:

1.1.1 Information Services. IHS will provide the full range of Office of Information Technology (OIT) national support to ANTHC and ANMC OIT will provide specified services directly to NSHC. In addition, OIT will provide support to ANTHC to assist it to carry out its responsibility to provide day-to-day technical support, user support, distribution of software and files and other typical information technology support to Co-Signers as defined in the Assurances Appendix to the ANTHC FA. Upon request of ANTHC, after good faith efforts to resolve NSHC's technical issue, OIT's support of NSHC will include technical support needed on-site by NSHC. A list of the services due under this paragraph, with identification of the method of delivery, is shown below.

Office of Information Technology Provides:	Directly to ANTHC	Directly to Co-Signer	Indirectly to Cosigner through ANTHC
National Database Services			
100% Data Center Services	X		
Process Data exports into National Database		X	
Evaluate, correct, convert site data for National Database		X	
Telecommunications Management Services			
100% Telecommunications Management Services	X		
Maintain IHS to Alaska connection		X	
Email transfer and global address listing		X	
SMTP Gateway		X	
Intranet and Internet Access (to available bandwidth)		X	
Antivirus Software			X

[1] All references to Appendix A and Appendix C in this FA are to the Appendix for the applicable fiscal year.

Office of Information Technology Provides:	Directly to ANTHC	Directly to Co-Signer	Indirectly to Cosigner through ANTHC
Software Development and Maintenance			
100% Software Development and Maintenance	X		
Use of IHS contract vehicles		X	
RPMS Integrated Commercial-Off-The-Shelf packages (Average Wholesale Prices, CPT, ICD-9, Immunization Algorithm) licenses (This does not include licenses for stand-alone or interfaced commercial software.)			X
RPMS Package Support/Installation			X
System Support and Training			
100% System Support and Training	X		
Nationally Available OIT Training instruction (as available)		X	
Alaska On-site training instruction (four annual classes)			X
Hardware and Operating System Support			X
Cache Upgrade (initial installations)			X
National Patient File (2000) conversion			X
Envoy (WebMD) installation			X
Additional Services - Fee for Service	X	X	X

1.1.2 Access to Training and Technical Assistance. To the extent funds are identified by the IHS, NSHC shall have access to training, continuing education, and technical assistance in the manner and to the same extent NSHC would have received such services if it were not a Self-Governance Co-Signer.

1.1.3 Intellectual Property. In the course of administering federal contracts, grants, subgrants, and other agreements, IHS acquired various copyrights and licenses, including licenses pursuant to 45 CFR § 74.36 and 45 CFR § 92.34, in works which the IHS possessed, reproduced, published and otherwise used and allowed others to possess, reproduce, publish, and otherwise use. To carry out the PSFAs assumed by NSHC under this and previous FAs and contracts NSHC has the delegated authority and permission from IHS to use and allow others to reproduce, publish, and otherwise make use of these works to the same extent as IHS, consistent with the copyrights or licenses acquired by IHS in such works.

1.1.4 HIPAA Compliance. IHS retains the responsibility for complying with the Health Insurance Portability and Accountability Act of 1996 for retained IHS health care component activities.

1.2 Historical PSFAs. NSHC has historically received certain PSFAs from ANMC and AANHS. Responsibility for these PSFAs has been transferred to ANTHC by ANMC and AANHS prior to the transfer of management to ANTHC and SCF, NSHC attached to its FY 2002 FA Addendum I entitled "Memorialization of Historical Level of PSFAs provided by ANMC and AANHS." The PSFAs listed in this addendum are taken from NSHC's FY 1999 Annual FA. The addendum was attached to the FY 2002 FA only for the purpose of identifying historical levels of PSFAs received by the NSHC from ANMC and AANHS, and is specifically not made part of this

FA.

1.3 Community Health Aide Program Certification. The IHS retains the responsibility, pursuant to Section 119 of the Indian Health Care Improvement Act, as amended, to maintain the IHS Community Health Aide Program Certification Board (CHAPCB), which was established by and is under the direct control and supervision of IHS, to accredit training for and to certify community health aides, which includes community health aides/practitioners, dental health aides, and behavioral health aides/practitioners.

Section 2 – Obligations of the Co-Signer.

2.1 Generally. This FA obligates NSHC to be responsible for and to provide health PSFAs identified in Section 3 [Tribal Programs and Budget], utilizing the resources transferred under this FA and other funds as they may become available to NSHC. This FA further authorizes NSHC to consolidate and redesign PSFAs as provided in the Act and the ATHC. Whether providing, purchasing, or authorizing health care services described in the Compact and this Funding Agreement, in accordance with Section 2901(b) of Pub. L. 111-148, the Affordable Care Act, and as otherwise provided in law, NSHC shall be the payer of last resort. NSHC is committed to and will strive to provide quality health services and will strive to meet standards NSHC believes to be appropriate and applicable to the delivery of those health services.

2.2 Tribal Facilities and Locations. NSHC operates the programs described in this FA out of more than one facility or location. These include, but are not limited to the facilities and locations listed in Appendix B, which will be submitted prior to the effective date of this FA, and will be incorporated by reference herein. The Area Division of Planning Evaluation and Health Statistics shall compile from this Appendix a list of all health facilities identified in the Appendix and forward that list annually to the Headquarters' Office of Program Statistics, which shall include each of these facilities and locations in the annual list it must provide to the Centers for Medicare and Medicaid Services (CMS) (formerly Health Care Financing Administration) pursuant to the Memorandum of Agreement between the Health Care Financing Administration and the IHS (December 19, 1996).

Section 3 – Tribal Programs and Budget.

The NSHC agrees to be responsible for the health PSFAs identified below in accordance with the ATHC and this FA, including administration of the Norton Sound Service Unit of the IHS, a tribally operated Service Unit of the IHS. NSHC provides and facilitates a range of services directly, and in cooperation with ANMC, ANTHC, SCF and other Co-signers, through field clinics, referrals to ANMC, and other arrangements with tribal health organizations. Any PSFA described in this section 3 [Tribal Programs and Budget] may be performed by any organizational unit of NSHC at NSHC's discretion. For the purposes of this FA, the NSHC's General Budget Categories consolidate related health PSFAs as listed below.

3.1 Executive Leadership. NSHC through its Board of Directors and administration provides policy and administrative/executive/legal direction and oversight for all PSFAs in this FA. Board members, officers, General Counsel, and staff represent NSHC on the local, regional,

state and national committees and boards to provide for advocacy, negotiations, coordination, consultation, development of new programs and information activities.

3.2 Hospital and Clinic Services. NSHC is committed to providing quality patient care achieved through maintaining qualified staff, physical plant, and adequate supply of medical provisions. Under a comprehensive health care delivery plan NSHC provides the following direct patient care services:

3.2.1 Acute patient care swing-bed;

3.2.2 Twenty-four hour emergency services, including those associated with being a Level IV trauma center;

3.2.3 Ambulatory care services, including after-hour nursing phone triage service;

3.2.4 Medevac/air ambulance services;

3.2.5 Referral/transport system from the villages and/or Nome to and from the next higher level of care (e.g. travel coordination and authorization, patient transport vehicle, medivac transport and patient transportation, including adult escort, health professional and other escort as NSHC deems appropriate and emergency or non-emergency air transportation where ground transportation is not feasible and transportation by private vehicle where no other means is available, including specially-equipped vehicle and ambulance) subject to available funding. NSHC may provide the above described patient transportation services in accordance with Section 213 of the Indian Health Care Improvement Act as amended at 25 U.S.C. § 1621*l*;

3.2.6 Specialty clinic support;

3.2.7 Sexual Assault Response Team (SART), including forensic exams and counseling of victims;

3.2.8 Comprehensive health care nursing services for the elderly, disabled and others needing long term health care services as defined by Section 205(a)(4) of the Indian Health Care Improvement Act, as amended, and in accordance with Section 205(c) of such Act. Such services will include but not be limited to the nursing facility services of Quyanna Care Center;

3.2.9 Emergency and minor surgery within the expected capability of Medical Practitioners;

3.2.10 Services associated with training medical students, residents, physician assistant students, nursing students, and allied health provider students from accredited institutions, under supervision of appropriate staff;

3.2.10.1 Physician coverage for services provided in the hospital and villages in person and through daily contact by telephone and/or video telemedicine equipment as needed with the physician assistants and/or Community Health Aides/Practitioners in the villages, and for teleradiology services;

3.2.11 Comprehensive, well person, emergency, acute and chronic care and preventive services at the subregional/community health centers and surrounding village clinics. These services include, but are not limited to, Early Periodic Screening, Diagnosis and Treatment (EPSDT), immunizations, maternal and child health services including family planning, prenatal care and case management of care provided to children and other high-risk individuals; urgent care services 24 hours a day; and specialty clinics, dental services, optometry services, diagnostic imaging services, laboratory services, and telemedicine, telehealth, telepharmacy, teleradiology, telepsychiatry services, dialysis, and mammography, colonoscopy and other cancer screenings, and cancer

treatment;

3.2.12 Diabetes prevention program, including community exercise and activity programs, such as "Summercise" programs, community health fairs, and water aerobics. As authorized under Section 204(d) of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621c, NSHC provides dialysis services and is committed to and shall provide quality dialysis services that will at all times meet standards applicable to such services;

3.2.13 Ancillary services will be maintained at levels sufficient to support medical diagnosis, including but not limited to physical therapy, smoking cessation, respiratory therapy, diagnostic imaging, laboratory, pharmacy, social services, nutrition services, and point of care testing;

3.2.14 Provide lodging for patients, family members of patients, and/or their escorts, including but not limited to housing at the patient hostel, and elder housing;

3.2.15 Coordination with, support of, and assistance to tribal and non-profit entities with their provision of health and social services; and

3.2.16 Provides training and continuing education for NSHC employees and NSHC beneficiaries, and, subject to availability of funding, provides limited financial support for NSHC beneficiaries to assist them to be prepared to pursue health related careers. NSHC also provides a nursing educational program.

3.3 Behavioral Health Services. Provides behavioral health services including, but not limited to:

3.3.1 Substance Abuse Services. Provide services to reduce and prevent substance abuse and associated problems through in/outpatient services, prevention/education, referral services, transitional/residential care services, outreach services, and community involvement, diagnostic and primary alcoholism and drug abuse treatment services, including individual assessment and referrals, individual and group counseling, detoxification services, case management, and substance abuse education classes and Alcoholics Anonymous and/or Narcotics Anonymous meeting sponsorship.

3.3.2 Mental Health Service. Provides professional and paraprofessional staff that travel within the Norton Sound Service Unit, and provides family, child, adolescent and community mental health programs. As needed, a psychiatrist provides mental health services in the hospital. Services include but are not limited to assessment and diagnostic services, individual and group therapy, crisis intervention services, suicide prevention and psychological testing, and telebehavioral health.

3.3.3 Village Based Counseling Program. Provides supportive counseling to identified clients, including abused children, children with behavioral health problems, families in crisis, adults and adolescents with substance abuse and/or mental health issues, and the chronically mentally ill. This program works in conjunction with the substance abuse and mental health program and includes the services of behavioral health aides.

3.3.4 Rainbow Services. Provides services to clients with developmental disabilities. The program assists clients to remain in their homes and communities by developing skills to increase self-control and participation in the community. When this is not possible, the

program assists families to find appropriate treatment and services outside the home for the client.

3.3.5 Transitional Living Services. Provides transitional living services, including residential programs, to assist clients in maintaining sobriety while attending outpatient substance abuse treatment, and after completion of treatment until the client is ready to return to his/her home community.

3.3.6 Fetal Alcohol Spectrum Disorder Prevention Services. Provides education and assistance regarding Fetal Alcohol Spectrum Disorder, targeting pregnant women with substance abuse issues to educate them about the effects of substance abuse on children and families.

3.3.7 Children's Services. Provides intensive outpatient behavioral health services to high risk clients with severe emotional problems ages 9-20 and their families. The program aims to help youth succeed at school, home and in the community while eliminating the need to send them elsewhere. Children's services also may include a full array of behavioral health prevention, early intervention, and treatment programs, including recreational and activity programs and residential and day camps. Providing culturally relevant services involving the community in the treatment process.

3.4 Other Health Services. Provides other health services, including but not limited to:

3.4.1 Dental Services. Provides services at the hospital and in field clinics to raise dental health and lower the incidence of dental disease. The field dental program offers visits to all the villages. Dental services may include dental health aide and dental health aide therapist, training, supervision, and services under the Standards and Procedures approved by the IHS Community Health Aide Program Certification Board.

3.4.2 Audiology. Audiology Services will be delivered, both at the hospital and through field clinics throughout the Norton Sound Service Unit.

3.4.3 Optometry Services. Optometry Services will be provided consistent with the needs of the patients, both in Nome and through field clinics throughout the region.

3.4.4 Village Health Services. Provides training, supervision and services of Community Health Aides/Practitioners (CHA/Ps) and the Clinic Travel Clerks who act as support staff to the village clinics. The Community Health Aide Program will be carried out under the Standards and Procedures approved by the IHS Community Health Aide Program Certification Board.

3.4.5 Health Aide Training. Provides Community Health Aide Program training to trainees from throughout Alaska.

3.4.6 Traditional and Alternative Medicine. Provides traditional healing-services in coordination with existing western medicine services; and alternative healing practices only upon a referral from a provider credentialed in accord with the standards cited in Section 8 of this FA.

These services will be provided in accordance with Section 831 of the Indian Health Care Improvement Act, amended at 25 U.S.C. § 1680u.

3.4.7 Emergency Medical Services. NSHC will maintain Emergency Medical Services (EMS) to lower the incidence of death and disability by providing air ambulance services. The NSHC departments also provide various levels of EMS and injury prevention training for staff and community members throughout the region. NSHC participates in EMS delivery in cooperative with community fire departments, other emergency response, and rescue services throughout the region.

3.4.8 Maternal and Child Health Program. Provides:

3.4.8.1 Prematernal home care for village women awaiting delivery in Norton Sound Regional Hospital;
3.4.8.2 Prenatal, family planning and newborn patient education; and
3.4.8.3 Assistance in risk screening and coordination of prenatal care.

3.4.9 Office of Environmental Health. Provides inspections of the hospital and clinics; technical assistance, training and research to help protect the public from illness and injury related to problems with water, waste, food, air, pests, safety, hazardous waste sites and bioterrorism. Technical assistance is provided to local, state and federal officials as necessary to assist with funding processes and the development of local environmental programs. Training is provided to regional water/wastewater operators and utility managers as needed to ensure safe operation and management of environmental systems.

3.4.10 Public Health Nursing. Provides public health nursing services, including but not limited to consultation to CHA/Ps in the villages, child health and developmental screening, prenatal care, EPSDT, school screenings, immunizations, and tuberculosis and other infectious disease screening and monitoring.

3.4.11 Research and Prevention. Participate in research activities to determine whether genetic factors predispose Alaska Natives to disease.

3.4.12 Home Care and Other Community Based Services. Through a combination of western methods and traditional modalities, provides home care and other community based services, which includes but is not limited to assistance with activities of daily living such as bathing, dressing, laundry, light housekeeping, cooking, vital signs, and medication reminders. These services are provided to all individuals throughout the Bering Straits region who are unable to perform their activities of daily living on their own, or when the families are unable to meet their needs. Home and Community Based Services also provides palliative care and other end-of-life services, such as hospice care, respite, chore, nutrition, transportation, and other supportive services including various senior programs and activities. Such services may also include Assisted Living Services. NSHC will provide home and community based services, hospice and assisted living in accordance with the requirements at § 205 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621d.

3.4.13 Nutrition Services for Women, Young Children, and Infants. Provides supplemental foods, and nutritional education, counseling and other services to women, infants and young children who are at nutritional risk.

3.4.14 Infant and Young Child Developmental Program. Provides services that promote growth and development of infants and young children. Children who qualify for services may have been born prematurely, have delays in their development, or have a diagnosed disability such as Down's syndrome or cerebral palsy. Other child development and family services include, but are not limited to, health-oriented education; socialization; health screening; growth and nutritional assessment; individualized culturally-appropriate child development services; family services; and family involvement.

3.4.15 Injury Prevention Services. Provides services to lower the incidence of death and disability, including but not limited to, the provision of safety information, equipment, and training.

3.4.16 HIV Services. Provides testing, referrals, data collection, and training end education.

3.4.17 Purchased/Referred Care Services. Purchases services, which are not otherwise available or accessible to eligible beneficiaries, on a contractual or open-market basis within funds available. NSHC agrees to be bound by 42 C.F.R. Part 136, subpart I, in the administration and provision of Purchased/Referred Care (PRC) services carried out under this Agreement. Accordingly, NSHC has opted to pay at Medicare Like Rates for PRC in accordance with that subpart of the regulations.

3.4.18 Morgue. Provides morgue services in each village.

3.5 Support Services. Support services required to support the provision of health services, including, but not limited, to plant operations, biomedical services, housekeeping and linen/laundry services, security (for patients and staff), human resources, information systems, administration and board support, corporate planner, grant management, compliance officer and performance improvement, material management (procurement, receiving, processing and distribution), central sterile supply, infection control/employee health, and financial, including business office functions, coding and medical records, planning and implementation of an electronic health records system, patient benefits coordinator, and the provision of staff housing.

3.6 Capital Projects. Provides technical assistance, planning, design, engineering, management and general contracting for construction, maintenance and operation of all facilities used by NSHC, including both federal facilities and those leased or owned by NSHC. This program also provides technical assistance and construction related services to other tribes and tribal organizations inside and outside NSHC's service area.

3.7 Village Built Clinic (VBC) Lease Program. Provides funds to eligible entities to

support the rental of CHA/P clinic space. NSHC will operate this program directly with all VBC lessees, who so elect, including the provision of support services and technical assistance. NSHC will ensure that each lessee is in compliance with the standards referenced in the VBC lease.

3.8 Public Health and Epidemiology. Directly and/or through ANTHC, including its Epidemiology Center,[2] NSHC carries out public health, epidemiology and health research functions. These activities include, but are not limited to: collecting and receiving personally identifiable health information for the purpose of

3.8.1 preventing or controlling disease, injury, or disability;

3.8.2 reporting disease, injury, and vital events such as birth and death; and

3.8.3 the conduct of public health and epidemiological investigations, surveillance, and interventions, including the maintenance of disease and injury registries.

3.9 Other Programs/Services Funded.

3.9.1 Generally. This FA includes programs, functions, services and activities resulting from tribal redesign, or consolidation, reallocation or redirection of funds, including its own funds or funds from other sources, provided that such consolidation, redesign, or reallocation or redirection of funds results in carrying out programs, functions, services and activities that may be included in the FA pursuant to section 505 of Title V and Article III, Section 6 [Consolidation with Other Programs] of the ATHC. This includes any other new health care programs, including, but not limited to, those identified in the Indian Health Care Improvement Act funded during the fiscal years.

3.9.2 Non-IHS Funding. NSHC will complement and supplement the PSFAs described throughout Section 3 [Tribal Programs and Budget] with funding from sources other than the IHS through this Funding Agreement, subject to the availability of such other funding sources. Consistent with Article III, Section 5 [Reallocation], 6 [Merging with Other Programs], and 7 [Program Income] of the ATHC, non-IHS funds will be added to or merged with funds provided by the IHS through this FA.

3.10 FTCA. The Federal Tort Claims Act applies to NSHC's PSFAs under this FA as provided in Section 516(a) of Title V (which incorporates Section 102(d) of Title I of the Act and Section 314 of P.L. 101-512). The extent of Federal Tort Claims Act coverage is described more particularly in 25 C.F.R. Sections §§ 900-180-900.210.

Section 4 – Amounts Available During the Term of the FA

4.1 The following amounts shall be available to NSHC pursuant to the ATHC and Title V of the Act and are subject to reductions only in accordance with Section 508(d) of Title V and Section 106 of Title I of the Act.[3]

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[2] The ANTHC Epidemiology Center was previously operated by the Alaska Native Health Board.

[3] A breakout of these funds is shown in Appendix A, which cites the source document used to determine the amount. These amounts are subject to change under the Act and as provided in this FA. For other fiscal

Recurring Base: Inclusive of all recurring funding, including recurring contract support funds and Village Built Clinic Funds of $425,417.[4]	$48,467,747
Non-recurring funds: inclusive of all non-recurring contract support funds and such other funding which may be added to the contract.[5]	$13,954,404
Subtotal: (This amount is subject to amendments in accordance with Section 14 [Amendment or Modification of this FA])[6]	$62,422,151
Area "Tribal" share to include funding identified from the Area Office and identified in Appendix A to this Agreement.[7]	$1,031,630
Headquarters-tribal share: "Tribal Size Adjustment Pool," including all funds identified in Appendix A. The amount identified is exclusive of funds for which distribution amount has not been determined. The final amount due shall be determined as set forth in this FA or Appendix A.[8]	$731,037
Headquarters-Tribal share: "Program Formula Pool" – to include all funds identified in Appendix A, and such additional funds which the IHS may make available on a program formula basis during the year based on the programs accepted for this allocation in Appendix A.	$0

years to which this FA may be applicable, the replacement Appendix A will be negotiated between IHS and NSHC for the respective year and amended to this FA and incorporated by reference, accordingly.

4 A breakout of these recurring costs is found in Appendix A, fully incorporated herein and citing the actual documents used to determine the amount. *See* Footnote 3.

5 These non-recurring funds include contract support costs and routine Maintenance and Improvement funds available at the beginning of the fiscal year. *See* Footnote 3.

6 The Radiologist Consultation funds in the amount of $195,131 and Biomed funds in the amount of $67,102 are not included in this amount (neither of these amounts include any adjustments for mandatory increases). These recurring funds and any mandatories associated with them are in the ANTHC FA and will be negotiated annually as a flow-thru from the ANTHC, in accordance with the interpretation of Section 325 of P.L. 105-83 by the IHS.

7 Funds from the Alaska Area were distributed according to methods agreed upon in a caucus open to all Alaska Tribes and tribal organizations. The specific methodology is identified in Appendix A.

8 Headquarters tribal shares were allocated according to the following process, which was adopted in a caucus open to all Alaska tribal organizations: The Alaska Area Tribal shares of Headquarters was first defined using the national IHS recommended methodology. The total Alaska Area Tribal shares was then reallocated to each Co-Signer according to the agreed upon Alaska Area methodology, which is identified specifically for each line in Appendix A.

Subtotal – Tribal Shares[9]	$1,762,667
TOTAL ATHC FUNDING	**$64,184,818**

These amounts are subject to additions for other reimbursements, and for new funds received during the term of this Agreement including amounts that have historically been distributed as non-recurring funds under the Act. Any amounts remaining unspent under the prior FA, after adjustments and services, as of the previous fiscal year, shall be included and spent under this FA.

Of the amount shown above for non-recurring program funds, $1,211,108 are for Routine Maintenance and Improvement (M&I); the Routine M&I amount paid as a part of the lump sum due NSHC was determined by multiplying the FY 2017 Routine M&I amount paid to the Co-Signer by 90%. The final Routine M&I amounts paid in FYs 2018-2020 will be based on the final 2018-2020 Routine M&I allocations. If the final Routine M&I amounts, as determined by the final FYs 2018-2020 Routine M&I allocations, is less than the 90% calculation, NSHC will return the difference to the IHS. See also Appendix A, footnote to line 19 on page 6.

Of the amount shown above for Headquarters Tribal Share "Program Formula," $141,878 are for Equipment Replacement, the Equipment Replacement amount paid as part of the lump sum due NSHC was determined by multiplying the FY 2017 Equipment Replacement amount paid to NSHC by 90%. The final Equipment Replacement amounts paid in FYs 2018-2020 will be based on the final FYs 2018-2020 Equipment Replacement allocations. If the final Equipment Replacement amounts, as determined by the final FYs 2018-2020 Equipment Replacement allocations, is less than the 90% calculation, NSHC will return the difference to the IHS. See also Appendix A, footnote to line 22 on page 6.

The Recurring Base amount shown above includes $291,158 that NSHC received, recurring in FY 2006 for Congressionally earmarked alcohol funds. Such funds are subject to "Adjustments Due to Congressional Actions" as described herein in Section 6 as well as any conditions on those funds that may be described in the FYs 2018-2020 Interior Appropriations Acts (Act) or Congressional Reports. After each Act is passed into law, such conditions, including Congressionally-directed reporting requirements, will be added by amendment not requiring NSHC's signature as described in Section 14 [Amendment or Modification of this FA].

The parties agree Section 505(b)(2) of Title V provides, among other things, that grants administered by the Department of Health and Human Services through the IHS may be added to NSHC's FA after award of such grants. In accordance with this provision of Title V and its implementing regulations, the Secretary will add NSHC's diabetes grants and any other statutorily mandated grant(s) administered by the Department through the IHS to this FA after such grant(s) have been awarded. Grant funds will be paid to NSHC as a lump sum advance payment through the PMS grants payment system as soon as practicable after award of the grant. NSHC will use interest

[9] The subtotal of Tribal shares does not include certain Headquarters for which the amount or availability has not been determined. This amount will be adjusted to make available all Tribal shares for which NSHC is eligible. IHS will pay mandatory increases on some Headquarters Tribal shares, subject to appropriations.

earned on such funds to enhance the purposes of the grant including allowable administrative costs. NSHC will comply with all terms and conditions of the grant award, including reporting requirements, and will not reallocate grant funds nor redesign the grant program, except as provided in the implementing regulations or the terms of the grant.

4.2 Contract Support Costs. Contract support costs (CSC) will be paid in accordance with 25 U.S.C. § 5325 and § 5388(c). The parties agree that, according to the best data available as of the date of execution of this agreement, the amount to be paid under FY 2018, which represents the parties' estimate of the Tribe's full CSC requirement pursuant to 25 U.S.C. § 5325, is $16,798,500, including $4,197,082 for direct CSC and $12,601,418 for indirect or indirect-like CSC.[10] This estimate shall be recalculated as necessary as additional data becomes available including information regarding the direct cost base, pass throughs and exclusions, and the indirect cost rates to reflect the full CSC required under 25 U.S.C. § 5325. The parties will cooperate in updating the relevant data to make any agreed upon adjustments. In the event the parties disagree on the CSC amounts estimated and paid pursuant to this paragraph and the Tribe's full CSC requirement under the ISDEAA, the parties may pursue any remedies available to them under the ISDEAA, the Compact, and the Contract Disputes Act, 41 U.S.C. §7101 et seq.

4.3 Base Budgets.

4.3.1 Categories and Base Year. At the end of the first period of the base budget option, the IHS and Co-Signers agreed to extend the three year (FY1998-FY2000) base budgets implemented for the ATHC for an additional two years (FY2001-FY2002). IHS and NSHC have subsequently agreed to additional extensions through FY 2009. The IHS and Co-Signers have agreed to further extend the base budget period at the Co-Signer's option. The following categories are subject to base budgeting for the base year period and the period, as noted below.

Category of Funding	Base Period for Base Funding	Extended through:
Headquarters TSA amounts[11]	FY 97	FY 2020
Equipment Replacement Funding	Not Included	N/A
Area Tribal Share	Not Included	N/A

4.3.2 Adjustments. Adjustments to base funding shall be permitted in direct proportion to changes in appropriated amounts (by sub-activity), as provided under Section 6.1 of this FA titled "Adjustments, Due to Congressional Actions." Adjustments shall also be permitted for the addition of new Co-Signers to the ATHC and when current Co-Signers add or retrocede PSFAs,

10 For other fiscal years to which this FA is applicable, the CSC estimates will be negotiated between the IHS and NSHC for the respective year and amended to this FA in Appendix A.

11 ATHC base budgets for TSA amounts shall be considered as a whole (entire ATHC amount) and shall be subject to adjustment of the internal allocation subject to ATHC agreements.

as provided in Section 14.4 [Due to Addition of New Programs].[12] Adjustments also shall be permitted when Co-Signer chooses to restrict or un-restrict previously "restricted" or "un-restricted" categories, provided that restrictions shall be changed only during annual negotiations. NSHC shall also be eligible for funding for new service increases, mandatories, specific Congressional appropriation for population growth, health services priority system, contract support costs and other increases in resources on the same basis as all other Tribes. Adjustments for changes required when a Tribe joins or withdraws from a Tribal consortium shall also be permitted, as provided under Section 10.3 [Withdrawal Procedures] of this FA. Co-Signers shall also remain eligible for the distribution of additional Tribal shares for Assessments, Workers Compensation, Emergency Reserve, Management Initiatives, and other PSFAs from Headquarters.

Section 5 – Methods of Payment.

5.1 Payment Schedule. Except as provided in subsection 5.2 [Availability of Tribal Shares], 5.3 [Buyback/Withholding], and 5.4 [Periodic Payments] of this Section, all funds identified in Section 4 [Amounts Available During the Term of the FA] of this FA shall be paid to NSHC, in accordance with Article II, Section 4(a) [Payment Schedule] of the ATHC; payment to NSHC to be made as follows: One annual lump sum payment to be made in advance.

5.2 Availability of Tribal Shares. NSHC will be paid 100 percent of Headquarters and Area Tribal Shares in its initial lump sum payment, as negotiated in this FA, for each year under the term of this FA.

5.3 Buyback/Withholding. NSHC may carry out its responsibility to provide certain PSFAs included in this FA by using services or other resources of the Federal government under Article V, Section 22 [Purchases from the IHS] of the ATHC, as permitted by law. Except as provided herein, the cost of such services and the terms under which they may be available to NSHC are set forth in the Buyback/Withhold Agreement between the IHS and NSHC, which is attached as Appendix D to this FA and incorporated by reference herein. The administrative surcharge provided for in Section 2.2.4 of the Buyback/Withhold Agreement for FY 2018 shall be .285 percent. During the term of this FA, the Administrative surcharge rates will be negotiated annually. Notwithstanding Section 5 of the Buyback/Withhold Agreement, upon the request of the IHS or any Co-Signer, such FA will be negotiated for future fiscal years annually during negotiation of this FA.

5.4 Periodic Payments. Payment of funds otherwise due to NSHC under this FA, which are added or identified after the initial payment is made, shall be made promptly upon request of NSHC by check or wire transfer.

Section 6 – Adjustments.

[12] This includes addition of new facilities when the addition of these facilities includes an increase in equipment funds identified for the new facilities.

6.1 Due to Congressional Actions. The parties to this FA recognize that the total amount of the funding in this FA is subject to adjustment due to Congressional action in appropriations Acts or other law affecting availability of funds to the IHS and the Department of Health and Human Services. Upon enactment of any such Act or law, the amount of funding provided to NSHC in this FA shall be adjusted as necessary, after NSHC has been notified of such pending action and subject to any rights which NSHC may have under this FA, the ATHC, or the law.

6.2 Proposals by Authorizing Tribes. Should any authorizing Tribe assume responsibility for PSFAs (or portions thereof) under a contract or annual FA pursuant to the Act, adjustment to funding amounts under this FA will be negotiated.

Section 7 – Records.

7.1 Incorporation of the Privacy Act. Pursuant to Section 506(d)(1) of Title V, records acquired, generated or maintained by NSHC shall not be treated as Federal records under chapter 5 of title 5 of the United States Code, except that:

7.1.1 Patient medical, financial records and personnel records may be disclosed only in accordance with 5 U.S.C § 552a(b); and

7.1.2 Medical records generated by NSHC shall be eligible for storage in Federal Records Centers at NSHC's option in accordance with Section 105(o) of Title I.

7.2 Confidentiality Standards. NSHC will seek to comply with the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including, but not limited to, privacy, security, transactions, and code set regulations, codified at 45 CFR Parts 160, 162, and 164. If a record is not subject to HIPAA, NSHC will maintain the confidentiality of its records in accordance with policies and procedures adopted by its Governing Body, which will be consistent with the purposes and guidelines of HIPAA and the Federal Privacy Act of 1974.

7.3 Quality Assurance Records. NSHC operates a medical quality assurance program and treats the records of such program as confidential and privileged in accordance with section 805 of the Indian Health Care Improvement Act as amended at 25 U.S.C. § 1674.

Section 8 – Program Rules.

NSHC in carrying out the PSFAs in this FA agrees to comply only with those guidelines, manuals, and policy directives that are listed below: Joint Commission (formerly known as JCAHO) standards, as applicable, and Community Health Aide/Practitioner certification standards.

Except as specifically set forth in this Section, pursuant to Section 517(e) of Title V, NSHC does not agree to be subject to any agency circular, policy, manual, guidance or rule adopted by the IHS, except for the eligibility provisions of Section 105(g) and the regulations promulgated under Section 517 of Title V, unless otherwise waived.

Section 9 - Real Property Reporting Requirements

9.1 Leases. The IHS must report on its federally leased facilities. NSHC agrees to notify the AANHS of changes of occupancy, size, use, and general condition of Village Built Clinic (VBC) leased facilities in locations where NSHC has bought back services from the IHS. IHS will annually, or upon renegotiation, provide to NSHC a copy of each VBC lease. No increase in the amount due to the lessor pursuant to a lease will be negotiated by IHS without advance notice to NSHC. In administering these leases, the IHS will work with NSHC to ensure that each lease is in compliance with the standards referenced in the VBC lease.

9.2 Maintenance and Improvement Funds. NSHC agrees to use maintenance and improvement funds received through this FA in accordance with the appropriation language for Indian Health Facilities in the Department of Interior and Related Agencies Appropriation Act for FYs 2018-2020 or any comparable Act of Congress that contains the subject appropriation and in accordance with 41 U.S.C. § 12 to the extent applicable.

Section 10 – Services to Non-Beneficiaries.

Section 813 of the Indian Health Care Improvement Act, as amended, 25 U.S.C. 1680c, (Section 813), authorizes the governing body of a Tribal Organization carrying out health services of the IHS under the Indian Self-Determination and Education Assistance Act to determine whether health services should be provided under the Tribal Organization's FA with the IHS "to individuals who are not eligible for such health services under any other subsection of this section or under any other provision of law", 25 U.S.C. 1680c(c). The NSHC Board of Directors has made such determination consistent with Section 813, and provides for its findings in Resolution No. 2010-16. Resolution No. 2010-16 is attached as Appendix E and incorporated by reference herein. NSHC may provide services under this FA to "non-beneficiaries" as described in Resolution No. 2010-16. In addition services may be provided to U.S. Public Health Service Commissioned Corps Officers and their dependents.

Section 11 – Retrocession and Discontinuance.

11.1 Retrocession. The retrocession provisions of Section 506(f) of the Act are herein adopted, except that the effective date from a retrocession request of the ATHC and FA, in whole or in part, shall be one year from the date of the request by an authorizing Tribe or Village, except as provided below. Retrocession may be effective with less then one years notice, providing the Tribe or Village requesting retrocession, NSHC and the IHS agree to an effective date of less than one year from the date of retrocession request.

11.2 Discontinuance. NSHC may discontinue its participation in the ATHC after written notice to each authorizing Tribe or Village and the IHS. Notice must be provided one year in advance of the effective date of the request except that the effective date of a request may be less than one year upon approval of all authorizing Tribes and Villages and the IHS.

11.3 Withdrawal Procedures.

11.3.1 Process. Unless prohibited by law and in accordance with § 506(g) of Title V, an Indian tribe may fully or partially withdraw from a participating inter-tribal consortium or tribal organization its share of any program, function, service or activity (or portions thereof) included in the ATHC or FA, and any such withdrawal will become effective within the time frame specified in the resolution which authorized transfer to the participating inter-tribal consortium or tribal organization, provided that in the absence of a specific time frame being set forth in the resolution, such withdrawal shall become effective on -

11.3.1.1 The earlier of

11.3.1.1.1 One year after the date of submission of such request; or

11.3.1.1.2 The date on which the FA expires, or

11.3.1.2 Such date as may be mutually agreed upon by the Secretary, the withdrawing Indian tribe, and the participating tribal organization or inter-tribal consortium that has signed the ATHC or FA on behalf of the withdrawing Indian tribe, inter-tribal consortium, or tribal organization.

11.3.2 Distribution of Funds. In accordance with Sections 503(b) and 506(g) of the Act, when a tribe proposing to enter into a contract under Title I or a compact and FA under Title V fully or partially withdraws from a participating tribal organization, the withdrawing Tribe shall, upon written request, be entitled to be paid its tribal share of funds supporting those PSFAs (or portions thereof) which it will be carrying out under its own contract or compact and FA, and such funds shall be removed from the FA of the tribal organization and awarded to the Tribe upon approval of a Title I contract or compact and FA. The IHS shall retain any funds removed, but not awarded in a Title I contract or compact and FA.

Section 12 – Memorandum of Agreement with Member Village.

Funds provided under this FA may be allocated to and expended by an Alaska Native Village ("Village") which is party to this FA in accordance with the terms of the ATHC, this FA and a Memorandum of Agreement (MOA) approved by NSHC and the Village. The Federal Tort Claims Act shall apply to PSFAs carried out by the Village under such MOA and to the Village and its employees to the same extent as if they had been carried out directly by NSHC. Such an MOA may include provisions for the assignment of federal employees under IPA assignment or Commissioned Corps detail. Such assignment shall be subject to the approval of the AANHS Director. NSHC shall be responsible for assuring compliance by the Village with the ATHC, this FA and the MOA.

Section 13 – Consolidation of Contract and Previous Annual FAs.

The contracts listed below and all previous Annual FAs shall be amended or terminated, as appropriate to transfer applicable contract funds into this FA for services, materials and activities, programs, functions and facilities provided to the Tribes represented by NSHC: Title I, P.L. 93-638 Contract #243-89-0011, as modified.

Section 14 – Amendment or Modification of this FA.

14.1 Form of Amendments. Except as otherwise provided by this FA, the ATHC, or by law, any modifications of this FA shall be in the form of a written amendment and shall require written consent of each of the signatory Tribes, acting directly or through NSHC as authorized by resolution, the NSHC, and the United States. Participation or written consent of Tribes and Co-Signers not subject to the terms of this FA shall not be required.

14.2 Funding Increases.

14.2.1 Written consent of NSHC shall only be required for issuing amendments for those funds which:

14.2.1.1 require a change to Section 3 [Tribal Programs and Budget];

14.2.1.2 require a specific commitment by NSHC (*e.g.*, Maintenance & Improvement projects and prior fiscal year Sanitation Facility Construction projects); or

14.2.1.3 reduce funding other than changes in Congressional appropriations pursuant to Section 6.1 [Adjustments Due to Congressional Actions].

14.2.2 Amendments not requiring written consent may include, but are not limited to:

14.2.2.1 Program/Area/HQ Mandatories;

14.2.2.2 Program/Area/HQ End-of-Year Distributions;

14.2.2.3 CHEF, subject to the condition that if a case initially qualifying for reimbursement is paid (in whole or in part) by an alternate resource or cancels for any reason, NSHC will return the unused amount to the IHS CHEF account;

14.2.2.4 PRC Deferred Services;

14.2.2.5 Routine Maintenance & Improvement; or

14.2.2.6 Collections and reimbursements.

14.2.3 Amendments reflecting payment of these funds shall be provided to NSHC after any such funds are added to the FA. NSHC retains the right to reject the addition of such funds to the FA and return the funds to the IHS.

14.3 Services from IHS. Should NSHC determine that it wishes the IHS to provide PSFAs included in this FA for which funding has been identified but not provided, the parties shall negotiate an amendment to the FA to reflect the transfer of responsibilities from NSHC back to the IHS and the pro-rata share of funding for that program, services, function or activity shall be retained by the IHS. Unless otherwise negotiated, IHS will not transfer centrally paid expenses including but not limited to Workers Compensation to any ATHC Co-Signer.

14.4 Due to the Addition of New Programs. Should NSHC determine that it wishes to provide a program, service, function or activity of the IHS not included in this FA, NSHC shall submit a proposal to the IHS to provide such program, service, function or activity. The parties agree to negotiate such a proposal and, should the parties fail to reach agreement, NSHC may submit a final offer in accordance with the Title V procedures set forth in Sections 507(b)-(d) of Title V. A

proposal submitted pursuant to this section shall be treated as a request for amendment to the FA and, once approved by the IHS, the Alaska Area Office shall prepare within 30 days an amendment to this FA and the amendment shall be executed through the Area Office and added to the FA.

14.5 Due to Availability of Additional Funding. NSHC shall be eligible for any increases in funding or funding for Medicaid, Medicare, maintenance and improvement, other reimbursements and new programs for which it would have been eligible had it been administering programs under a self-determination contract, rather than under the ATHC and this FA, and for any other funds that are not restricted by appropriations language for which any Alaska Tribe or tribal organizations may be eligible, including any new funds appropriated for IHS Headquarters and funds passed to Alaska Area as recurring or non recurring funds, and this FA shall be amended to provide for timely payment of such new funds to NSHC. Such amendment shall be originated and prepared within 30 days by the Alaska Area Office and executed through the Area Office in consultation with the Co-Signer.

14.6 Other Adjustments. Upon written authorization by NSHC and agreed to by the IHS, the IHS may reallocate funds retained by the IHS, which are obligated to NSHC, for the purpose of reimbursing the IHS for services or equipment provided to NSHC to assist NSHC in carrying out the terms of the ATHC and this FA.

14.7 General Procedures for Amending or Modifying this FA. Amendments or modifications proposed by NSHC shall be submitted in writing to the IHS Alaska Area Director with a copy to the Office of Tribal Self Governance at IHS. Except as provided with respect to the incorporation of a provision of Title I under Article V, Section 21 [Applicability of Title I Provisions] of the ATHC, or as provided above in paragraphs .1, .2, .3 and .4 of this Section 14 [Amendment or Modification of this FA], a request to amend or modify this FA submitted by NSHC shall be processed in accordance with Sections 507(b)-(d) of Title V and all provisions of those identified sub-sections are incorporated herein for this purpose.

Section 15 – Third Party Recoveries.

Any funds recovered by NSHC through the filing, litigating, or settling a claim against a third party to require that third party to pay for services previously provided to IHS-eligible beneficiaries by NSHC, or for such services previously provided by the IHS in a PSFA now operated by NSHC, shall be the property of the Co-Signer and shall be considered program income to be utilized by NSHC as provided in Article III, Section 7 [Program Income] of the ATHC. Any prospective recovery of funds for such services shall likewise be considered program income to be utilized pursuant to Article III, Section 7 [Program Income] of the ATHC.

Section 16 – Severability.

This FA shall not be considered invalid, void or voidable if any section or provision of this FA is found to be invalid, unlawful or unenforceable by a court of competent jurisdiction. Should such a court make such a finding, the parties will seek agreement to amend, revise or delete any such

invalid, unlawful or unenforceable section or provision, in accordance with the provisions of the ATHC.

Section 17 – Memorializing Disputes.

The parties to this FA may have failed to reach agreement on certain matters which remain unresolved and in dispute. Such matters may be addressed through the process set forth in Sections 507(b)-(d) of Title V, or, at the option of NSHC, may be set forth in Addendum II to this FA, which shall be identified as "Memorialization of Matters Remaining in Dispute." This attachment shall not be considered a part of this FA but is attached for the purpose of recording matters in dispute for future reference, discussion and resolution as appropriate. The NSHC does not waive any remedy it may have under the law with regard to these issues and any others not listed herein.

Section 18 – Title I Provisions Applicable to This FA. As authorized in 25 U.S.C. § 5396(b), NSHC exercises its option to include the following provisions of Title I of the Act as part of this FA, and these provisions shall have the force and effect as if they were set out in full in Title V of the Act.

18.1. 25 U.S.C. § 5304(e) (definition of "Indian Tribe");
18.2. 25 U.S.C. § 5322(b) (related to grants for health facility construction and planning, training and evaluation);
18.3. 25 U.S.C. § 5322(d)(1) (related to duty of IHS to provide technical assistance);
18.4. 25 U.S.C. § 5324(a)(1) (exemption from Federal procurement and other contracting laws and regulations);
18.5. 25 U.S.C. § 5328(b), (conflicting provisions of law);
18.6. 25 U.S.C. § 5329(c), section 1(b)(8)(F) (screener identification);
18.7. 25 U.S.C. § 5329(c), section 1(b)(9) (availability of funds);
18.8. 25 U.S.C. § 5329(c), section 1(d)(1)(B) (construction of contract);
18.9. 25 U.S.C. § 5329(c), section 1(d)(2) (good faith).

Section 19 – Exemption from Licensing Fees.

In accordance with Section 124 of the IHCIA, as amended at 25 U.S.C. 1616q, employees of the NSHC health programs shall be exempt from payment of licensing, registration, and any other fees imposed by a federal agency to the same extent that officers of the Public Health Service commissioned corps and other employees of the Indian Health Service are exempt from such fees.

Section 20 – Licensure.

Licensed NSHC health professionals will be licensed in accordance with section 221 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621t.

Section 21 – Purchase of Health Coverage.

NSHC may use federal funds for purchase of health care coverage in accordance with section

402 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1642.

Section 22 – Medicare & Medicaid Reimbursements.

22.1 Medicare & Medicaid. NSHC has elected to directly collect Medicare and Medicaid payments as provided in 25 U.S.C. § 1641, as amended. NSHC is obligated and entitled to directly collect and retain reimbursement for Medicare and Medicaid and any other third party payers for services provided under this Agreement in accordance with section 401 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1641 and section 206 of such Act, 25 U.S.C. § 1621e, as amended.

22.2 Recovery Right. NSHC has the right to recover reimbursement from certain third parties of the reasonable charges for health services in accordance with section 206 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621e.

Section 23 – Federal Insurance. IHS will assist NSHC to obtain information about the coverage, rights and benefits available for its employees under chapters 87 and 89 of title 5, United States Code, the cost of such coverage, rights and benefits (including any options in coverage, rights and benefits that may be available), and the procedures by which NSHC may exercise its rights under Section 409 of the IHCIA, as amended, to have access to such Federal insurance for its employees.

Section 24 – Environmental and Cultural Resources. The National Environmental Policy Act (NEPA), National Historic Preservation Act (NHPA), and related provisions of law require the IHS to review and approve actions resulting in the use or commitment of IHS funds or that affect IHS property, and which may significantly impact the environment or cultural resources. Unless NSHC has assumed these responsibilities under a construction project agreement in accordance with Section 509 of Title V and 42 C.F.R. § 137.285-312, the IHS must carry out these responsibilities and has elected to utilize Appendix H. Where NSHC plans to undertake an action, as described in Appendix H, on IHS owned real property or utilizing IHS funds received through this Funding Agreement, and NSHC has not assumed these responsibilities, NSHC will provide the IHS with a Project Summary Document (see Appendix F) and a completed Environmental Information and Documentation Form (see Appendix G) so that the IHS can accomplish these requirements, and issue a Determination Document (Categorical Exclusion (CATEX) or Finding of No Significant Impact (FONSI)), as soon as possible. All documentation shall be submitted to the IHS as early as possible in the planning phase of the project to prevent delays in the action. No irreversible action can be taken by NSHC until the IHS completes its compliance responsibilities and so advises NSHC with a Determination Document. Pending resource availability, the IHS is available for education and consultation on NEPA, NHPA, and related provisions of law on an as needed basis.

Section 25 – Effective Date and Duration.

This Funding Agreement becomes effective on October 1, 2017, and will remain in effect through the 2020 Federal Fiscal Year or until a subsequent agreement is negotiated and becomes effective pursuant to Article II, Section 12 [Subsequent Funding Agreements] of the ATHC.

United States of America
Secretary of Department of Health and Human Services

By: _____
Director, Indian Health Service

Date: 6-14-2019

Norton Sound Health Corporation On Behalf of Itself and Certain Alaska Native Tribes, Identified in Exhibit A of the Compact.

By: _____
Angie Gorn
President/CEO

JUN 1 4 2019

Date: _____

FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

Amendment Effective October 1, 2018

In accordance with Section 14.1 of the Norton Sound Health Corporation (NSHC) FYs 2018-2020 Multi-Year Funding Agreement (MFA), NSHC's MFA is hereby amended as follows:

1. Section 3.2.9 is amended as follows: "Emergency surgery, and minor and other outpatient day surgery, within the scope of qualified ~~expected capability of~~ Medical Practitioners;"

2. Section 3.3.4 is amended to change the title from "Rainbow Services" to "Developmental Disability Program."

3. Appendix B, the list of facilities in which Norton Sound is carrying out health services, is amended as follows:

   In the portion pertaining to "Nome and all Villages," change the Facility Name to add the underlined language: "staff housing owned/rented including "Lawyer's apts," St. Michael Triplex, Golovin 2-bedroom home, and Savoogna duplexes".

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

By: Angie Gorn
Angie Gorn, President/CEO

6/4/2019
Date

United States of America
Secretary of
Department of Health and Human Services

By:
Director, Indian Health Service

8/2/2019
Date

FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

In accordance with Section 14.1 of the FYs 2018-2020 Funding Agreement made and entered into by Norton Sound Health Corporation (NSHC) and the Secretary of the Department of Health and Human Services of the United States of America, effective October 1, 2017, the Funding Agreement, as amended, is hereby further amended as follows:

1. **Appendices.** The following appendices are incorporated by reference and attached:

   - Appendix A (Financial Summary Agreement) FY 2021
   - Appendix B (Facility List) FY 2021

2. **Effective Date**. This amendment is effective October 1, 2020.

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

Angie Gorn

4/30/2021

By: _____ _____
Angie Gorn, President/CEO Date

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S Digitally signed by Evangelyn L. Dotomain -S Date: 2022.03.11 16:22:11 -09'00' _____
Alaska Area Director, Indian Health Service Date

Norton Sound Health Corporation

Appendix A - Financial Summary Tribal Shares Funding Agreement - FY 2021

Tribal Share Summary Norton Sound Health Corporation	FY 2021 Negotiated Amount	NSHC Restricted	Total Due NSHC	Initial Lump Sum Payment
Area TS Amount	$1,094,886	$45,473	$1,049,412	$1,049,412
	0		0	0
Subtotal Area TS Amount	$1,094,886	$45,473	$1,049,412	$1,049,412
Headquarters TSA Amount	$828,953	$93,107	$735,846	$735,846
Headquarters Other Program Formula (OEHE)	$48,412	$48,412	$0	$0
Subtotal Headquarters TS amounts	$877,365	$141,519	$735,846	$735,846
Total Tribal Shares	$1,972,250	$186,992	$1,785,258	$1,785,258

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Driving Variables Norton Sound Health Corporation	FY 2021
Population (2010 Census AN/AI population)	7749
Tribes (Federally Recognized Tribes)	20
Recurring Base - FY 2013 (less VBC)	$34,794,479
Percentage of Total Area TS (of all Alaska Tribes)	8.12295%
Percentage of ATHC (of all Title V Alaska Tribes)	8.22359%
Number of MOA employees	3
Number of IPA employees	0

Individually Restricted Items Norton Sound Health Corporation	FY 2021
Area Office (Individual Restricted Only)	
Supply Service Center	YES
Emergency Medical Services	NO
Village Clinic Leasing Management	YES
Headquarters (ATHC Restricted Only)	
ACOG	YES
OIT - Negotiated Alaska Plan	YES
Clinical Sup. Ctr. (Inc. CME Cert.)	YES

Appendix A - Financial Summary for Funding Agreement-Area Tribal Shares
Norton Sound Health Corporation

Line #	FY 2021 Budget Activity/Service	Total Area Budget	Residual Amount	ATHC restricted		Total AO Tribal Shares	NSHC AK Dist.	NSHC Retained	NSHC Total TS Due
				Trans. Fed.	ANTHC				
		(Column 1)	*(Column 2)*	*(Column 3)*	*(Column 4)*	*(Column 5)*	*(Column 6)*	*(Column 7)*	*(Column 8)*
1	TRIBAL SHARE FUNDS	$11,900,108	$0		$0	$11,900,108	$966,640		$966,640
2									
3	AREA OFFICE PFSAs (excluding OEHE)								
4	Area Office PFSA's	$4,193,809	$2,442,960	$681,500	$1,069,349	$0	$0		$0
5	Lease Costs-	$1,657,267	$185,820	$193,220	$1,278,227	$0	$0		$0
5a	Space Costs- negotiations	$19,000	$0	$19,000					
6	Area Director's Reserve	$100,000	$0	$100,000	$0	$0	$0		$0
7	Headquarters Assessments	$488,590	$54,720	$230,202	$203,668	$0	$0		$0
8	Human Resources	$849,441	$210,962	$356,311	$282,168	$0	$0		$0
9	Human Resources (ANMC) funds	$0	$0	$0	$0	$0	$0		$0
10	Area PFSA transferred to ANTHC	$3,028,546	$0	$0	$3,028,546	$0	$0		$0
11	CHC Reserve	$1,555,064	$0	$0	$1,555,064	$0	$0		$0
12	Area Managed Care	$723,423	$0	$0	$723,423	$0	$0		$0
13	ANHB (inc. tobacco funds)	$389,983	$0	$0	$389,983	$0	$0		$0
14	Supply Service Center	$853,749	$0	$0	$335,598	$518,151	$42,089	$42,089	$0
15	Epidemiologists	$196,885	$0	$0	$0	$196,885	$15,993		$15,993
16	EMS program at ANMC	$195,140	$0		$0	$195,140	$15,851	*$0*	$15,851
17	Centers for Disease Control	$282,902	$0	$0	$282,902	$0	$0		$0
18	Subtotal Area PFSAs (ex. OEHE)	$14,533,798	$2,894,462	$1,580,233	$9,148,927	$910,176	$73,933	$42,089	$31,844
19									
20	OFFICE OF ENVIRONMENTAL HEALTH AND DESIGN								
21	Office of Envir. Hlth and Eng.-.(EH	$5,961,749	$244,466		$5,127,476	$589,807	$47,910		$47,910
22	Real Property/Realty (FSA)	$148,888	$92,682		$14,547	$41,659	$3,384	$3,384	$0
23	Health Facilities/Main./ Spec. Pro	$1,368,036	$114,204		$1,216,669	$37,163	$3,019		$3,019
24	Subtotal OEHE	$7,478,673	$451,352	$0	$6,358,692	$668,629	$54,312	$3,384	$50,928
25	**TOTAL AREA OFFICE**	$33,912,579	$3,345,814	$1,580,233	$15,507,619	$13,478,914	$1,094,886	$45,473	$1,049,412

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General Notes on Alaska Area Office Tribal Shares

Column 1 - Includes all FY17 changes allocated to TS, Residual, & Transitional as of FY17. In FY 2019 TS changes will be added as received.

Column 2 - Residual includes no changes in residual functions. Based on FY2018 Area approved residual budgets.
Remaining funds at 9/30 distributed (Non-Recurring) to all Alaska Area health programs based on recurring base.

Column 3 - Transitional funds agreed by co-signers to remain at Area Office. Based on FY2018 approved transitional budget.

Column 4 - Restricted by all co-signers & transferred to the ANTHC to provide "Area PSFAs" .

Column 5 - Includes Area TS for all Alaska Tribes, including Title I & Title V. FY19 mandatories to be added if received.

Column 6 - Available Tribal shares for Co-Signer (amounts for ANTHC include pass-through to awardees with shares captured by Sec. 325).
Distributed by the approved ATHC methodology of - 30% # of Tribes / 35% 2010 Census Pop. / 35% 2013 Rec. Base (less VBC).
All Area TS for Services line items will be recurring, Area TS for Facilities will be non recurring.

Column 7 - Items restricted by individual co-signer to pay for continued services from ANTHC. (Restricted amounts are added to ANTHC FA.)

Column 8 - The agreed upon amount due (col. 6 - col. 7) to the co-signer after all retained shares are withheld.

Line 1 - All TS funds for non-OEHE Area Office PSFAs except where co-signers have individually decided to retain certain PSFAs at the ANTHC or AANHS.

Line 5 - Lease on Inuit Building.

Line 5a - $20,000 (less sequester) from transitional funding held by IHS to rent space for annual negotiations. Funds transferred to ANTHC upon confirmation of space availa

Line 7 - Centrally paid expenses, including personnel & finance support for Area positions, costs & funds for departmental assessments.

Line 8 - Area Human Resources functions (previously Office of Personnel & Training).

Line 9 - Funding originally from ANMC - have all been returned to SCF/ANTHC as IPA/MOAs were reduced.

Line 10 - Includes funding for Area PSFAs transferred to ANTHC under Section 325.

Line 11 - Funds to ANTHC to support the statewide Contract Health Services reserve program.

Line 12 - Funds to ANTHC to support specialized services in Barrow, NSHC, & BBAHC & certain statewide laboratory contracts.

Line 13 - ANHB funds from Loc 77 including previous tobacco prevention funding.

Line 14 - Supply Service Center individually withheld amounts retained for ANTHC for all co-signers except YKHC, Seldovia, & Eklutna.

Line 15 - Funds distributed to support the Epidemiology Center distributed to co-signers for individual payment to ANTHC.

Line 16 - Funds for EMS training. Retained by IHS for transfer to ANTHC for Maniilaq, BBAHC, & Chugachmiut for EMS training at ANMC.

Line 18 - Does not include funds from surcharge, assessments, or other services purchased through Area Office.

Line 22 - Funds retained for ANTHC for all co-signers except YKHC, SCF, & KIC.

Line 24 - Does not include NR SFC funds for Health Facilities design and construction oversight.

Appendix A - Financial Summary for Annual Funding Agreement - Headquarters Tribal Shares
Norton Sound Health Corporation

Sub Act.	Line Item	Account	TSA	PF	BB	National FY 2021 TSA Pool	Chickaloon inc in All AK	Knik in All AK	All Alaska	ATHC Eligible Shares Total ATHC TS	ATHC Eligible Shares NSHC Eligible shares	Co - Signer 0% Retained	Co - Signer 0 Due	
						Column 1				*Column 2*	*Column 3*	*Column 4*	*Column 5*	
Hospitals and Clinics														
	101	Emergency Fund		x		$3,956,016			$462,063	462,063	End of year funds to be dist. on AK TSA formula.			
	104	Inter-Agency Agreements				$0			$138,380	138,380	$11,380	$0	$11,380	
	105	Management Initiatives		x		$2,049,512			$239,383	239,383	End of year funds to be dist. on AK. TSA formula.			
	106	A.C.O.G. Contract	x			$98,592			11,209	11,209	$922	$922	$0	
	107	H.P./D.P. Initiatives	x			$3,484,867			200,844	200,844	$16,517	$0	$16,517	
	110	N.E.C.I.	x			$1,107,951			124,173	124,173	$10,211	$0	$10,211	
	111	Nurse Initiatives	x			$1,287,656			140,892	140,892	$11,586	$0	$11,586	
	112	Nursing Co-steps	x			$648,528			72,677	72,677	$5,977	$0	$5,977	
	113	Chief Clinical Consultant	x			$277,340			31,086	31,086	$2,556	$0	$2,556	
	115	Emer. Medical Svcs	x			$465,222			41,980	41,980	$3,452	$0	$3,452	
	117	Traditional Advocacy Prog.	x			$100,578			11,272	11,272	$927	$0	$927	
	118	Research Projects	x			$1,283,252			143,088	143,088	$11,767	$0	$11,767	
	119	A.A.I.P. Contract	x			$26,731			2,994	2,994	$246	$0	$246	
	120	Clinical Support Center-Phoenix	x			$1,744,883			204,917	204,917	$16,852	$2,549	$14,302	
	121	Co-steps Non-physicians	x			$81,839			9,159	9,159	$753	$0	$753	
	123	Physician Residency	x			$277,416			31,093	31,093	$2,557	$0	$2,557	
	124	Recruitment/Retention	x			$2,057,393			230,592	230,592	$18,963	$0	$18,963	
	125	U.S.U.H.S., etc.	x			$3,071,317			344,246	344,246	$28,309	$0	$28,309	
	126	DIR Support Fund	x			$24,915,898			2,762,946	2,762,946	$227,213	$63,165	$164,048	
	127	Evaluation	x			$1,063,992			119,272	119,272	$9,808	$0	$9,808	
	128	National Indian Health Board	x			$459,114			51,111	51,111	$4,203	$0	$4,203	
	129	Albq./HQ Administration	x			$892,404			112,813	112,813	$9,277	$0	$9,277	
	130	Nutrition Training Center	x			$345,053			41,806	41,806	$3,438	$0	$3,438	
	131	Diabetes Program- Albq./HQ	x			$1,295,589			151,342	151,342	$12,446	$0	$12,446	
	132	Cancer Prevention- Albq./HQ	x			$716,968			84,278	84,278	$6,931	$0	$6,931	
	133	Health Records	x			$136,277			12,043	12,043	$990	$0	$990	
	134	AIDS Program	x			$422,971			78,823	78,823	$6,482	$0	$6,482	
	135	Handicapped Children	x			$346,083			40,775	40,775	$3,353	$0	$3,353	
	137	National OIT Sup.- Albq./HQ	x			$8,292,508			925,939	925,939	$76,145	$21,168	$54,977	
	154	Prescription Drug Monitoring	x			$1,002,361			$115,171	115,171	$9,471	$0	$9,471	
Dental Health														
	201	IHS Dental Program	x			$2,505,120			$300,609	300,609	$24,721	$0	$24,721	
	202	IHS Dental Program- Program formula		x		$5,269,192					$0	$0	$0	
Mental Health														
	301	MH/SS Tech. Asst.	x			$1,542,507			$174,272	174,272	$14,331	$0	$14,331	
	302	C.M.I. Grants	x			$628,310			$70,130	70,130	$5,767	$0	$5,767	
	303	National Conference	x			$107,552			$11,990	11,990	$986	$0	$986	
Alcohol/Sub. Abuse														
	401	Clinical Advocacy	x			$3,148,617			$516,623	516,623	$42,485	$0	$42,485	
	402	Collaborative Initiatives	x			$848,033			$48,451	48,451	$3,984	$0	$3,984	

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Appendix A - Financial Summary for Annual Funding Agreement - Headquarters Tribal Shares
Norton Sound Health Corporation

Sub Act.	Line Item	Account	TSA	PF	BB	National FY 2021 TSA Pool	Chickaloon inc in All AK	Knik in All AK	All Alaska	ATHC Eligible Shares Total ATHC TS	ATHC Eligible Shares NSHC Eligible shares	Co - Signer 0% Retained	Co - Signer 0 Due
						Column 1				*Column 2*	*Column 3*	*Column 4*	*Column 5*
Contract Health Care													
	501	Fiscal Immediary		x						$0	$0	$0	$0
	504	C.H.S. Reserve & Undistrib.	x			$3,377,832			$361,250	361,250	$29,708	$0	$29,708
Public Health Nursing													
	601	Preventive Health Initiatives	x			$951,210			$103,180	103,180	$8,485	$0	$8,485
	602	Preventive H. Init. - Prog. Formula		x							$0	$0	$0
Health Education													
	701	IHS Health Education Program	x			$1,133,793			$127,796	127,796	$10,509	$0	$10,509
CHR													
	801	IHS CHR Program	x			$2,412,266			$267,854	267,854	$22,027	$0	$22,027
Direct Operations													
	1301	Direct Operations	x			$13,847,784			$1,557,559	1,557,559	$128,087	$0	$128,087
	1301a	Direct Operations- OIT	x			$2,716,551			$305,550	305,550	$25,127	$5,302	$19,825
	1302	Direct Ops Dental	x			$0			$0	-	$0	$0	$0
Facilities and Environmental Health Services													
	2401	Sanitation Fac. Construction Sup.		x		$6,761,916				$325,101	$0	$0	$0
	2402	Environmental Health Ser. Support		x		$5,114,837				$197,905	$25,264	$25,264	$0
	2403	Facilities & Property Support		x		$24,019,205				$221,409	$17,947	$17,947	$0
	2404	Facilities Engineering Support		x						$0	$0	$0	$0
	2405	Engineering Services Support		x						$51,699	$5,201	$5,201	$0
TOTAL TSA AMOUNT						$89,122,358	$0	$0	$10,080,185	10,080,185	$828,953	$93,107	$735,846
TOTAL PROGRAM FORMULA AMOUNT						$47,170,678				$1,497,560	48,412	$48,412	$0
TOTAL HEADQUARTERS TRIBAL SHARE						$136,293,036				$11,577,745	$877,365	$141,519	$735,846

Column 1 - All numbers are based on HQ PFSAs for FY20 Table #4 dated 1/13/20 & FY21 Table 4F dated 7/16/20 (facilities)
Column 2 - All numbers are based on HQ PFSAs for FY20 Table #4 dated 1/13/20 & FY21 Table 4F dated 7/16/20 (facilities)

Column 3 - Individual Co-Signer share of column 2.
Column 4 - Co-Signer amounts left with (retained by) IHS to provide service- If service is not available IHS shall pay to each Co-Signer amount provided.
Column 5 - This column (col. 3 - col. 4) is the HQ. TS funds due to Co-Signer, calculated by Alaska TSA formula.
All Headquarters Tribal Shares shall be recurring except for Facilities (lines 2401 -2405) and funds in lines 101 and 105.
Line 101 - Any funds remaining will be distributed non recurring on 9/30 (from HQ by TSA formula) and to each Co-Signer on ATHC distribution method.
Line 105 - Any funds remaining will be distributed non recurring on 9/30 (from HQ by TSA formula) and to each Co-Signer on ATHC distribution method.
Line 106 - All Alaska Co-Signers restricted all funds to continued advanced OB training opportunities for all Alaska Area physicians.
Line 120 -Alaska Co-Signers restricted a total of $31,000 dollars for the clinical support center for CME certification and "IHS Provider" magazine.
Line 124 - BBAHC, EAT, Chugachmiut, Eyak, and Maniilaq retrocede 50% of line 124 to IHS in exchange for use of recruitment website ihs.gov/jobs.
Line 126, 137 -DIR withheld were computed at 27.8% of each Co-Signer on ATHC proposal. See Section 1 of the Funding Agreement.
Line 0154 New line for Prescription Drug monitoring. Full share included in co-signers TS.
Line 201 - Dental Program - approximately $800,000 transferred to line 1302 in Direct Ops Dental. No impact on TS.
Line 1301a - DIR Withheld was computed at 21.1% of each Co-Signer share based on continuing agreements with Dir. DIR.
Linr 1302 - Direct Ops Dental is now in line 201
Lines 2401-2405 - Funds available for OEHE support functions (from table 4f) provided based on national formula at tribal option.

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Name of Tribe/Tribal Org. **Norton Sound Health Corporation** **58G950016**

Contract/Compact Period **October 1, 2020 through September 30, 2021**

	Budget Activity	Initial Negotiated Annual Funding Agreement					
		Program/Service Unit Base		Area Tribal Share	Headquarter Tribal Share	Contract (Reductions)	Net Annual Payment Obligation
		Recurring	Non-Recurring	0.081229506		IPA/MOA	
		(1)	(2)	(3)	(4)	(5)	1+2+3+4+5=(6)
1	Hospitals & Clinics	$23,213,352		$275,437	$424,929	($224,613)	$23,689,105
2	Dental	$2,533,887		$17,016	$24,721	$0	$2,575,624
3	Mental Health	$765,746		$104,878	$21,085		$891,708
4	Alcohol & Substance Abuse	$1,174,320		$69,541	$46,469		$1,290,330
5	Public Health Nursing	$1,063,687		$9,956	$8,485		$1,082,128
6	Health Education	$117,928		$20,402	$10,509		$148,840
7	Community Health Representativ	$329,970		$7,517	$22,027		$359,515
8	Immunization (AK only)	$10,316		$28,276	$0	$0	$38,592
9	Direct Operations	$40,186		$347,386	$147,913		$535,484
10							
11							
12	Self-Governance				$0		$0
13	Other, Services (Annual)						
14	TOTAL, Services (Annual)	$29,249,392	$0	$880,409	$706,138	($224,613)	$30,611,327
15	Purchased/Referred Care	$13,412,656		$118,066	$29,708		$13,560,429
16	Operational Cost for Tribal Clinics					0	$0
17	Environmental Health Support	$661,707		$47,910			$709,617
18	Facilities Support	$1,828,331		$3,028			$1,831,359
19	OEHE Support				$0		$0
20	Maintenance & Improvement		$1,462,821		$0		$1,462,821
21	Sanitation Facilities - Housing				$0		$0
22	Sanitation Facilities - Regular				$0		$0
23	Equipment		$180,666				$180,666
24	TOTAL, Facilities	$2,490,038	$1,643,487	$50,937	$0	$0	$4,184,463
25	Current year CSC Direct	$4,630,788					$4,630,788
26	Current year CSC Indirect		$12,264,014				$12,264,014
27							
28	Other (*See* Remarks)						$0
29	TOTAL, CSC	$4,630,788	$12,264,014	$0	$0	$0	$16,894,802
30	Quarters						$0
31	Contract Health Services (Prior Year)						$0
32	Indian Health Facilities (Prior Year)						$0
33	Others						
34	TOTAL, Other	$0	$0	$0	$0	$0	$0
35					$0		$0
36	**GRAND TOTAL, AFA**	**$49,782,874**	**$13,907,501**	**$1,049,412**	**$735,846**	**($224,613)**	**$65,251,021**

Footnotes:

The FA program funding amount in column 1 and 2 are as of FA 12 dated 7/31/2020

The FA funding also includes all funds from Diomede ISDA TI agreement transferred in FY15.

Line 20 and 23 - Routine M&I and Equipment funding is estimated at 90% of prior FY amount for lump sum payment -subject to adjustn with Sec. 4 of the FA.

d Health Corporation

Norton Sound Health Corporation
Withhold Calculation

The Co-Signer will "withhold" 100% of all estimated costs for IPA/MOA, SSC, VBC, **No**

surcharge **0.285%** **(Yes or No)**

The Co-Signer will "withhold" the minimum initial amount for IPA, etc., and "buyback" services. **Yes**

0.285% **(Yes or No)**

Service	Annual Amount (1)	(2)	(3)	Total Annual Estimated Costs	Est. Monthly Payment	Initial Auth. Withhold
	(1)	(2)	(3)	1+2+3=(4)	(4)/12=(5)	*see* Footnotes
H & C						
IPA/MOA Personnel Costs	$566,729	18,731	$1,615	$587,076	$48,923	$195,692
VBC	$0		$0	$0	$0	$0
Other	$86,516		$247	$86,763	$7,230	$28,921
SUBTOTAL H & C	$653,245	$18,731	$1,862	$673,838	$56,153	$224,613
DENTAL						
IPA/MOA personnel costs			$0	$0	$0	$0
Supply Service Center		$0	$0	$0	$0	$0
All other costs-			$0	$0	$0	$0
SUBTOTAL DENTAL	$0	$0	$0	$0	$0	$0
IMMUNIZATION						
IPA/MOA personnel costs			$0	$0	$0	$0
Supply Service Center		$0	$0	$0	$0	$0
Village Clinic Leases			$0	$0	$0	$0
All other costs-			$0	$0	$0	$0
SUBTOTAL IMMUNIZATION	$0	$0	$0	$0	$0	$0
T-CLINIC						
VBC Increases			$0	$0	$0	$0
		$0	$0	$0	$0	$0
			$0	$0	$0	$0
SUBTOTAL T-CLINIC	$0	$0	$0	$0	$0	$0
Withhold Total	$653,245	$18,731	$1,862	$673,838	$56,153	$224,613

Footnotes:

Column 2 - IPA/MOA Centrally Paid Expenses are estimated at $588 for each IPA and $6,243.81 for each MOA.

Column 2 - IPA/MOA Centrally Paid Expenses are estimated at $588 for each IPA and $5,293.74 for each MOA.
Employee Dispute Pool Costs are no longer charged in advance (*see* Section 2.3.2.3 of Buyback Agreement).

Column 3 - Surcharge for all Co-Signers using buyback is .285%

This sheet not to be included in Appendix A - Provided to assist in completing Section 4 of the FA then disca

Norton Sound Health Corporation	
Recurring base	$49,782,874
Non Recurring base	$13,907,501
Subtotal recurring and non recurrir	$63,690,375
Area tribal Share	$1,049,412
HDQ TSA Tribal Share	$735,846
HDQ program formula tribal share	**$0**
Subtotal tribal shares	$1,785,258
TOTAL Funding Agreement	$65,475,634

non recurring includes M & I $1,462,821

FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

Amendment Effective December 30, 2018

In accordance with Section 14.1 of the Norton Sound Health Corporation (NSHC) FYs 2018-2020 Multi-Year Funding Agreement (MFA), as amended, the NSHC and IHS agree to the following revision:

> Appendix B (as previously amended) is hereby further amended and restated by the version of Appendix B attached.

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

Angie Gorn 12/9/20

By: _____ _____
Angie Gorn, President/CEO Date

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S Digitally signed by Evangelyn L. Dotomain -S Date: 2021.01.05 14:53:56 -09'00' _____
Director, Indian Health Service Date

Norton Sound Health Corporation Funding Agreement - Appendix B
Fiscal Years 2018-2020

This non-exhaustive list of Tribal Facilities and Locations identifies the sites where Norton Sound Health Corporation owns, leases, occupies, or otherwise used real property to carry out its responsibilities under the Alaska Tribal Health Compact and its Funding Agreement. Each description of facilities and locations is intended to include surrounding and adjacent grounds.

Additionally, the cross references to specific PSFAs are not intended to limit the scope of PSFAS that may be performed at a facility or for which a facility may be used; rather, cross references are intended as an example of the type of PSFA that may be performed at the facility or of the manner in which a facility may be utilized. Cross references are not exhaustive and may not be construed to be exclusory of other PSFAs that may be performed at a facility or of the uses of the facility.

LOCATION	FACILITY NAME	TRIBAL PROGRAMS (including but not limited to)
Nome	Norton Sound Regional Hospital-Main Campus (Replacement Facility)	Section 3.1; Sections 3.2.1-3.2.7; Sections 3.2.9-3.2.13; Section 3.2.15; Section 3.2.16; Section 3.3.6; Sections 3.4.1-3.4.4; Sections 3.4.6-3.4.8; Sections 3.4.11-3.4.14; Section 3.5; Section 3.6; Section 3.7; Section 3.8.
Nome	Quyanna Care Center	Section 3.2.8
Nome	Hostel	Section 3.2.14
Nome	BIA EMT Training Center/Drug and Alcohol Rehabilitation Center	Section 3.2.13; Sections 3.3.1-3.3.3, 3.3.5-3.3.7; Section 3.4.6, 3.4.12
Nome	Kusgi House	Section 3.3.5, 3.3.6
Nome 607 Division Street	NSHC Behavioral Health Clinic	Section 3.3.1-3.3.3, 3.3.5-3.3.7; Section 3.4.10; Section 3.8
Nome	Health Aide Training	Section 3.4.5
Brevig Mission	Brevig Mission Clinic	Section 3.2.5, 3.2.10, 3.2.11; Section 3.3.1-3.3.3; Section 3.4.1-3.4.4, 3.4.12; Section 3.7; Section 3.8
Diomede	Diomede Clinic	Section 3.2.5, 3.2.10, 3.2.11; Section 3.3.1-3.3.3; Section 3.4.1-3.4.4, 3.4.12; Section 3.7; Section 3.8

All Villages	Village-Based Counselor Office Space	Section 3.3
All Villages	Village Based Morgues	Section 3.4.17

AMENDMENT TO
FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

In accordance with Section 14.1 of the FY's 2018-2020 Funding Agreement made and entered into by Norton Sound Health Corporation and the Secretary of the Department of Health and Human Services of the United States of America, effective October 1, 2017, the funding agreement, as amended, is hereby further amended as follows:

1. **Appendices.** The following appendices are incorporated by reference and attached:

   - Appendix C – FY 2020 Continuing Services Agreement

2. **Effective Date**. This amendment is effective October 1, 2019.

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

By: Angie Gorn _____ 3/29/21
Angie Gorn, President/CEO Date

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S Digitally signed by Evangelyn L. Dotomain -S Date: 2021.04.27 16:07:52 -08'00' _____
Director, Indian Health Service Date

MEMORANDUM OF AGREEMENT DESCRIBING THE CONTINUING SERVICES OF THE INDIAN HEALTH SERVICE, ALASKA AREA NATIVE HEALTH SERVICE TO NORTON SOUND HEALTH CORPORATION FOR FY 2020

I. INTRODUCTION

This agreement provides for the continuation by the Indian Health Service (IHS) of certain services from the Alaska Area Office for the benefit of Norton Sound Health Corporation under its Funding Agreement (FA) under the Alaska Tribal Health Compact (ATHC) Self-Governance Compact.

This agreement is limited to the programs, services, functions, and activities (PSFAs) performed by the residual and transitional federal staff of the Alaska Area Office.

This agreement should be interpreted in conjunction with Norton Sound Health Corporation's FA and Appendix A to that FA, which may provide for additional detail on "restrictions" of funds at the Area or Headquarters level to ensure that specific services are continued to the individual Co-Signer.

In FY 2020, funding for these continuing services and activities will be from the funds, which have been designated as residual and from funds, which have been designated in support of temporary transitional federal PSFAs. In addition funding to purchase specific services, i.e., use of IPA/MOA assignees and Village Built Clinic leases, may be provided through reimbursement by Norton Sound Health Corporation to the IHS.

II. DEFINITIONS

The following definitions are in common usage in the Alaska Area:

A. ATHC Tribal Restricted Share - Used in Alaska to refer to those retained Tribal shares all compacting Tribes jointly initially agreed to leave in the Area Office in support of Alaska Area state wide PSFAs. Pursuant to Section 325 of PL 105-83, these shares now are in the Alaska Native Tribal Health Consortium (ANTHC) FA or are used for transitional federal PSFAs.

B. Buyback - The process by which Co-Signers use cash to purchase Area services from the Area Office. Requires accurate description and pricing of service, and mechanism for Area to invoice and receive payment.

C. Co-Signer Restricted Shares - Used in Alaska to refer to "retained Tribal shares" that have been left at the Area Office or Headquarters on an individual basis by a Co-Signer to allow the Area, Headquarters or ANTHC to provide specific services to the Co-Signer. Pursuant to Section 325 of PL 105-83, these Area shares now are in the ANTHC FA or are used for transitional federal PSFAs.

D. Residual - The resources necessary to support the PSFAs required for the United

A. OFFICE OF THE DIRECTOR

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Director	Provides overall executive direction and support on behalf of the Secretary.	R	1
Deputy Director, Chief Medical Officer	Provides public health advocacy; clinical consultation (CMO); legally required certification of health aide credentials and oversight of CHAP certification process; consultation in CHAP/Rural Health program management.	R	1
Executive Officer	Serves as principal advisor to the Director on overall management policies and procedures.	R	1
Attorney	Provides Region X attorney support and consultation.	R	1
EEO	Provides EEO support. 1		
Support Staff	Secretarial, clerical and administrative support to inherent and transitional federal functions at all levels of the Area Office.	R T	3 1
Planning, Evaluation & Statistics	Prepare statistical reports and publications in support of planning, evaluation and resource allocation requirements.	R	2
	Total		10

The Office will provide the specific PSFAs defined below:

1. Executive direction on behalf of the Secretary to the remaining inherently federal functions.
2. Advocacy at national level on behalf of the Tribes of Alaska including: legislative, policy, resource allocation, and appropriation advocacy.
3. Policy formulation and interpretation; supervision of non-IPA/MOA federal employees; negotiate, execute and administer compacts and FAs; resource allocation.
4. Public health coordination with Tribal, state and federal governments.
5. Provide legal advice and consultation on behalf of the Secretary.
6. Provides representation on the Executive Committee and Planning Committee of the Alaska Federal Health Care Partnership (AFHCP). Through the government-to-government relationship with Tribes and Tribal organizations, provides the mechanism for Tribal membership on the AFHCP.
7. Eligibility determinations assistance.
8. Equal Employment Opportunity program management in support of federal employment rights.
9. Oversight of certification of Community Health Aides as outlined by law and the *IHS Community Health Aide Program Certification Board Standards and Procedures.*
10. Consultation and technical assistance to Tribes and Tribal organizations staff and programs including
    a. Program review or evaluation at the request of the Area Director or the invitation of Tribal programs;
    b. Submission of electronic health record data to IHS National Data Warehouse; and
    c. Maintain current Area statistics to provide statistical analysis in support of resource needs and allocations.

1 The EEO function is provided under an intra-agency agreement among the IHS Alaska, California and Portland Area Offices.

B. OFFICE OF ACQUISITION AND PROPERTY MANAGEMENT [2]

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Federal Contracting ,, Personal Property, and FOIA Coordinatio n	Responsible for federal acquisitions to support the Alaska Area Office, including the federal credit card program. Maintains the federal personal property inventory. Provides or coordinates various administrative services for the Alaska Area Office.	R	1
	Total		1

The Office will provide the specific PSFAs defined below:

1. Negotiate, award and administer federal acquisitions.
2. Maintain or develop Alaska Area Interagency and Cooperative Agreements in close partnership with appropriate IHS or other federal, state or Tribal entity(s).
3. Coordinate various administration functions including Freedom of Information Act requests and IHS delegations and directives.
4. Maintain the federal personal property management inventory, including excess and disposal.
5. Provide technical assistance to Tribally managed facilities on procurement issues as requested regarding procurement issues and acquired federal excess property.
6. Maintain the federal credit card program.

2 Residual (1) FTE moved to Office of Tribal Programs in support of Title 1 contracts and audit resolution.

a. Overall direction of resources and related environmental surveillance for statewide public health impacts.

b. Continue to carry out functions related to serving as one of the health and medical representatives to the Alaska Federal Emergency Response Group.

c. Provide management and verification of tribal input data in the IHS Environmental Health Services data system known as the Web-based Environmental Health Reporting System (WebEHRS).

d. Provide safety assurance, compliance and reporting relating to federal workers, and professional programmatic support for staff.

e. In the event of a national disaster situation as defined in the Federal Response Plan, IHS is the lead agency for emergency response related to water and sewer damage assessment and mitigation.

3. Health Facilities: PSFAs include:

a. Perform budget allocation;

b. Support and approve project or resource allocations derived through a priority system developed through the Maintenance & Improvement Resource Allocation Committee (MIRAC) and ANTHC process consistent with IHS national project eligibility criteria. Verify data submittals and manage IHS facilities databases in conformance with IHS national project and health facilities space eligibility criteria.

c. Respond to Congressional inquiries;

d. Review Project Justification Document/Program Of Requirements (PJD/POR) documents prepared by others;

e. Review and approve national priority systems applications, including Tribal Equipment Funds and Dental Facilities Funds;

f. Maintenance of Alaska portion of the IHS Healthcare Facilities Data System (HFDS) including the Facilities Maintenance and Improvement/Equipment database for federally and Tribally owned health facilities;

g. Support for new health facility construction project funds distribution and project development;

h. Stewardship responsibility for oversight of environmental cleanup of federally owned real property;

i. Approve workload statistics;

j. Advocate statewide and nationally for the DEHE program and facilitates its implementation.

4. **Realty:** PSFAs include:

a. Monitor and manage real property assets in accordance with Executive Order 13327, "Federal Real Property Asset Management" and existing authority under law or by executive order for real property, capital improvements, square footage, use or disposal.

b. Maintain the IHS Real Property Inventory by updating the asset book values with costs relating to acquisition of real property, capital improvements, square footage, use or disposal.

c. Verify construction project closeout documentation for capital improvements made to federal facilities prior to adjusting the real property subsidiary ledger.

d. Perform annual review of real property.

e. Warranted Lease Contracting Officer authorized to lease Village Built Clinics

Co-Signers and contractors to maintain accurate records of funding allocations, reconciliations and cash management issues.

8. Reconciliation, billing and amendment management related to contractor and compactor use of federal resources including but not limited to IPA/MOA employees and the Village Built Clinic lease program. Reconciliation includes transaction verification of buyback services with corrections and reports.

9. Support withhold and buyback management including payment for continuing government contracts for goods and services, permanent change of station moves, etc.

10. Monthly general ledger reconciliation including cash management related to Prompt Pay Act, Treasury, cash and others.

11. Process reimbursement requests including Beneficiary Medical Program (BMP), Interagency Payment and Collections (IPAC), quarters collections, CHEF and others. Make deposits and transfers of such reimbursements to Co-Signers no less often than monthly.

12. Assist Tribes during annual Budget Formulation for the second succeeding year's annual budget, including preparation for the National Budget Formulation meeting.

E. OFFICE OF HUMAN RESOURCES

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Civil Service Staffing, Classification & Employee/ Labor Relations	Advertise and recruit for federal, direct and IPA/MOA replacements; process personnel and pay actions; provide job information; maintain official records; rate applicants, appoint new employees, and provide HR consultation; Title 38 and Physician's Comparability Allowance, Market Pay & Locality Pay maintenance; process Reduction in Force and counseling; provides transportation services and relocation assistance for federal employees and consultation re: Tribal direct hires as requested; administers Workers' Compensation program; grievances, discipline/adverse actions; Merit Systems Protection Board, appeals and agency representation; performance management; retirements; payroll; benefits; outside activities; ethics program; suitability adjudication; manage Federal Employee Assistance program and Family Medical Leave and Family Friendly Acts consultation; conducts desk audits; applies Classification Standards and consultation. Initiate and assure completion of suitability investigations as needed on federal employees and personal services contractors.	R T	2 0
	Total		2

Under the direction of the IHS Western Region Human Resources Director, the Office of Human Resources will provide the specific PSFAs defined below for the current approximately 340 federal employees employed either directly or through Civil Service IPAs (58) or Commissioned Corps MOAs (254):

1. Advertise and recruit for direct federal employees. Replacement IPA positions may be filled with a current IPA already on board (such as by reassignment) or a new or replacement MOA. Process Reductions In Force (RIF). Provide counseling on RIF.

2. Maintain official personnel files (electronic and paper) and records for Civil Service employees.

F. COMMISSIONED CORPS PERSONNEL[4]

P/S/F/A	MAJOR FUNCTIONS	Buyback	Staffing (FTE)
Commissioned Corps Personnel	Orient and assist officers and their families to include: recruitment support, liaison between areas, TRICARE advice, wage verifications, grievances, leave programs, COERs and COSTEP. As necessary, Corps-specific personnel discipline advice to CEOs and HR staff of 638 awardees with MOA assignees and supervisors of MOAs.	B	2
	Total		2

Under the direction of the IHS Division of Commissioned Personnel Support, the Commissioned Corps Personnel component will provide the specific PSFAs defined below for the approximately 259 USPHS Commissioned Officers in the Alaska Area:

1. Provide general orientation to new Commissioned Officers.
2. Counsel Commissioned Officers; provide Corps-specific discipline advice to appropriate Co-Signer managers.
3. Maintain unofficial files and records for Commissioned Officers.
4. Process required federal personnel actions for Commissioned Officers including orders for deployment.
5. Assist and consult with officers and their supervisors.

G. OFFICE OF TRIBAL PROGRAMS

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Director	Management of Area Title V responsibilities for Self-Governance and Title I review, approval and technical assistance. Managing CHEF submissions, and fund distribution; clerical and secretarial support.	T	1
Health Care (Management) Consultation	Title V compacts/FAs (including amendments and database management of same), cooperative agreements, and grants; negotiate and administer CSC funds.	T	3
Health Care [5] (Management) Consultation	Negotiate, manage, and execute Title I contracts. Review audit findings and work with Tribal contractors to resolve as needed.	R	1
	Total		5

The Office will provide the specific PSFAs defined below:

1. Provide or facilitate technical assistance to Tribes which may or may not lead to the preparation of proposal(s) to assume PSFAs for Title I contracting, Title V compacting and Tribal Management grants for Tribes and Tribal organizations
2. Evaluate P.L. 93-638 proposal(s) to determine acceptance, declination or rejection; if

4 During FY 2005 this PSFA was centralized under the Division of Commissioned Personnel Support at IHS Headquarters. Effective FY 2006, it is funded by assessing the locations that use Commissioned Officers. See, also, Appendix A.

5 Formally P/S/F/A: Federal Contracting Title I awards, (1) Residual FTE moved from the Office of Acquisition and Property Management; to support Title I contracts and audit resolution.

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S Digitally signed by Evangelyn L. Dotomain -S Date: 2021.04.27 16:06:22 -08'00'

Director
Alaska Area Native Health Service, IHS

Date: _____

Norton Sound Health Corporation
on Behalf of Itself and Certain Alaska Tribes,
Identified in Exhibit A to the Compact.

By: Angie Gorn

Angie Gorn, President/CEO
Norton Sound Health Corporation

Date: 10/30/2020

Appendix D
Buyback/Withhold Agreement
between
the Indian Health Service
and
Norton Sound Health Corporation

Section 1. Generally. Pursuant to Section 5.3 of the Funding Agreement between Certain Alaska Native Tribes Served by Norton Sound Health Corporation (hereinafter "NSHC") and the Secretary of the Department of Health and Human Services of the United States of America (hereinafter "Secretary"), NSHC has determined that it wishes to carry out its responsibility to provide certain programs, activities, functions or services (e.g. salaries of IPA/MOA employees, and Village Built Clinics Program) included in its Funding Agreement utilizing services, personnel or other resources of the Federal Government, (hereinafter "services") under Article V, section 22 of the Compact, as permitted by law. These services may include some that are expected to be used throughout the year and some incidental services to be identified by NSHC on an as needed basis, and provided by the Indian Health Service (hereinafter "IHS") when IHS has the capacity to do so. The cost of providing the purchased services to NSHC shall be determined under section 2 below. NSHC's purchase of services is contingent upon the availability of IHS resources to provide those services. In addition, services must be paid for in advance, in order to avoid violation of the Anti-Deficiency Act and are subject to full cost recovery in accord with 25 USC 458aaa-7(f) and 31 USC 9701.

Section 2. Determination of Cost.

2.1 Generally. NSHC may acquire services from the IHS by either providing for full year withhold (with appropriate reconciliation) under terms agreed upon in this funding agreement, in which case the administrative surcharge provided for under section 2.2.4 shall not apply. In the alternative, NSHC may acquire services by authorizing partial year withhold amounts, as provided for in section 2.2, in which case the payment schedule and administrative surcharge provided for in section 2.2.4 shall apply. Whether full or partial year withhold is authorized, the full costs of IPA/MOAs including those detailed in section 2.3, Determination of IPA/MOA Costs, shall be paid by NSHC.

2.2 Conditions for Partial Year Withhold and Buyback.

2.2.1 IPA/MOA.

2.2.1.1 Advance withhold. The funds for IPA/MOA salary and other costs detailed in section 2.3, "Determination of IPA/MOA Costs," will be paid as a lump sum in accord with Section 5(a) of the Funding Agreement, except that an amount equal to three monthly payments based on the initial mutually agreed upon estimate of the annual IPA/MOA salary costs and related surcharges, as provided in section 2.2.4, will be withheld and retained by the Indian Health Service pending final disbursement for the last three months of the fiscal year as provided in section 3.2.2.2.

services to NSHC.

2.3 Determination of IPA/MOA Costs.

2.3.1 List of Costs. It is agreed by the parties that the entire cost of IPA/MOA assignments, including costs associated with the initiation, maintenance, and termination of the assignments are the responsibility of NSHC. The IHS must be reimbursed for all such costs which include but are not limited to the following:

2.3.1.1 Permanent change of station costs including the cost of moving replacement IPAs from the lower forty-eight to Alaska and the cost of moving IPA employees who separate back to the lower forty-eight.

2.3.1.2 Recruitment, relocation and retention bonuses if such funds are necessary to attract or retain employees.

2.3.1.3 Severance pay for employees who are released by NSHC and separated without cause.

2.3.1.4 Payment of turnaround leave travel expenses. All individuals who are eligible for these expenses shall be identified in the IPA negotiated between the parties. The IHS will retain liability for existing IPAs. NSHC assumes the liability for new IPAs and upon renewal of an existing IPA.

2.3.1.5 Lump sum leave payments for employees who leave federal service. All leave accrued prior to the employee becoming employed by NSHC shall be identified in the IPA/MOA negotiated between the parties. The liability for accrued leave on existing, renewing, and new IPA/MOAs shall be the responsibility of NSHC.

2.3.1.6 Costs associated with settling or resolving employment related disputes, subject to the terms specified in section 2.3.2 below.

2.3.1.7 Centrally paid expenses, subject to the terms specified in section 2.3.3 below.

2.3.1.8 The cost of paying unemployment benefits assessed to the Area in FY 2002 and thereafter on behalf of an employee who was employed by NSHC under an IPA immediately prior to voluntary or involuntary separation from IHS regardless of the year in which unemployment benefits were paid. The NSHC is not responsible for unemployment costs that were assessed to the Area in Fiscal Years 2000 and 2001.

2.3.2 Costs Related to Employment Related Disputes.

2.3.2.1 Responsibilities of the IHS. The Indian Health Service shall be responsible for the payment of all costs of the IHS Office of Human Resources and any other section of the Indian Health Service, the Office of General Counsel, and the Department of

2.3.3 Costs Related to IPA/MOA Centrally Paid Expenses. Certain costs associated with IPA and MOA employees are paid centrally by Headquarters from Area funds. These include costs detailed in columns 6, 7, and 8 of the spreadsheet entitled "Allocation of Centrally Paid Expenses (Excluding FTS)," Corrected May 11, 1998, that was prepared by David Mather. These are costs associated with Commissioned Corps, Personnel and Payroll, and Balance of Human Resources. The Alaska Area Native Health Service may pay for or recover assessments from Headquarters to cover these identified costs by including in the monthly charge for each IPA or MOA the monthly cost to the IHS of such Centrally Paid Expenses. The cost charged NSHC for each IPA/MOA may not exceed the average cost per federal employee actually paid by IHS. For purposes of calculating the initial withhold amount and estimated monthly payments, the estimated average cost per month for each IPA or MOA is shown in Appendix A of the Funding Agreement.

2.4 Limitation on Obligations and Notice.

2.4.1 Obligations. IHS shall within 30 days provide notice to NSHC of the best available estimate of the costs that may be incurred under this Agreement of leases, contracts, salaries and related expenses and permanent change of station.

2.4.2 Content of Notices of Best Available Estimates and Costs. Notice of best available estimates under section 2.4.1 and full accounting of all costs due under section 3.3.1 shall include the amount, vendor and reason for obligation or expenditure, including the name of the employee, if any.

Section 3. Method of Payment.

3.1 Full Year Withhold. Payment for services being purchased from the IHS may be made by NSHC authorizing a withhold of the full year's initial mutually agreed upon estimate of the annual cost of each category of services NSHC proposes to purchase from the IHS. In such case, no monthly payments are due from NSHC. Upon periodic reconciliation, provided for under section 3.3.1, excess withheld funds will be paid by the IHS to NSHC and adjustments in the amount of withhold or payments needed to pay for all services NSHC has purchased, or proposes to purchase, will be made to the IHS by NSHC. *See* "Summary of Withhold/Buyback" page of Appendix A for calculation of the amount NSHC hereby authorizes for full year withhold, if any.

3.2 Purchases through Buyback under section 2.2.

3.2.1 Calculations.

3.2.1.1 Of Initial Estimated Monthly Payment. The initial estimated monthly payment is determined by estimating the annual cost of services to be purchased from IHS, including the surcharge on all services under section 2.2.4, and dividing by 12. *See* "Summary of Withhold/Buyback" page of Appendix A for calculation of the amount of the initial estimated monthly payment.

reconciliation is due any under recovery must be paid by NSHC.

3.3.2 For Administrative Surcharge.

3.3.2.1 Use and Rebate. The administrative surcharge shall be used exclusively for administration of the buyback provisions under this Buyback/Withholding Agreement. All income from the administrative surcharge will be accounted for separately and compared on an annual basis to the cost of administering buyback at the Area Office. This accounting and reconciliation shall be complete within 60 days of the end of the last day of the fiscal year. Any surplus in administrative surcharges shall be returned to the Co-Signers who participated in the buyback option on a pro rata basis depending on the amount of administrative surcharge paid.

3.3.3 Adjustment in Estimated Monthly Payment. In addition to adjustments in estimated payments that may occur under sections 3.3.1 and 3.3.2.1, the parties may at any time mutually agree, based on a change in circumstances, to change the estimated monthly payment due from NSHC.

3.4 Use of Other Funds Due NSHC to Avoid Default or Satisfy Obligations to IHS and other Remedies.

3.4.1 Avoiding Default. Default may be avoided to the extent funds are held by the IHS from other funds due to NSHC, which may be withheld to satisfy the amount of the payment, which would otherwise be in default or to satisfy amounts due IHS after reconciliation of costs and payments when an amount is due to IHS.

3.4.2 Recoupment. Any amount due to the IHS by reason of NSHC's failure to pay in full all amounts owing under the buyback provisions of the Funding Agreement for the immediately preceding fiscal year shall be recouped by the IHS from any funds due to NSHC under this funding agreement.

3.4.3 Full Year Withhold as Penalty for Default. Notwithstanding any other provision of this Buyback/Withholding Agreement, the IHS may require "full year withhold" as permitted herein as a condition of permitting a Co-Signer who was in arrears at the end of the immediately preceding fiscal year to buyback services from the IHS under the terms of this Agreement.

Section 4. Dispute Resolution. The parties shall endeavor to resolve any disputes concerning amounts due by NSHC under this Agreement in a manner agreeable to NSHC and to the IHS. In the event of a failure to reach agreement on the resolution of any such dispute, NSHC may, after providing written notice to the IHS, choose not to include the disputed amount in any subsequent payment due. Payment in such a manner shall not be considered as a resolution of the dispute. The parties shall thereafter attempt to resolve the dispute through Alternative Dispute Resolution following, as appropriate, the principles and processes set forth in Executive Order 12988 signed by President Clinton on February 5, 1996, and made effective as of May 5, 1996. NSHC shall have the option of resolving the dispute in accordance with Article

Funding Agreement Appendix E

P.O. BOX 966
NOME, ALASKA 99762
(907) 443-3311

NORTON SOUND HEALTH CORPORATION

Norton Sound Health Corporation

RESOLUTION # 2010-16
Services for Non-Eligible Individuals

WHEREAS, the Norton Sound Health Corporation (NSHC) is a tribal organization that is a Co-Signer of the Alaska Tribal Health Compact (ATHC) and has negotiated a Funding Agreement (FA) with the Indian Health Service (IHS) under Title V of the Self-Determination Education and Assistance Act (ISDEAA); and

WHEREAS, the ATHC authorizes Co-Signers to provide services to non-eligible individuals provided Section 813 of the Indian Health Care Improvement Act (IHCIA) is complied with (*See* ATHC Article III, Section 4), and Section 813, as amended at 25 U.S.C. § 1680c(c)(2), provides that a tribe or tribal organization which operates a health facility under an ISDEAA agreement may make its own determination whether to provide health services to persons not otherwise eligible (i.e. non-beneficiaries) to receive IHS-funded health services; and

WHEREAS, NSHC is authorized to determine whether it will provide health services under its IHS-funded programs to persons who are not eligible beneficiaries under federal law, provided that NSHC gives consideration to whether the provision of such services will result in a denial or diminution of health services to eligible beneficiaries; and

WHEREAS, NSHC has determined that the provision of health services on a fee-for-service basis to non-beneficiaries, in an amount not less than the actual costs of providing such services, will not result in a denial or diminution of health services to beneficiaries; and

NOW THEREFORE, BE IT RESOLVED, that NSHC has decided to extend all available health services under the ATHC and its FAs to non-beneficiaries on a fee-for-service basis; and

BE IT FURTHER RESOLVED, that whenever significant evidence is presented to NSHC Board of Directors that services to non-eligible, non-beneficiaries have resulted in a denial or diminution of health services to beneficiaries, NSHC may suspend the delivery of such services to non-beneficiaries.

DATED this 25 day of June, 2010.

CERTIFICATION

The above Resolution was passed at a regular meeting of the Norton Sound Health Corporation Executive Board held on this 25 day of June, 2010 at Nome, Alaska at which a quorum was present. 8 FOR, 0 AGAINST, 0 ABSTAIN.

Attest: _____ Attest: Berda Willson
Emily Hughes, Board Chair — Berda Willson, Board Secretary

"Serving the communities of: Brevig Mission, Council, Diomede, Elim, Gambell, Golovin, King Island, Koyuk, Mary's Igloo, Nome, St. Michael, Savoonga, Shaktoolik, Shishmaref, Solomon, Stebbins, Teller, Unalakleet, Wales, White Mountain"

Norton Sound Health Corporation

APPENDIX F

PROJECT SUMMARY DOCUMENT

requirements. Cite specific, code or JCAHO references by standard clause, chapter, paragraph, etc.]

III. DEFICIENCIES

The following deficiencies will be corrected as part of this project:

[List and describe only those facility deficiencies this project will address. The types of deficiencies include BEMAR, JCAHO, NFPA, HFPM, Public Law compliance items, ADA, etc.]

IV. COST ESTIMATE

Provide a budgetary cost estimate and the funding sources for the proposed project, including separate line items for design Architect/Engineer fees, project construction, construction contract administration fees, and project contingency.

V. PROJECT SCORE SHEET DOCUMENT (*only required for BEMAR competitive pool funds*)

Complete a project score sheet further detailing the scope, impact and benefits of this project. Provide the information required by the project score sheet.

VI. OTHER PROJECT ITEMS TO BE ADDRESSED

Supporting Documents: Drawings, Photos, Estimates, Etc.

Norton Sound Health Corporation

APPENDIX G

ENVIRONMENTAL INFORMATION AND DOCUMENTATION

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

6. Does the proposed action have significant adverse direct or indirect effects on park land, other public lands, or areas of recognized scenic or recreational value?	Yes or No. Explanation.
7. Does the proposed action include construction of a new municipal solid waste landfill at a new solid waste disposal site?	Yes or No. Explanation.
8. Will the proposed action create a need for additional capacity at solid waste disposal facilities?	Yes or No. Explanation.
9. Does the proposed action include construction of a new wastewater treatment facility that will discharge treated sewage effluent to the waters of the U.S.	Yes or No. Explanation.
10. Will the proposed action create a need for additional capacity at wastewater treatment facilities?	Yes or No. Explanation.
11. Will the proposed action create a need for additional capacity in the drinking water supply?	Yes or No. Explanation.
12. Are there other considerations about the proposed action that could adversely affect the environment and/or public health and safety?	Yes or No. Explanation.

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

19. Will the proposed action require major sedimentation and erosion control measures?	Yes or No. Explanation.
20. Will the proposed action violate a storm water permit or a wastewater discharge permit either for construction or on-going operations?	Yes or No. Explanation.
21. Safe Drinking Water Act: Will the proposed action impact an EPA designated sole source aquifer?	Yes or No. Explanation.
22. Wetlands and Water Resources (lakes, rivers, ponds, streams, etc.): Will the proposed action violate a Section 404 (Clean Water Act) permit for actions in a wetland and/or Section 10 (Rivers and Harbors Act) permit for actions in a stream or river?	Yes or No. Explanation.
23. Floodplains: a. Is the proposed action located in either a 100-year or, for critical actions, a 500-year floodplain? (If Flood Insurance Rate Maps do not exist for the project site, a floodplain survey or consultation may be required. Also may need to consider if the facility will require flood insurance).	Yes or No. Explanation.
b. Will the proposed action adversely impact flood flows in a floodplain or support development in a floodplain?	Yes or No. Explanation.

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

27. Does the proposed action involve the sale or transfer of real property, on which any hazardous substance was stored for one year or more, known to have been released, or disposed of? (Provide relevant documentation for any hazardous substance releases. See 40 CFR 373.2(b), 302.4, and 261.30 for reportable quantities.)	Yes or No. Explanation.
28. Does the proposed action involve the sale or transfer of real property, on which underground or above ground storage tanks are located?	Yes or No. Explanation.
29. Will the proposed action violate Tribal, local, state, or federal law on the use and storage of hazardous substances or the transportation, storage, and disposal of hazardous wastes or medical wastes? (Activities that may generate reportable quantities include air conditioning repair and service, pesticide application, motor pools, automobile repair, welding, landscaping, agricultural activities, print shops, hospitals, clinics, & medical centers. Repair, renovation, or demolition activities can generate waste that has asbestos-containing materials, asbestos, lead-based paint, PCBs, CFCs, etc.)	Yes or No. Explanation.

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

36. Wild and Scenic Rivers Act: Will the proposed action affect a wild, scenic, or recreational river area or create conditions inconsistent with the character of the river? (A consideration for activities that are in or near any wild and scenic waterway including construction of stream/river crossings, intake structures, outfalls, etc.)	Yes or No. Explanation.

I certify that to the best of my knowledge and ability the information presented above is true and correct. The record was examined to identify potential extraordinary or exceptional circumstances which would require further environmental review.

Review by:

Title Date Environmental Coordinator Date

Norton Sound Health Corporation

APPENDIX H

ACTIONS REQUIRING IHS ENVIRONMENTAL REVIEW AND DETERMINATION

[]	Pg 571 (K)(4): Those involving the use of technology where the possible effects are highly uncertain or involve unique or unknown risks and where such technology has not been assessed previously for environmental impact;
[]	Pg 571 (K)(5): Those which have adverse effects on unique geographic characteristics (e.g. historic, archeological, or cultural resources, park recreation or refuge lands, wilderness, areas, wild or scenic rivers, sole or principal drinking water aquifers, prime farmlands, wetlands, floodplains, coastal management zones, or ecological or critical areas including those listed on the Department of Interior National Register of National landmarks);
[]	Pg 571 (K)(6): Those which establish a precedent for future action or represent a decision in principle about future actions with potentially significant environmental effects;
[]	Pg 571 (K)(7): Those which have adverse effects on properties listed or eligible for listing on the National Register of Historic Places;
[]	Pg 571 (K)(8): Those which have adverse effects on species listed by the Federal Government as Endangered or Threatened Species, or which have adverse effects on any designated critical habitat for these species;
[]	Pg 571 (K)(9): Those which require assessment in accordance with Executive Order 11988 (Floodplain Management), or Executive Order 11990 (Protection of Wetlands), or the Fish and Wildlife Coordination Act; and
[]	Pg 572 (K)(10): Those which involve the use, transfer, or lease of real property which has been determined, after investigation in accordance with the provisions of CERCLA 120 (h), to have been used as a storage facility for hazardous waste for more than 1 year; and
[]	Pg 572 (K)(11): Construction projects which are significantly greater in scope or size than normally experienced for a particular category of action.

Any action NOT categorically excluded per Federal Register Vol. 58, No. 3, pg 569-572, dated January 6, 1993 attached hereto.	**The Environmental Review and Determination Process for this group of actions ranges from 60 to 180 days from the receipt by the IHS of the proposal package.**

* The time needed to complete Environmental Reviews is highly dependent on required consultations with other Federal and State Agencies. As an example, the NHPA Section 106 Process requires the State Historic Preservation Officer (SHPO) be allotted 30 days to review and comment on a proposed action (36 CFR Part 800.3(c)(4)). Furthermore, additional time beyond the 30 days may be required for consultation with SHPO to adequately review and determine the effects of the proposed action on existing historical resources. Coordination early in the planning phase of the project can help identify these potential issues and allow NSHC and IHS to resolve them early.

employed varies from Area to Area. Population, health indices, and facilities and services available from sources other than the IHS are evaluated to determine the methods IHS uses to provide services.

The IHS program consists of two major systems: (1) A Federal health care delivery system, administered by Federal employees, and (2) a tribal health delivery system, administered by tribes and tribal groups under grants, contracts or cooperative agreements. The categorical exclusions apply to IHS program actions whether carried out directly by the IHS, or funded or otherwise sponsored by the IHS. The IHS contracts, grants, and cooperative agreements are actions defined in NEPA and are subject to the IHS review procedures established to ensure NEPA compliance, including provisions covering extraordinary and exceptional circumstances. The NEPA compliance for the tribal health care delivery system is ensured through IHS administrative procedures for contracts, grants, and cooperative agreements.

The selection of IHS program actions to list as categorical exclusions has been determined, in part, by agency experience in complying with NEPA, during the past 10 years. Actions required to provide health care services will not have significant impact on the environment except when exceptional or extraordinary circumstances exist. The IHS has categorically excluded these actions, since enactment of NEPA; however, actions involving construction normally have required completion of an environmental review/assessment.

The IHS administers programs for the construction of domestic sanitation facilities (water, wastewater, and solid waste) for Indian homes and communities, construction of new or replacement health care facilities and staff quarters, and renovations to existing health care facilities and quarters units.

Environmental reviews/assessments of construction projects undertaken during the past 10 years have concluded that an EIS was not required for any of them. Approximately 2,300 sanitation facilities construction projects and fewer than 60 health care facilities/staff quarters construction projects have been approved during this time.

The type of program and procedures employed to administer the construction of sanitation facilities for Indian homes and communities, and the consistent determinations that these projects do not have a significant impact on the environment, are the basis for the decision to list most sanitation facilities projects as categorically excluded.

Factors considered in making this determination include:

1. Projects are undertaken to improve health and/or environment.

2. Projects are untaken at the request and with approval of the tribal governing body, which provides for discussion and evaluation of the project and its impacts.

3. Projects are normally constructed on tribally owned or individually owned tribal land within reservation boundaries.

4. Projects are constructed to comply with all current applicable environmental regulations and plans and specifications are submitted to State and Federal agencies as necessary for review and comment.

5. Projects are constructed to provide utilities (water, sewer, solid waste) either for existing American Indian or Alaska Native homes or for new homes constructed with Federal, tribal, State or other resources. New homes are constructed at sites and locations approved by the Tribal Governing Board. Utilities are not provided for future development or undeveloped parcels, and capacity provided is limited to that routinely provided by standard engineering practice for the current design population.

6. The IHS projects fall into the category of minor construction projects based on cost. During the last 10 years, 85 of the 2,300 projects exceeded $1 million, and the average estimated cost was $250,000.

7. Standard IHS procedures require documentation of an environmental review of each construction project to identify any exceptional or extraordinary circumstances and to ensure compliance with all environmental laws, regulations, and executive orders; e.g., those concerning floodplains, wetlands, endangered species, etc. This review is required early in the project planning process.

The categorical exclusion for construction of health care facilities and staff quarters has been limited to renovation or new construction at existing health care delivery sites, and construction or development of relatively small facilities at new locations. The procedures noted in item 7 above for sanitation facilities construction projects also apply to all health care facility and staff quarters construction projects. Most health care facility and staff quarters renovation projects can be classified as minor construction projects based on cost. Fewer than 200 major renovation projects have been undertaken and only a few were funded at a level exceeding $1 million.

Categorical Exclusions

A. Health Services

Direct delivery of medical, dental, nursing, and other related health services; e.g., patient care/counseling administered from hospitals, health centers, health stations, satellite clinics, and in private homes by IHS staff or contract providers to authorized recipients.

B. Research

Research activities that are consistent with the mission of IHS including: (a) Biological and behavioral studies conducted in laboratories, clinics, and the field; (b) studies on the development and delivery of prevention and treatment services and their administration and financing; and (c) evaluations of prevention and treatment.

C. Pesticides

Application of pesticides which are not classified for restricted use under provisions of the Federal Insecticide, Fungicide and Rodenticide Act when used for routine pest control purposes.

D. Contracts, Grants, and Cooperative Agreements

Contracts, grants, and cooperative agreements and continuations, supplements, extensions, and amendments of these documents for IHS programs or actions that are categorically excluded. (Includes Self-Determination Act contracts, Contract Health Care contracts, etc.)

E. Technical Assistance

Action involving the provision of technical assistance to American Indian and Alaska Native tribes and groups, other Federal agencies, State and local governments, and non-profit organizations are excluded. These actions include but are not limited to:

1. The provision of technical assistance to American Indian and Alaska Native tribes and groups for the purpose of developing management capabilities needed to enable eventual tribal assumption of health program operation;

2. The provision of technical assistance to American Indian and Alaska Native tribes and groups for the purpose of developing capabilities in the areas of epidemiology, disease reduction, injury prevention, environmental improvement, and the operation and maintenance of sanitation facilities; and

3. The assignment of IHS personnel to agencies/organizations for the purpose of providing technical expertise (e.g.,

Order 11990 (Protection of Wetlands), or the Fish and Wildlife Coordination Act; and

10. Those which involve the use, transfer, or lease of real property which has been determined, after investigation in accordance with the provisions of CERCLA 120 (h), to have been used as a storage facility for hazardous waste for more than 1 year; and

11. Construction projects which are significantly greater in scope or size than normally experienced for a particular category of action.

Dated: December 29, 1992.

Michael E. Lincoln,

Deputy Director.

[FR Doc. 93-179 Filed 1-5-93; 8:45 am]

BILLING CODE 4310-14-M

ADDENDUM I

MEMORIALIZATION OF HISTORICAL LEVEL OF PFSA'S PROVIDED BY ANMC AND AANHS TO THE NORTON SOUND HEALTH CORPORATION

The ANMC and the Alaska Area Native Health Services, Area Office, subject to available appropriations, has historically provided the following PFSAs to Norton Sound Health Corporation as of October 1, 1997 and continued to provide such services through December 31, 1998:

- Coordination and support for the NSHC dental clinic, including dental specialty referral services, and the annual Alaska dental chiefs meeting. Commissioned Corp recruitment assistance including transportation costs of the recruiter to and from Nome, any applicable documentation, award information for Commissioned Officer promotions, and career counseling for officers desiring long term affiliation with IHS.

- Specialty care field clinics, consultation to Norton Sound Health Corporation physicians, arrange contracts for reference laboratory services, routine reading of x-rays, medivacs support for neonatal emergencies patient travel support for NSHC patients returning home from treatment at the ANMC.

- Accepting all referrals of Alaskan Natives from the Norton Sound Regional Hospital.

- The ANMC EMS program provided specialized training such as ACLS, ATLS, PALS, including hypothermia, cold water drowning and frostbite.

- The NSHC Laboratory received the following services from ANMC: (a) pathologist consultation and visitation twice a year; (b) Anatomical tissue analysis and reporting; and (c) Access to TDY Services as needed and available.

- The ANMC provided consultation and informational support for the NSHC Social Services program, including JCAHO standards and other licensure issues.

- The ANMC provided support including screening, diagnosis, consultations, referrals, personnel training, information, network and recruitment assistance for the FAS program at NSHC and for its Maternal Child Health Program.

- The ANMC provided recruitment assistance to the Mental Health program as needed.

- STD/HIV testing, counseling, partner notification, education and consultation as requested by NSHC.

- Nutrition education and counseling services from the statewide Diabetes program based at ANMC.

- Environmental Health /Sanitation services including, but not limited to, appropriate village visits for environmental services, injury prevention, institutional services.

- Diabetes patients tracking and registration.

- Engineering services inclusive of maintenance and improvement for federal facilities and projects;

- Purchasing activities under GSA contracts;

- Office of Environmental Health Services and activities, health facilities support, real property support especially for village built clinics; projects for health facilities management, special projects and sanitations facilities.

- Administration and management of IPA/MOAs;

- Certain contract health services, not otherwise contracted under Title I;

- Region X legal consultation.

ADDENDUM II
NORTON SOUND HEALTH CORPORATION
MEMORIALIZATION OF MATTERS REMAINING IN DISPUTE

(1) Norton Sound Health Corporation (NSHC) does not agree with the IHS' position that Area Office tribal shares that were restricted by individual Co-Signer decision or by a consensus decision of all Co-Signers from FY 1995 through FY 2000 are not available for inclusion in FY 2002 because of Section 325, P.L. 105-83. NSHC believes it has the right to include such tribal shares in its FY 2002 funding agreements notwithstanding Section 325. NSHC reserves any remedies it may have under law.

ALASKA TRIBAL HEALTH COMPACT

BETWEEN

CERTAIN ALASKA NATIVE TRIBES

AND THE

UNITED STATES OF AMERICA

OCTOBER 1, 1994

—

AMENDED AND RESTATED

OCTOBER 1, 2017

ALASKA TRIBAL HEALTH COMPACT

OCTOBER 1, 1994

AMENDED AND RESTATED
OCTOBER 1, 2017

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ALASKA TRIBAL HEALTH COMPACT
BETWEEN
CERTAIN ALASKA NATIVE TRIBES
AND THE
UNITED STATES OF AMERICA
OCTOBER 1, 1994
AMENDED AND RESTATED
OCTOBER 1, 2010

This Compact of Self-Governance, which under Title III of Public Law No. 93-638, as amended, became effective October 1, 1994, was amended and restated effective October 1, 1995, October 1, 1996, October 1, 1997, October 1, 1998, October 1, 2000, and was further amended and restated in FY 2001, effective October 1, 2000, to conform with Public Law 106-260, Title V of the Indian Self-Determination and Education Assistance Act, as amended (hereinafter Title V), October 1, 2003, October 1, 2006, October 1, 2008, and October 1, 2010 is made and entered into by and between the Secretary of Health and Human Services of the United States of America, represented by the Director of the Indian Health Service, and certain Alaska Native Tribes recognized by the United States acting collectively, and the Alaska Native Tribal Health Consortium, as set forth in Exhibit A. This Compact is entered into under the Title V, which authorizes the Secretary to enter into Compacts and Funding Agreements with the governing bodies of participating Tribal governments. The Secretary has delegated the authority to enter into this Compact and funding agreements to the Director, Indian Health Service (hereinafter IHS). This Compact reflects the United States' special trust responsibility and legal obligations to Indians and Alaska Natives, as stated in 25 U.S.C. section 1602, and the unique tribal cooperation that has developed in Alaska to assure that all Alaska Natives have access to a comprehensive, integrated, and tribally-controlled health care delivery system. The parties are committed to ensuring that the essential statewide functions of the Alaska Native Medical Center in Anchorage remain intact, whether operated by the Indian Health Service, the Alaska Native Tribal Health Consortium or by Alaska Native Tribes recognized by the United States.

WITNESSETH:

WHEREAS, the Alaska Native people have governed themselves and lived in the area known as Alaska since time immemorial;

WHEREAS, federally recognized tribal governments in the State of Alaska

> . . . have the same governmental status as other federally acknowledged Indian tribes by virtue of their status as Indian tribes with a government-to-government relationship with the United States; are entitled to the same protection, immunities, privileges as other acknowledged tribes; have the right, subject to general principles of Federal Indian law, to exercise the same inherent and delegated authorities available to other tribes; and are subject to the same limitations imposed by law on other tribes;

(*Indian Entities Recognized and Eligible to Receive Services from the United States Bureau of Indian Affairs*, 58 Fed. Reg. 54364 (October 21, 1993));

WHEREAS, for the purposes of ensuring that all Alaska Natives and America Indians in Alaska can receive the services provided by the Federal Government through an Alaska Native provider, the Congress has defined the term, "Indian Tribe," to mean:

> . . . any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(Indian Self-Determination and Education Assistance Act, as amended, 25 U.S.C. § 450b(e));

WHEREAS, to prioritize between the entities eligible to authorize contracting under the Indian Self-Determination and Education Assistance Act, as amended, the Indian Health Service has established in the Alaska Area the following order of preference:

> If there is an Indian Reorganization Act (IRA) Council, and it provides governmental functions for the village, it will be recognized.
>
> If there is no IRA Council, or it does not provide governmental functions, then the traditional village council will be recognized.
>
> If there is no IRA Council and no traditional village council, then the village profit corporation will be recognized.
>
> If there is no IRA Council, no traditional village council, and no village profit corporation, then the regional profit corporation will be recognized for that particular village.

(*Alaska Area Guidelines for Tribal Clearances for Indian Self-Determination Contracts*, 46 Fed.

Reg. 27178);

WHEREAS, the United States of America has recognized certain entities in Alaska as American Indian Tribes for purposes of the Indian Self-Determination and Education Assistance Act (*See* 25 U.S.C. § 450b(e); *Indian Entities Recognized and Eligible To Receive Services from the United States Bureau of Indian Affairs*, 58 Fed. Reg. 54364 (October 21, 1993); and *Alaska Area Guidelines for Tribal Clearances for Indian Self-Determination Contracts*, 46 Fed. Reg. 27178, (hereinafter "the Tribes");

WHEREAS, certain Tribes of Alaska have formed and authorized certain Tribal Organizations and Inter-Tribal Consortia as defined in 25 U.S.C. § 450b(*l*) and section 501(a)(5) of Title V, for the purpose of providing health care to Alaska Natives and to contract with the Indian Health Service and other federal and non-tribal agencies for such purpose as well as to provide health care to the other residents of their respective service areas, as permitted by section 813 of the Indian Health Care Improvement Act, as amended, or other applicable law;

WHEREAS, the Congress has declared its commitment to the maintenance of the Federal Government's unique and continuing relationship with, and responsibility to, Alaska Native and American Indian Tribes and to the Alaska Native and American Indian people as a whole through the permanent establishment of a meaningful Indian self-governance policy, which will permit an orderly transition from the federal domination of programs for, and services to, Alaska Natives and American Indians to effective and meaningful participation by the Alaska Native and American Indian people in the planning, conduct, and administration of those programs and services; 25 U.S.C. § 458aaa(note);

WHEREAS, the Congress has declared its commitment to strengthening the government-to-government relationship and to supporting and assisting Alaska Native and American Indian Tribes in the orderly transition from the federal domination of programs and services to provide Alaska Native and American Indian Tribes with meaningful authority, control, funding and discretion to plan, conduct, redesign and administer programs, services, functions and activities (or portions thereof) that meet the needs of the individual tribal communities, 25 U.S.C. § 458aaa(note);

WHEREAS, Federal health services to maintain and improve the health of the Indians and Alaska Natives are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian and Alaska Native people, 25 U.S.C.§§ 1601(1), (2);

WHEREAS, in accordance with 25 U.S.C. § 1601(2) a major national goal of the United States is to provide resources, processes and structures that will enable Indians and Alaska Natives to obtain the quality and quantity of health care services and opportunities that will eradicate health disparities between Indians and Alaska Natives and the general population of the United States;

WHEREAS, the Congress has declared that it is the policy of the United States as stated in 25 U.S.C. § 1602, in fulfillment of its special trust responsibilities and legal obligations to the American Indian and Alaska Native people, to ensure the highest possible health status for Indians

and Alaska Natives and to provide all resources necessary to effect that policy; to raise the health status of Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives; and also the ensure maximum Indian and Alaska Native participation in the direction of health care services so as to render the person administering such services and the services themselves more responsive to the needs and desires of Indian and Alaska Native communities;

WHEREAS, for the purposes of this Compact,

"ANTHC" shall mean only the Alaska Native Tribal Health Consortium;

"Co-Signer" shall mean all Tribes and tribal organizations or Inter-Tribal Consortia, including the ANTHC, participating in the Compact;

"Signatory Tribe(s)" shall mean all Tribes participating in the Compact either directly or through a tribal organization or Inter-Tribal Consortium that has been authorized to participate by resolution;

"Tribal Co-Signer" shall mean only those Tribes, tribal organizations and Inter-Tribal Consortia authorized by resolution of a Tribe, as defined in 25 U.S.C. § 450b(*l*) and sections 501(a)(5) and (b) of Title V, to participate in the Compact and shall not include the ANTHC; and

WHEREAS, under authority from the Tribes, certain Tribal Organizations and Inter-Tribal Consortia in Alaska have provided health services for many years under self-determination contracts with the Indian Health Service and have been recognized by the Indian Health Service as tribally-operated service units;

WHEREAS, pursuant to section 325 of P.L. 105-83, the Alaska Native Tribal Health Consortium (herein "ANTHC"), a tribal organization and Inter-tribal Consortium, as defined in section 501(a)(5) of Title V, was organized and is controlled by the Alaska Native tribes and tribal organizations which are represented on its Board of Directors;

WHEREAS, Tribes, Tribal Organizations and Inter-Tribal Consortia throughout Alaska are reliant on the services to be provided by the ANTHC;

WHEREAS, participation by the ANTHC in the Alaska Tribal Health Compact promotes the commitment of Alaska Native Tribes, Tribal Organizations and Inter-Tribal Consortia to maintain the unique tribal cooperation that has developed in Alaska to assure that all Alaska Natives have access to a comprehensive, integrated, organized, tribally controlled health care delivery system in which Alaska tribal health providers participate in numerous joint activities including utilization review and provide their health services in a clinically integrated care setting in which individuals typically receive health care from more than one of these Alaska tribal providers;

WHEREAS, in furtherance of the federal policy of Alaska Native and American Indian tribal self-determination and self-governance, Congress has directed the Secretary of Health and Human Services (herein the "Secretary") to carry out the Tribal Self-Governance Program under Title V.;

WHEREAS, Congress, in Title V, has authorized the Secretary to negotiate and implement a Compact of Self-Governance and Funding Agreements with the governing bodies of participating Tribal governments of qualified Alaska Native and American Indian Tribes that have completed a planning activity;

WHEREAS, Congress has directed that the Funding Agreements, which the Secretary negotiates with Alaska Native and American Indian tribes, shall authorize the Co-Signers to plan, conduct, consolidate, administer, receive full tribal shares of funding, redesign programs, and reallocate funds for programs, services, functions and activities as provided in sections 505(b)(1) and, (b)(2) and 506 (e) of Title V;

WHEREAS, each Funding Agreement shall specify the programs, services, functions or activities to be performed or administered, the funds to be provided, and the responsibilities of the Co-Signer and the Secretary in accordance with section 505 of Title V;

WHEREAS, the Funding Agreement shall specify the authority of the Co-Signer to redesign or consolidate programs, functions, services and activities (or portions thereof) and to reallocate or redirect funds or modify budget allocations pursuant to section 506(e) of Title V;

WHEREAS, to the extent to which, funding is provided to a Co-Signer, as authorized by Alaska Native Tribes, pursuant to a Funding Agreement, such Co-Signer shall be responsible for administration of programs, services, functions and activities pursuant to the Agreement, consistent with section 505 of Title V;

WHEREAS, nothing in this Compact or associated Funding Agreements shall be construed to limit or reduce in any way the funding for any program, project or activity serving an Indian Tribe under Title V or any other applicable Federal law, pursuant to section 515(a) of Title V;

WHEREAS, in Title V, Congress has directed that the Funding Agreements, which the Secretary negotiates with Co-Signers shall contain certain provisions and, at the option of the Co-Signers, apply to certain programs, activities, functions and services of the Indian Health Service (including construction) as specified in sections 505, 507(a)(2)(A), and 509 of Title V;

WHEREAS, Congress has directed that, at the request of the governing body of qualifying Tribes and the ANTHC and under the terms of a Funding Agreement, the Secretary shall provide funding to the Tribes and the ANTHC to implement the Funding Agreement in accordance with section 508 of Title V;

WHEREAS, Congress has directed that the Secretary shall interpret federal laws and regulations in a manner that will facilitate the implementation of a Compact of Self-Governance and Funding Agreement authorized by section 512(a) of Title V;

WHEREAS, Congress has directed that the Secretary shall interpret federal laws and regulations in a manner that will facilitate the inclusion of activities, programs, services, and functions (or portions thereof) in Compacts of Self-Governance and Funding Agreements authorized by section 512(a) of Title V;

WHEREAS, it is the intent of certain Alaska Native Tribes to collectively enter into a single Compact with the Secretary. To carry out that intent, such Tribes (hereafter referred to as signatory Tribes) enter into this Compact either by individual signature or by means of a delegation of signature authority as authorized by resolution of the Tribal government. Such resolutions are attached as Exhibit "A".

WHEREAS, it is the intent of the signatory Tribes that this Compact will be carried out either by the Tribe itself, by tribal organizations or Inter-Tribal Consortia, as authorized by resolution of Tribe(s) as defined by 25 USC § 450b(e), section 501(b), and by the ANTHC under section 325 of P.L. 105-83. These Tribes, tribal organizations and Inter-Tribal Consortia, including the ANTHC, are bound by the terms of this Compact and are signing separately as Co-Signers.

WHEREAS, it is the intent of the parties that each Tribal Co-Signer Funding Agreement entered into under this Compact shall be executed by the Tribes, either by individual signature or by means of a delegation of signature authority as authorized by resolution of the Tribal government. Each such Funding Agreement also will be signed by a Tribal Co-Signer, designated by the Tribal governing body. The Tribal Co-Signer will carry out the terms of the Funding Agreement for the signatory Tribe(s) from which it has obtained a resolution of authority and be bound by its terms;

WHEREAS, the ANTHC may enter into this Compact and into Funding Agreements under this Compact as authorized by the Board of Directors of the Alaska Native Tribal Health Consortium; and

WHEREAS, for purposes of clarification, and to recognize the government to government relationship between the signatory Tribes and the Secretary, the parties agree that the signatory Tribes, by entering into this Compact, do not relinquish any aspects of Tribal sovereignty to the Co-Signers. The Tribal Co-Signers act only for and on behalf of the signatory Tribe(s) within the scope of the authority granted to them by tribal resolution or by law and the ANTHC has only the authority granted to it under section 325 of P.L. 105-83. Tribal Co-Signers and the ANTHC by carrying out the terms of this Compact and the associated Funding Agreements do not gain the status of a sovereign tribal government;

WHEREAS, the parties have determined that all of the provisions of this Compact are authorized by Title V or other provisions of federal law and the parties have executed this Compact in reliance on this representation;

NOW, THEREFORE, the Secretary, signatory Tribes and the Co-Signers do hereby agree to enter into, undertake, and be bound by this Compact in accordance with the foregoing principles.

ARTICLE I — AUTHORITY AND PURPOSE

Section 1 – Authority. This Compact of Self-Governance, which became effective October 1, 1994, was amended and restated effective October 1, 1995, October 1, 1996, October 1, 1997, October 1, 1998, and October 1, 2000, and was further amended and restated in FY 2001 effective October 1, 2000, to conform with Title V, October 1, 2003, October 1, 2006, October 1,

2008, and October 1, 2010 (hereinafter the "Compact"), is authorized by Title V of the Indian Self-Determination and Education Assistance Act, as amended, and is hereby entered into by the Secretary of the Department of Health and Human Services of the United States of America (hereinafter the "Secretary"), represented by the Director of the Indian Health Service, certain Alaska Native Tribes, as identified in Exhibit A, recognized by the United States, acting individually or collectively, and the Alaska Native Tribal Health Consortium (hereinafter the "ANTHC"). The Director of the Indian Health Service by signing this Compact commits the Secretary to the extent and within the scope of the Secretary's delegation of authority to enter into Compacts and Funding Agreements pursuant to Title V or as otherwise authorized.

Section 2 – Purpose. This Compact shall be liberally construed to achieve its purposes:

(a) This Compact is to carry out a Self-Governance Program authorized by Title V, and is intended to transfer to tribal governments, at a tribe's request, the power to decide how federal programs, services, functions and activities (or portions thereof) shall be funded and carried out. Title V is meant to strengthen the government-to-government relationship and to uphold the United States trust responsibility for each Indian Tribe. This Compact promotes the autonomy of the Tribes in Alaska in the realm of health care.

(b) This Compact is to enable the signatory Tribes and the Co-Signers to re-design health programs, activities, functions, and services of the Indian Health Service; to reallocate funds for programs, activities, functions, or services according to the priorities of the signatory Tribes and Co-Signers; to enhance the effectiveness and long-term financial stability of the Tribes and the Co-Signers; and to streamline the federal Indian Health Service bureaucracy.

(c) This Compact is to enable the United States to maintain and improve its unique and continuing relationship with, and special trust responsibilities and legal obligations, pursuant to 25 U.S.C. 1602 of the IHCIA, to the Tribes through tribal self-governance and to permit an orderly transition from federal domination of programs and services.

(d) This Compact and Funding Agreement shall transfer to signatory Tribes, acting individually or collectively, and the ANTHC the responsibility for the programs, activities, functions and services of the Indian Health Service included in the Funding Agreement. This Compact allows signatory Tribes, acting individually or collectively, and the ANTHC to exercise meaningful authority to plan, conduct, and administer those programs and services to meet the health care needs of the Alaska Native Tribes. In fulfilling its responsibilities under the Compact and consistent with 25 U.S.C. §§ 1602(5), (6), and the November 5, 2009 Memorandum for the Heads of Executive Departments and Agencies, the April 29, 1994, Memorandum from the President of the United States of America for the Heads of Executive Departments and Agencies, attached hereto as Exhibit B, Executive Order 13175 on Consultation and Coordination with Indian Tribal Governments, the September 23, 2004, Memorandum from the President of the United States of America for the Heads of Executive Departments and Agencies, and the Department of Health and Human Services Tribal Consultation Policy, the Secretary hereby pledges that the Indian Health Service will conduct all relations with the Tribes on a government-to-government basis.

ARTICLE II — TERMS, PROVISIONS AND CONDITIONS

Section 1 – Term and Resolutions.

(a) Term. The term of this Compact begins as to each Co-Signer on the effective date of the Co-Signer's first Funding Agreement and shall extend thereafter as to each Co-Signer throughout the period authorized by Title V of the Indian Self-Determination and Education Assistance Act, and any subsequent amendment thereto, provided the Co-Signer has a Funding Agreement in effect, and shall remain in effect for so long as is permitted by Federal law or until terminated by mutual written agreement, retrocession, or reassumption pursuant to section 504(d) of Title V.

(b) Resolutions from Signatory Tribes. Those Tribes which intend to participate in this Compact and the applicable Funding Agreement through delegation of signature authority as provided in this Compact must have issued a written resolution authorizing the Tribal Co-Signer, on their behalf, to enter into this Compact and Funding Agreement on or before the date the Compact and the applicable Funding Agreement is signed by the Tribal Co-Signer for that Tribe, provided that if a Tribal Co-Signer negotiates a Funding Agreement prior to obtaining an authorizing resolution from a Tribe, nothing herein shall be construed to limit or impair in any way a tribal government's sovereign right to decide whether or not to sign such a resolution.

(c) Resolution from the Board of the ANTHC. The ANTHC may participate in this Compact and the applicable Funding Agreement upon receipt of an authorizing resolution of the Board of Directors of the ANTHC, attached hereto as a part of Exhibit A.

Section 2 – Effective Date.

(a) Once this Compact and the Funding Agreements, attached hereto as Exhibit C, are approved and signed by the Co-Signers and the Secretary, they shall be effective as of October 1, 2008. Subsequent Funding Agreements will be effective on the date signed by the Secretary and Co-Signer or another date mutually agreed upon.

(b) During the term of this Compact any Co-Signer which has not previously negotiated a Funding Agreement may do so. All Funding Agreements shall be subject to, and all the activities thereunder shall be governed by, the terms of this Compact to the same extent as the initial Funding Agreements. New Funding Agreements will be effective on the date signed by the Secretary and Co-Signer or another date mutually agreed upon.

(c) Each Funding Agreement and subsequent Funding Agreement of a Co-Signer is deemed to be incorporated, as negotiated, by reference into this Compact, for the purposes only of that Co-Signer and the United States. In the event of inconsistency between the Compact and any subsequent Funding Agreement, the provisions of the Compact shall prevail.

Section 3 – Funding Amount. Subject only to the appropriation of funds by the Congress of the United States and in accordance with section 508 of Title V, the Secretary shall provide the total amounts specified in the Funding Agreements.

Section 4 – Payment.

(a) Payment Schedule. Payment shall be made expeditiously and shall include financial arrangements to cover funding during periods under continuing resolutions to the extent permitted by such resolutions. For each fiscal year covered by the Compact, the Secretary shall make available the funds specified for that fiscal year under the Funding Agreements by paying the respective total amount as provided for in each Funding Agreement in advance lump sum, as permitted by law, or such other payments as provided in the schedule set forth in each Funding Agreement. The first payment shall be made on or before ten calendar days after the date on which the Office of Management and Budget (hereinafter "OMB") apportions the appropriations for that fiscal year for the programs, activities, functions and services subject to the Compact. The Prompt Payment Act, Chapter 39 of Title 31, United States Code, shall apply to the payment of funds due under this Compact and to each Funding Agreement negotiated thereunder.

(b) Interest on Advances. Co-Signers receiving funds under applicable Funding Agreements pursuant to this Compact shall be permitted to retain interest earned on funds advanced pending disbursement as authorized by law. Interest earned on advances shall not diminish the amount of funds the Co-Signer is authorized to receive under its Funding Agreement in the year earned or in any subsequent fiscal year. All funds transferred under Funding Agreements pursuant to this Compact shall be managed using the prudent investment standard pursuant to section 508(h) of Title V.

Section 5 – Reports to Congress. In accordance with section 514 of Title V, the Secretary shall submit to the Senate Committee on Indian Affairs and the House Resources Committee a written report not later than January 1 of each year on the administration of Title V. Each report shall include a detailed analysis on the level of need being presently funded or unfunded for each signatory Tribe and Co-Signer. The contents of each report shall comply with section 514(b). In compiling the reports, the Secretary may not impose any reporting requirements on Co-Signers not otherwise provided in Title V. The Secretary shall provide each Co-Signer with a draft of each report required to be submitted to Congress under this provision for a thirty (30) day comment period prior to the submission of the report to Congress so that the Co-Signers may comment on the report. The Secretary shall include each Co-Signer's comments in the final report to Congress.

Section 6 – Audits

(a) Single Audit. Each Co-Signer that has executed a Funding Agreement pursuant to this Compact shall provide to the National External Audit Review Center (or its successor), which is the designee of the Secretary for the purposes of this section, an annual single organization-wide audit as prescribed by the Single Audit Act of 1984, as amended, 31 U.S.C. § 7501, *et seq*. A copy of this audit will be sent simultaneously to the Indian Health Service Area Office, the cognizant agency, and the Federal Audit Clearinghouse.

(b) Cost Principles. Each Co-Signer shall apply cost principles under the applicable OMB Circular, except as modified by section 106(k) of the Indian Self-Determination and Education Assistance Act, as amended, which section is hereby incorporated into this Compact, or by any exemptions subsequently granted by OMB. To the extent that OMB Circular A-87 or its successor, or other applicable circulars, permit agency pre-approval of allowable costs,

the agency hereby grants that pre-approval. The Secretary will assist the Co-Signers in obtaining such additional waivers from OMB as are requested by the Co-Signers. No other audit or accounting standards shall be required by the Secretary. Any claim by the Federal Government against any Co-Signer receiving funds under a Funding Agreement based on any audit under this section shall be subject to the provisions of section 106(f) of the Indian Self-Determination and Education Assistance Act, as amended.

Section 7 – Records. Each Co-Signer's practices relating to document disclosure and record-keeping associated with this Compact shall, in accordance with applicable law, be set forth in the respective Funding Agreement.

Section 8 – Property.

(a) In General. The provisions of section 512(c) and section 1(b)(8) of the Model Agreement set forth in section 108(c) of the Indian Self-Determination and Education Assistance Act, as amended, are hereby incorporated into this Compact.

(b) Property Management. Management of property under this Compact shall be in accordance with additional provisions included in each Co-Signer's Funding Agreement.

(c) Access to Property Subject to Destruction. Prior to the destruction of federal property which would otherwise be declared surplus or excess and which is located within the service area of a Co-Signer, the Secretary, if previously requested by the Co-Signer, shall provide notice of such proposed destruction to the Co-Signer. Such notice shall inform the Co-Signer of the name and address of the official responsible for determining whether such property will be destroyed or declared surplus or excess. If the Secretary is the responsible official, the Secretary will consider information provided by the Co-Signer regarding transfer of the property, rather than destruction, and, if not the responsible official, the Secretary will assist the Co-Signer in communicating information to the responsible official.

(d) Leases. Upon the request of a Co-Signer, the Secretary shall enter into a lease with the Co-Signer in accordance with section 105(*l*) of the Indian Self-Determination and Education Assistance Act, as amended.

Section 9 – Regulatory Authority. The Secretary and the Co-Signers agree to utilize the following procedures governing the establishment and application of program rules and regulations under this Compact:

(a) Program Rules. No Co-Signer is required to comply with any agency circular, policy, manual, guidance or rule adopted by the Indian Health Service other than those identified in this section or expressly incorporated by reference in the individual Co-Signer's Funding Agreement in carrying out the programs, services, activities and functions under the Compact, except for the eligibility provisions of section 105(g) of the Indian Self-Determination and Education Assistance Act, as amended, and regulations promulgated under section 517 of Title V.

(b) Federal Regulations.

(1) Applicable Federal Regulations. The Co-Signers, in carrying out the provisions of this Compact and applicable Funding Agreements, will be required to comply only with applicable federal regulations, which include regulations promulgated under section 517 of Title V unless waived as provided in section 512(b) of Title V.

(2) Waiver of Federal Regulations.

(A) The Secretary and the Co-Signer will seek to identify federal regulations promulgated pursuant to section 517 or under the authorities specified in section 512(b) of Title V which may require waiver in order to effectively carry out this Compact or any Funding Agreement.

(B) Waivers of regulations shall be submitted and addressed in accordance with the procedures set forth in section 512(b).

(c) Title I Section Incorporated by Reference. Section 105(a)(1) of the Indian Self-Determination and Education Assistance Act, as amended, 25 U.S.C. § 450j(a)(1), is hereby incorporated in this Compact and shall have the same force and effect as if it were set forth in full in Title V of the Act.

Section 10 – Disputes.

(a) All disputes between the Indian Health Service and any Co-Signer or between the Indian Health Service and all Co-Signers under this Compact shall be subject to Title V and the provisions of section 110 of the Indian Self-Determination and Education Assistance Act, as amended, and all remedies provided for therein shall be available to each Co-Signer of this Compact. Actions and proceedings to enforce the Co-Signer's rights and the Secretary's obligations under this Compact shall be subject to the Equal Access to Justice Act, Public Law 96-481, as amended, to the same extent as are actions and proceedings involving Public Law 93-638 contracts.

(b) In the alternative, the Indian Health Service and the Co-Signers may use the processes authorized and encouraged in the Administrative Dispute Resolution Act, 5 U.S.C. § 581 note, for more informal resolution of disputes arising under this Compact and associated Funding Agreements.

Section 11 – Retrocession and Withdrawal

(a) Retrocession. Section 506(f) of the Act is herein adopted. A Co-signer may retrocede, fully or partially, to the Secretary programs, services, functions, or activities (or portions thereof) included in the compact or funding agreement. Unless the Co-signer rescinds the request for retrocession, such retrocession will become effective within the timeframe specified by the parties in the compact or funding agreement. In the absence of such a specification, such retrocession shall become effective on

(1) the earlier of

(A) one year after the date of submission of such request; or

(B) the date on which the funding agreement expires; or

(2) such date as may be mutually agreed upon by the Secretary and the Co-signer.

(b) Withdrawal. Section 506(g) of the Act is herein adopted. Unless prohibited by law and in accordance with Section 506(g) of the Act, a Tribe may fully or partially withdraw from a participating inter-tribal consortium or tribal organization its share of any program, function, service, or activity (or portions thereof) included in a compact or funding agreement. The withdrawal shall become effective within the timeframe specified in the resolution which authorizes transfer to the participating tribal organization or inter-tribal consortium. In the absence of a specific timeframe set forth in the resolution, such withdrawal shall become effective on

(1) the earlier of

(A) one year after the date of submission of such request; or

(B) the date on which the funding agreement expires; or

(2) such date as may be mutually agreed upon by the Secretary, the withdrawing Indian tribe, and the participating tribal organization or inter-tribal consortium that has signed the compact or funding agreement on behalf of the withdrawing Indian tribe, inter-tribal consortium, or tribal organization.

Section 12 – Discontinuance. Co-signer may discontinue its participation in the Alaska Tribal Health Compact after written notice to each authorizing Tribe or Village and the IHS. Notice must be provided one year in advance of the effective date of the request except that the effective date of a request may be less than one year upon approval of all authorizing Tribes and Villages and the IHS.

Section 13 – Subsequent Funding Agreements.

(a) Negotiations for subsequent Funding Agreements, as provided for in Article VI, section 2, shall begin no later than 120 days in advance of the conclusion of the preceding Funding Agreement. Each Co-Signer is hereby assured that future funding of the Co-Signer's subsequent Funding Agreements shall only be reduced pursuant to the provisions of section 508(d) of Title V provided, however, that future funding for each Co-Signer's non-recurring funds and tribal shares shall be subject to adjustments in accordance with a yearly reallocation decision by the Co-Signers. The Secretary agrees to prepare and supply relevant information, and promptly to comply with the Co-Signers' requests for information reasonably needed to determine the funds that may be available for a subsequent Funding Agreement as provided for in Article VI, Section 2 of this Compact.

(b) If the parties are unable to conclude negotiation of a subsequent Funding Agreement, the terms of this Compact and the existing Funding Agreement shall, at the option of the Co-Signer, continue on in 30-day, 90-day or longer increments until a subsequent Funding Agreement is agreed to. As provided in section 505(e) of Title V, the terms of the subsequent Funding Agreement will become retroactive to the end of the term of the preceding Funding Agreement. Any increases in funding to which Tribes are entitled by law or which have been made available by Congress, or increases which Co-Signers subsequently negotiate, shall be included in each Co-Signer's subsequent Funding Agreement.

Section 14 – Health Status Reports. In accordance with section 507(a)(1), Co-Signers shall provide the Secretary a health status and service delivery report to the extent that relevant data is not otherwise available to the Secretary and specific funds for this purpose are provided to the Co-Signer in its Funding Agreement. Such reporting may impose only minimal burdens on the Co-Signer and shall be consistent with regulations promulgated under section 517 of Title V.

Section 15 – Secretarial Approval. For the term of the Compact, the provisions of 25 U.S.C. § 81 and 25 U.S.C. § 476 shall not apply to attorney and other professional contracts of signatory tribal governments of Alaska Native Tribes operating under the Compact pursuant to section 511(b) of Title V.

Section 16 – Transportation and Other Supply Sources.

(a) Use of Motor Vehicles. Subject to agreement of the General Services Administration, the Secretary hereby authorizes each Co-Signer to obtain Interagency Motor Pool vehicles and related services for performance of any programs, activities, functions and services under this Compact.

(b) Other Supply Sources. Federal supply sources (including lodging, airline transportation, and other means of transportation) shall be available to each Co-Signer in accordance with sections 508(e) and 516(a) of Title V.

Section 17 – Limitation of Costs. Each Co-Signer shall not be obligated to continue performance that requires an expenditure of funds in excess of funds awarded under the Funding Agreement. In accordance with section 508(k), if, at any time the Co-Signer has reason to believe that the total amount required for performance of a Funding Agreement, or a specific activity conducted under the Funding Agreement, would be greater than the amount of funds awarded under the Funding Agreement, the Co-Signer shall provide reasonable notice to the Indian Health Service and affected Tribes and tribal organizations. If the Indian Health Service does not take such action as may be necessary to increase the amount of funds awarded under the Funding Agreement, the Co-Signer may suspend performance of the Funding Agreement until such time as additional funds are transferred.

ARTICLE III — OBLIGATIONS OF EACH CO-SIGNER

Section 1 – Consolidation. Each Co-Signer will be responsible for performing the health programs, activities, functions and services as specified in Section 3 of this Article III and in their respective Funding Agreements, as provided for in Article VI, Section 2 of this Compact. To the extent a program, activity, function, or service included within a contract or grant entered into pursuant to sections 102 or 103 of the Indian Self-Determination and Education Assistance Act, as amended, is included within a Funding Agreement, that contract or grant shall be modified or terminated as appropriate. The parties' obligations shall be governed by this Compact and all funds previously obligated under contracts or grants (including carry-over funds) will be re-obligated to the Co-Signer under the applicable Funding Agreement. Such terminated contracts shall be identified by contract number in each Funding Agreement.

Section 2 – Amount of Funds. The total amount of funds covered by the consolidation and redesign provided for in Section 1 of this Article that the Secretary shall make available to the Co-Signers shall be determined in accordance with section 508(c) of Title V and shall be set forth in the respective Funding Agreements between the Secretary and each Co-Signer.

Section 3 – Compact Programs. The health programs, activities, functions and services will be the responsibility of each Co-Signer under this Compact and shall be identified in each Co-Signer's Funding Agreement.

Section 4 – Eligibility for Services. In determining eligibility for services, the Co-Signers shall comply with applicable eligibility provisions set forth in the Indian Health Care Improvement Act, as amended, applicable regulations, and other statutory law.

Section 5 – Reallocation, Redesign and Consolidation. In accordance with section 506(e) of Title V, a Co-Signer may redesign or consolidate programs, services, functions, and activities (or portions thereof) included in a Funding Agreement and reallocate or redirect funds for such programs, services, functions, and activities (or portions thereof) in any manner in which the Co-Signer deems to be in the best interest of the health and welfare of the Indian community being served, only if the redesign or consolidation does not have the effect of denying eligibility for services to population groups otherwise eligible to be served under applicable federal law.

Section 6 – Consolidation with Other Programs. Each Co-Signer may consolidate programs, services, functions, and activities and associated funds identified in its funding agreement with other programs, services, functions, and activities provided with its own funds or funds from other sources, provided that the programs, services, functions, and activities are allowable for inclusion in a funding agreement under Section 505 of Title V. When programs, services, functions, and activities are consolidated in a funding agreement by a Co-Signer in accordance with the terms of the Funding Agreement and Title V, the Co-signer and its employees carrying out those programs, services, functions, and activities may receive Federal Tort Claims Act coverage in accordance with the statutory provisions and regulations cited in the Compact. Whether the Federal Tort Claims Act applies in any particular case is decided on an individual case-by-case basis by the United States Department of Justice and subsequently by the Federal courts. In cases in which a Co-Signer consolidates programs, services, functions, and activities under this section, the Co-Signer shall not be required to separate dollars or programs, services, functions, and activities so long as the Co-Signer can provide sufficient data to permit an acceptable program and financial audit to be conducted.

Section 7 – Program Income, including Medicare/Medicaid. All Medicare, Medicaid or other program income earned by a Co-Signer shall be treated as additional supplemental funding to that negotiated in the Funding Agreement and the Co-Signer may retain all such income, including Medicare/Medicaid, and expend such funds in the current year or in future years, nor shall such funds result in any off-set or reduction in the negotiated amount of the Funding Agreement. Medicare/Medicaid collections of a Co-Signer under Title IV of Public Law 94-437, as amended, shall be used by the Co-Signer in accordance with any applicable statutory restrictions on the use of such funds.

Section 8 – Carry-over. Congressionally appropriated funds allocated in accordance with

a Funding Agreement under this Compact are "no year" funds and may be expended by the Co-Signer in accordance with its budget for the year for which the funds are appropriated or carried over and expended in any subsequent fiscal year, and such carry-over shall not diminish the amount of funds the Co-Signer is authorized to receive under its Funding Agreement for any such subsequent fiscal year.

Section 9 – Matching Funds. Funds may be used to meet matching and other cost participation requirements under any other federal or non-federal programs pursuant to section 512(d) of Title V.

ARTICLE IV — OBLIGATIONS OF THE UNITED STATES

Section 1 – Trust Responsibility. In accordance with sections 507(g) and 515(b) of Title V, nothing in this Compact waives, modifies, or diminishes in any way the trust responsibility of the United States with respect to the Alaska Native Tribes or individual Alaska Natives and American Indians which exists under treaty, executive orders, and acts of Congress.

Section 2 – Programs Retained.

(a) The Secretary hereby retains the responsibility for the programs, activities, functions and services with respect to the signatory Tribes that are not specifically assumed by the signatory Tribes, acting individually or collectively, or by the ANTHC through their applicable Funding Agreements and they shall continue to be entitled to the full benefit of those programs, activities, functions, and services retained by the Indian Health Service. In accordance with section 506(h), each Co-Signer shall be eligible for new programs, activities, functions and services of the Secretary and the Indian Health Service on the same basis as other Tribes and Tribal Organizations. The Indian Health Service, in consultation with the Tribes, may reorganize to sustain its ability to provide, in the most effective and efficient manner, all programs, activities, functions, and services that have not been included in the Funding Agreement.

(b) No later than 120 days prior to the end of each fiscal year, the Indian Health Service shall provide each signatory Tribe and Co-Signer with a written list of the retained programs, activities, functions, and services relevant to Native health care in Alaska for the upcoming fiscal year. To the fullest extent permitted by law, the Secretary shall provide any requesting signatory Tribe and Co-Signer access to, and copies of, all documents and other information relevant to any ongoing retained programs, activities, functions, or services, and shall cooperate with any evaluation which the Co-Signer or signatory Tribe may wish to conduct. The Secretary will cooperate with each Tribe and Co-Signer to facilitate the inclusion of programs, activities, functions and services in future Funding Agreements of those Tribes and Co-Signer.

Section 3 – Financial and Other Information.

(a) To assist the Tribes and Co-Signers in monitoring compliance with section 508(c) of the Indian Self-Determination and Education Assistance Act, as amended, the Secretary shall provide to Co-Signers:

(1) all monthly reports of obligations and allowances, including all reports from Central Office, Headquarters, the Office of Tribal Self-Governance and the Alaska Area Office, concerning funds provided to support programs, activities, functions and services provided by Tribes or Tribal Organizations under this Compact and funds retained by the Indian Health Service to support programs, activities, functions and services retained by the Indian Health Service; and

(2) prompt notice of any new programs, activities, functions and services for which the Tribes or Co-Signers are eligible, including the funding available for such programs, activities, functions and services.

(b) The Secretary shall prepare and promptly supply relevant financial information and comply with each Co-Signer's request for information needed to determine funds that may be available for a successor Funding Agreement.

Section 4 - Savings. If the programs, services, functions and activities carried out under Title V Funding Agreements and this Compact result in a reduction to the administrative or other responsibilities of the Secretary, with respect to the operation of Indian programs, and thereby result in saving that have not otherwise been included in the amount of tribal shares and other funds determined under section 508(c) of Title V, the Secretary shall make such savings available to the Co-Signers for the provision of additional services in accordance with section 507(f) of Title V.

ARTICLE V — OTHER PROVISIONS

Section 1 – Designated Officials/Agent.

(a) Parties. On or before the effective date of this Compact, both the Secretary and each Co-Signer shall provide a written designation of an individual as their representative/liaison. The Secretary shall direct all communications about the Compact, and relevant Funding Agreement to the Co-Signer's designee, except in the case where the Compact or Funding Agreement requires notice to the signatory Tribes, in which case notice shall also be sent to the Tribes. Reference herein to Co-Signers or the Secretary shall include the respective Designated Official thereof.

(b) Agent for Notice. If Co-Signers assign an agent to accept and distribute notices, those Co-Signers shall provide the name and address of the agent and a description of the limited powers and duties of the agent.

Section 2 – Indian Preference in Employment, Contracting and Sub-Contracting. The Co-Signers will comply with the Indian and Alaska Native preference provisions of sections 7(b) and 7(c) of the Indian Self-Determination and Education Assistance Act, as amended. The parties agree that any Co-Signer may comply with any Indian or Alaska Native preference established by their respective Tribes, including preference based on tribal affiliation.

Section 3 – Federal Tort Claims Act Coverage; Insurance.

(a) The Tribes and Co-Signers are deemed by statute to be part of the Public Health

Service (PHS), and the employees of the Tribes and Co-Signers are deemed by statute to be part of or employed by the Public Health Service, for purposes of coverage under the Federal Tort Claims Act, while performing programs, activities, functions or services under this Compact and described in the Co-Signer's Funding Agreement (including new and existing programs, services, functions and activities as provided under Article III, Section 5 or 6, or supported with income received in accordance with Article III, Section 7), including coverage for claims of medical malpractice, as is more fully described in 25 C.F.R. Part 900 Subpart M, attached hereto as Exhibit E, and incorporated by reference herein, and section 102(d) of the Indian Self-Determination and Education Assistance Act, as amended, as required by section 516(a).

(b) The above status of a Tribe or Co-Signer, or an employee's status as an employee of a Tribe or employee of a Co-Signer, is not affected by the source of the funds used by the Tribe or Co-Signer to carry out the programs, services, functions or activities or to pay the employee's salary and benefits as long as the employee does not receive any additional compensation for the performance of covered services from anyone other than the Tribe or Co-Signer.

(c) The Tribe's employee or the Co-Signer's employee may, while performing under this Compact and any applicable Co-Signer's Funding Agreement and as a condition of employment, be required by the Tribe or Co-Signer to provide services to non-Indian Health Service beneficiaries in order to meet the obligations under this Compact either in facilities of the Tribe or Co-Signer or in facilities other than those of the Tribe or Co-Signer.

(d) Funds provided under a Funding Agreement may be used to purchase such additional liability and other insurance as is prudent in the judgment of a Co-Signer performing under this Compact and Funding Agreement for its protection and the protection of its employees.

(e) Personal services contracts shall be covered under this provision to the extent provided under section 102(d) of the Indian Self-Determination and Education Assistance Act, as amended.

(f) Coverage shall also apply in accordance with Section 813(e) of the IHCIA, as amended.

Section 4 – Compact Modifications or Amendments.

(a) Any request for a modification of this Compact must be communicated in writing to all signatory Tribes and Co-Signers and to the Indian Health Service. To be effective any modifications of this Compact shall be in the form of a written amendment to the Compact, and shall require written consent of each of the signatory Tribes, acting directly or through an agent authorized by resolution, and the Secretary.

(b) This provision shall not apply to amendment of the Compact to include additional Tribes and/or Co-Signers. Such amendment shall only require the concurrence of the additional Tribe and/or Co-Signer, and the Secretary.

Section 5 – Construction. This Compact shall apply to funds included in the facilities category of Indian Health Service appropriations. A Co-signer may assume construction projects or programs in accordance with Titles I or V or P.L. 86-121. In doing so, the Co-Signer elects to comply with the regulations of the elected statutory provision.

Section 6 – Officials Not To Benefit. No member of or delegate to Congress shall be admitted to any share or part of any Compact executed pursuant to this Compact, or to any benefit that may arise there from; but this provision shall not be construed to extend to any contract under this Compact if made with a corporation for its general benefit.

Section 7 – Covenant Against Contingent Fees. The parties warrant that no person or selling agency has been employed or retained to solicit or secure any contract executed pursuant to this Compact upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial or selling agencies maintained by the contractor for the purpose of securing business.

Section 8 – Penalties. The parties agree that the criminal penalties set forth in 25 U.S.C. § 450d apply to all activities conducted pursuant to this Compact.

Section 9 – Use of Federal Employees. Section 104 of the Indian Self-Determination and Education Assistance Act, as amended, shall apply to this Compact and to any individuals assigned or detailed to any Co-Signer performing functions under this Compact or leaving federal employment to perform services under this Compact, including assignments either on detail or on leave without pay and with or without reimbursement by the Co-Signer for the travel and transportation expenses to or from the place of assignment and for the pay, or supplemental pay, or a part thereof, of the employee during assignment.

Section 10 – Extraordinary or Unforeseen Events. This Compact is intended to obligate each Co-Signer to carry out all usual and ordinary functions respecting the programs, activities, functions and services that it is undertaking to assume responsibility for under its Funding Agreement. In the event major unforeseen or extraordinary events occur, as jointly identified by each Co-Signer and the Secretary, with consequences beyond the control of the Co-Signer, that the Co-Signer shall have access to additional services and funding amounts for its Funding Agreement as described in its Funding Agreement. The parties will seek to ensure that funds available to the Co-Signer to deal with the unforeseen circumstance will not be less than would have been available to non-Compact Tribes or the Indian Health Service had they encountered a similar circumstance. Each Co-Signer's participation in the Indian Health Service Catastrophic Health Emergency Funds will be identified in the Co-Signer's Funding Agreement.

Section 11 – Mature Contractor Status upon Compact Termination. In accordance with section 506(g)(3) of Title V, should any signatory Tribe, tribal organization at the direction of a signatory Tribe or Tribes, or the ANTHC, elect to convert all or some of the programs operated under the Compact back to contract status under Public Law 93-638, as amended, such conversion shall not affect the Co-Signer's or the Tribe's status as having operated a mature contract within the meaning of section 4(h) of the Indian Self-Determination and Education Assistance Act, as amended. Such conversion would occur only at the end of the Compact term, on another date mutually acceptable to the Tribe, the Co-Signer and the Secretary, or as otherwise provided in this Compact, and will be implemented in a manner which avoids any interruption of services to

individual tribal members. If the Compact is terminated or a Tribe determines that it will retrocede any program, activity, function or service operated under the Compact, neither the Tribe nor the Co-Signer shall lose its mature contractor status under section 4(h) as provided above.

Section 12 – Startup Costs. In accordance with section 508(c) of Title V, startup costs may be separately negotiated by each Co-Signer and shall be included in each Co-Signer's Funding Agreement, if available. Startup costs are designed to compensate the Tribe for costs associated with implementing this Compact which the Co-Signer would not normally incur. Upon agreement to such costs on an annual basis, funds for such costs shall be included in the Funding Agreement, if available.

Section 13 – Limitation of Liability. Any liability to the United States or to any third party incurred by a Co-Signer arising out of its performance of or expenditure of funds under this Compact and each Co-Signer's Funding Agreement shall be the obligation only of that Co-Signer and shall not be the obligation of any Co-Signer of this Compact which did not participate in such performance or expenditure.

Section 14 – Contracting Rights. Nothing in this Compact or in any Funding Agreement shall be construed to preclude a Co-Signer from contracting with the Secretary to perform a program, activity, function, or service under Title I of P.L. 93-638, as amended, subject, however, to constraints against duplication pursuant to section 506(h) of Title V.

Section 15 – Sovereign Immunity. Nothing in this Compact or in any Funding Agreement shall be construed to affect the sovereign immunity, to the extent that it may exist, of any Tribe or Co-Signer.

Section 16 – Interpretation of Federal Law. In the implementation of this Compact, the Secretary, to the extent feasible, shall interpret all federal laws, executive orders, and regulations and this Compact in a manner that effectuates and facilitates the purposes of this Compact and achievement of the Co-Signers' health goals and objectives in accordance with section 512(a) of Title V.

Section 17 – Inadequacy of Program Funding. The parties to this Compact understand that the Indian Health Service budget is inadequate to fully meet the special responsibilities and legal obligations of the United States to assure the highest possible health status for American Indians and Alaska Natives and that, accordingly, the funds provided to the Co-Signers are inadequate to permit the Co-Signers to achieve this goal. The Secretary commits to advocate for increases in the Indian Health Service budget to further the ability of the Co-Signers to provide the full range of services that are the responsibility and obligation of the United States to make available to American Indian and Alaska Native people and to meet the goals of the Indian Health Care Improvement Act.

Section 18 – Effect on Non-Signatory Tribes.

(a) Nothing in this Compact or associated Funding Agreements shall be construed to limit or reduce in any way the service, contracts or funds that any Indian tribe, inter-tribal

consortium or tribal organization is eligible to receive. It is the intent of the parties to this Compact that the Compact will not have an adverse impact on any tribe choosing not to participate in this Compact directly or through a tribal organization.

(b) The Compact shall not be construed to limit or curtail the right of any Tribe to pursue a contract under Title I of the Indian Self-Determination and Education Assistance Act, as amended, individual participation in this Compact under Title V, or an independent compact under Title V.

Section 19 – Gaining Mature Contractor Status. Subject to Secretarial approval, a tribe that participates in this Compact by authorizing a tribal organization or inter-tribal consortium to be a Co-signer and receive funds on its behalf, which enters into a Memorandum of Agreement with the Co-Signer, for three years manages a program, activity, function or service identified in the Co-Signer's Funding Agreement and obtains three audits with no material unresolved audit exceptions, shall be deemed a mature contractor for all purposes, including entering into a Compact under section 503(c) of Title V. Nothing in this section precludes the right of a tribe to become a mature contractor under other provisions of law.

Section 20 – Severability. This Compact shall not be considered invalid, void or voidable if any section or provision of this Compact is found to be invalid, unlawful or unenforceable by a court of competent jurisdiction. Should such a court make such a finding, the parties will seek agreement to amend, revise or delete any such invalid, unlawful or unenforceable section or provision, in accordance with the provisions of this Compact.

Section 21 – Applicability of Title I Provisions. At the request of a Co-Signer, any provision of Title I, not already specified in section 516(a) of Title V, to the extent such provision does not conflict with a provision in Title V, shall be made a part of a Funding Agreement. The Secretary is obligated to include such provision at the option of the Co-Signer. If such provision is incorporated it shall have the same force and effect as if it were set out in full in Title V and in the Funding Agreement. Should the Co-Signer request such an incorporation sometime other than during the negotiation stage of the Funding Agreement, the Co-Signer will present the proposed incorporated Section to the Indian Health Service, OTSG, with a copy to the Alaska Area IHS Director. The Director of the Indian Health Service shall approve a written addendum to the Funding Agreement within 30 days after verifying that the provision is in Title I. In the case of any such provision, it shall be deemed incorporated in the Funding Agreement at the end of the 30 day period unless the Co-Signer receives a written notice from the Indian Health Service stating that the provision is not in Title I. In the event a Co-Signer requests such incorporation at the negotiation stage of this Compact or a Funding Agreement, such incorporation shall be deemed effective immediately and shall control the negotiation and resulting Compact and Funding Agreement.

Section 22 — Purchases from the Indian Health Service. With respect to functions transferred by the Indian Health Service to a Co-Signer under this Compact or an applicable Funding Agreement, the Indian Health Service shall provide goods and services to the Co-Signer, on a reimbursable basis, including payment in advance with subsequent adjustment. The reimbursements received from those goods and services, along with the funds received from the Co-Signer pursuant to this section, may be credited to the same or subsequent appropriation account which provided the funding, such amounts to remain available until expended.

ARTICLE VI — ATTACHMENTS

Section 1 – Approval of Compact. The resolutions of the Tribes approving this Compact for each Co-Signer are attached as part of Exhibit A. Additional resolutions for each Co-Signer may be filed with the Indian Health Service and included in Exhibit A up to the effective date of each Co-Signer's Funding Agreement. The resolution of the Board of Directors of the ANTHC is attached as part of Exhibit A.

Section 2 – Funding Agreements. Each Co-Signer's Funding Agreement shall be attached hereto as Exhibit C.

ARTICLE VII — COUNTERPART SIGNATURES

This Compact may be signed in counterparts.

CITY OF NOME
ADMINSTRATIVE REVIEW AND APPEAL FORM

Appeal #: 25

This form is for you to appeal the assessed valuation on your property. Complete Sections 1, 2 and 3. Retain a copy for your records, and return or mail the original copy to the City Clerk's Office. Appeals must be returned or postmarked no later than the date indicated on the Assessment Notice. The Assessor will contact you regarding your appeal.

****

RECEIVED
APR 21 2022
CITY OF NOME
CLERKS DEPARTMENT

1) I appeal the value of tax parcel #: 0 0 1 . 1 3 1 . 0 1 A

Property legal description: Block 33, Lot 19, Mineral Survey _____, Other _____

Print Owner's Name: Norton Sound Health Corporation

Owner's Mailing Address: PO Box 966, Day Phone: ( ) 443-3337

Nome, AK 99762, Evening Phone: ( ) ____-____

Address to which all correspondence should be mailed (if different than above): _____

Please also email all information to: dpardee@nshcorp.org

****

2)

Assessor's Value	Land:	Bldg:	Total:	Purchase Date:
	$27,200	$425,100	$452,300	
Owner's Estimate of Value	$0.00	$0.00	exempt	

Owner's reason for estimate of value (including inventory corrections, sales of comparable properties, and property income statements, if appropriate). The Appellant bears the burden of proof. Grounds for adjustment of assessment are proof of unequal, excessive, improper, or under-valuation based on facts that are stated in a valid written appeal or proven at the appeal hearing.

Appeal based on AS 29.45.030 (a)(3), Hospital, Charitable Activities and Federal Law. Assessment is improper.

See attached

(PLEASE ATTACH STATEMENT IF YOU NEED MORE SPACE)

****

3) I hereby affirm that the foregoing information is true and correct, that I have read and understand the guidelines above, and that I am the owner or owner's authorized agent of the property described above.

Angie Gom — **Signature of owner or authorized agent**

4/20/22 — Date signed

Angie Gom — Print Name (if different form item # 1)

SUBSCRIBED and SWORN to before me this 20 day of April, 2022

NOTARY PUBLIC in and for the STATE of ALASKA: Meredith Ahmasuk

Commission Expires: 2026, Jan. 5

Seal:

STATE OF ALASKA
NOTARY PUBLIC
Meredith Ahmasuk
My Commission Expires Jan 5, 2026

Appeal#: 25

4)

Assessor's Decision	From:	Land:	Building:	Total:
	To:			

Assessor's Reason for Decision: _____

(PLEASE ATTACH STATEMENT IF YOU NEED MORE SPACE)

Date Rec'd	Decision made by	Date	Approved by	Date	Date mailed

5) **Appellant's Response**:

☐ **I ACCEPT** the assessor's decision in Block 4 above and hereby withdraw my appeal.

☒ **I DO NOT ACCEPT** the assessor's decision and desire to have my appeal presented to the Board of Equalization.

Signature of owner or authorized agent	Date	Printed Name
	4/19/2022	Geoffrey D. Strommer

6)

BOARD OF EQUALIZATION DECISION	LAND:	BUILDING:	TOTAL:

Date Received	Date Heard	Certified (Chairman or Clerk of Board)	Date	Date Mailed

2022 BOARD OF EQUALIZATION DATE: MAY 4, 5, & 6 2022

THE FINAL DAY TO APPEAL (April 25, 2022) IS 30 DAYS AFTER THE POSTMARK OF YOUR ASSESSMENT NOTICE (*March 25, 2022*)

Attachment to Administrative Review and Appeal Form
Block 33, Lot 19, 711 E. 3rd Avenue ("Kusqii House")

I. Property Use Description

1. General Scope of Activities on Hospital-Owned Properties.

The Norton Sound Health Corporation (NSHC) is a tribally owned and operated, independent, not-for-profit healthcare organization founded in 1970 to meet the healthcare needs of the Inupiat, Siberian Yup'ik, and Yup'ik people of the Bering Strait region. NSHC is governed by a 22-member board of directors who represent all communities and areas of the Bering Strait region, a 44,000 square-mile section of Northwestern Alaska. The NSHC service area encompasses these 44,000 square miles. NSHC is the only regional health system serving Northwestern Alaska.

The NSHC healthcare system includes a tribally owned regional hospital which is operated pursuant to an Indian Self-Determination and Education Assistance Act (ISDEAA) agreement. NSHC operates health facilities and provides health care services to Alaska Natives and other beneficiaries pursuant to the Alaska Tribal Health Compact (ATHC), a multi-tribe self-governance compact with the Indian Health Service (IHS) under Title V of the ISDEAA, 25 U.S.C. § 5381, et seq., and funding agreements (FAs), which include program funding amounts that are negotiated for each fiscal year between the IHS and NSHC to fund the programs, functions, services, and activities (PFSAs) that NSHC performs on behalf of IHS. IHS funds the administration of the PFSAs, including the operation of the hospital facilities in Nome, that NSHC has contracted to perform on behalf of IHS.[1]

NSHC is an "instrumentality" of the United States in providing healthcare services under Title V of the ISDEAA. Healthcare services are federal PFSAs provided under the ISDEAA pursuant to the federal trust responsibility to Indians for health care.[2]

The ISDEAA deems tribes and tribal organizations carrying out ISDEAA agreements to be federal executive agencies for purposes of coverage under the Federal Tort Claims Act (FTCA) and access to federal sources of supply.[3] NSHC employees, like employees of other tribal entities operating agreements with IHS under the ISDEAA, are similarly equally covered by the FTCA and are "federal employees" for these purposes.[4] The ISDEAA also authorizes tribal contractors and compactors to perform personal services otherwise performed by federal employees in determining eligibility for IHS services and benefits, the amounts of such services and benefits, and how such services and benefits should be provided.[5] In addition, tribal

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[1] 25 U.S.C. § 5325; 25 U.S.C. § 5396(a) (mandatory application of § 5325 to Title V agreements).

[2] 25 U.S.C. § 1602.

[3] 25 U.S.C. §§ 450f(d) and 450j(k).

[4] *See* 25 U.S.C. §§ 5321(d) and 5396(a); *M.J. ex rel. Beebe v. United States*, 721 F.3d 1079, 1084 (9th Cir. 2013).

[5] 25 USC § 450j(g).

facilities operated under the ISDEAA are interpreted by the Centers for Medicare and Medicaid Services as IHS facilities for purposes of the 100 percent Federal Medical Assistance Percentage under Section 1905 of the Social Security Act.[6]

The ATHC expressly provides that ATHC co-signers, such as NSHC, "are deemed by statute to be part of the Public Health Service (PHS), and the employees of the Tribes and Co-Signers are deemed by statute to be part of or employed by the Public Health Service, for purposes of coverage under the [FTCA]," while performing PFSAs under the ATHC's compact and as described in its Funding Agreement.[7] The current NSHC Funding Agreement expressly provides that "support services required to support the provision of health services," including human resources activities, administration and board support, performance management, financial functions, and the provision of staff housing, are part of the scope of work,[8] as is the training of community health aides;[9] emergency medical services training for staff and community members throughout the region;[10] and the provision of lodging for patients, family members of patients, and their escorts.[11]

2. Specific Use of Kusqii House.

This property was owned by the U.S. Department of Health and Human Services (HHS), a federal agency. In 2002, it was deeded to NSHC with covenants of use imposed by the federal government for the duration of NSHC's ownership. Those covenants mandate utilization of the building "continuously for health purposes." (Deed attached). The building houses individuals who travel to Nome from outer villages to receive emergency medical care training including:

a. Emergency Medical Technician training;

b. Health-aide training (HAT), which NSHC is required to conduct as part of its funding agreement;

c. Training conducted as part of the IHS Community Health Aide Program (CHAP) in Alaska, which provides the only local source of health care for many Alaska Native people in rural areas. The CHAP is mandated by Congress as the instrument for providing basic health services in remote Alaska Native villages.

NSHC is licensed and legally required to provide this training pursuant to its Bylaws and funding agreement. All of the training is conducted and supervised by NSHC personnel.

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[6] 42 U.S.C. § 1396(d).

[7] *See* ATHC Article V Sec. 3(a).

[8] Funding Agreement Between Certain Alaska Native Tribes Served By The Norton Sound Health Corporation And The Secretary Of Human Health And Human Services Of The United States of America Fiscal Years 2018-2020 § 3.5.

[9] *Id.* §§ 3.4.4, 3.4.5.

[10] *Id.* § 3.4.7.

[11] *Id.* at § 3.2.14.

The building also provides housing for staff from outer villages, including contract labor, Lab, Primary Care, Acute Care, Health Aides, and Diabetes program staff.

The building has a 99% occupancy rate throughout the year and serves only the above-described purposes.

II. NSHC Enjoys the Sovereign Immunity of its Member Tribes and is Immune from Suits to Collect Taxes

Tribal healthcare entities like NSHC performing self-determination contracts under the ISDEAA for health services enjoy sovereign immunity,[12] including those operating off-reservation.[13] "Indian tribes have long been recognized as possessing the common-law immunity from suit traditionally enjoyed by sovereign powers."[14] "As a matter of federal law, an Indian tribe is subject to suit only where Congress has authorized the suit or the tribe has waived its immunity."[15] "[T]ribal immunity is a matter of federal law and is not subject to diminution by the States."[16] Tribal immunity extends to tribal governing bodies and to tribal agencies or entities that act as an "arm of the tribe."[17] Lastly, "[i]t is settled that a waiver of [tribal] sovereign immunity cannot be implied but must be unequivocally expressed."[18]

In *Barron v. Alaska Native Tribal Health Consortium*, the U.S. District Court for the District of Alaska held a tribal health consortium organization enjoyed sovereign immunity where the organization was formed by Alaska Native tribes; its creation was authorized pursuant to the ISDEAA; it received federal funding to conduct activities that benefitted tribal members; the structure of its board placed control over its ownership and management in representatives of the Alaska Native tribes; its purpose of entering into self-determination and self-governance agreements was "core to the notion of sovereignty"; and it received federal funding "to carry out governmental functions critical to Alaska Native tribes," i.e., healthcare services.[19] Like the entity in *Barron*, and as more fully discussed below, NSHC shares these same attributes.

Tribal immunity extends to suits to collect unpaid taxes. This is because, as the U.S. Supreme Court noted in *Oklahoma Tax Commission v. Citizen Band Potawatomi Indian Tribe of Oklahoma*, "[a]lthough Congress has occasionally authorized limited classes of suits against Indian tribes, *it has never authorized suits to enforce tax assessments*."[20]

In *Matter of 1981–85 Delinquent Property Taxes Owed to the City of Nome, Alaska*, the Supreme Court of Alaska held that the Indian Reorganization Act (IRA) barred a city from

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[12] *Manzano v. S. Indian Health Council, Inc.*, No. 20-cv-02130-BAS-BGS, 2021 WL 2826072, at *1 (S.D. Cal. July 7, 2021) (non-profit healthcare corporation formed by membership of seven tribes entitled to sovereign immunity).
[13] *See Pink v. Modoc Indian Health Proj., Inc.*, 157 F.3d 1185, 1189 (9th Cir. 1998) (nonprofit corporation created and controlled by two tribes entitled to sovereign immunity).
[14] *Santa Clara Pueblo v. Martinez*, 436 U.S. 49, 58 (1978).
[15] *Kiowa Tribe of Okla.* v. *Mfg. Techs., Inc.*, 523 U.S. 751, 754 (1998) (citations omitted).
[16] *Id.* at 756 (citations omitted).
[17] *Cook v. AVI Casino Enters., Inc.*, 548 F.3d 718, 725 (9th Cir. 2008).
[18] *Santa Clara Pueblo*, 436 U.S. at 58 (citation omitted) (internal quotation omitted).
[19] 373 F.Supp.3d 1232, 1239–40 (D. Alaska 2019).
[20] 498 U.S. 505, 510 (1991) (emphasis added).

foreclosing on lands held by groups of Alaska Natives organized under Section 16 of the IRA on the basis of non-payment of local property taxes.[21] In that case, the city sought to foreclose on two tracts owed by the Alaska Native group which were "purchased in part with funds from a federal grant under the [ISDEAA]."[22] In that case, the Court found the IRA was "intended to promote tribal self-government and conserve Indian lands and resources," and that had any doubt remained, the Court "would rest on the settled principle that, in Indian law, all ambiguities must be resolved in favor of the Indians."[23]

In the U.S. Circuit Court of Appeals for the Ninth Circuit, where NSHC is located, courts look to the following factors to determine whether a tribal entity functions as an "arm of the tribe" and is therefore entitled to share in the tribe's sovereign immunity: "(1) the method of creation of the economic entities; (2) their purpose; (3) their structure, ownership, and management, including the amount of control the tribe has over the entities; (4) the tribe's intent with respect to the sharing of its sovereign immunity; and (5) the financial relationship between the tribe and the entities."[24] In *White v. University of California*, the Ninth Circuit upheld the district court's application of this test to hold that a tribal repatriation committee formed by twelve tribes was entitled to sovereign immunity because it was created by resolution of each of the tribes; comprised solely of tribal members appointed by each tribe; funded exclusively by the tribes; and its purpose, "to recover remains and educate the public, [was] 'core to the notion of sovereignty.'"[25] And in *Pink v. Modoc Indian Health Project, Inc.*, the court held that a subsidiary tribal entity established and controlled by several tribes to provide health care services was protected by sovereign immunity.[26]

1. NSHC's method of creation supports immunity.

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[21] 780 P.2d 363 (Alaska 1989).
[22] *Id.* at 364.
[23] *Id.* at 367 (citation omitted).
[24] *White v. Univ. of Cal.*, 765 F.3d at 1025 (2014) (citation omitted). Although not included in the Ninth Circuit's "arm of the tribe" test, an additional factor is examined by the Tenth Circuit: "the policies underlying tribal sovereign immunity and its connection to tribal economic development, and whether those policies are served by granting immunity to the economic entities." *Breakthrough Mgmt. Grp., Inc. v. Chukchansi Gold Casino and Resort*, 629 F.3d 1173, 1187 (2010).
Here, a grant of immunity to NSHC furthers the policies underlying tribal sovereign immunity. The doctrine of tribal sovereign immunity exists in order to avoid "interference with tribal autonomy and self-government," *Santa Clara Pueblo*, 436 U.S. at 59, and "infringe[ment] on the right of the Indians to govern themselves." *Williams v. Lee*, 358 U.S. 217, 223 (1959). Like the doctrine of tribal sovereign immunity, the fundamental policy underlying the ISDEAA is to enhance tribal autonomy and control in the provision of services to tribal communities. *See, e.g.*, 25 U.S.C. § 5302(a) (declaring that policy of ISDEAA is to assure "maximum Indian participation in the direction of educational as well as other Federal services to Indian communities so as to render such services more responsive to the needs and desires of those communities"). NSHC has taken on the entire federal responsibility for health care services for its member tribes. The essential federal-tribal nature of the ISDEAA program and the fact ISDEAA programs are funded by the federal resources that would have been spent on programs serving those tribes shows that NSHC is completely financially dependent on the tribes' right to ISDEAA funding, and has stepped into the tribes' shoes and operates as the "health arm" of its member tribes. Because NSHC has stepped into the shoes of its member tribes as the "health arm" of those tribes in order to enter a government-to-government relationship with the United States, NSHC's immunity from suit protects the tribal autonomy of NSHC's member governments.
[25] *White*, 765 F.3d at 1025.
[26] 157 F.3d at 1188–89.

NSHC was incorporated on November 27, 1970 under the Alaska Non-Profit Corporation Act. Article VII of the NSHC Articles of Incorporation names three individuals representing the Alaska Native villages of Shaktoolik, Gambell, and Teller to the initial Board of Directors, and Article VIII shows the same three Village representatives as the initial incorporators. The formation and governance of NSHC was thereby tied directly to the member Villages. Article I and Article III of the Articles of Incorporation also provide that NSHC shall be "non-profit in nature," weighing in favor of treating it as an arm of the tribes. It is clear that NSHC's member tribes have delegated their governmental, rather than commercial, responsibility to provide health care to NSHC, which is not a for-profit venture but a vehicle for providing government health services.

2. NSHC's purpose to provide governmental health care supports immunity.

NSHC's Bylaws, adopted in 1977 and revised in 1978–79, expressly establish the Corporations purposes as follows:

1. To establish and maintain facilities, including but not limited to hospital and clinics, for the care of people suffering from injury, illness or disability requiring medical and hospital services and utilizing both inpatient and outpatient facilities and services, such care to be given regardless of the person's race, color, creed, age, sex, nationality or ability to pay.
2. To participate, so far as the circumstances may warrant, in any activity to promote the general health of the principal area.
3. To carry on educational programs, including the training of healing arts personnel, relating to rendering care to the sick and the promotion of health and the maintenance of high health care standards.
4. To advance general community understanding of, confidence in and proper use of the total program of health services.
5. To carry out the foregoing purposes [through the receipt and disbursement of funds and assets].

Each of these purposes reflects the delegation from the member tribes of their respective governmental health care responsibilities to NSHC. Indeed, the purpose of NSHC is to "step into the shoes" of the federal government to carry out, through the ISDEAA, the United States' responsibility to provide health care for Alaska Native and American Indian people.[27]

3. The tribal governments' close ownership, and management and control of NSHC support immunity.

NSHC is structured such that NSHC's member tribes directly control the governance of NSHC. Article IV of the Bylaws established a Board of Directors of 22 elected directors. Each of the 16 member villages elects one representative to the Board of Directors, and the Nome Eskimo Community elects two directors. The Nome City Council may elect one director, and the Board of Directors, among themselves, elects three additional directors representing Nome.

[27] *See* 25 U.S.C. § 5302.

Article V provides that the NSHC officers, including the Chairman, are elected from among the Board of Directors.

To this point, in 1980, the United States Department of the Interior unequivocally determined, based on the member tribal organizations' direct control of NSHC, that NSHC is an arm of the member tribes.[28]

In his Memorandum, Alaska Regional Solicitor Dennis J. Hopewell informed the BIA Area Director, Juneau Area Office that "[NSHC] is not only considered the 'health arm' of the Bering Straits Native Corporation . . . which is a recognized Indian tribe . . . but the Norton Sound Health Corporation is controlled, sanctioned and chartered by other tribal governing bodies." Hopewell considered the NSHC Bylaws to be conclusive evidence of NSHC's direct control by its member tribal entities, stating "[s]ince the Bylaws for the [NSHC] also spell out that '[t]he management of the property, funds, affairs and business of this Corporation shall be vested in a Board of Directors consisting of ...' the members listed above, there can be no doubt that the corporation is controlled by tribal governing bodies." Hopewell found that NSHC "in addition to being controlled by, is also sanctioned and chartered by such tribal governing bodies," and "[t]his representation also shows that the operation and management of [NSHC] includes the maximum participation of Indians in all phases of its activities."

4. The tribal governments intended that NSHC share in their tribal sovereign immunity.

In 1975, Congress signed the ISDEAA (Pub. L. No. 93-638) into law. In 1978 and 1979, NSHC's member Alaska Native Villages each executed resolutions authorizing NSHC to enter contracts and grants with the United States on their behalf.[29] In 1994, the member Villages executed additional resolutions, which provide the current authority for NSHC to enter into the compact and funding agreements.[30]

Each resolution acknowledged that Congress enacted the ISDEAA as a "far reaching Indian Self-Determination Policy" that "grants Alaska Native villages the *sovereign right to designate tribal organizations which shall have the authority to provide services through contracts or grants with the Federal Government* under Public Law 93-638 for the provision of Government services to Native peoples."[31] The resolutions further note that NSHC "has village representation and traditionally provided information both to and from the village on health related matters" and that NSHC "is controlled and operated by a Board of Directors appointed by the tribal governments" of its member communities.[32]

In recognition of the foregoing, the resolutions authorize NSHC "to apply for, negotiate, appeal from adverse decisions, and secure contracts and grants with the Indian Health Service of the Department of Health, Education and Welfare for health care and related programs serving

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[28] Status of Norton Sound Health Corporation As A Tribal Organization Pursuant to P.L. 93-638.
[29] A representative resolution from the Native Village of Elim is attached [hereafter Elim Resolution].
[30] A representative resolution from the Native Village of Diomede is attached.
[31] *See, e.g.,* Elim Resolution at 1 (emphasis added).
[32] *Ibid.*

Native people" in the region.[33] The resolutions further authorize NSHC and its Board of Directors "to act on behalf of this village on health and related services" and "to accept funding for health and related service projects for this village from all funding agencies private and public."[34] The United States Supreme Court has noted that "[t]he common law sovereign immunity possessed by the Tribe is a necessary corollary to Indian sovereignty and self-governance."[35] The resolutions' provisions that NSHC would "act on behalf" of the villages as their health arm and delegation of governmental duties to NSHC reflects their intent that NSHC would share in the "corollary" privilege of immunity from suit in carrying out those functions.

5. NSHC is wholly financially dependent on the member tribes' assignment of their right to contract with IHS to provide health services to their members.

Under the ATHC, all Alaska tribes participate in the delivery of health care services to their members and other beneficiaries in accordance with the principles of tribal self-governance. The Compact allowed NSHC, on behalf of its member tribes, to enter into a government-to-government relationship with the United States. Since 1994, NSHC has participated each year with other co-signers and the IHS in the negotiation of annual funding agreements and amendments to the ATHC.

The funding agreement (FA) NSHC negotiates annually with IHS on behalf of the member tribes includes a broad scope of work covering a wide variety of health care services, from hospital and clinic services to long-term care, from dental services to lodging for patients.[36] In fact, while NSHC is the *signatory* to the funding agreement, the *parties* to the FA are the HHS Secretary and NSHC's member villages themselves. The 2018 Funding Agreement, titled, "Funding Agreement Between Certain Alaska Native Tribes Served by the Norton Sound Health Corporation and the Secretary Of Health And Human Services Of The United States Of America," states:

> This Funding Agreement is entered into by and between certain Alaska Native Tribes in the Bering Straits region of the Norton Sound Service Unit, as identified on the signature page herein, and the Secretary of the Department of Health and Human Services. These Tribes have authorized the Norton Sound Health Corporation to sign this Funding Agreement for them and to be responsible for and carry out the terms of this Funding Agreement.[37]

Section 2.1 of the 2018 FA "obligates NSHC to be responsible for and to provide health PSFAs identified in Section 3 [Tribal Programs and Budget], utilizing the resources transferred under this FA and other funds as they may become available to NSHC." Section 5.2 provides these resources represent the entirety of the member Tribes' entitlement to these funds: "NSHC

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[33] *Ibid.*
[34] *Ibid.*
[35] *Three Affiliated Tribes of Fort Berthold Reservation v. Wold Eng'g*, 476 U.S. 877, 890 (1986) (emphasis added).
[36] Funding Agreement Between Certain Alaska Native Tribes Served By The Norton Sound Health Corporation And The Secretary Of Health And Human Services Of The United States Of America Fiscal Years 2018-2020 §§ 3.2, 3.4.1, and 3.2.14.
[37] *Id.* at 1.

will be paid 100 percent of Headquarters and Area Tribal Shares in its initial lump sum payment, as negotiated in this FA." Section 4 of the 2018 FA describes the total FY 2018 funding made available to NSHC from funds that would otherwise be allocated to NSHC's member tribes. Without the Compact and Funding Agreements, through which NSHC performs governmental functions for their member villages, NSHC would be unable to function. Accordingly, the financial relationship between NSHC and the tribal entities supports NSHC's immunity.[38]

In substance and in form, NSHC serves as an arm of its member tribes. NSHC is dependent on the authorization and support of its member tribal governments to operate, and it fills a critically under-resourced governmental function–far different from a private, for-profit economic venture or other state-incorporated non-profits that may operate in the public sector but are not fulfilling government functions. NSHC shares in the sovereign immunity of its member tribes, and this immunity from suit extends to suits to collect unpaid taxes. This sovereign immunity operates unless specifically and unequivocally waived, and NSHC has not waived its immunity.

III. The City's Taxation is Preempted by Federal Law

Alaska Statute 29.45.030(a)(8) exempts from tax, "property of a political subdivision, agency, corporation, or other entity of the United States to the extent required by federal law..." The city of Nome's tax on all real property owned by NSHC is preempted by federal law.

In *United States v. New Mexico*, the U.S. Supreme Court announced a rule to apply generally to determine immunity from state and local taxation under the supremacy doctrine:

> [T]ax immunity is appropriate in only one circumstance; when the levy falls on the United States itself, or on an agency or *instrumentality* so closely connected to the Government that the two cannot realistically be viewed as separate entities, *at least insofar as the activity being taxed is concerned.*[39]

Under the implied federal preemption doctrine, space that is used to carry out federal programs and that is subject to comprehensive and pervasive federal oversight is exempt from state or local taxation.[40]

In *Ketchikan Gateway Borough v. Ketchikan Indian Corporation*, the Alaska Supreme Court upheld application of the implied federal preemption doctrine to exempt from borough taxes "*all space in a building that contains a tribally operated clinic.*"[41] In that case, the tribally operated clinic was funded by the IHS and operated on land conveyed by the United States.[42] The only space held not to be exempt from taxation was "space not committed to use by the clinic," because it was "uncertain how the uncommitted space would be used" and it "appear[ed]

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[38] *See White*, 765 F.3d at 1025 (fact that entity was funded solely by the tribe supported determination that entity was an "arm of the tribe" entitled to immunity).
[39] 455 U.S. 720, 735 (1982) (emphasis added).
[40] *Ketchikan Gateway Borough v. Ketchikan Indian Corp.*, 75 P.3d 1042, 1048 (Alaska 2003).
[41] *Id.* at 1044 (emphasis added).
[42] *Ibid.*

that at least for near-term purposes it [would] either be leased to others or used for other [i.e., non-clinic-related] programs of [the Indian corporation]."[43]

This property is integral to the provision of healthcare under NSHC's ISDEAA agreement. As programs and services that support the healthcare operations are included under the scope of work as defined in NSHC's Funding Agreement, all areas used for human resources, administration and board support, performance management, training, medical personnel housing, patient housing, and financial function are integral to NSHC's healthcare operations under the ISDEAA.

The Alaska Supreme Court, in *Ketchikan Gateway Borough,* acknowledged that federal law preempts state taxation where the activity is subject to comprehensive and pervasive federal oversight.[44]

The federal and tribal interests in the instant case are clear and strong. Provision of Indian health care services is comprehensively and pervasively regulated; this is manifest both in the ISDEAA and in the Indian Health Care Improvement Act (IHCIA). Congress expressed its intention in the ISDEAA that those operating under self-determination contracts receive the same amount of funding as would the federal government if one of its departments was still providing the services in question. NSHC is subject to comprehensive and pervasive oversight by virtue of its operation under the ISDEAA. Accordingly, the city's tax is preempted.[45]

Although tribes step into the shoes of the IHS when carrying out programs and providing services under the ISDEAA, the ultimate responsibility for those programs and services remains with IHS, which therefore retains a pervasive oversight role. Participation in the self-governance program requires a rigorous planning process and demonstration of financial stability and financial management capability for three (3) years.[46] ISDEAA contractors are subject to annual audits, with penalties for noncompliance with applicable cost principles.[47] And every ISDEAA agreement must, by law, include a provision allowing the Secretary to reassume operation of a program, and the associated funding, if the agency finds gross mismanagement or imminent danger to public health.[48] The regulations at 25 C.F.R. Part 900 and 42 C.F.R. Part 137 elaborate these and other limitations. As noted above, nothing in the ISDEAA abrogates or weakens the trust responsibility to tribes and individual Indians,[49] and IHS consequently retains comprehensive and pervasive oversight.

That property be deeded from the federal government with covenants of use consistent with federal law was not a requirement articulated by the Alaska Supreme Court in *Ketchikan Gateway Borough*; however, the ownership history of this parcel clearly supports that these properties are part of a healthcare program that is "pervasively regulated" by the federal

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[43] *Id.* at 1049; 1048 n.27.
[44] *Id.* at 1048.
[45] *Ketchikan Gateway Borough*, 75 P.3d at 1048.
[46] 25 U.S.C. § 5383(c)(1)(C).
[47] *Id.* § 5386(c).
[48] *Id.* § 5387(a)(2).
[49] *E.g.*, *id.* § 5332(2); *id.* § 5329(c), Model Agreement § (d)(1) ("The United States reaffirms the trust responsibility of the United States" to the contracting tribe); *id.* § 5395(b) ("Nothing in this chapter shall be construed to diminish in any way the trust responsibility of the United States to Indian tribes and individual Indians . . .").

government due to these covenants.[50] In *Ketchikan Gateway Borough*, the Alaska Supreme Court noted that while the rule of strict construction requires that "[t]axpayer exemptions are strictly construed against the taxpayer and in favor of the taxing authority . . . . where the question is whether federal law requires the exemption of tribal interests from taxation, ambiguities in federal law should be resolved *in favor of the tribe.*"[51]

IV. Alaska Law Exempts All Hospital Property from Taxation

A. The Subject Property Constitutes a "Hospital."

The Alaska Constitution provides that: "All, or any portion of, property used exclusively for non-profit religious, charitable, cemetery, or educational purposes, as defined by law, shall be exempt from taxation."[52] Pursuant to this provision, Alaska Statute (AS) 29.45.030(a)(3) provides that "property used exclusively for nonprofit religious, charitable, cemetery, hospital, or educational purposes" is exempt from general taxation.

The use of this building for training of individuals to provide emergency medical care within the Bering Strait region is directly related to the operation of the hospital. NSHC operates pursuant to a federal contract to fulfill the function of ensuring care of village-based citizens throughout the region. Training individuals from the outlying villages to provide emergency medical assistance is integral to NSHC's purpose and activity.[53] Further, NSHC is legally required to provide training pursuant to its funding agreement.

The Alaska A.G. has concluded that the definition of "hospital" includes its training facilities.[54] Further, the meaning of "hospital" is generally understood to include the structures operated as part of a hospital complex in addition to the limited area at which care is directly provided to patients.[55] In this opinion, the Alaska A.G. cites the Alaska Hospital and Medical Facilities Survey and Construction Act ("Construction Act") for the definition of "hospital", although the issue at hand did not directly implicate the Construction Act. The Alaska A.G. found as follows:

> 'hospital' includes a public health center and general, tuberculosis, mental, chronic disease, and other type of hospital, and related facilities, including laboratory, outpatient department, nurses' **homes, and training facilities**, and central services facilities operated in connection with a hospital, but does not include a hospital furnishing primarily domiciliary care.[56]

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[50] *Ketchikan Gateway Borough*, 75 P.3d at 1048.

[51] *Id.* at 1045 (citing *Cotton Petroleum Corp. v. New Mexico*, 490 U.S. 163, 177 (1989)).

[52] Alaska Const. art. IX, § 4.

[53] *See* NSHC Bylaws art. II, § 3 (identifying training as a core hospital charitable purpose).

[54] AK Office of Attorney General Opinion, 1981 WL 38838 (Alaska A.G.) (1981) (hereinafter "A.G. Opinion").

[55] *Id.*

[56] A.G. Opinion (third emphasis added) (citing AS 18.20.210(3)).

Accordingly, this housing for medical personnel and to facilitate training, although off-site from the main hospital facility, is by definition a "hospital" for purposes of AS 29.45.030(a)(3).

B. The Subject Property is Exclusively Used for NSHC's Exempt Purposes.

The use of this property for medical training and housing is for the direct and primary purpose for which the hospital was incorporated.[57] Alaska courts interpret "exclusive use" to require that all uses of the property be for the "direct and primary" exempt purpose.[58]

In jurisdictions similar to Alaska which exempt real property used "exclusively for charitable purposes," the fact that an operation is conducted in a facility off site from the main hospital does not preclude exemption. If the activity within the off-site building is integrated with the hospital and serves core hospital purposes, it is exempt hospital use.[59]

For example, housing necessary to accomplish a hospital purpose is considered an exclusive use for tax exempt purposes. The court in *Cedars of Lebanon Hospital v County of Los Angeles* 35 Cal.2d 729, 221 P.2d 31 (Cal. 1950), held that hospital-owned buildings used to house hospital staff were exempt. Resident physicians, interns, nurses, student nurses, supervisory and maintenance personnel, and other employees lived in various buildings that several hospitals maintained for their staffs. Describing a building immediately adjacent to one of the hospitals, which housed nurses who paid nominal rent as typical of the quarters at issue, the court pointed out that housing employees on or near hospital property was necessary to cope with emergency situations requiring extra personnel and to otherwise conduct an efficient operation.

On two occasions, Alaska courts have distinguished the *Cedars of Lebanon* ruling because of factual differences. In *Harmon v. North Pacific Union Conference Association of Seventh Day Adventists*, 462 P.2d 432 (Alaska 1969), the *Cedars* case was found to be inapplicable because the *Harmon* matter involved a specific statutory exemption for the residences of clergy, and not a question of use of property by a hospital.[60] In *Greater Anchorage Area Borough v. Sisters of Charity of the House of Providence*, 553 P.2d 467 (Alaska 1976), the issue concerned office buildings owned by the hospital and being used for the private practice of medical providers and which were not being used by the hospital. The court found *Cedars* to be inapplicable to situations where the property is being leased out for private use.[61] Those distinctions do not apply in the instant case. The subject property temporarily houses medical personnel from the outlying villages for training purposes.

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[57] *See* NSHC Bylaws art. II, § 3 (identifying training as a core hospital charitable purpose).

[58] *Fairbanks North Star Borough v. Denâ Nenâ Henash*, 88 P.3d 124 (Alaska 2004).

[59] *Hunterdon Med. Ctr. v. Readington Twp.*, 416 N.J. Super. 127, 3 A.3d 593 (N.J. Super. Ct. App. Div. 2010) (portion of non-profit hospital operator's off-site building containing physical therapy service was exempt from property tax since the building was integrated into delivery of core hospital purposes).

[60] *Id.* at 438.

[61] *Sisters of Charity*, 553 P.2d at 470.

Temporary housing to train medical personnel and house patients was similarly found exempt in *Abbott-Northwestern Hospital, Inc. v County of Hennepin*, 389 N.W.2d 916 (Minn. 1986) wherein the court recognized that the exemption was broad enough to include auxiliary property reasonably necessary to effectuate hospital purposes and held that a hospital-owned facility providing temporary lodging for patients, medical personnel, and others was exempt. As part of its complex, a public hospital, which had been organized to provide health care services, maintained low-cost temporary housing for preadmission patients, outpatients, patients' families, and medical personnel attending seminars at the hospital. The building included such features as handicap accessibility, indoor access to all medical facilities, and late checkout to coordinate with hospital schedules. The court acknowledged the increasing role of family members in patient treatment and recovery and pointed out that the facility's major advantage over hospital rooms and hotels was cost containment.

The use of this property to support training, which NSHC is legally obligated to conduct, is distinguishable from uses that merely promote the charitable activity. *See, e.g., Evangelical Covenant Church of America v. City of Nome,* 394 P.2d 882 (Alaska 1964) (revenue from church's operation of radio station supported the charitable purposes but was not itself the direct and primary purpose of the church). The use and operation of this property is an integral part of its operation, without which it could not provide medical care to the outlying villages and could not conduct the necessary training of personnel from outside the Nome area. This is use which is directly for the charitable purposes for which NSHC was incorporated and is not use for the primary purpose of production of income. *Matanuska-Susitna Borough v. King's Lake Camp,* 439 P.2d 441, 445 (Alaska 1968) (distinguishing *Evangelical Covenant Church*, income from participant camp fees were "incidental to and reasonably necessary for the carrying out of the primary charitable purposes of the camp"). As the Alaska court stated in *Sisters of Charity,* exemption is warranted when the property must be provided and utilized for purposes necessary to the functioning of the hospital. 553 P.2d at 471 n.12.

See also,* additional legal citations and support for exemption for housing of NSHC medical personnel set forth in the appeal of *Block 91, Lots 3 & 4, 117 101-201 W. 5th Avenue.

C. Assessor's Reliance on the "Vitally Necessary" Standard is Misplaced and Misconstrued.

The assessor appears to rely upon the case of *City of Nome v. Catholic Bishop of Northern Alaska*, 707 P.2d 870 (Alaska 1985), to deny tax exemptions to these properties. The *Catholic Bishop* case entailed an interpretation of AS 29.53.020(a)(3) (repealed and replaced by AS 29.45.030(a)(3)) with respect to use of certain church properties. The assessor suggests that the standard for determining whether property is "exclusively used" for exempt purposes is set forth in *Catholic Bishop* as whether the use of the property is "vitally necessary" to the hospital's exempt purposes. This is a misinterpretation of *Catholic Bishop* and is not the applicable standard.

The *Catholic Bishop* court stated the standard for interpreting "exclusive use" is whether the use is "direct and primary" to the exempt purposes:

> We have interpreted "exclusive use" in accord with our rule of strict construction. In *Harmon v. North Pacific Union Conference Association of Seventh Day Adventists,* 462 P.2d 432 (Alaska 1969), we decided that "[e]ven when the uses of a piece of property are highly related to the primarily exempted activity, the exemption will not apply when the statute requires 'exclusive' use." 462 P.2d at 437. All uses of the property must be for the "direct and primary" exempt purpose. *Evangelical Covenant Church v. City of Nome,* 394 P.2d 882, 883 (Alaska 1964) (citing Annot., 154 A.L.R. 895, 898 (1945)). *See Matanuska-Susitna Borough v. King's Lake Camp,* 439 P.2d 441, 445 (Alaska 1968).[62]

The "vitally necessary" test was first referenced in *Harmon* for purposes of interpreting a different statutory exemption from the instant case, the religious parsonage exemption under AS 29.10.336 (now AS 29.45.030(b)). The church in *Harmon* sought to exempt buildings used for the residences of church administrators, teachers, and visiting church staff members. The buildings were also used for counseling and church social gatherings. The court stated that it must strictly construe whether property is used "exclusively for religious purposes" based on the legislative intent to narrowly define the type of residence which qualifies for exemption.[63]

Similarly, in *Catholic Bishop* the court addressed the same parsonage exemption under AS 29.53.020(b)(1) (now AS 29.45.030(b)(1)). The court stated that it recognizes a narrow exception to the exclusive-use standard when evaluating the parsonage allowance, as follows:

> Residences that are not exempt under AS 29.53.020(b)(1) may still be exempt if their use was directly incidental to and vitally necessary for the exempt use **of other church property**.[64]

In *Catholic Bishop,* three churches sought to exempt religious residences, administrative offices, sanctuaries, and property used for both religious educational and charitable purposes. They also sought to exempt properties used as support for exempt properties, and church property leased to other nonprofit organizations. With respect to the residence of a religious worker/volunteer, the court evaluated this as "other property" not specifically listed in the applicable statute (i.e., residence of bishop, pastor, priest, rabbi, minister), and applied the narrow "vitally necessary" alternative standard to exclusive use. The *Catholic Bishop* court explained that the "vitally necessary" standard applies only to use of other [church] property and does not supplant the "direct and primary" exclusive-use standard for property used directly with the particular exempt activity.[65]

NSHC submits that the *Catholic Bishop* "vitally necessary" standard does not apply outside of interpreting the special definition of "exclusive religious use" for housing ministers, pastors, et al., under AS 29.45.030(b). Even if *Catholic Bishop* were found to be controlling in the instant matter, the case confirms that the test for determining "exclusive use" is whether the

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[62] 707 P.2d. at 879.
[63] 462 P.2d at 436.
[64] 707 P.2d at 880, 884–85 (emphasis added).
[65] *Id.* at 880.

use is direct and primary to the exempt purposes.[66] NSHC's temporary housing for training medical personnel from outer regions of its service area is an exempt activity of the hospital. The *Catholic Bishop* court acknowledges that residential accommodations which are "institutionally necessary" to the operation of a hospital are exempt.[67]

Since *Catholic Bishop,* Alaska courts have confirmed that "direct and primary" is the standard for evaluating exclusive use:

> Most of our charitable-purposes tax exemption cases revolve around the second part of the analysis: whether the property is being used exclusively for a charitable purpose. We have interpreted "exclusive use" to require that all uses of the property be for the "direct and primary" exempt purpose.[68]

The *Dená Nená Henash* court declined to use the "vitally necessary" standard when determining whether property used to house, in part, fundraising activities for non-exempt purposes was an "exclusive" charitable use.[69]

This is not a case of "other property" discrete from the hospital being used for ancillary purposes or purposes outside of the statutory definition of hospital use. As described previously, this property is used directly for the charitable purposes for which NSHC was incorporated and is used to accomplish its core charitable purposes and its legal obligations under the funding agreement.

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[66] *Id.* at 879.

[67] *Id.* at 880-881.

[68] *Dená Nená Henash*, 88 P.3d at 132.

[69] *Id.* at 141.

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ALASKA

CCC

THIS COVER SHEET HAS BEEN ADDED TO THIS DOCUMENT TO PROVIDE SPACE FOR RECORDING DATA AND TO COMPLY WITH MARGIN REQUIREMENTS SET FORTH IN 11 AAC 06.040 OF TITLE 11 OF THE ALASKA ADMINISTRATIVE CODE.

THIS COVER SHEET APPEARS AS THE FIRST PAGE OF THE DOCUMENT IN THE OFFICIAL RECORD.

DO NOT DETACH

Contract No. 09-AK-2244

QUITCLAIM DEED

THIS INDENTURE, made this 24th day of July, 2002 , between the United States of America, acting through the Secretary of Health and Human Services, by the Director, Division of Property Management,, Program Support Center, U.S. Department of Health and Human Services (hereinafter referred to as "Grantor"), under and pursuant to the power and authority delegated by the Federal Property and Administrative Services Act of 1949 (40 U.S.C. § 484[k]), as amended (hereinafter referred to as "the Act"), and regulations promulgated pursuant thereto at 45 C.F.R. Part 12, and the Norton Sound Health Corporation (hereinafter referred to as "Grantee").

WITNESSETH

WHEREAS, by letter dated June 20, 2002, from the General Services Administration, Auburn, Washington, certain surplus property consisting of 0.12 of an acre, more or less, and improved with a 3200 square foot duplex residence, hereinafter described (hereinafter referred to as "the Property"), was assigned to the Department of Health and Human Services for disposal upon the recommendation of the Grantor that the Property is needed for public health purposes in accordance with the provisions of the Act; and

WHEREAS, said Grantee has made a firm offer to purchase the Property under the provisions of the Act, has made application for a public benefit allowance, and proposes to use the Property in accordance with the approved program of utilization; and

WHEREAS, Grantor has accepted the offer of the Grantee,

NOW, THEREFORE, Grantor, for and in consideration of the foregoing and of the observance and performance by Grantee of the covenants, considerations and restrictions hereinafter contained and other good and valuable consideration, the receipt of which is hereby acknowledged, has remised, released and quitclaimed and by these presents does remise, release and quitclaim to Grantee, its successors and assigns, all right, title, interest, claim and demand, excepting and reserving such rights as may arise from the operation of the conditions subsequent hereinafter expressed, which the United States of America has in and to the Property, situate, lying, and being in the Nome Recording District, Second Judicial District, State of Alaska, and more particularly described as follows:

A parcel of land consisting of Lot 19, Block 33, Townsite of Nome; located in Section 36, Township 11 South, Range 34 West, Kateel River Meridian, Cape Nome Recording District, second Judicial District, State of Alaska. Contains 0.12 of an acre, more or less.

SUBJECT to any and all other existing easements, encumbrances, covenants, restrictions, reservations or conditions affecting the above described property whether or not the same appear on record.

Grantee shall comply with all applicable Federal, State, municipal, and local laws, rules, orders, ordinances, and regulations in the occupation, use, and operation of the Property.

TO HAVE AND TO HOLD the Property subject, however, to each of the following conditions subsequent, which shall be binding upon and enforceable against Grantee, its successors and assigns, as follows:

1. That for a period of thirty (30) years from the date hereof the Property herein conveyed will be used continuously for health purposes in accordance with Grantee's approved program of utilization as set forth in its application dated the 3rd day of May 2002, amended on May 22 and June 6, 2002, and for no other purpose;

2. That during the aforesaid period of thirty (30) years Grantee will not resell, lease, mortgage, or encumber or otherwise dispose of any part of the Property or interest therein except as Grantor or its successor in function may authorize in writing;

3. Where construction or major renovation is not required or proposed, the Property must be placed into use within twelve (12) months from the date of this Deed. Where construction or major renovation is contemplated at the time of transfer, the Property must be placed into use within thirty-six (36) months from the date of this Deed;

4. That one year from the date hereof and annually thereafter for the aforesaid period of thirty (30) years, unless Grantor or its successor in function directs otherwise, Grantee will file with Grantor or its successor in function reports on the operation and maintenance of the Property and will furnish, as requested, such other pertinent data evidencing continuous use of the Property for the purposes specified in the above-identified application;

5. That during the aforesaid period of thirty (30) years Grantee will at all times be and remain a tax-supported organization or a nonprofit institution, organization, or association exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986, as amended; and

6. That, for the period during which the Property is used for the purpose for which the Federal assistance is hereby extended by Grantor or for another purpose involving the provision of similar services or benefits, Grantee hereby agrees that it will comply with the requirements of section 606 of the Act (40 U.S.C. § 476); the Fair

Housing Act (42 U.S.C. § 3601-19) and implementing regulations; and, as applicable, Executive Order 11063 (Equal Opportunity in Housing) and implementing regulations; Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d to d-4) (Nondiscrimination in Federally Assisted Programs) and implementing regulations; Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681) and implementing regulations; the prohibitions against discrimination on the basis of age under the Age Discrimination Act of 1975 (42 U.S.C. § 6101-07) and implementing regulations; the prohibitions against otherwise qualified individuals with handicaps under Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and implementing regulations, and all requirements imposed by or pursuant to the regulations of Grantor (45 CFR Parts 12, 80, 84, 86 and 91) issued pursuant to said Acts and now in effect, to the end that, in accordance with said Acts and regulations, no person in the United States shall, on the ground of race, color, national origin, sex, age, or handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under the program and plan referred to in condition numbered 1 above or under any other program or activity of Grantee, its successors or assigns, to which said Acts and regulations apply by reason of this conveyance.

In the event of a breach of any of the conditions subsequent set forth above, whether caused by the legal or other inability of Grantee, its successors and assigns, to perform any of the obligations herein set forth, Grantor or its successor in function will, at its option, have an immediate right of reentry thereon, and to cause all right, title, and interest in and to the Property to revert to the United States of America, and Grantee, its successors and assigns, shall forfeit all right, title, and interest in and to the Property and to any and all of the tenements, hereditaments, and appurtenances thereunto belonging;

PROVIDED, HOWEVER, that the failure of Grantor or its successor in function to insist in any one or more instance upon complete performance of any of the said conditions subsequent shall not be construed as a waiver of or a relinquishment of the future performance of any of said conditions subsequent, but the obligations of Grantee with respect to such future performance shall continue in full force and effect;

PROVIDED FURTHER, that, in the event Grantor or its successor in function fails to exercise its option to reenter the premises and to revert title thereto for any such breach of conditions numbered 1, 2, 3, 4, or 5 herein within thirty-one (31) years from the date of this conveyance, conditions numbered 1, 2, 3, 4, and 5 herein, together with all rights to reenter and revert title for breach of condition, will, as of that date, terminate and be extinguished; and

PROVIDED FURTHER, that the expiration of conditions numbered 1, 2, 3, 4, and 5 and the right to reenter and revert title for breach thereof, will not affect the obligation of Grantee, its successors and assigns, with respect to condition numbered 6 herein or the right reserved to Grantor, or its successor in function, to reenter and revert title for breach of condition numbered 6.

Grantee may secure abrogation of the conditions subsequent numbered 1, 2, 3, 4, and 5 herein by:

a. Obtaining the consent of Grantor, or its successor in function, therefor; and

b. Payment to the United States of America of 1/360th of the percentage public benefit allowance granted of the fair market value as of the date of such requested abrogation, exclusive of the value of improvements made by Grantee to the extent that they add to the value of that portion of the Property to be released, for each month of the period to be abrogated.

Grantee, by acceptance of this Deed, covenants and agrees for itself, its successors and assigns, with respect to the Property or any part thereof--which covenant shall attach to and run with the land for so long as the Property is used for a purpose for which Federal assistance is hereby extended by Grantor or for another purpose involving the provision of similar services or benefits, and which covenant shall in any event, and without regard to technical classification or designation, legal or otherwise, be binding to the fullest extent permitted by law and equity, for the benefit of and in favor of and enforceable by Grantor or its successor in function against Grantee, its successors and assigns for the Property, or any part thereof--that it will comply with the requirements of section 606 of the Act (40 U.S.C. § 476); the Fair Housing Act (42 U.S.C. § 3601-19) and implementing regulations; Executive Order 11063 (Equal Opportunity in Housing) and implementing regulations; Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d to d-4) (Nondiscrimination in Federally Assisted Programs) and implementing regulations; the prohibitions against discrimination on the basis of age under the Age Discrimination Act of 1975 (42 U.S.C. § 6101-07) and implementing regulations; and the prohibitions against otherwise qualified individuals with handicaps under Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and implementing regulations; and all requirements imposed by or pursuant to the regulations of Grantor (45 CFR Parts 12, 80, 84 and 91) issued pursuant to said acts and now in effect, to the end that, in accordance with said acts and regulations, no person in the United States shall, on the ground of race, color, national origin, sex, age, or handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under the program and plan referred to in condition numbered 1 above or under any other program or activity of Grantee, its successors or assigns, to which such Acts and regulations apply by reason of this conveyance.

Grantee covenants and agrees that the Property will be used for secular purposes, with no more than a de minimis level of other activity.

The Grantee, by acceptance of this deed, covenants and agrees for itself, it successors and assigns, and every successor in interest to the property herein described, or any part thereof, that any construction or alteration is prohibited unless a determination of no hazard to air navigation is issued by the Federal Aviation Administration in accordance with Title 14, Code of Federal Regulations, Part 77, entitled "Objects Affecting Navigable Airspace," or under the authority of the Federal Aviation Act of 1958, as amended.

Grantee, by acceptance of this Deed, covenants and agrees for itself, its successors and assigns, that in the event Grantor exercises its option to revert all right, title, and interest in and to the Property to Grantor, or Grantee voluntarily returns title to the Property in lieu of a reverter, then Grantee shall provide protection to and maintenance of the Property at all times until such time as the title is actually reverted or returned to and accepted by Grantor. Such protection and maintenance shall, at a minimum, conform to the standards prescribed by the General Services Administration and codified in the Federal Property Management Regulations at 41 C.F.R. Subpart 101-47.4913 now in effect, a copy of which is attached to Grantee's aforementioned application.

In the event title to the Property or any part thereof is reverted to the United States of America for noncompliance or is voluntarily reconveyed in lieu of reverter, Grantee, its successors or assigns, at the option of Grantor, or its successor in function, shall be responsible for and shall be required to reimburse the United States of America for the decreased value thereof that is not the result of reasonable wear and tear, an act of God, or alterations and conversions made by Grantee, its successors or assigns, to adapt the property to the health use for which the property was transferred. The United States of America shall, in addition thereto, be reimbursed for such damage, including such costs as may be incurred in recovering title to or possession of the above-described property, as it may sustain as a result of such noncompliance.

Grantee, by acceptance of this deed, further covenants and agrees for itself, its successors and assigns, that in the event the Property or any part thereof is, at any time within the period of thirty (30) years from the date of this conveyance, sold, leased, disposed of, or used for purposes other than those designated in condition numbered 1 above without the consent of Grantor, or its successor in function, all revenues therefrom or the reasonable value, as determined by Grantor, or its successor in function, of benefits to Grantee, deriving directly or indirectly from such sale, lease, disposal, or use, shall be considered to have been received and held in trust by Grantee for the United States of America and shall be subject to the direction and control of Grantor, or its successor in function; but the provisions of this paragraph shall not impair or affect the rights reserved to Grantor under any other provision of this deed.

Grantee, by acceptance of this Deed, covenants and agrees for itself, its successors and assigns, that the Property is transferred on an "as is, where is," basis, without warranty of any kind, either expressed or implied, including as to the condition of the Property. Grantee also covenants and agrees for itself, its successors and assigns, that Grantor has no obligation to provide any additions, improvements, or alterations to the Property.

The following covenants and restrictions are provided pursuant to the aforementioned letter of assignment from the General Services Administration, Region 9:

(A) **NOTICE REGARDING HAZARDOUS SUBSTANCE ACTIVITY**: Pursuant to 40 CFR Part 373.2 and Section 120(h)(3)(A)(i) of the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended (CERCLA) 42 U.S.C. §9630(h)(3)(A)(i), and based upon a complete search of agency files, the United States of America gives notice that no hazardous substance have been released or disposed of or stored for one year or more on the property.

(B) **CERCLA COVENANT**: The United States of America warrants that all remedial action necessary to protect human health and the environment has been taken before the date of this conveyance. The United States of America further warrants that it shall take any additional response action found to be necessary after the date of this conveyance regarding hazardous substances located on the Property on the date of this conveyance.

(1) This covenant shall not apply:

(a) in any case in which the Grantee, its successor(s) and assign(s), or any successor in interest to the Property or part thereof is a Potentially Responsible Party (PRP) with respect to the Property immediately prior to the date of this conveyance; **OR**

(b) to the extent but only to the extent that such additional response action or part thereof found to be necessary is the result of an act or failure to act of the Grantee, its successor(s) and assign(s), or any party in possession after the date of this conveyance that either:

(i) results in a release of hazardous substance that was not located on the Property on the date of this conveyance; **OR**

(ii) cause or exacerbates the release or threatened release of a hazardous substance the existence and location of which was known and identified to the applicable regulatory authority as of the date of this conveyance.

(2) In the event Grantee, its successor(s) and assign(s) seeks to have the United States conduct or pay for any additional response action, and, as a condition precedent to the United States incurring an additional cleanup obligation or related expenses, the Grantee, its successor(s) and assign(s), shall provide Grantor at least 45 days written notice of such claim and provide credible evidence that:

(a) the associated contamination existed prior to the date of this conveyance; and,

(b) the need to conduct any additional response action or part thereof was not the result of any failure to act by the Grantee, its successor(s) and assign(s), or any party in possession.

(C) **ACCESS**: The United States reserve a right of access to all portions of the Property for environmental investigation, remediation or other corrective action. This reservation includes the right of access to, and use of, available utilities at reasonable cost to the United

States of America, its successors, assigns. These rights shall be exercisable in any case in which a response action, corrective action or remedial action is found to be necessary to carry out a remedial action, response action, on adjoining property. Pursuant to this reservation, the United States of America and its respective officers, agents, employees, contractors and subcontractors shall have the right (upon reasonable advance written notice to the record title owner) to enter upon the Property and conduct investigations and surveys, to include drilling, test-pitting, borings, data and records compilation and other activities related to environmental investigation, and to carry out any remedial or removal actions required or necessary, including but not limited to the installation and operation of monitoring wells, pumping wells, and treatment facilities. Any such entry, including such activities, responses or remedial actions, shall be coordinated with the record title owner and shall be performed in a manner, which minimizes interruption with activities of authorized occupants.

(D) **Grantee** has inspected the hereinabove-described and quitclaimed property and has satisfied itself that the property is free of any hazardous substances or petroleum products or their derivatives, and Grantee, its successors and assigns and every successor in interest to all or any part of the property, will indemnify, protect, defend, save and hold harmless the United States of America, and the United States' employees, officers, representatives, attorneys and agents, from and against any and all debts, duties, obligations, liabilities, suits, claims, demands, causes of action, damages, losses, costs and expenses (including without limitation, attorneys' fees and expenses and court costs) in any way relating to, connected with, and/or arising out of the discovery of any hazardous substance(s) or petroleum products or their derivatives which may have contaminated the hereinabove and conveyed property after the date of this Quitclaim Deed, including but not limited to any environmental response action, corrective action, or remediation action, the costs of any investigation or removal, monitoring, investigation, sampling, or testing in connection therewith.

IN WITNESS WHEREOF, Grantor has caused this instrument to be executed as of the day and year first above written.

UNITED STATES OF AMERICA
Acting through the Secretary of Health and Human Services

By: _____
Brian J. Rooney, Chief, Real Property Branch
Division of Property Management
Program Support Center

ACKNOWLEDGMENT

STATE OF MARYLAND)
COUNTY OF MONTGOMERY) SS

On this 24th day of July 2002, before me the undersigned officer, personally appeared Brian J. Rooney, known to me to be the Chief, Real Property Branch, Division of Property Management, Department of Health and Human Services, and known to me to be the person who executed the foregoing instrument on behalf of the Secretary of Health and Human Services, for the United States of America, and acknowledged to me that he subscribed to the said instrument in the name of the Secretary of Health and Human Services and on behalf of the United States of America.

Witness my hand and official seal.

Shirley A. Kramer
Notary Public

My commission expires 10/11/2004

ACCEPTANCE

The Norton Sound Health Corporation hereby accepts this deed and thereby agrees to all the terms, covenants, conditions and restrictions contained therein.

By _____
Joe Cladouhos

ACKNOWLEDGMENT

STATE OF ALASKA)
SECOND JUDICIAL DISTRICT) SS

On this 1st day of August, 2002, before me, a Notary Public in and for the State of Alaska, personally appeared Joe Cladouhos, known to me to be the President and CEO, and known to me to be the person who executed the foregoing instrument on behalf of the Norton Sound Health Corporation, and acknowledged to me that he executed the same as the free act and deed of the Norton Sound Health Corporation Board of Directors.

Witness my hand and official seal.

(SEAL)

NOTARY PUBLIC STATE OF ALASKA ALASSA A. SOBOCIENSKI

Natasa Sobocienski
Notary Public

My commission expires 10/25/05

Return to:
Norton Sound
Health Corporation
P.O. Box 966
Nome, AK 99762
Attn: Alice Bioff

Community Health Needs Assessment Survey Report

Norton Sound Health Corporation

January 2021

For additional information regarding the Norton Sound Health Corporation Community Health Needs Assessment, contact Quality Improvement at (907) 443-4501.

EXECUTIVE SUMMARY

Norton Sound Regional Hospital

Norton Sound Health Corporation (NSHC) is a tribally owned and operated, independent, not-for profit health care organization, founded in 1970 to meet the health care needs of the Inupiat, Siberian Yup'ik and Yup'ik people of the Being Strait region. NSHC is governed by a 22-member board of directors who represent all communities and areas of the Bering Strait region, a 44,000 square-mile section of northwestern Alaska.

Norton Sound Health Corporation puts the patient first. This principle applies equally at the new Norton Sound Regional Hospital and at the 15 village clinics managed by NSHC.

Every day, NSHC's approximately 750 employees – about 62% of them Alaska Native – demonstrate their commitment to our mission: providing quality health services and promoting wellness within our people and environment. NSHC strives to train local people to deliver and manage its services. NSHC offers a 2-year Registered Nurse Program through the University of Alaska Anchorage, a Certified Nursing Assistant Course, and other local trainings in partnership with the local Nome Northwest Campus and the region's partners.

In 2019, Norton Sound Health Corporation was recognized as one of the nation's top clinically performing community health centers. HRSA named NSHC as a "gold tier" Health Center Quality Leader awardee, meaning that the organization is among the top 10% of health centers to achieve best overall clinical performance nationwide. NSHC improved on measures such as tobacco intervention, colorectal cancer screening, and childhood immunization status.

The organization also increased the level of medical and mental health care provided to patients. Significant steps have been taken by NSHC to ensure that whole-person care is being delivered; behavioral health services have been prioritized, and resources have been increased. Full-time psychiatry services were implemented to better meet the needs of our patients. In FY19, NSHC opened a drug rehabilitation program, known as the "day shelter", which utilizes the skills of recovery coaches to facilitate lifestyle changes. The resource and recovery program has resulted in guests securing jobs, housing, reducing emergency department visits, and achieving GED status. The day shelter is just one of the critical steps necessary to enhance the behavioral health continuum of care model.

The goal to increase access to care for all communities is being realized; village visits have doubled and more mid-level providers have been hired to provide higher level care in the village clinics, to provide relief to health aides, and to facilitate additional on-call coverage. A Population Health Department was implemented to coordinate prevention care and to ensure clinical standards of care are being met for patients. An In-home support program was also initiated, in which NSHC will administer the Personal Care Attendant (P.C.A) Program for the region with the goal to offer end-of-life care for families who need the services.

In January 2019, NSHC started offering MRI services locally, with its new state-of-the-art MRI machine, the only one of its kind in Alaska and in the nation serving rural health needs. A staff neurologist was also hired. NSHC continued to offer tribal healing services and acupuncture services to compliment its pain management services.

NSHC continues to promote state-of-the-art facilities. Since 2017, NSHC has completed the construction of four new health clinics located in Savoonga, Gambell, Shaktoolik, and Little Diomede. The construction of two new health clinics are underway in St. Michael and Shishmaref, and a new clinic with staffing housing is under design for the village of Wales. NSHC has made village-based housing a priority to ensure the staff who work at the clinic have adequate housing available. New housing has been constructed in St. Michael, Savoonga, and Golovin to-date. The responsibility for the maintenance and oversight of the village-based facilities has also improved through NSHC's ability to establish 105(l) leases with the Indian Health Services.

Although significant improvements been made in health care delivery, five of the fifteen villages remain without water and sewer. One of NSHC's highest priorities is to continue to strengthen the region's best practice scores to remain eligible for water and sewer capital infrastructure funding. A sanitation engineer was hired in FY19 to manage and coordinate the region's water and sewer goals and objectives.

NSHC is excited to open its new Wellness and Training Center in June 2021; the new facility will include a sobering center with integrated wellness services to facilitate sobriety. The new training facility will provide expanded classroom space to train the organization's health aide workforce. It

Norton Sound Health Corporation is a model of how Indian Self-Determination is meant to work, with tribes taking responsibility for their own health and well-being.

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BACKGROUND INFORMATION

In 1969, the Alaska Federation of Natives (AFN) sought a demonstration project to give Alaska Natives greater power in health care decisions. Norton Sound was selected for development of a model for community-based health care services as an alternative to regional, hospital-based care. Norton Sound Health Corporation (NSHC) was incorporated November 27, 1970. The first board had just three directors: William Takak of Shaktoolik, president; Winfred James of Gambell, treasurer; and Dorothy Isabell of Teller, secretary.

That first NSHC Board of Directors faced a formidable task: Bring health care services to a remote area with limited resources. At the time, northwest Alaskans had little access to health care, and getting medical treatment often meant traveling long distances to regional hospitals. One of the first initiatives NSHC launched was the health aide program, established in 1971. While health aides continue to be the backbone of the NSHC organization today, more than 40 years later, NSHC's services have expanded to include clinic travel clerks, village-based counselors, patient benefit coordinators, dental health therapists and nurse practitioners in all the villages served.

At its first meeting in November 1970, the NSHC Board of Directors established its highest goal: provide a "comprehensive and quality inpatient facility in Nome." That year, NSHC opened its first office in the basement of Maynard-McDougall Memorial Hospital in Nome, with a budget of $143,000. Six years later, NSHC purchased the hospital, and in 1978 Norton Sound Regional Hospital opened in Nome. It was quickly followed by Unalakleet' s sub-regional health clinic, staffed by a physician assistant and community health aides serving four villages.

In 1975, NSHC became the first Native health corporation to become independent of AFN and contract directly with the Indian Health Service. The following year, the board assumed responsibility for regional environmental health services through assignment of a federal Public Health Service sanitarian.

Over the years, NSHC's board focused on expanding patient care in the Bering Strait region of Alaska, adding basic services in 15 villages throughout the Norton Sound area as well as specialty clinics in Nome. In 2008, the Board of Directors opened The Patient Hostel, a 38-bed facility, located on the east side of Nome and positioned close to where the new facility would be constructed someday.

Another milestone was reached in 2009, when Indian Health Services awarded NSHC full funding to complete a new hospital building in Nome. Construction began in October 2009 and was completed in 2012. The first patients were seen at the new Norton Sound Regional Hospital and Quyanna Care Center in March 2013.

In October 2014, NSHC went live with its new electronic medical record, "Cerner" and completed the renovation for the Wales clinic and replaced the Shishmaref clinic. In 2015, NSHC initiated a village clinic improvement program and assumed oversight and responsibility for nearly all village clinics and hired housekeepers and maintenance workers to keep the clinics maintained in all the villages. The Nome outpatient clinic received a HRSA new access point grant and was integrated with the village primary health care services for the first time.

In 2016, NSHC began an ambitious mission to replace and/or update aging clinic facilities throughout the region. In 2017, saw NSHC's Nome Primary Care Center receive recognition as a Patient Centered Medical Home by the National Committee on Quality Assurance. New clinics were completed in the villages of Gambell, Savoonga, and Shaktoolik. Village-based housing projects were also completed in Savoonga and Golovin.

In 2018 an MRI was added to the NSHC hospital to further advanced our diagnostic capabilities and a new health clinic for the village of Shakoolik was opened.

In 2020, NSHC achieved its vision to complete construction for a new health clinic for the remote village of Little Diomede.

In 2021, NSHC expects to open the long- awaited Wellness and Training Center which will create the first sobering center in the region as well as add intensive outpatient mental health services to our comprehensive service wrap around services.

The COVID-19 pandemic saw Norton Sound Health Corporation face the challenge of the generations while minimizing morbidity and mortality, supporting communities in mitigation and suppression methods while retaining high quality preventative, chronic and emergency care.

NORTON SOUND HEALTH CORPORATION: MISSION, VISION, AND VALUES

Our purpose, core values and vision for the future are built on our commitment to providing the Native people of the Norton Sound region with the highest quality health care possible.

Our mission:
Providing quality health services and promoting wellness within our people and environment.

Our core values:

- Integrity
- Cultural sensitivity and respect for traditional values
- Always learning and improving
- Compassion
- Teamwork
- Pride

Our vision for the future:

- We will ensure that all patients receive quality and respectful health care.
- We will educate our patients and communities to be proactive in caring for themselves and promoting wellness.
- We will listen to, honor, and respect our elders, preserve their right to speak, and ensure they receive the best care in gratitude for their leadership.
- We will increase wellness efforts to reduce addictive behaviors and to raise the quality of life among our people and communities.
- We will advocate that our environment (air, land and water) will be clean, and our water and waste disposal systems are safe and affordable, in order to ensure our subsistence way of life.

- We will assert and implement tribal self-governance to achieve our vision through effective leadership.
- We will hire and support our tribal members to deliver and manage our services.
- We will develop state of the art and efficient health care facilities throughout the region.
- We will be financially strong through aggressive, effective and efficient financial management.
- We will support and develop our youth to pursue higher education and health care careers to ensure there is future tribal leadership.

SCOPE OF THE STUDY

The purpose of the 2020 Norton Sound Health Corporation Community Health Needs Assessment is to collect data on specific information regarding community perception of the Use of Healthcare Services, Awareness of Services, Community Health, and Health Insurance. Additionally, data were collected regarding the demographics of survey responders. The data are presented in a format that can be useful to Norton Sound Health Corporation board of directors, administration, health care providers and community.

METHODOLOGY

A comprehensive survey was developed by the Quality Assurance/Performance Improvement Team "Aquutaq". The survey was loaded electronically into Microsoft Forms. It was distributed electronically via advertisement, QR code, email, public information, Facebook, community meetings and other avenues. Paper copies of the form were also mailed to all box holders in the region as well as made available at all clinics and within the Nome hospital site. The survey was also distributed at various Health Forums held within the region.

Data collection began in early 2019 and continued until early 2020 with a goal of at least 1000 responses. Processing of data and this report was delayed due to reallocation of staff during the pandemic and completed in 2021. The survey was closed for responses in January 2020, after 1004 responses had been received, (32.4% of households in the region). The data was entered into a Microsoft Forms/ Microsoft Excel database and are presented in the Survey Results section of this report. At the time of survey closure, data was first prepared and shared with the NSHC Board of Directors, final report was completed on January 26, 2021.

Population Data

PEOPLE		
Population		
Population estimates, July 1, 2019, (V2019)	**10,004**	**731,545**
Population estimates base, April 1, 2010, (V2019)	9,492	710,249
Population, percent change - April 1, 2010 (estimates base) to July 1, 2019, (V2019)	5.4%	3.0%
Population, Census, April 1, 2010	9,492	710,231
Age and Sex		
Persons under 5 years, percent	10.0%	7.0%
Persons under 18 years, percent	34.6%	24.6%
Persons 65 years and over, percent	8.0%	12.5%
Female persons, percent	47.4%	47.9%
Race and Hispanic Origin		
White alone, percent	15.7%	65.3%
Black or African American alone, percent(a)	0.9%	3.7%
American Indian and Alaska Native alone, percent(a)	75.3%	15.6%
Asian alone, percent(a)	1.5%	6.5%
Native Hawaiian and Other Pacific Islander alone, percent(a)	0.2%	1.4%
Two or More Races, percent	6.5%	7.5%
Hispanic or Latino, percent(b)	2.9%	7.3%
White alone, not Hispanic or Latino, percent	14.9%	60.2%
Population Characteristics		
Veterans, 2015-2019	394	65,186
Foreign born persons, percent, 2015-2019	2.5%	7.8%
Housing		
Housing units, July 1, 2019, (V2019)	4,100	319,854
Owner-occupied housing unit rate, 2015-2019	60.5%	64.3%
Median value of owner-occupied housing units, 2015-2019	$154,600	$270,400
Median selected monthly owner costs -with a mortgage, 2015-2019	$1,470	$1,933
Median selected monthly owner costs -without a mortgage, 2015-2019	$469	$582
Median gross rent, 2015-2019	$1,287	$1,244
Building permits, 2019	6	1,680
Families & Living Arrangements		
Households, 2015-2019	2,844	253,346
Persons per household, 2015-2019	3.30	2.80
Living in same house 1 year ago, percent of persons age 1 year+, 2015-2019	84.1%	82.1%

Language other than English spoken at home, percent of persons age 5 years+, 2015-2019	31.0%	16.1%
Computer and Internet Use		
Households with a computer, percent, 2015-2019	90.7%	94.1%
Households with a broadband Internet subscription, percent, 2015-2019	74.1%	85.5%
Education		
High school graduate or higher, percent of persons age 25 years+, 2015-2019	84.6%	92.8%
Bachelor's degree or higher, percent of persons age 25 years+, 2015-2019	16.1%	29.6%
Health		
With a disability, under age 65 years, percent, 2015-2019	6.8%	8.9%
Persons without health insurance, under age 65 years, percent	18.4%	13.9%
Economy		
In civilian labor force, total, percent of population age 16 years+, 2015-2019	64.8%	65.5%
In civilian labor force, female, percent of population age 16 years+, 2015-2019	66.8%	63.1%
Total accommodation and food services sales, 2012 ($1,000)(c)	14,821	2,221,335
Total health care and social assistance receipts/revenue, 2012 ($1,000)(c)	D	6,375,483
Total manufacturers shipments, 2012 ($1,000)(c)	D	D
Total merchant wholesaler sales, 2012 ($1,000)(c)	D	5,216,303
Total retail sales, 2012 ($1,000)(c)	78,672	10,474,275
Total retail sales per capita, 2012(c)	$7,935	$14,320
Transportation		
Mean travel time to work (minutes), workers age 16 years+, 2015-2019	6.7	19.1
Income & Poverty		
Median household income (in 2019 dollars), 2015-2019	$61,048	$77,640
Per capita income in past 12 months (in 2019 dollars), 2015-2019	$23,581	$36,787
Persons in poverty, percent	20.7%	10.1%
BUSINESSES		
Businesses		
Total employer establishments, 2018	168	21,293
Total employment, 2018	2,119	261,053
Total annual payroll, 2018 ($1,000)	121,975	15,732,010
Total employment, percent change, 2017-2018	-2.9%	-0.4%
Total nonemployer establishments, 2018	551	57,391

All firms, 2012	676	68,032
Men-owned firms, 2012	380	35,402
Women-owned firms, 2012	212	22,141
Minority-owned firms, 2012	381	13,688
Nonminority-owned firms, 2012	264	51,147
Veteran-owned firms, 2012	61	7,953
Nonveteran-owned firms, 2012	578	56,091

GEOGRAPHY

Geography		
Population per square mile, 2010	0.4	1.2
Land area in square miles, 2010	22,961.76	570,640.95
FIPS Code	02180	02

About datasets used in this table

Value Notes

Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable.

The vintage year (e.g., V2019) refers to the final year of the series (2010 thru 2019). *Different vintage years of estimates are not comparable.*

Fact Notes

- (a)Includes persons reporting only one race
- (b)Hispanics may be of any race, so also are included in applicable race categories
- (c)Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

Value Flags

- -Either no or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest or upper interval of an open ended distribution.
- D- Suppressed to avoid disclosure of confidential information

QuickFacts data are derived from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area Health Insurance Estimates, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits.

Source: US Department of Commerce. US Census Bureau

http://quickfacts.census.gov/qfd/index.html

BEHAVIORAL RISK FACTOR DATA

Alaska Behavioral Risk Factor Surveillance System

2018 Nome Region

Risk Fact	Nome (%)	Alaska (%)
Health Status: General Health Excellent/Very Good	41.7	51.3
Health Status: Poor physical health	18.0	16.4
Health Status: Frequent mental distress	18.8	11.3
Thoughts of Suicide in past 12 months (2013)	5.0	4.2
Ever told had depressive disorder	15.4	21.2
HTN: Ever told HTN (2017)	25.7	29.9
CVD: Ever told heart attack	3.7	4.4
CVD: Diagnosis of Angina or Coronary Heart Disease	1	2.8
COPD	4.6	5.3
Cancer: Any type	4.2	7.8
Weight Status: Severely Obese (BM>40)	10.3	7.8
Weight Status: Obese (BMI 30-39.9)	26.5	31.2
Weight Status: Overweight	28.1	35.1
Weight Status: Underweight	0.6	1.8
Seen a provider in the last 12 months	56.0	69.3
Access: No Health Care Coverage	6.1	9.1
Follow Subsistence Lifestyle (2017)	79.7	30.2
Rent Home	20.3	27.2
Believe currently get enough physical activity (2015)	59.7	46.9
Activity Time: Adequate Aerobic Physical Activity (at least 150 minutes per week) (2017)	86.9	56.7
Activity Time: Adequate Aerobic Physical Activity (at least 300 minutes per week) (2017)	69.9	36.2
Received Food Assistance from Community Program(s) (2013)	14.7	7
Received Food Assistance from Government Program(s) (2013)	34.9	15.6
Less than 3 vegetables and 2 fruits per day	81.5	93.8
Sweetened carbonated beverages 1+ per day (2017)	27.5	13.2
Sweetened non-carbonated beverages 1+ per day (2017)	45.4	12.1
Cigarette Smoking: Current Smoker Everyday (2018)	30.3	17.1
Cigarette Smoking: Former Smoking (2018)	27.7	28.3
Cigarette Smoking: Never Smoked (2018)	42.1	54.6
Tobacco Use (not including e-cig) (2018)	63.4	25.2
Current Marijuana Use (2018)	44.6	17.3
Current Alcohol Use (2018)	34.9	58.6
Binge Drinking (2018)	13.4	16.4
Before age 18, lived with problem drinker/alcoholic/drugs/rx med (2015)	47.4	32.3
Seat Belt Use: always use a seatbelt (2018)	73.1	83.0
Hurt by intimate partner last 5 years (2017)	15.2	6.6

NOME CA MAPP: BRFSS DATA: 2015-2018: MIXED

COMMUNITY HEALTH NEEDS SURVEY RESULTS (as of 1/26/2021) (1004 households reporting)

Norton Sound Health Corporation

*NOTE SOME TOTALS MAY NOT EQUAL TO 100% DUE TO ROUNDING AND ALLOWANCE FOR MULTIPLE RESPONSES PER ITEM. ALSO NUMBER OF RESPONSES DIFFERS TO EACH ITEM ALLOWING FOR NON-RESPONDERS AND MULTIPLE RESPONSES TO SOME ITEMS.

Section A: Please tell us about yourself

1. What is your zip code?

Village	Zip Code	Number	Percentage
Nome, Golovin, Diomede	99762	481	47.91%
Brevig	99785	28	2.79%
Elim	99739	73	7.27%
Gambell	99742	55	5.48%
Koyuk	99753	25	2.49%
St. Michael	99659	15	1.49%
Savoonga	99769	31	3.09%
Shaktoolik	99771	17	1.69%
Shishmaref	99772	56	5.58%
Stebbins	99671	49	4.88%
Teller	99778	16	1.59%
Unalakleet	99684	96	9.56%
Wales	99783	9	0.90%
White Mountain	99784	29	2.89%
OTHER		11	1.10%
NO RESPONSE		13	1.29%
Total		**1004**	**100%**

2. What is your gender?

Gender	Number	Percentage
Male	295	29.38%
Female	679	67.63%
Transgender	2	0.20%
Other	1	0.10%
Prefer not to answer	27	2.69%
Total	**1004**	**100.0%**

3. What is your age range?

Age	Number	Percentage
18-25	100	9.96%
26-35	260	25.90%
36-45	163	16.24%
46-55	164	16.33%
56-65	197	19.62%
66-75	79	7.87%
76-85	21	2.09%
86+	1	0.10%
Unanswered/Prefer not to say	19	1.89%
Total	**1004**	**100.0%**

4. Are you an IHS beneficiary?

Response	Count	Percentages
Yes	660	65.74%
No	286	28.49%
Unanswered/Prefer not to say	58	5.78%
Total	**800**	**100%**

5. How many people, including yourself, live in your household?

Number	Count	Percentage
1	141	14.04%
2	196	19.52%
3	167	16.63%
4	150	14.94%
5	118	11.75%
6	75	7.47%
7	61	6.08%
8	38	3.78%
9	16	1.59%
10+	30	3%
Unanswered/ Prefer not to say	12	1.2%
Total	**1004**	**100%**

6. How many children under the age of 18 live in your household?

Number	Count	Percentage
0	425	42.37%
1	164	16.35%
2	160	15.95%
3	110	10.97%
4	61	6.08%
5	37	3.69%
6	18	1.79%
7	7	0.70%
8	1	0.10%
9+	2	0.20%
Unanswered/ Prefer not to say	19	1.89%
Total	**1004**	**100%**

7. What is your employment status?

Response	Count	Percentage
Work full-time	529	52.69%
Work part-time	129	12.85%
Retired	116	11.55%
Unemployed and looking for employment	103	10.26%
Not currently seeking employment	69	6.87%
Disabled	25	2.49%
Student	21	2.09%
Unanswered/Prefer not to say	12	1.20%
Total	**1004**	**100%**

8. Do you access the internet in your home?

Response	Count	Percentages
Yes	646	64.34%
No	343	34.16%
Unanswered/Prefer not to say	15	1.49%
Grand Total	**1004**	**100.00%**

9. Do you have plumbed drinking water in your home?

Response	Count	Percentages
No	180	17.93%
Yes	813	80.98%
Unanswered/Prefer not to say	11	1.10%

Grand Total	1004	100.00%

10. Do you have plumbed septic/sewer in your home?

Response	Count	Percentages
No	203	20.22%
Yes	789	78.59%
Unanswered/Prefer not to say	12	1.20%
Grand Total	**1004**	**100.00%**

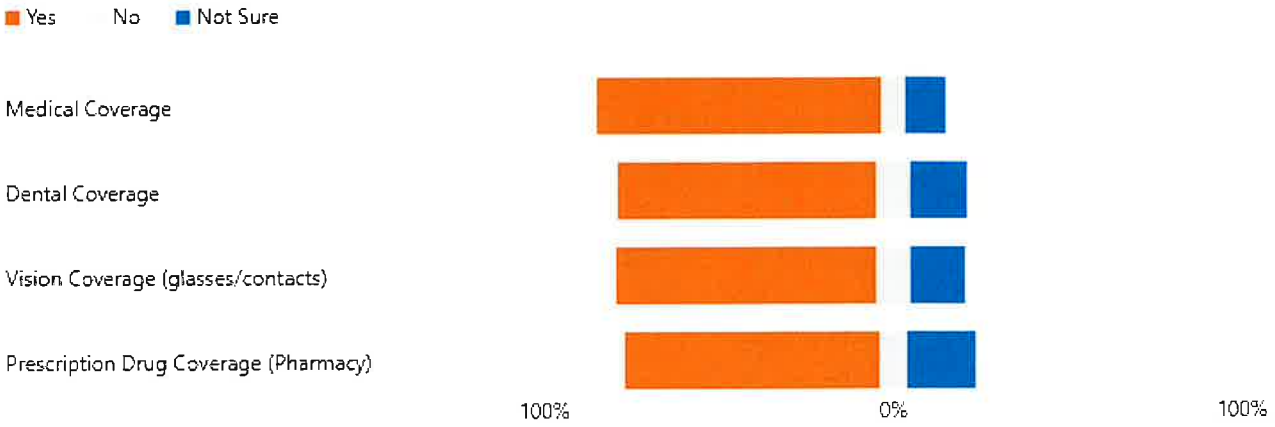
11. What is the best way for NSHC to communicate with you? (Preferential choice ranking, only first preference listed below)

Response	Count	Percentage
Email	112	11.16%
Mail	90	8.96%
Phone	156	25%
Text Message	366	36.45%
Other Media	11	1.1%
Unanswered/Prefer not to say	296	29.48%
Total	**1004**	**100%**

12. What type(s) of health care coverage do you have? (Multiple responses allowed).

Response	Count	Percentage
Indian Health Services (IHS)	507	33.82%
Employer Sponsored	494	32.96%
Medicaid	259	17.28%
Medicare	111	7.40%
No coverage	38	3.78%
VA/Military	20	1.33%
Health Savings Account	9	0.60%
Other	38	3.78%
Unanswered/Prefer not to say	11	1.01%
Total	1004	100%

13. What types of coverage do you have?



Section B: Tell us about your healthcare experience

1. Have you used any Norton Sound Health Corporation facilities?

Response	Count	Percentages
Yes	943	93.92%
No	38	3.78%
Unanswered/Prefer not to say	23	2.29
Total	**1004**	**100%**

2. Why do you choose to use NSHC facilities?
(multiple responses allowed)

Response	Count
Only clinic available	759
Has services I need	264
Needed medication refefilled	187
Emergency, no other choices	185
Provider listens to me	126
Provider knows me by name	119
Referred	92
Great experiences prior	89
Short waiting time	87
Hospital/Clinic reputation for quality	70
Required by my insurance	46
Recommended by family/friends	42
Cost of Care	35
n/a, I NEVER use NSHC facilities	18
Other, free text responses	17
VA/Military requirement	6

3. If you ever choose not to use NSHC facilities, why not?
(multiple responses allowed)

Response	Count	Percentage
n/a, I ONLY use NSHC	336	27.77%
Service I needed was unavailable	213	17.60%
Lack of privacy/confidentiality	83	6.86%
Costs too much money	77	6.36%
No appointment available in a timely manner	77	6.36%
Did not trust the provider	63	5.21%
Unsure if service I need is available	62	5.12%
Not treated with respect	52	4.30%
Do not like provider	50	4.13%
Appointments do not fit my schedule	46	3.80%
My insurance would not cover my care	30	2.48%
Provider is my co-worker/relative	26	2.15%
Other – free text response	66	5.45%
Unanswered/Prefer not to say	191	19.02%

4. In the past 12 months, was there a time when you or someone living in your home needed medical care from NSHC but were not seen?

Response	Count	Percentages
Yes	202	20%
No	731	73%
Other	39	4%
Unanswered/Prefer not to say	32	3%
Total	**788**	**100%**

5. If you answered "yes" above, what service were you not able to use:

Response	Count
Nome Hospital	20
Nome Clinic	45
Village Clinic	80
BHS Nome	11
BHS Village	4
Other	41

6. Check any of the reasons below that help explain why you were not seen. (multiple responses allowed)

Reason	Count
Clinic is too far away	3
Costs too much money	19
Did not trust the provider	21
Do not like provider (MD, DO, PA, NP, Health Aide)	14
Had no one to watch kids	6
Lack of privacy/confidentiality	21
Language barrier	0
My insurance would not cover	8
No appointment available in a timely manner	73
No appointments that fit my schedule	26
No transportation	14
Not treated with respect	25
Other	47
Provider is my co-worker/relative	7
Too afraid or nervous	7
Unsure if service I need is available	11
Service I needed was unavailable	40

7. In the past 12 months, check all of the health care providers you or anyone living your home has seen: (multiple responses allowed)

Provider	Count
General practice provider (MD, DO, PA, NP)	646
Dentist/DHAT	488
Optometrist (Eye doctor)	420
Health Aide	394
Audiologist (hearing)	276
Pediatrician	212
Physical Therapist	179
Behavioral Health Clinician/Therapist	164
ENT Specialist (ear, nose, throat specialist)	156
Obstetrician/Gynecologist (female reproductive specialist)	134
Tribal Healer	128
Orthopedist (bone/joint specialist)	93
Cardiologist (heart specialist)	89
Dietitian	73
Neurologist (brain/nerve specialist)	72
Urologist (kidney/bladder/male reproductive specialist)	69
Surgeon	68
Diabetes Specialist	66
Psychiatrist	61
Rheumatologist (arthritis specialist)	42
Dermatologist (skin specialist)	35
Oncologist (cancer specialist)	34
Chiropractor	33
Social Worker	31
Tobacco Counselor	31
Pulmonologist (lung specialist)	30
Infant Learning Program	30
Podiatrist (foot/ankle specialist)	23
Allergy Specialist	23
Substance Abuse Counselor	15
Other (Free text)	44

8. How long did you have to wait to see the specialist from the time you were referred or requested an appointment?

Column1	Count	Percentage
1 month	240	23.90%
2 months	102	10.16%
3 months	60	5.98%
4 months	24	2.39%
5 months	13	1.29%
6 moths or more	50	4.98%
Unanswered/choose not to respond	515	51.29%
Total	**1004**	**100%**

9. Please rate the following services Norton Sound Health Corporation offers and tell where you used that service most:

	Excellent	Good	Fair	Poor
Emergency Room	44.20%	43.30%	7.59%	4.91%
Inpatient (Acute Care)	16.57%	40.51%	35.54%	7.38%
QCC (Quyanna Care Center, Nursing Home)	31.76%	44.12%	20.00%	4.12%
Nome Primary Care	25.48%	52.71%	18.59%	3.22%
Village Clinic	32.13%	44.68%	20.91%	2.28%
Laboratory	33.28%	47.68%	17.50%	1.54%
Physical Therapy	33.04%	46.67%	17.39%	2.90%
Eye Care Clinic (Optometry)	42.48%	42.48%	12.07%	2.98%
Audiology	38.39%	47.16%	12.32%	2.13%
Dental	39.55%	42.93%	13.67%	3.86%
Behavioral Health	27.09%	44.15%	21.40%	7.36%
Case Management	22.87%	40.96%	23.55%	12.63%
CAMP Program	36.33%	39.45%	19.92%	4.30%
Tribal Healing	50.76%	36.64%	9.54%	3.05%
Infant Learning Program	34.68%	42.74%	18.55%	4.03%
Radiology/Diagnostic Imaging	39.64%	44.42%	13.44%	2.51%
EMS-Medevac Team	57.38%	32.07%	10.13%	0.42%
WIC Program	42.93%	41.46%	13.66%	1.95%
Environmental Health (OEH)	27.93%	45.95%	22.52%	3.60%
Respiratory Therapy	33.74%	51.53%	12.88%	1.84%
Medical Records/HIM	27.73%	45.48%	21.81%	4.98%
Billing Department	27.38%	38.39%	22.32%	11.90%
Human Resources Department	24.91%	37.37%	24.57%	13.15%
Patient Driver	39.21%	40.84%	14.15%	5.80%
Patient Advocate	33.69%	36.56%	19.71%	10.04%
Administration	29.52%	38.10%	21.59%	10.79%

10. Have you or anyone in your household been affected by these community issues:

	% Yes
Elder abuse	5.87%
Child Abuse	7.39%
Domestic Violence	17.54%
Drug Abuse	17.87%
Alcohol Abuse	29.63%
Tobacco Use	44.82%
Chronic Disease	22.83%
Obesity	28.12%
Heart Disease	19.98%
Diabetes	22.05%
Stroke	13.74%
Cancer	26.08%
Teen Pregnancy	10.23%
Sexually Transmitted Infections	17.16%
Suicide	23.58%
Lack of Access to Healthcare	19.41%
Lack of Access to Medications	15.47%
Lack of Quality childcare	19.41%
Lack of Quality Schooling	14.67%
Lack of Quality Housing	31.62%
Lack of Strong Family Support	14.51%
Lack of Safety	11.89%
Lack of Good Jobs	34.26%
Lack of Food due to expense	28.37%
Lack of healthy food available	36.08%
Lack of Native/Traditional foods	24.80%
Lack of Indoor Exercise Facilities	37.66%
Lack of Outdoor Recreational Spaces (parks, walking paths, etc)	24.85%
Lack of Running Water/Sewer	22.20%
Lack of Sobering Center	20.82%
Lack of Homeless Shelter	19.11%
Lack of Law Enforcement	30.87%

11. What would improve your access to care? (multiple responses allowed)

	Count
More providers/health aides	352
More specialty clinics	309
End of Life Care Program	126
Prescription deliver	127
Home visits by providers/health aides	164
Longer hours at the clinics	145
Telemedicine availability	67
Personal Care Attendants	152
Transportation to clinic or hospital	152
Assisted Living Center	171
Availability of Long Term Care	109
Financial Support for Out of Region	91
Other (free text)	

Nurse Call Line

12. Have you ever used the NSHC Nurse Call Line, and based on your experience, how would you rate it? (1 – Excellent, 5 - poor)

Row Labels	Count of ID	Sum of ID
No - but I've head of it	**103**	**18.35%**
1	28	6.47%
2	16	3.21%
3	38	5.12%
4	7	1.28%
5	14	2.28%
No - but I've heard of it	**3**	**1.08%**
1	3	1.08%
No - Never heard of it	**8**	**1.26%**
1	1	0.22%
2	2	0.53%
3	3	0.37%
5	2	0.13%
Yes, I have used the Nurse Call Line	**392**	**79.31%**
1	108	22.31%
2	75	14.64%
3	101	19.89%
4	46	9.87%
5	62	12.60%
Grand Total	**506**	**100.00%**

Performance Improvement Goals Summary

Over the next three years, NSHC will strive to:

1) Improve Communication with Patients by asking the patient what their preferred method of communication is and utilizing it to provide meaningful feedback to patients.

2) Improve Access to Care for Patient by ensuring the NSHC Primary Care System has both appointments available for patients to accommodate same-day access to care when needed.

3) Improve Notification and Reminders to Patients about scheduled appointments.

4) Improve customer service by training staff on phone etiquette and by improving the switchboard operator experience.

5) Improve the quality of patient care by performing audits of patients who present to NSHC's outpatient clinics for care on a frequent basis; reports will be made to the HRSA quality committee to ensure there is accountability.

6) Continue the initiatives of the Population Health Department to ensure patients are receiving coordinated care and referrals for prevention tests and receiving care that meets clinical standards for disease states.

7) Continue to strengthen the nurse call line by listening to consumer feedback; share success stories when possible.

8) Ensure patient privacy and confidentiality is preserved at all times by providing training to all staff at regular intervals.

9) Continue to focus on Tobacco cessation counseling and prevention activities, substance abuse treatment programs, and suicide prevention activities.

10) Improve access to healthy foods region-wide by collaborating with village leadership.

11) Increase access to indoor workout space region-wide by working with local leaders to develop partnerships for solutions.

12) Continue to develop and expand NSHC's in-home support program to provide personal care attendant services (PCA Program) and to offer end-of-life care for family's in the region at all locations.

13) Continue to provide patient transport services in all locations and to deliver prescription medications.

FUNDING AGREEMENT
BETWEEN CERTAIN ALASKA NATIVE TRIBES
SERVED BY THE
NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
OF THE
UNITED STATES OF AMERICA
FISCAL YEARS 2018-2020

This Funding Agreement is entered into by and between certain Alaska Native Tribes in the Bering Straits region of the Norton Sound Service Unit, as identified on the signature page herein, and the Secretary of the Department of Health and Human Services. These Tribes have authorized the Norton Sound Health Corporation to sign this Funding Agreement for them and to be responsible for and carry out the terms of this Funding Agreement.

Section 1 – Obligations of the IHS.

1.1 Generally. Under the authority of Section 325 of P.L. 105-83, and P.L. 93-638 as amended, non-residual programs, services, functions and activities (PSFAs) of the Alaska Area Office and the Alaska Native Medical Center (ANMC) have been transferred to tribal management.

Delivery of PSFAs shall be consistent with each Co-Signer's Funding Agreement (FA). The Indian Health Service (IHS) shall remain responsible for performing all federal residual PSFAs. The IHS shall remain responsible for negotiating assurances with the Alaska Native Tribal Health Consortium (ANTHC) and Southcentral Foundation (SCF) on behalf of Alaska Natives and American Indians to the effect that Co-Signers continue to receive non-residual PSFAs from the ANMC and Area Office and provided by ANTHC and SCF at a minimum at the level that such PSFAs were provided by the IHS as of October 1, 1997, to the extent permitted by Section 325 of P.L. 105-83. To the extent authorized by federal law, the IHS will respond to written Co-Signer concerns about the extent with which such assurances have not been complied and take appropriate action. IHS shall further be responsible for performing its special trust responsibilities and legal obligations as provided in the Indian Health Care Improvement Act, the Indian Self-Determination and Education Assistance Act, and other applicable provisions of federal law.

This FA obligates the IHS to provide funding and services identified herein and as provided in the Alaska Tribal Health Compact (ATHC) between the Norton Sound Health Corporation (NSHC) and certain other Co-Signers thereof and the United States in Fiscal Years 2018-2020.

The "Memorandum of Agreement Describing the Continuing Services of the IHS, Alaska Area Native Health Service" among the Co-Signers and the Alaska Area Native Health Service

(AANHS) reflects the understanding of the parties regarding services to be provided by the AANHS to Co-Signers. This document, attached as Appendix C, is hereby incorporated by reference.[1]

In addition, although funds are provided from Headquarters and Area Office in support of this ATHC, the IHS will agree to continue to make available to NSHC PSFAs from both Area Office and Headquarters unless 100 percent of the tribal shares for these PSFAs have been specifically included in this FA. In cases where a portion of tribal shares has been transferred, there may be some diminishment in the level of PSFAs provided by IHS. Furthermore, the IHS will reorganize both Headquarters and the Area Office to continue to provide the remaining PSFAs which have not been included in this FA, in the most effective and efficient manner possible, provided that the decisions about the array and level of PSFAs to be offered by the IHS shall be made in consultation with Alaska Tribes. The IHS PSFAs not negotiated into or listed in Appendix A are the responsibility of the IHS.

Unless funds are specifically provided from Headquarters, Headquarters retains all PSFAs and NSHC will not be denied access to, or services from, Headquarters. Specifically, NSHC will receive the following services from IHS Headquarters:

1.1.1 Information Services. IHS will provide the full range of Office of Information Technology (OIT) national support to ANTHC and ANMC OIT will provide specified services directly to NSHC. In addition, OIT will provide support to ANTHC to assist it to carry out its responsibility to provide day-to-day technical support, user support, distribution of software and files and other typical information technology support to Co-Signers as defined in the Assurances Appendix to the ANTHC FA. Upon request of ANTHC, after good faith efforts to resolve NSHC's technical issue, OIT's support of NSHC will include technical support needed on-site by NSHC. A list of the services due under this paragraph, with identification of the method of delivery, is shown below.

Office of Information Technology Provides:	Directly to ANTHC	Directly to Co-Signer	Indirectly to Cosigner through ANTHC
National Database Services			
100% Data Center Services	X		
Process Data exports into National Database		X	
Evaluate, correct, convert site data for National Database		X	
Telecommunications Management Services			
100% Telecommunications Management Services	X		
Maintain IHS to Alaska connection		X	
Email transfer and global address listing		X	
SMTP Gateway		X	
Intranet and Internet Access (to available bandwidth)		X	
Antivirus Software			X

[1] All references to Appendix A and Appendix C in this FA are to the Appendix for the applicable fiscal year.

Office of Information Technology Provides:	Directly to ANTHC	Directly to Co-Signer	Indirectly to Cosigner through ANTHC
Software Development and Maintenance			
100% Software Development and Maintenance	X		
Use of IHS contract vehicles		X	
RPMS Integrated Commercial-Off-The-Shelf packages (Average Wholesale Prices, CPT, ICD-9, Immunization Algorithm) licenses (This does not include licenses for stand-alone or interfaced commercial software.)			X
RPMS Package Support/Installation			X
System Support and Training			
100% System Support and Training	X		
Nationally Available OIT Training instruction (as available)		X	
Alaska On-site training instruction (four annual classes)			X
Hardware and Operating System Support			X
Cache Upgrade (initial installations)			X
National Patient File (2000) conversion			X
Envoy (WebMD) installation			X
Additional Services - Fee for Service	X	X	X

1.1.2 Access to Training and Technical Assistance. To the extent funds are identified by the IHS, NSHC shall have access to training, continuing education, and technical assistance in the manner and to the same extent NSHC would have received such services if it were not a Self-Governance Co-Signer.

1.1.3 Intellectual Property. In the course of administering federal contracts, grants, subgrants, and other agreements, IHS acquired various copyrights and licenses, including licenses pursuant to 45 CFR § 74.36 and 45 CFR § 92.34, in works which the IHS possessed, reproduced, published and otherwise used and allowed others to possess, reproduce, publish, and otherwise use. To carry out the PSFAs assumed by NSHC under this and previous FAs and contracts NSHC has the delegated authority and permission from IHS to use and allow others to reproduce, publish, and otherwise make use of these works to the same extent as IHS, consistent with the copyrights or licenses acquired by IHS in such works.

1.1.4 HIPAA Compliance. IHS retains the responsibility for complying with the Health Insurance Portability and Accountability Act of 1996 for retained IHS health care component activities.

1.2 Historical PSFAs. NSHC has historically received certain PSFAs from ANMC and AANHS. Responsibility for these PSFAs has been transferred to ANTHC by ANMC and AANHS prior to the transfer of management to ANTHC and SCF, NSHC attached to its FY 2002 FA Addendum I entitled "Memorialization of Historical Level of PSFAs provided by ANMC and AANHS." The PSFAs listed in this addendum are taken from NSHC's FY 1999 Annual FA. The addendum was attached to the FY 2002 FA only for the purpose of identifying historical levels of PSFAs received by the NSHC from ANMC and AANHS, and is specifically not made part of this

FA.

1.3 Community Health Aide Program Certification. The IHS retains the responsibility, pursuant to Section 119 of the Indian Health Care Improvement Act, as amended, to maintain the IHS Community Health Aide Program Certification Board (CHAPCB), which was established by and is under the direct control and supervision of IHS, to accredit training for and to certify community health aides, which includes community health aides/practitioners, dental health aides, and behavioral health aides/practitioners.

Section 2 – Obligations of the Co-Signer.

2.1 Generally. This FA obligates NSHC to be responsible for and to provide health PSFAs identified in Section 3 [Tribal Programs and Budget], utilizing the resources transferred under this FA and other funds as they may become available to NSHC. This FA further authorizes NSHC to consolidate and redesign PSFAs as provided in the Act and the ATHC. Whether providing, purchasing, or authorizing health care services described in the Compact and this Funding Agreement, in accordance with Section 2901(b) of Pub. L. 111-148, the Affordable Care Act, and as otherwise provided in law, NSHC shall be the payer of last resort. NSHC is committed to and will strive to provide quality health services and will strive to meet standards NSHC believes to be appropriate and applicable to the delivery of those health services.

2.2 Tribal Facilities and Locations. NSHC operates the programs described in this FA out of more than one facility or location. These include, but are not limited to the facilities and locations listed in Appendix B, which will be submitted prior to the effective date of this FA, and will be incorporated by reference herein. The Area Division of Planning Evaluation and Health Statistics shall compile from this Appendix a list of all health facilities identified in the Appendix and forward that list annually to the Headquarters' Office of Program Statistics, which shall include each of these facilities and locations in the annual list it must provide to the Centers for Medicare and Medicaid Services (CMS) (formerly Health Care Financing Administration) pursuant to the Memorandum of Agreement between the Health Care Financing Administration and the IHS (December 19, 1996).

Section 3 – Tribal Programs and Budget.

The NSHC agrees to be responsible for the health PSFAs identified below in accordance with the ATHC and this FA, including administration of the Norton Sound Service Unit of the IHS, a tribally operated Service Unit of the IHS. NSHC provides and facilitates a range of services directly, and in cooperation with ANMC, ANTHC, SCF and other Co-signers, through field clinics, referrals to ANMC, and other arrangements with tribal health organizations. Any PSFA described in this section 3 [Tribal Programs and Budget] may be performed by any organizational unit of NSHC at NSHC's discretion. For the purposes of this FA, the NSHC's General Budget Categories consolidate related health PSFAs as listed below.

3.1 Executive Leadership. NSHC through its Board of Directors and administration provides policy and administrative/executive/legal direction and oversight for all PSFAs in this FA. Board members, officers, General Counsel, and staff represent NSHC on the local, regional,

state and national committees and boards to provide for advocacy, negotiations, coordination, consultation, development of new programs and information activities.

3.2 Hospital and Clinic Services. NSHC is committed to providing quality patient care achieved through maintaining qualified staff, physical plant, and adequate supply of medical provisions. Under a comprehensive health care delivery plan NSHC provides the following direct patient care services:

3.2.1 Acute patient care swing-bed;

3.2.2 Twenty-four hour emergency services, including those associated with being a Level IV trauma center;

3.2.3 Ambulatory care services, including after-hour nursing phone triage service;

3.2.4 Medevac/air ambulance services;

3.2.5 Referral/transport system from the villages and/or Nome to and from the next higher level of care (e.g. travel coordination and authorization, patient transport vehicle, medivac transport and patient transportation, including adult escort, health professional and other escort as NSHC deems appropriate and emergency or non-emergency air transportation where ground transportation is not feasible and transportation by private vehicle where no other means is available, including specially-equipped vehicle and ambulance) subject to available funding. NSHC may provide the above described patient transportation services in accordance with Section 213 of the Indian Health Care Improvement Act as amended at 25 U.S.C. § 1621*l*;

3.2.6 Specialty clinic support;

3.2.7 Sexual Assault Response Team (SART), including forensic exams and counseling of victims;

3.2.8 Comprehensive health care nursing services for the elderly, disabled and others needing long term health care services as defined by Section 205(a)(4) of the Indian Health Care Improvement Act, as amended, and in accordance with Section 205(c) of such Act. Such services will include but not be limited to the nursing facility services of Quyanna Care Center;

3.2.9 Emergency and minor surgery within the expected capability of Medical Practitioners;

3.2.10 Services associated with training medical students, residents, physician assistant students, nursing students, and allied health provider students from accredited institutions, under supervision of appropriate staff;

3.2.10.1 Physician coverage for services provided in the hospital and villages in person and through daily contact by telephone and/or video telemedicine equipment as needed with the physician assistants and/or Community Health Aides/Practitioners in the villages, and for teleradiology services;

3.2.11 Comprehensive, well person, emergency, acute and chronic care and preventive services at the subregional/community health centers and surrounding village clinics. These services include, but are not limited to, Early Periodic Screening, Diagnosis and Treatment (EPSDT), immunizations, maternal and child health services including family planning, prenatal care and case management of care provided to children and other high-risk individuals; urgent care services 24 hours a day; and specialty clinics, dental services, optometry services, diagnostic imaging services, laboratory services, and telemedicine, telehealth, telepharmacy, teleradiology, telepsychiatry services, dialysis, and mammography, colonoscopy and other cancer screenings, and cancer

treatment;

3.2.12 Diabetes prevention program, including community exercise and activity programs, such as "Summercise" programs, community health fairs, and water aerobics. As authorized under Section 204(d) of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621c, NSHC provides dialysis services and is committed to and shall provide quality dialysis services that will at all times meet standards applicable to such services;

3.2.13 Ancillary services will be maintained at levels sufficient to support medical diagnosis, including but not limited to physical therapy, smoking cessation, respiratory therapy, diagnostic imaging, laboratory, pharmacy, social services, nutrition services, and point of care testing;

3.2.14 Provide lodging for patients, family members of patients, and/or their escorts, including but not limited to housing at the patient hostel, and elder housing;

3.2.15 Coordination with, support of, and assistance to tribal and non-profit entities with their provision of health and social services; and

3.2.16 Provides training and continuing education for NSHC employees and NSHC beneficiaries, and, subject to availability of funding, provides limited financial support for NSHC beneficiaries to assist them to be prepared to pursue health related careers. NSHC also provides a nursing educational program.

3.3 Behavioral Health Services. Provides behavioral health services including, but not limited to:

3.3.1 Substance Abuse Services. Provide services to reduce and prevent substance abuse and associated problems through in/outpatient services, prevention/education, referral services, transitional/residential care services, outreach services, and community involvement, diagnostic and primary alcoholism and drug abuse treatment services, including individual assessment and referrals, individual and group counseling, detoxification services, case management, and substance abuse education classes and Alcoholics Anonymous and/or Narcotics Anonymous meeting sponsorship.

3.3.2 Mental Health Service. Provides professional and paraprofessional staff that travel within the Norton Sound Service Unit, and provides family, child, adolescent and community mental health programs. As needed, a psychiatrist provides mental health services in the hospital. Services include but are not limited to assessment and diagnostic services, individual and group therapy, crisis intervention services, suicide prevention and psychological testing, and telebehavioral health.

3.3.3 Village Based Counseling Program. Provides supportive counseling to identified clients, including abused children, children with behavioral health problems, families in crisis, adults and adolescents with substance abuse and/or mental health issues, and the chronically mentally ill. This program works in conjunction with the substance abuse and mental health program and includes the services of behavioral health aides.

3.3.4 Rainbow Services. Provides services to clients with developmental disabilities. The program assists clients to remain in their homes and communities by developing skills to increase self-control and participation in the community. When this is not possible, the

program assists families to find appropriate treatment and services outside the home for the client.

3.3.5 Transitional Living Services. Provides transitional living services, including residential programs, to assist clients in maintaining sobriety while attending outpatient substance abuse treatment, and after completion of treatment until the client is ready to return to his/her home community.

3.3.6 Fetal Alcohol Spectrum Disorder Prevention Services. Provides education and assistance regarding Fetal Alcohol Spectrum Disorder, targeting pregnant women with substance abuse issues to educate them about the effects of substance abuse on children and families.

3.3.7 Children's Services. Provides intensive outpatient behavioral health services to high risk clients with severe emotional problems ages 9-20 and their families. The program aims to help youth succeed at school, home and in the community while eliminating the need to send them elsewhere. Children's services also may include a full array of behavioral health prevention, early intervention, and treatment programs, including recreational and activity programs and residential and day camps. Providing culturally relevant services involving the community in the treatment process.

3.4 Other Health Services. Provides other health services, including but not limited to:

3.4.1 Dental Services. Provides services at the hospital and in field clinics to raise dental health and lower the incidence of dental disease. The field dental program offers visits to all the villages. Dental services may include dental health aide and dental health aide therapist, training, supervision, and services under the Standards and Procedures approved by the IHS Community Health Aide Program Certification Board.

3.4.2 Audiology. Audiology Services will be delivered, both at the hospital and through field clinics throughout the Norton Sound Service Unit.

3.4.3 Optometry Services. Optometry Services will be provided consistent with the needs of the patients, both in Nome and through field clinics throughout the region.

3.4.4 Village Health Services. Provides training, supervision and services of Community Health Aides/Practitioners (CHA/Ps) and the Clinic Travel Clerks who act as support staff to the village clinics. The Community Health Aide Program will be carried out under the Standards and Procedures approved by the IHS Community Health Aide Program Certification Board.

3.4.5 Health Aide Training. Provides Community Health Aide Program training to trainees from throughout Alaska.

3.4.6 Traditional and Alternative Medicine. Provides traditional healing-services in coordination with existing western medicine services; and alternative healing practices only upon a referral from a provider credentialed in accord with the standards cited in Section 8 of this FA.

These services will be provided in accordance with Section 831 of the Indian Health Care Improvement Act, amended at 25 U.S.C. § 1680u.

3.4.7 Emergency Medical Services. NSHC will maintain Emergency Medical Services (EMS) to lower the incidence of death and disability by providing air ambulance services. The NSHC departments also provide various levels of EMS and injury prevention training for staff and community members throughout the region. NSHC participates in EMS delivery in cooperative with community fire departments, other emergency response, and rescue services throughout the region.

3.4.8 Maternal and Child Health Program. Provides:

3.4.8.1 Prematernal home care for village women awaiting delivery in Norton Sound Regional Hospital;
3.4.8.2 Prenatal, family planning and newborn patient education; and
3.4.8.3 Assistance in risk screening and coordination of prenatal care.

3.4.9 Office of Environmental Health. Provides inspections of the hospital and clinics; technical assistance, training and research to help protect the public from illness and injury related to problems with water, waste, food, air, pests, safety, hazardous waste sites and bioterrorism. Technical assistance is provided to local, state and federal officials as necessary to assist with funding processes and the development of local environmental programs. Training is provided to regional water/wastewater operators and utility managers as needed to ensure safe operation and management of environmental systems.

3.4.10 Public Health Nursing. Provides public health nursing services, including but not limited to consultation to CHA/Ps in the villages, child health and developmental screening, prenatal care, EPSDT, school screenings, immunizations, and tuberculosis and other infectious disease screening and monitoring.

3.4.11 Research and Prevention. Participate in research activities to determine whether genetic factors predispose Alaska Natives to disease.

3.4.12 Home Care and Other Community Based Services. Through a combination of western methods and traditional modalities, provides home care and other community based services, which includes but is not limited to assistance with activities of daily living such as bathing, dressing, laundry, light housekeeping, cooking, vital signs, and medication reminders. These services are provided to all individuals throughout the Bering Straits region who are unable to perform their activities of daily living on their own, or when the families are unable to meet their needs. Home and Community Based Services also provides palliative care and other end-of-life services, such as hospice care, respite, chore, nutrition, transportation, and other supportive services including various senior programs and activities. Such services may also include Assisted Living Services. NSHC will provide home and community based services, hospice and assisted living in accordance with the requirements at § 205 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621d.

3.4.13 Nutrition Services for Women, Young Children, and Infants. Provides supplemental foods, and nutritional education, counseling and other services to women, infants and young children who are at nutritional risk.

3.4.14 Infant and Young Child Developmental Program. Provides services that promote growth and development of infants and young children. Children who qualify for services may have been born prematurely, have delays in their development, or have a diagnosed disability such as Down's syndrome or cerebral palsy. Other child development and family services include, but are not limited to, health-oriented education; socialization; health screening; growth and nutritional assessment; individualized culturally-appropriate child development services; family services; and family involvement.

3.4.15 Injury Prevention Services. Provides services to lower the incidence of death and disability, including but not limited to, the provision of safety information, equipment, and training.

3.4.16 HIV Services. Provides testing, referrals, data collection, and training end education.

3.4.17 Purchased/Referred Care Services. Purchases services, which are not otherwise available or accessible to eligible beneficiaries, on a contractual or open-market basis within funds available. NSHC agrees to be bound by 42 C.F.R. Part 136, subpart I, in the administration and provision of Purchased/Referred Care (PRC) services carried out under this Agreement. Accordingly, NSHC has opted to pay at Medicare Like Rates for PRC in accordance with that subpart of the regulations.

3.4.18 Morgue. Provides morgue services in each village.

3.5 Support Services. Support services required to support the provision of health services, including, but not limited, to plant operations, biomedical services, housekeeping and linen/laundry services, security (for patients and staff), human resources, information systems, administration and board support, corporate planner, grant management, compliance officer and performance improvement, material management (procurement, receiving, processing and distribution), central sterile supply, infection control/employee health, and financial, including business office functions, coding and medical records, planning and implementation of an electronic health records system, patient benefits coordinator, and the provision of staff housing.

3.6 Capital Projects. Provides technical assistance, planning, design, engineering, management and general contracting for construction, maintenance and operation of all facilities used by NSHC, including both federal facilities and those leased or owned by NSHC. This program also provides technical assistance and construction related services to other tribes and tribal organizations inside and outside NSHC's service area.

3.7 Village Built Clinic (VBC) Lease Program. Provides funds to eligible entities to

support the rental of CHA/P clinic space. NSHC will operate this program directly with all VBC lessees, who so elect, including the provision of support services and technical assistance. NSHC will ensure that each lessee is in compliance with the standards referenced in the VBC lease.

3.8 Public Health and Epidemiology. Directly and/or through ANTHC, including its Epidemiology Center,[2] NSHC carries out public health, epidemiology and health research functions. These activities include, but are not limited to: collecting and receiving personally identifiable health information for the purpose of

3.8.1 preventing or controlling disease, injury, or disability;

3.8.2 reporting disease, injury, and vital events such as birth and death; and

3.8.3 the conduct of public health and epidemiological investigations, surveillance, and interventions, including the maintenance of disease and injury registries.

3.9 Other Programs/Services Funded.

3.9.1 Generally. This FA includes programs, functions, services and activities resulting from tribal redesign, or consolidation, reallocation or redirection of funds, including its own funds or funds from other sources, provided that such consolidation, redesign, or reallocation or redirection of funds results in carrying out programs, functions, services and activities that may be included in the FA pursuant to section 505 of Title V and Article III, Section 6 [Consolidation with Other Programs] of the ATHC. This includes any other new health care programs, including, but not limited to, those identified in the Indian Health Care Improvement Act funded during the fiscal years.

3.9.2 Non-IHS Funding. NSHC will complement and supplement the PSFAs described throughout Section 3 [Tribal Programs and Budget] with funding from sources other than the IHS through this Funding Agreement, subject to the availability of such other funding sources. Consistent with Article III, Section 5 [Reallocation], 6 [Merging with Other Programs], and 7 [Program Income] of the ATHC, non-IHS funds will be added to or merged with funds provided by the IHS through this FA.

3.10 FTCA. The Federal Tort Claims Act applies to NSHC's PSFAs under this FA as provided in Section 516(a) of Title V (which incorporates Section 102(d) of Title I of the Act and Section 314 of P.L. 101-512). The extent of Federal Tort Claims Act coverage is described more particularly in 25 C.F.R. Sections §§ 900-180-900.210.

Section 4 – Amounts Available During the Term of the FA

4.1 The following amounts shall be available to NSHC pursuant to the ATHC and Title V of the Act and are subject to reductions only in accordance with Section 508(d) of Title V and Section 106 of Title I of the Act.[3]

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[2] The ANTHC Epidemiology Center was previously operated by the Alaska Native Health Board.

[3] A breakout of these funds is shown in Appendix A, which cites the source document used to determine the amount. These amounts are subject to change under the Act and as provided in this FA. For other fiscal

Recurring Base: Inclusive of all recurring funding, including recurring contract support funds and Village Built Clinic Funds of $425,417.[4]	$48,467,747
Non-recurring funds: inclusive of all non-recurring contract support funds and such other funding which may be added to the contract.[5]	$13,954,404
Subtotal: (This amount is subject to amendments in accordance with Section 14 [Amendment or Modification of this FA])[6]	$62,422,151
Area "Tribal" share to include funding identified from the Area Office and identified in Appendix A to this Agreement.[7]	$1,031,630
Headquarters-tribal share: "Tribal Size Adjustment Pool," including all funds identified in Appendix A. The amount identified is exclusive of funds for which distribution amount has not been determined. The final amount due shall be determined as set forth in this FA or Appendix A.[8]	$731,037
Headquarters-Tribal share: "Program Formula Pool" – to include all funds identified in Appendix A, and such additional funds which the IHS may make available on a program formula basis during the year based on the programs accepted for this allocation in Appendix A.	$0

years to which this FA may be applicable, the replacement Appendix A will be negotiated between IHS and NSHC for the respective year and amended to this FA and incorporated by reference, accordingly.

4 A breakout of these recurring costs is found in Appendix A, fully incorporated herein and citing the actual documents used to determine the amount. *See* Footnote 3.

5 These non-recurring funds include contract support costs and routine Maintenance and Improvement funds available at the beginning of the fiscal year. *See* Footnote 3.

6 The Radiologist Consultation funds in the amount of $195,131 and Biomed funds in the amount of $67,102 are not included in this amount (neither of these amounts include any adjustments for mandatory increases). These recurring funds and any mandatories associated with them are in the ANTHC FA and will be negotiated annually as a flow-thru from the ANTHC, in accordance with the interpretation of Section 325 of P.L. 105-83 by the IHS.

7 Funds from the Alaska Area were distributed according to methods agreed upon in a caucus open to all Alaska Tribes and tribal organizations. The specific methodology is identified in Appendix A.

8 Headquarters tribal shares were allocated according to the following process, which was adopted in a caucus open to all Alaska tribal organizations: The Alaska Area Tribal shares of Headquarters was first defined using the national IHS recommended methodology. The total Alaska Area Tribal shares was then reallocated to each Co-Signer according to the agreed upon Alaska Area methodology, which is identified specifically for each line in Appendix A.

Subtotal – Tribal Shares[9]	$1,762,667
TOTAL ATHC FUNDING	**$64,184,818**

These amounts are subject to additions for other reimbursements, and for new funds received during the term of this Agreement including amounts that have historically been distributed as non-recurring funds under the Act. Any amounts remaining unspent under the prior FA, after adjustments and services, as of the previous fiscal year, shall be included and spent under this FA.

Of the amount shown above for non-recurring program funds, $1,211,108 are for Routine Maintenance and Improvement (M&I); the Routine M&I amount paid as a part of the lump sum due NSHC was determined by multiplying the FY 2017 Routine M&I amount paid to the Co-Signer by 90%. The final Routine M&I amounts paid in FYs 2018-2020 will be based on the final 2018-2020 Routine M&I allocations. If the final Routine M&I amounts, as determined by the final FYs 2018-2020 Routine M&I allocations, is less than the 90% calculation, NSHC will return the difference to the IHS. See also Appendix A, footnote to line 19 on page 6.

Of the amount shown above for Headquarters Tribal Share "Program Formula," $141,878 are for Equipment Replacement, the Equipment Replacement amount paid as part of the lump sum due NSHC was determined by multiplying the FY 2017 Equipment Replacement amount paid to NSHC by 90%. The final Equipment Replacement amounts paid in FYs 2018-2020 will be based on the final FYs 2018-2020 Equipment Replacement allocations. If the final Equipment Replacement amounts, as determined by the final FYs 2018-2020 Equipment Replacement allocations, is less than the 90% calculation, NSHC will return the difference to the IHS. See also Appendix A, footnote to line 22 on page 6.

The Recurring Base amount shown above includes $291,158 that NSHC received, recurring in FY 2006 for Congressionally earmarked alcohol funds. Such funds are subject to "Adjustments Due to Congressional Actions" as described herein in Section 6 as well as any conditions on those funds that may be described in the FYs 2018-2020 Interior Appropriations Acts (Act) or Congressional Reports. After each Act is passed into law, such conditions, including Congressionally-directed reporting requirements, will be added by amendment not requiring NSHC's signature as described in Section 14 [Amendment or Modification of this FA].

The parties agree Section 505(b)(2) of Title V provides, among other things, that grants administered by the Department of Health and Human Services through the IHS may be added to NSHC's FA after award of such grants. In accordance with this provision of Title V and its implementing regulations, the Secretary will add NSHC's diabetes grants and any other statutorily mandated grant(s) administered by the Department through the IHS to this FA after such grant(s) have been awarded. Grant funds will be paid to NSHC as a lump sum advance payment through the PMS grants payment system as soon as practicable after award of the grant. NSHC will use interest

[9] The subtotal of Tribal shares does not include certain Headquarters for which the amount or availability has not been determined. This amount will be adjusted to make available all Tribal shares for which NSHC is eligible. IHS will pay mandatory increases on some Headquarters Tribal shares, subject to appropriations.

earned on such funds to enhance the purposes of the grant including allowable administrative costs. NSHC will comply with all terms and conditions of the grant award, including reporting requirements, and will not reallocate grant funds nor redesign the grant program, except as provided in the implementing regulations or the terms of the grant.

4.2 Contract Support Costs. Contract support costs (CSC) will be paid in accordance with 25 U.S.C. § 5325 and § 5388(c). The parties agree that, according to the best data available as of the date of execution of this agreement, the amount to be paid under FY 2018, which represents the parties' estimate of the Tribe's full CSC requirement pursuant to 25 U.S.C. § 5325, is $16,798,500, including $4,197,082 for direct CSC and $12,601,418 for indirect or indirect-like CSC.[10] This estimate shall be recalculated as necessary as additional data becomes available including information regarding the direct cost base, pass throughs and exclusions, and the indirect cost rates to reflect the full CSC required under 25 U.S.C. § 5325. The parties will cooperate in updating the relevant data to make any agreed upon adjustments. In the event the parties disagree on the CSC amounts estimated and paid pursuant to this paragraph and the Tribe's full CSC requirement under the ISDEAA, the parties may pursue any remedies available to them under the ISDEAA, the Compact, and the Contract Disputes Act, 41 U.S.C. §7101 et seq.

4.3 Base Budgets.

4.3.1 Categories and Base Year. At the end of the first period of the base budget option, the IHS and Co-Signers agreed to extend the three year (FY1998-FY2000) base budgets implemented for the ATHC for an additional two years (FY2001-FY2002). IHS and NSHC have subsequently agreed to additional extensions through FY 2009. The IHS and Co-Signers have agreed to further extend the base budget period at the Co-Signer's option. The following categories are subject to base budgeting for the base year period and the period, as noted below.

Category of Funding	Base Period for Base Funding	Extended through:
Headquarters TSA amounts[11]	FY 97	FY 2020
Equipment Replacement Funding	Not Included	N/A
Area Tribal Share	Not Included	N/A

4.3.2 Adjustments. Adjustments to base funding shall be permitted in direct proportion to changes in appropriated amounts (by sub-activity), as provided under Section 6.1 of this FA titled "Adjustments, Due to Congressional Actions." Adjustments shall also be permitted for the addition of new Co-Signers to the ATHC and when current Co-Signers add or retrocede PSFAs,

10 For other fiscal years to which this FA is applicable, the CSC estimates will be negotiated between the IHS and NSHC for the respective year and amended to this FA in Appendix A.

11 ATHC base budgets for TSA amounts shall be considered as a whole (entire ATHC amount) and shall be subject to adjustment of the internal allocation subject to ATHC agreements.

as provided in Section 14.4 [Due to Addition of New Programs].[12] Adjustments also shall be permitted when Co-Signer chooses to restrict or un-restrict previously "restricted" or "un-restricted" categories, provided that restrictions shall be changed only during annual negotiations. NSHC shall also be eligible for funding for new service increases, mandatories, specific Congressional appropriation for population growth, health services priority system, contract support costs and other increases in resources on the same basis as all other Tribes. Adjustments for changes required when a Tribe joins or withdraws from a Tribal consortium shall also be permitted, as provided under Section 10.3 [Withdrawal Procedures] of this FA. Co-Signers shall also remain eligible for the distribution of additional Tribal shares for Assessments, Workers Compensation, Emergency Reserve, Management Initiatives, and other PSFAs from Headquarters.

Section 5 – Methods of Payment.

5.1 Payment Schedule. Except as provided in subsection 5.2 [Availability of Tribal Shares], 5.3 [Buyback/Withholding], and 5.4 [Periodic Payments] of this Section, all funds identified in Section 4 [Amounts Available During the Term of the FA] of this FA shall be paid to NSHC, in accordance with Article II, Section 4(a) [Payment Schedule] of the ATHC; payment to NSHC to be made as follows: One annual lump sum payment to be made in advance.

5.2 Availability of Tribal Shares. NSHC will be paid 100 percent of Headquarters and Area Tribal Shares in its initial lump sum payment, as negotiated in this FA, for each year under the term of this FA.

5.3 Buyback/Withholding. NSHC may carry out its responsibility to provide certain PSFAs included in this FA by using services or other resources of the Federal government under Article V, Section 22 [Purchases from the IHS] of the ATHC, as permitted by law. Except as provided herein, the cost of such services and the terms under which they may be available to NSHC are set forth in the Buyback/Withhold Agreement between the IHS and NSHC, which is attached as Appendix D to this FA and incorporated by reference herein. The administrative surcharge provided for in Section 2.2.4 of the Buyback/Withhold Agreement for FY 2018 shall be .285 percent. During the term of this FA, the Administrative surcharge rates will be negotiated annually. Notwithstanding Section 5 of the Buyback/Withhold Agreement, upon the request of the IHS or any Co-Signer, such FA will be negotiated for future fiscal years annually during negotiation of this FA.

5.4 Periodic Payments. Payment of funds otherwise due to NSHC under this FA, which are added or identified after the initial payment is made, shall be made promptly upon request of NSHC by check or wire transfer.

Section 6 – Adjustments.

[12] This includes addition of new facilities when the addition of these facilities includes an increase in equipment funds identified for the new facilities.

6.1 Due to Congressional Actions. The parties to this FA recognize that the total amount of the funding in this FA is subject to adjustment due to Congressional action in appropriations Acts or other law affecting availability of funds to the IHS and the Department of Health and Human Services. Upon enactment of any such Act or law, the amount of funding provided to NSHC in this FA shall be adjusted as necessary, after NSHC has been notified of such pending action and subject to any rights which NSHC may have under this FA, the ATHC, or the law.

6.2 Proposals by Authorizing Tribes. Should any authorizing Tribe assume responsibility for PSFAs (or portions thereof) under a contract or annual FA pursuant to the Act, adjustment to funding amounts under this FA will be negotiated.

Section 7 – Records.

7.1 Incorporation of the Privacy Act. Pursuant to Section 506(d)(1) of Title V, records acquired, generated or maintained by NSHC shall not be treated as Federal records under chapter 5 of title 5 of the United States Code, except that:

7.1.1 Patient medical, financial records and personnel records may be disclosed only in accordance with 5 U.S.C § 552a(b); and

7.1.2 Medical records generated by NSHC shall be eligible for storage in Federal Records Centers at NSHC's option in accordance with Section 105(o) of Title I.

7.2 Confidentiality Standards. NSHC will seek to comply with the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including, but not limited to, privacy, security, transactions, and code set regulations, codified at 45 CFR Parts 160, 162, and 164. If a record is not subject to HIPAA, NSHC will maintain the confidentiality of its records in accordance with policies and procedures adopted by its Governing Body, which will be consistent with the purposes and guidelines of HIPAA and the Federal Privacy Act of 1974.

7.3 Quality Assurance Records. NSHC operates a medical quality assurance program and treats the records of such program as confidential and privileged in accordance with section 805 of the Indian Health Care Improvement Act as amended at 25 U.S.C. § 1674.

Section 8 – Program Rules.

NSHC in carrying out the PSFAs in this FA agrees to comply only with those guidelines, manuals, and policy directives that are listed below: Joint Commission (formerly known as JCAHO) standards, as applicable, and Community Health Aide/Practitioner certification standards.

Except as specifically set forth in this Section, pursuant to Section 517(e) of Title V, NSHC does not agree to be subject to any agency circular, policy, manual, guidance or rule adopted by the IHS, except for the eligibility provisions of Section 105(g) and the regulations promulgated under Section 517 of Title V, unless otherwise waived.

Section 9 - Real Property Reporting Requirements

9.1 Leases. The IHS must report on its federally leased facilities. NSHC agrees to notify the AANHS of changes of occupancy, size, use, and general condition of Village Built Clinic (VBC) leased facilities in locations where NSHC has bought back services from the IHS. IHS will annually, or upon renegotiation, provide to NSHC a copy of each VBC lease. No increase in the amount due to the lessor pursuant to a lease will be negotiated by IHS without advance notice to NSHC. In administering these leases, the IHS will work with NSHC to ensure that each lease is in compliance with the standards referenced in the VBC lease.

9.2 Maintenance and Improvement Funds. NSHC agrees to use maintenance and improvement funds received through this FA in accordance with the appropriation language for Indian Health Facilities in the Department of Interior and Related Agencies Appropriation Act for FYs 2018-2020 or any comparable Act of Congress that contains the subject appropriation and in accordance with 41 U.S.C. § 12 to the extent applicable.

Section 10 – Services to Non-Beneficiaries.

Section 813 of the Indian Health Care Improvement Act, as amended, 25 U.S.C. 1680c, (Section 813), authorizes the governing body of a Tribal Organization carrying out health services of the IHS under the Indian Self-Determination and Education Assistance Act to determine whether health services should be provided under the Tribal Organization's FA with the IHS "to individuals who are not eligible for such health services under any other subsection of this section or under any other provision of law", 25 U.S.C. 1680c(c). The NSHC Board of Directors has made such determination consistent with Section 813, and provides for its findings in Resolution No. 2010-16. Resolution No. 2010-16 is attached as Appendix E and incorporated by reference herein. NSHC may provide services under this FA to "non-beneficiaries" as described in Resolution No. 2010-16. In addition services may be provided to U.S. Public Health Service Commissioned Corps Officers and their dependents.

Section 11 – Retrocession and Discontinuance.

11.1 Retrocession. The retrocession provisions of Section 506(f) of the Act are herein adopted, except that the effective date from a retrocession request of the ATHC and FA, in whole or in part, shall be one year from the date of the request by an authorizing Tribe or Village, except as provided below. Retrocession may be effective with less then one years notice, providing the Tribe or Village requesting retrocession, NSHC and the IHS agree to an effective date of less than one year from the date of retrocession request.

11.2 Discontinuance. NSHC may discontinue its participation in the ATHC after written notice to each authorizing Tribe or Village and the IHS. Notice must be provided one year in advance of the effective date of the request except that the effective date of a request may be less than one year upon approval of all authorizing Tribes and Villages and the IHS.

11.3 Withdrawal Procedures.

11.3.1 Process. Unless prohibited by law and in accordance with § 506(g) of Title V, an Indian tribe may fully or partially withdraw from a participating inter-tribal consortium or tribal organization its share of any program, function, service or activity (or portions thereof) included in the ATHC or FA, and any such withdrawal will become effective within the time frame specified in the resolution which authorized transfer to the participating inter-tribal consortium or tribal organization, provided that in the absence of a specific time frame being set forth in the resolution, such withdrawal shall become effective on -

11.3.1.1 The earlier of

11.3.1.1.1 One year after the date of submission of such request; or

11.3.1.1.2 The date on which the FA expires, or

11.3.1.2 Such date as may be mutually agreed upon by the Secretary, the withdrawing Indian tribe, and the participating tribal organization or inter-tribal consortium that has signed the ATHC or FA on behalf of the withdrawing Indian tribe, inter-tribal consortium, or tribal organization.

11.3.2 Distribution of Funds. In accordance with Sections 503(b) and 506(g) of the Act, when a tribe proposing to enter into a contract under Title I or a compact and FA under Title V fully or partially withdraws from a participating tribal organization, the withdrawing Tribe shall, upon written request, be entitled to be paid its tribal share of funds supporting those PSFAs (or portions thereof) which it will be carrying out under its own contract or compact and FA, and such funds shall be removed from the FA of the tribal organization and awarded to the Tribe upon approval of a Title I contract or compact and FA. The IHS shall retain any funds removed, but not awarded in a Title I contract or compact and FA.

Section 12 – Memorandum of Agreement with Member Village.

Funds provided under this FA may be allocated to and expended by an Alaska Native Village ("Village") which is party to this FA in accordance with the terms of the ATHC, this FA and a Memorandum of Agreement (MOA) approved by NSHC and the Village. The Federal Tort Claims Act shall apply to PSFAs carried out by the Village under such MOA and to the Village and its employees to the same extent as if they had been carried out directly by NSHC. Such an MOA may include provisions for the assignment of federal employees under IPA assignment or Commissioned Corps detail. Such assignment shall be subject to the approval of the AANHS Director. NSHC shall be responsible for assuring compliance by the Village with the ATHC, this FA and the MOA.

Section 13 – Consolidation of Contract and Previous Annual FAs.

The contracts listed below and all previous Annual FAs shall be amended or terminated, as appropriate to transfer applicable contract funds into this FA for services, materials and activities, programs, functions and facilities provided to the Tribes represented by NSHC: Title I, P.L. 93-638 Contract #243-89-0011, as modified.

Section 14 – Amendment or Modification of this FA.

14.1 Form of Amendments. Except as otherwise provided by this FA, the ATHC, or by law, any modifications of this FA shall be in the form of a written amendment and shall require written consent of each of the signatory Tribes, acting directly or through NSHC as authorized by resolution, the NSHC, and the United States. Participation or written consent of Tribes and Co-Signers not subject to the terms of this FA shall not be required.

14.2 Funding Increases.

14.2.1 Written consent of NSHC shall only be required for issuing amendments for those funds which:

14.2.1.1 require a change to Section 3 [Tribal Programs and Budget];

14.2.1.2 require a specific commitment by NSHC (*e.g.*, Maintenance & Improvement projects and prior fiscal year Sanitation Facility Construction projects); or

14.2.1.3 reduce funding other than changes in Congressional appropriations pursuant to Section 6.1 [Adjustments Due to Congressional Actions].

14.2.2 Amendments not requiring written consent may include, but are not limited to:

14.2.2.1 Program/Area/HQ Mandatories;

14.2.2.2 Program/Area/HQ End-of-Year Distributions;

14.2.2.3 CHEF, subject to the condition that if a case initially qualifying for reimbursement is paid (in whole or in part) by an alternate resource or cancels for any reason, NSHC will return the unused amount to the IHS CHEF account;

14.2.2.4 PRC Deferred Services;

14.2.2.5 Routine Maintenance & Improvement; or

14.2.2.6 Collections and reimbursements.

14.2.3 Amendments reflecting payment of these funds shall be provided to NSHC after any such funds are added to the FA. NSHC retains the right to reject the addition of such funds to the FA and return the funds to the IHS.

14.3 Services from IHS. Should NSHC determine that it wishes the IHS to provide PSFAs included in this FA for which funding has been identified but not provided, the parties shall negotiate an amendment to the FA to reflect the transfer of responsibilities from NSHC back to the IHS and the pro-rata share of funding for that program, services, function or activity shall be retained by the IHS. Unless otherwise negotiated, IHS will not transfer centrally paid expenses including but not limited to Workers Compensation to any ATHC Co-Signer.

14.4 Due to the Addition of New Programs. Should NSHC determine that it wishes to provide a program, service, function or activity of the IHS not included in this FA, NSHC shall submit a proposal to the IHS to provide such program, service, function or activity. The parties agree to negotiate such a proposal and, should the parties fail to reach agreement, NSHC may submit a final offer in accordance with the Title V procedures set forth in Sections 507(b)-(d) of Title V. A

proposal submitted pursuant to this section shall be treated as a request for amendment to the FA and, once approved by the IHS, the Alaska Area Office shall prepare within 30 days an amendment to this FA and the amendment shall be executed through the Area Office and added to the FA.

14.5 Due to Availability of Additional Funding. NSHC shall be eligible for any increases in funding or funding for Medicaid, Medicare, maintenance and improvement, other reimbursements and new programs for which it would have been eligible had it been administering programs under a self-determination contract, rather than under the ATHC and this FA, and for any other funds that are not restricted by appropriations language for which any Alaska Tribe or tribal organizations may be eligible, including any new funds appropriated for IHS Headquarters and funds passed to Alaska Area as recurring or non recurring funds, and this FA shall be amended to provide for timely payment of such new funds to NSHC. Such amendment shall be originated and prepared within 30 days by the Alaska Area Office and executed through the Area Office in consultation with the Co-Signer.

14.6 Other Adjustments. Upon written authorization by NSHC and agreed to by the IHS, the IHS may reallocate funds retained by the IHS, which are obligated to NSHC, for the purpose of reimbursing the IHS for services or equipment provided to NSHC to assist NSHC in carrying out the terms of the ATHC and this FA.

14.7 General Procedures for Amending or Modifying this FA. Amendments or modifications proposed by NSHC shall be submitted in writing to the IHS Alaska Area Director with a copy to the Office of Tribal Self Governance at IHS. Except as provided with respect to the incorporation of a provision of Title I under Article V, Section 21 [Applicability of Title I Provisions] of the ATHC, or as provided above in paragraphs .1, .2, .3 and .4 of this Section 14 [Amendment or Modification of this FA], a request to amend or modify this FA submitted by NSHC shall be processed in accordance with Sections 507(b)-(d) of Title V and all provisions of those identified sub-sections are incorporated herein for this purpose.

Section 15 – Third Party Recoveries.

Any funds recovered by NSHC through the filing, litigating, or settling a claim against a third party to require that third party to pay for services previously provided to IHS-eligible beneficiaries by NSHC, or for such services previously provided by the IHS in a PSFA now operated by NSHC, shall be the property of the Co-Signer and shall be considered program income to be utilized by NSHC as provided in Article III, Section 7 [Program Income] of the ATHC. Any prospective recovery of funds for such services shall likewise be considered program income to be utilized pursuant to Article III, Section 7 [Program Income] of the ATHC.

Section 16 – Severability.

This FA shall not be considered invalid, void or voidable if any section or provision of this FA is found to be invalid, unlawful or unenforceable by a court of competent jurisdiction. Should such a court make such a finding, the parties will seek agreement to amend, revise or delete any such

invalid, unlawful or unenforceable section or provision, in accordance with the provisions of the ATHC.

Section 17 – Memorializing Disputes.

The parties to this FA may have failed to reach agreement on certain matters which remain unresolved and in dispute. Such matters may be addressed through the process set forth in Sections 507(b)-(d) of Title V, or, at the option of NSHC, may be set forth in Addendum II to this FA, which shall be identified as "Memorialization of Matters Remaining in Dispute." This attachment shall not be considered a part of this FA but is attached for the purpose of recording matters in dispute for future reference, discussion and resolution as appropriate. The NSHC does not waive any remedy it may have under the law with regard to these issues and any others not listed herein.

Section 18 – Title I Provisions Applicable to This FA. As authorized in 25 U.S.C. § 5396(b), NSHC exercises its option to include the following provisions of Title I of the Act as part of this FA, and these provisions shall have the force and effect as if they were set out in full in Title V of the Act.

18.1. 25 U.S.C. § 5304(e) (definition of "Indian Tribe");
18.2. 25 U.S.C. § 5322(b) (related to grants for health facility construction and planning, training and evaluation);
18.3. 25 U.S.C. § 5322(d)(1) (related to duty of IHS to provide technical assistance);
18.4. 25 U.S.C. § 5324(a)(1) (exemption from Federal procurement and other contracting laws and regulations);
18.5. 25 U.S.C. § 5328(b), (conflicting provisions of law);
18.6. 25 U.S.C. § 5329(c), section 1(b)(8)(F) (screener identification);
18.7. 25 U.S.C. § 5329(c), section 1(b)(9) (availability of funds);
18.8. 25 U.S.C. § 5329(c), section 1(d)(1)(B) (construction of contract);
18.9. 25 U.S.C. § 5329(c), section 1(d)(2) (good faith).

Section 19 – Exemption from Licensing Fees.

In accordance with Section 124 of the IHCIA, as amended at 25 U.S.C. 1616q, employees of the NSHC health programs shall be exempt from payment of licensing, registration, and any other fees imposed by a federal agency to the same extent that officers of the Public Health Service commissioned corps and other employees of the Indian Health Service are exempt from such fees.

Section 20 – Licensure.

Licensed NSHC health professionals will be licensed in accordance with section 221 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621t.

Section 21 – Purchase of Health Coverage.

NSHC may use federal funds for purchase of health care coverage in accordance with section

402 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1642.

Section 22 – Medicare & Medicaid Reimbursements.

22.1 Medicare & Medicaid. NSHC has elected to directly collect Medicare and Medicaid payments as provided in 25 U.S.C. § 1641, as amended. NSHC is obligated and entitled to directly collect and retain reimbursement for Medicare and Medicaid and any other third party payers for services provided under this Agreement in accordance with section 401 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1641 and section 206 of such Act, 25 U.S.C. § 1621e, as amended.

22.2 Recovery Right. NSHC has the right to recover reimbursement from certain third parties of the reasonable charges for health services in accordance with section 206 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621e.

Section 23 – Federal Insurance. IHS will assist NSHC to obtain information about the coverage, rights and benefits available for its employees under chapters 87 and 89 of title 5, United States Code, the cost of such coverage, rights and benefits (including any options in coverage, rights and benefits that may be available), and the procedures by which NSHC may exercise its rights under Section 409 of the IHCIA, as amended, to have access to such Federal insurance for its employees.

Section 24 – Environmental and Cultural Resources. The National Environmental Policy Act (NEPA), National Historic Preservation Act (NHPA), and related provisions of law require the IHS to review and approve actions resulting in the use or commitment of IHS funds or that affect IHS property, and which may significantly impact the environment or cultural resources. Unless NSHC has assumed these responsibilities under a construction project agreement in accordance with Section 509 of Title V and 42 C.F.R. § 137.285-312, the IHS must carry out these responsibilities and has elected to utilize Appendix H. Where NSHC plans to undertake an action, as described in Appendix H, on IHS owned real property or utilizing IHS funds received through this Funding Agreement, and NSHC has not assumed these responsibilities, NSHC will provide the IHS with a Project Summary Document (see Appendix F) and a completed Environmental Information and Documentation Form (see Appendix G) so that the IHS can accomplish these requirements, and issue a Determination Document (Categorical Exclusion (CATEX) or Finding of No Significant Impact (FONSI)), as soon as possible. All documentation shall be submitted to the IHS as early as possible in the planning phase of the project to prevent delays in the action. No irreversible action can be taken by NSHC until the IHS completes its compliance responsibilities and so advises NSHC with a Determination Document. Pending resource availability, the IHS is available for education and consultation on NEPA, NHPA, and related provisions of law on an as needed basis.

Section 25 – Effective Date and Duration.

This Funding Agreement becomes effective on October 1, 2017, and will remain in effect through the 2020 Federal Fiscal Year or until a subsequent agreement is negotiated and becomes effective pursuant to Article II, Section 12 [Subsequent Funding Agreements] of the ATHC.

United States of America
Secretary of Department of Health and Human Services

By: P. B. Slater
Director, Indian Health Service

Date: 6-14-2019

Norton Sound Health Corporation On Behalf of Itself and Certain Alaska Native Tribes, Identified in Exhibit A of the Compact.

By: Angie Gorn
Angie Gorn
President/CEO

JUN 14 2019

Date:

FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

Amendment Effective October 1, 2018

In accordance with Section 14.1 of the Norton Sound Health Corporation (NSHC) FYs 2018-2020 Multi-Year Funding Agreement (MFA), NSHC's MFA is hereby amended as follows:

1. Section 3.2.9 is amended as follows: "Emergency surgery, and minor and other outpatient day surgery, within the scope of qualified ~~expected capability of~~ Medical Practitioners;"

2. Section 3.3.4 is amended to change the title from "Rainbow Services" to "Developmental Disability Program."

3. Appendix B, the list of facilities in which Norton Sound is carrying out health services, is amended as follows:

   In the portion pertaining to "Nome and all Villages," change the Facility Name to add the underlined language: "staff housing owned/rented including "Lawyer's apts," St. Michael Triplex, Golovin 2-bedroom home, and Savoogna duplexes".

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

By: Angie Gorn
Angie Gorn, President/CEO

6/4/2019
Date

United States of America
Secretary of
Department of Health and Human Services

By:
Director, Indian Health Service

8/2/2019
Date

FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

In accordance with Section 14.1 of the FYs 2018-2020 Funding Agreement made and entered into by Norton Sound Health Corporation (NSHC) and the Secretary of the Department of Health and Human Services of the United States of America, effective October 1, 2017, the Funding Agreement, as amended, is hereby further amended as follows:

1. **Appendices.** The following appendices are incorporated by reference and attached:

   - Appendix A (Financial Summary Agreement) FY 2021
   - Appendix B (Facility List) FY 2021

2. **Effective Date**. This amendment is effective October 1, 2020.

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

Angie Gorn 4/30/2021

By: _____ _____
Angie Gorn, President/CEO Date

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S Digitally signed by Evangelyn L. Dotomain -S Date: 2022.03.11 16:22:11 -09'00' _____
Alaska Area Director, Indian Health Service Date

Norton Sound Health Corporation

Appendix A - Financial Summary Tribal Shares Funding Agreement - FY 2021

Tribal Share Summary Norton Sound Health Corporation	FY 2021 Negotiated Amount	NSHC Restricted	Total Due NSHC	Initial Lump Sum Payment
Area TS Amount	$1,094,886	$45,473	$1,049,412	$1,049,412
	0		0	0
Subtotal Area TS Amount	$1,094,886	$45,473	$1,049,412	$1,049,412
Headquarters TSA Amount	$828,953	$93,107	$735,846	$735,846
Headquarters Other Program Formula (OEHE)	$48,412	$48,412	$0	$0
Subtotal Headquarters TS amounts	$877,365	$141,519	$735,846	$735,846
Total Tribal Shares	$1,972,250	$186,992	$1,785,258	$1,785,258

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Driving Variables Norton Sound Health Corporation	FY 2021
Population (2010 Census AN/AI population)	7749
Tribes (Federally Recognized Tribes)	20
Recurring Base - FY 2013 (less VBC)	$34,794,479
Percentage of Total Area TS (of all Alaska Tribes)	8.12295%
Percentage of ATHC (of all Title V Alaska Tribes)	8.22359%
Number of MOA employees	3
Number of IPA employees	0

Individually Restricted Items Norton Sound Health Corporation	FY 2021
Area Office (Individual Restricted Only)	
Supply Service Center	YES
Emergency Medical Services	NO
Village Clinic Leasing Management	YES
Headquarters (ATHC Restricted Only)	
ACOG	YES
OIT - Negotiated Alaska Plan	YES
Clinical Sup. Ctr. (Inc. CME Cert.)	YES

Appendix A - Financial Summary for Funding Agreement-Area Tribal Shares
Norton Sound Health Corporation

Line #	FY 2021 Budget Activity/Service	Total Area Budget	Residual Amount	ATHC restricted		Total AO Tribal Shares	NSHC AK Dist.	NSHC Retained	NSHC Total TS Due
		(Column 1)	*(Column 2)*	*(Column 3)*	*(Column 4)*	*(Column 5)*	*(Column 6)*	*(Column 7)*	*(Column 8)*
1	TRIBAL SHARE FUNDS	$11,900,108	$0		$0	$11,900,108	$966,640		$966,640
2									
3	AREA OFFICE PFSAs (excluding OEHE)								
4	Area Office PFSA's	$4,193,809	$2,442,960	$681,500	$1,069,349	$0	$0		$0
5	Lease Costs-	$1,657,267	$185,820	$193,220	$1,278,227	$0	$0		$0
5a	Space Costs- negotiations	$19,000	$0	$19,000					
6	Area Director's Reserve	$100,000	$0	$100,000	$0	$0	$0		$0
7	Headquarters Assessments	$488,590	$54,720	$230,202	$203,668	$0	$0		$0
8	Human Resources	$849,441	$210,962	$356,311	$282,168	$0	$0		$0
9	Human Resources (ANMC) funds	$0	$0	$0	$0	$0	$0		$0
10	Area PFSA transferred to ANTHC	$3,028,546	$0	$0	$3,028,546	$0	$0		$0
11	CHC Reserve	$1,555,064	$0	$0	$1,555,064	$0	$0		$0
12	Area Managed Care	$723,423	$0	$0	$723,423	$0	$0		$0
13	ANHB (inc. tobacco funds)	$389,983	$0	$0	$389,983	$0	$0		$0
14	Supply Service Center	$853,749	$0	$0	$335,598	$518,151	$42,089	$42,089	$0
15	Epidemiologists	$196,885	$0	$0	$0	$196,885	$15,993		$15,993
16	EMS program at ANMC	$195,140	$0		$0	$195,140	$15,851	*$0*	$15,851
17	Centers for Disease Control	$282,902	$0	$0	$282,902	$0	$0		$0
18	Subtotal Area PFSAs (ex. OEHE)	$14,533,798	$2,894,462	$1,580,233	$9,148,927	$910,176	$73,933	$42,089	$31,844
19									
20	OFFICE OF ENVIRONMENTAL HEALTH AND DESIGN								
21	Office of Envir. Hlth and Eng.-.(EH	$5,961,749	$244,466		$5,127,476	$589,807	$47,910		$47,910
22	Real Property/Realty (FSA)	$148,888	$92,682		$14,547	$41,659	$3,384	$3,384	$0
23	Health Facilities/Main./ Spec. Pro	$1,368,036	$114,204		$1,216,669	$37,163	$3,019		$3,019
24	Subtotal OEHE	$7,478,673	$451,352	$0	$6,358,692	$668,629	$54,312	$3,384	$50,928
25	**TOTAL AREA OFFICE**	$33,912,579	$3,345,814	$1,580,233	$15,507,619	$13,478,914	$1,094,886	$45,473	$1,049,412

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General Notes on Alaska Area Office Tribal Shares

Column 1 - Includes all FY17 changes allocated to TS, Residual, & Transitional as of FY17. In FY 2019 TS changes will be added as received.

Column 2 - Residual includes no changes in residual functions. Based on FY2018 Area approved residual budgets.
Remaining funds at 9/30 distributed (Non-Recurring) to all Alaska Area health programs based on recurring base.

Column 3 - Transitional funds agreed by co-signers to remain at Area Office. Based on FY2018 approved transitional budget.

Column 4 - Restricted by all co-signers & transferred to the ANTHC to provide "Area PSFAs" .

Column 5 - Includes Area TS for all Alaska Tribes, including Title I & Title V. FY19 mandatories to be added if received.

Column 6 - Available Tribal shares for Co-Signer (amounts for ANTHC include pass-through to awardees with shares captured by Sec. 325).
Distributed by the approved ATHC methodology of - 30% # of Tribes / 35% 2010 Census Pop. / 35% 2013 Rec. Base (less VBC).
All Area TS for Services line items will be recurring, Area TS for Facilities will be non recurring.

Column 7 - Items restricted by individual co-signer to pay for continued services from ANTHC. (Restricted amounts are added to ANTHC FA.)

Column 8 - The agreed upon amount due (col. 6 - col. 7) to the co-signer after all retained shares are withheld.

Line 1 - All TS funds for non-OEHE Area Office PSFAs except where co-signers have individually decided to retain certain PSFAs at the ANTHC or AANHS.

Line 5 - Lease on Inuit Building.

Line 5a - $20,000 (less sequester) from transitional funding held by IHS to rent space for annual negotiations. Funds transferred to ANTHC upon confirmation of space availa

Line 7 - Centrally paid expenses, including personnel & finance support for Area positions, costs & funds for departmental assessments.

Line 8 - Area Human Resources functions (previously Office of Personnel & Training).

Line 9 - Funding originally from ANMC - have all been returned to SCF/ANTHC as IPA/MOAs were reduced.

Line 10 - Includes funding for Area PSFAs transferred to ANTHC under Section 325.

Line 11 - Funds to ANTHC to support the statewide Contract Health Services reserve program.

Line 12 - Funds to ANTHC to support specialized services in Barrow, NSHC, & BBAHC & certain statewide laboratory contracts.

Line 13 - ANHB funds from Loc 77 including previous tobacco prevention funding.

Line 14 - Supply Service Center individually withheld amounts retained for ANTHC for all co-signers except YKHC, Seldovia, & Eklutna.

Line 15 - Funds distributed to support the Epidemiology Center distributed to co-signers for individual payment to ANTHC.

Line 16 - Funds for EMS training. Retained by IHS for transfer to ANTHC for Maniilaq, BBAHC, & Chugachmiut for EMS training at ANMC.

Line 18 - Does not include funds from surcharge, assessments, or other services purchased through Area Office.

Line 22 - Funds retained for ANTHC for all co-signers except YKHC, SCF, & KIC.

Line 24 - Does not include NR SFC funds for Health Facilities design and construction oversight.

Appendix A - Financial Summary for Annual Funding Agreement - Headquarters Tribal Shares
Norton Sound Health Corporation

Sub Act.	Line Item	Account	TSA	PF	BB	National FY 2021 TSA Pool *Column 1*	Chickaloon inc in All AK	Knik in All AK	All Alaska	ATHC Eligible Shares Total ATHC TS *Column 2*	NSHC Eligible shares *Column 3*	Co - Signer 0% Retained *Column 4*	0 Due *Column 5*
Hospitals and Clinics													
	101	Emergency Fund		x		$3,956,016			$462,063	462,063	End of year funds to be dist. on AK TSA formula.		
	104	Inter-Agency Agreements				$0			$138,380	138,380	$11,380	$0	$11,380
	105	Management Initiatives		x		$2,049,512			$239,383	239,383	End of year funds to be dist. on AK. TSA formula.		
	106	A.C.O.G. Contract	x			$98,592			11,209	11,209	$922	$922	$0
	107	H.P./D.P. Initiatives	x			$3,484,867			200,844	200,844	$16,517	$0	$16,517
	110	N.E.C.I.	x			$1,107,951			124,173	124,173	$10,211	$0	$10,211
	111	Nurse Initiatives	x			$1,287,656			140,892	140,892	$11,586	$0	$11,586
	112	Nursing Co-steps	x			$648,528			72,677	72,677	$5,977	$0	$5,977
	113	Chief Clinical Consultant	x			$277,340			31,086	31,086	$2,556	$0	$2,556
	115	Emer. Medical Svcs	x			$465,222			41,980	41,980	$3,452	$0	$3,452
	117	Traditional Advocacy Prog.	x			$100,578			11,272	11,272	$927	$0	$927
	118	Research Projects	x			$1,283,252			143,088	143,088	$11,767	$0	$11,767
	119	A.A.I.P. Contract	x			$26,731			2,994	2,994	$246	$0	$246
	120	Clinical Support Center-Phoenix	x			$1,744,883			204,917	204,917	$16,852	$2,549	$14,302
	121	Co-steps Non-physicians	x			$81,839			9,159	9,159	$753	$0	$753
	123	Physician Residency	x			$277,416			31,093	31,093	$2,557	$0	$2,557
	124	Recruitment/Retention	x			$2,057,393			230,592	230,592	$18,963	$0	$18,963
	125	U.S.U.H.S., etc.	x			$3,071,317			344,246	344,246	$28,309	$0	$28,309
	126	DIR Support Fund	x			$24,915,898			2,762,946	2,762,946	$227,213	$63,165	$164,048
	127	Evaluation	x			$1,063,992			119,272	119,272	$9,808	$0	$9,808
	128	National Indian Health Board	x			$459,114			51,111	51,111	$4,203	$0	$4,203
	129	Albq./HQ Administration	x			$892,404			112,813	112,813	$9,277	$0	$9,277
	130	Nutrition Training Center	x			$345,053			41,806	41,806	$3,438	$0	$3,438
	131	Diabetes Program- Albq./HQ	x			$1,295,589			151,342	151,342	$12,446	$0	$12,446
	132	Cancer Prevention- Albq./HQ	x			$716,968			84,278	84,278	$6,931	$0	$6,931
	133	Health Records	x			$136,277			12,043	12,043	$990	$0	$990
	134	AIDS Program	x			$422,971			78,823	78,823	$6,482	$0	$6,482
	135	Handicapped Children	x			$346,083			40,775	40,775	$3,353	$0	$3,353
	137	National OIT Sup.- Albq./HQ	x			$8,292,508			925,939	925,939	$76,145	$21,168	$54,977
	154	Prescription Drug Monitoring	x			$1,002,361			$115,171	115,171	$9,471	$0	$9,471
Dental Health													
	201	IHS Dental Program	x			$2,505,120			$300,609	300,609	$24,721	$0	$24,721
	202	IHS Dental Program- Program formula		x		$5,269,192					$0	$0	$0
Mental Health													
	301	MH/SS Tech. Asst.	x			$1,542,507			$174,272	174,272	$14,331	$0	$14,331
	302	C.M.I. Grants	x			$628,310			$70,130	70,130	$5,767	$0	$5,767
	303	National Conference	x			$107,552			$11,990	11,990	$986	$0	$986
Alcohol/Sub. Abuse													
	401	Clinical Advocacy	x			$3,148,617			$516,623	516,623	$42,485	$0	$42,485
	402	Collaborative Initiatives	x			$848,033			$48,451	48,451	$3,984	$0	$3,984

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Appendix A - Financial Summary for Annual Funding Agreement - Headquarters Tribal Shares
Norton Sound Health Corporation

Sub Act.	Line Item	Account	TSA	PF	BB	National FY 2021 TSA Pool	Chickaloon inc in All AK	Knik in All AK	All Alaska	ATHC Eligible Shares Total ATHC TS	ATHC Eligible Shares NSHC Eligible shares	Co - Signer 0% Retained	Co - Signer 0 Due
						Column 1				*Column 2*	*Column 3*	*Column 4*	*Column 5*
Contract Health Care													
	501	Fiscal Immediary		x						$0	$0	$0	$0
	504	C.H.S. Reserve & Undistrib.	x			$3,377,832			$361,250	361,250	$29,708	$0	$29,708
Public Health Nursing													
	601	Preventive Health Initiatives	x			$951,210			$103,180	103,180	$8,485	$0	$8,485
	602	Preventive H. Init. - Prog. Formula		x							$0	$0	$0
Health Education													
	701	IHS Health Education Program	x			$1,133,793			$127,796	127,796	$10,509	$0	$10,509
CHR													
	801	IHS CHR Program	x			$2,412,266			$267,854	267,854	$22,027	$0	$22,027
Direct Operations													
	1301	Direct Operations	x			$13,847,784			$1,557,559	1,557,559	$128,087	$0	$128,087
	1301a	Direct Operations- OIT	x			$2,716,551			$305,550	305,550	$25,127	$5,302	$19,825
	1302	Direct Ops Dental	x			$0			$0	-	$0	$0	$0
Facilities and Environmental Health Services													
	2401	Sanitation Fac. Construction Sup.		x		$6,761,916				$325,101	$0	$0	$0
	2402	Environmental Health Ser. Support		x		$5,114,837				$197,905	$25,264	$25,264	$0
	2403	Facilities & Property Support		x		$24,019,205				$221,409	$17,947	$17,947	$0
	2404	Facilities Engineering Support		x						$0	$0	$0	$0
	2405	Engineering Services Support		x						$51,699	$5,201	$5,201	$0
TOTAL TSA AMOUNT						$89,122,358	$0	$0	$10,080,185	10,080,185	$828,953	$93,107	$735,846
TOTAL PROGRAM FORMULA AMOUNT						$47,170,678				$1,497,560	48,412	$48,412	$0
TOTAL HEADQUARTERS TRIBAL SHARE						$136,293,036				$11,577,745	$877,365	$141,519	$735,846

Column 1 - All numbers are based on HQ PFSAs for FY20 Table #4 dated 1/13/20 & FY21 Table 4F dated 7/16/20 (facilities)
Column 2 - All numbers are based on HQ PFSAs for FY20 Table #4 dated 1/13/20 & FY21 Table 4F dated 7/16/20 (facilities)

Column 3 - Individual Co-Signer share of column 2.
Column 4 - Co-Signer amounts left with (retained by) IHS to provide service- If service is not available IHS shall pay to each Co-Signer amount provided.
Column 5 - This column (col. 3 - col. 4) is the HQ. TS funds due to Co-Signer, calculated by Alaska TSA formula.
All Headquarters Tribal Shares shall be recurring except for Facilities (lines 2401 -2405) and funds in lines 101 and 105.
Line 101 - Any funds remaining will be distributed non recurring on 9/30 (from HQ by TSA formula) and to each Co-Signer on ATHC distribution method.
Line 105 - Any funds remaining will be distributed non recurring on 9/30 (from HQ by TSA formula) and to each Co-Signer on ATHC distribution method.
Line 106 - All Alaska Co-Signers restricted all funds to continued advanced OB training opportunities for all Alaska Area physicians.
Line 120 -Alaska Co-Signers restricted a total of $31,000 dollars for the clinical support center for CME certification and "IHS Provider" magazine.
Line 124 - BBAHC, EAT, Chugachmiut, Eyak, and Maniilaq retrocede 50% of line 124 to IHS in exchange for use of recruitment website ihs.gov/jobs.
Line 126, 137 -DIR withheld were computed at 27.8% of each Co-Signer on ATHC proposal. See Section 1 of the Funding Agreement.
Line 0154 New line for Prescription Drug monitoring. Full share included in co-signers TS.
Line 201 - Dental Program - approximately $800,000 transferred to line 1302 in Direct Ops Dental. No impact on TS.
Line 1301a - DIR Withheld was computed at 21.1% of each Co-Signer share based on continuing agreements with Dir. DIR.
Linr 1302 - Direct Ops Dental is now in line 201
Lines 2401-2405 - Funds available for OEHE support functions (from table 4f) provided based on national formula at tribal option.

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Name of Tribe/Tribal Org. **Norton Sound Health Corporation** **58G950016**

Contract/Compact Period **October 1, 2020 through September 30, 2021**

	Budget Activity	Initial Negotiated Annual Funding Agreement					
		Program/Service Unit Base		Area Tribal Share	Headquarter Tribal Share	Contract (Reductions)	Net Annual Payment Obligation
		Recurring	Non-Recurring	0.081229506		IPA/MOA	
		(1)	(2)	(3)	(4)	(5)	1+2+3+4+5=(6)
1	Hospitals & Clinics	$23,213,352		$275,437	$424,929	($224,613)	$23,689,105
2	Dental	$2,533,887		$17,016	$24,721	$0	$2,575,624
3	Mental Health	$765,746		$104,878	$21,085		$891,708
4	Alcohol & Substance Abuse	$1,174,320		$69,541	$46,469		$1,290,330
5	Public Health Nursing	$1,063,687		$9,956	$8,485		$1,082,128
6	Health Education	$117,928		$20,402	$10,509		$148,840
7	Community Health Representativ	$329,970		$7,517	$22,027		$359,515
8	Immunization (AK only)	$10,316		$28,276	$0	$0	$38,592
9	Direct Operations	$40,186		$347,386	$147,913		$535,484
10							
11							
12	Self-Governance				$0		$0
13	Other, Services (Annual)						
14	TOTAL, Services (Annual)	$29,249,392	$0	$880,409	$706,138	($224,613)	$30,611,327
15	Purchased/Referred Care	$13,412,656		$118,066	$29,708		$13,560,429
16	Operational Cost for Tribal Clinics					0	$0
17	Environmental Health Support	$661,707		$47,910			$709,617
18	Facilities Support	$1,828,331		$3,028			$1,831,359
19	OEHE Support				$0		$0
20	Maintenance & Improvement		$1,462,821		$0		$1,462,821
21	Sanitation Facilities - Housing				$0		$0
22	Sanitation Facilities - Regular				$0		$0
23	Equipment		$180,666				$180,666
24	TOTAL, Facilities	$2,490,038	$1,643,487	$50,937	$0	$0	$4,184,463
25	Current year CSC Direct	$4,630,788					$4,630,788
26	Current year CSC Indirect		$12,264,014				$12,264,014
27							
28	Other (*See* Remarks)						$0
29	TOTAL, CSC	$4,630,788	$12,264,014	$0	$0	$0	$16,894,802
30	Quarters						$0
31	Contract Health Services (Prior Year)						$0
32	Indian Health Facilities (Prior Year)						$0
33	Others						
34	TOTAL, Other	$0	$0	$0	$0	$0	$0
35					$0		$0
36	**GRAND TOTAL, AFA**	**$49,782,874**	**$13,907,501**	**$1,049,412**	**$735,846**	**($224,613)**	**$65,251,021**

Footnotes:

The FA program funding amount in column 1 and 2 are as of FA 12 dated 7/31/2020

The FA funding also includes all funds from Diomede ISDA TI agreement transferred in FY15.

Line 20 and 23 - Routine M&I and Equipment funding is estimated at 90% of prior FY amount for lump sum payment -subject to adjustn with Sec. 4 of the FA.

d Health Corporation

Norton Sound Health Corporation
Withhold Calculation

The Co-Signer will "withhold" 100% of all estimated costs for IPA/MOA, SSC, VBC, **No** (Yes or No)

surcharge **0.285%**

The Co-Signer will "withhold" the minimum initial amount for IPA, etc., and "buyback" services. **Yes** (Yes or No)

0.285%

Service	Annual Amount (1)	(2)	(3)	Total Annual Estimated Costs	Est. Monthly Payment	Initial Auth. Withhold
	(1)	(2)	(3)	1+2+3=(4)	(4)/12=(5)	*see* Footnotes
H & C						
IPA/MOA Personnel Costs	$566,729	18,731	$1,615	$587,076	$48,923	$195,692
VBC	$0		$0	$0	$0	$0
Other	$86,516		$247	$86,763	$7,230	$28,921
SUBTOTAL H & C	$653,245	$18,731	$1,862	$673,838	$56,153	$224,613
DENTAL						
IPA/MOA personnel costs			$0	$0	$0	$0
Supply Service Center		$0	$0	$0	$0	$0
All other costs-			$0	$0	$0	$0
SUBTOTAL DENTAL	$0	$0	$0	$0	$0	$0
IMMUNIZATION						
IPA/MOA personnel costs			$0	$0	$0	$0
Supply Service Center		$0	$0	$0	$0	$0
Village Clinic Leases			$0	$0	$0	$0
All other costs-			$0	$0	$0	$0
SUBTOTAL IMMUNIZATION	$0	$0	$0	$0	$0	$0
T-CLINIC						
VBC Increases			$0	$0	$0	$0
		$0	$0	$0	$0	$0
			$0	$0	$0	$0
SUBTOTAL T-CLINIC	$0	$0	$0	$0	$0	$0
Withhold Total	$653,245	$18,731	$1,862	$673,838	$56,153	$224,613

Footnotes:

Column 2 - IPA/MOA Centrally Paid Expenses are estimated at $588 for each IPA and $6,243.81 for each MOA.

Column 2 - IPA/MOA Centrally Paid Expenses are estimated at $588 for each IPA and $5,293.74 for each MOA.

Employee Dispute Pool Costs are no longer charged in advance (*see* Section 2.3.2.3 of Buyback Agreement).

Column 3 - Surcharge for all Co-Signers using buyback is .285%

This sheet not to be included in Appendix A - Provided to assist in completing Section 4 of the FA then disca

Norton Sound Health Corporation	
Recurring base	$49,782,874
Non Recurring base	$13,907,501
Subtotal recurring and non recurrir	$63,690,375
Area tribal Share	$1,049,412
HDQ TSA Tribal Share	$735,846
HDQ program formula tribal share	**$0**
Subtotal tribal shares	$1,785,258
TOTAL Funding Agreement	$65,475,634

non recurring includes M & I $1,462,821

FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

Amendment Effective December 30, 2018

In accordance with Section 14.1 of the Norton Sound Health Corporation (NSHC) FYs 2018-2020 Multi-Year Funding Agreement (MFA), as amended, the NSHC and IHS agree to the following revision:

> Appendix B (as previously amended) is hereby further amended and restated by the version of Appendix B attached.

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

Angie Gorn 12/9/20

By: _____ _____
Angie Gorn, President/CEO Date

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S Digitally signed by Evangelyn L. Dotomain -S Date: 2021.01.05 14:53:56 -09'00' _____
Director, Indian Health Service Date

Norton Sound Health Corporation Funding Agreement - Appendix B
Fiscal Years 2018-2020

This non-exhaustive list of Tribal Facilities and Locations identifies the sites where Norton Sound Health Corporation owns, leases, occupies, or otherwise used real property to carry out its responsibilities under the Alaska Tribal Health Compact and its Funding Agreement. Each description of facilities and locations is intended to include surrounding and adjacent grounds.

Additionally, the cross references to specific PSFAs are not intended to limit the scope of PSFAS that may be performed at a facility or for which a facility may be used; rather, cross references are intended as an example of the type of PSFA that may be performed at the facility or of the manner in which a facility may be utilized. Cross references are not exhaustive and may not be construed to be exclusory of other PSFAs that may be performed at a facility or of the uses of the facility.

LOCATION	FACILITY NAME	TRIBAL PROGRAMS (including but not limited to)
Nome	Norton Sound Regional Hospital-Main Campus (Replacement Facility)	Section 3.1; Sections 3.2.1-3.2.7; Sections 3.2.9-3.2.13; Section 3.2.15; Section 3.2.16; Section 3.3.6; Sections 3.4.1-3.4.4; Sections 3.4.6-3.4.8; Sections 3.4.11-3.4.14; Section 3.5; Section 3.6; Section 3.7; Section 3.8.
Nome	Quyanna Care Center	Section 3.2.8
Nome	Hostel	Section 3.2.14
Nome	BIA EMT Training Center/Drug and Alcohol Rehabilitation Center	Section 3.2.13; Sections 3.3.1-3.3.3, 3.3.5-3.3.7; Section 3.4.6, 3.4.12
Nome	Kusgi House	Section 3.3.5, 3.3.6
Nome 607 Division Street	NSHC Behavioral Health Clinic	Section 3.3.1-3.3.3, 3.3.5-3.3.7; Section 3.4.10; Section 3.8
Nome	Health Aide Training	Section 3.4.5
Brevig Mission	Brevig Mission Clinic	Section 3.2.5, 3.2.10, 3.2.11; Section 3.3.1-3.3.3; Section 3.4.1-3.4.4, 3.4.12; Section 3.7; Section 3.8
Diomede	Diomede Clinic	Section 3.2.5, 3.2.10, 3.2.11; Section 3.3.1-3.3.3; Section 3.4.1-3.4.4, 3.4.12; Section 3.7; Section 3.8

All Villages	Village-Based Counselor Office Space	Section 3.3
All Villages	Village Based Morgues	Section 3.4.17

AMENDMENT TO
FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

In accordance with Section 14.1 of the FY's 2018-2020 Funding Agreement made and entered into by Norton Sound Health Corporation and the Secretary of the Department of Health and Human Services of the United States of America, effective October 1, 2017, the funding agreement, as amended, is hereby further amended as follows:

1. **Appendices.** The following appendices are incorporated by reference and attached:

   - Appendix C – FY 2020 Continuing Services Agreement

2. **Effective Date**. This amendment is effective October 1, 2019.

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

By: Angie Gorn 3/29/21

Angie Gorn, President/CEO — Date

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S Digitally signed by Evangelyn L. Dotomain -S Date: 2021.04.27 16:07:52 -08'00'

Director, Indian Health Service — Date

MEMORANDUM OF AGREEMENT DESCRIBING THE CONTINUING SERVICES OF THE INDIAN HEALTH SERVICE, ALASKA AREA NATIVE HEALTH SERVICE TO NORTON SOUND HEALTH CORPORATION FOR FY 2020

I. INTRODUCTION

This agreement provides for the continuation by the Indian Health Service (IHS) of certain services from the Alaska Area Office for the benefit of Norton Sound Health Corporation under its Funding Agreement (FA) under the Alaska Tribal Health Compact (ATHC) Self-Governance Compact.

This agreement is limited to the programs, services, functions, and activities (PSFAs) performed by the residual and transitional federal staff of the Alaska Area Office.

This agreement should be interpreted in conjunction with Norton Sound Health Corporation's FA and Appendix A to that FA, which may provide for additional detail on "restrictions" of funds at the Area or Headquarters level to ensure that specific services are continued to the individual Co-Signer.

In FY 2020, funding for these continuing services and activities will be from the funds, which have been designated as residual and from funds, which have been designated in support of temporary transitional federal PSFAs. In addition funding to purchase specific services, i.e., use of IPA/MOA assignees and Village Built Clinic leases, may be provided through reimbursement by Norton Sound Health Corporation to the IHS.

II. DEFINITIONS

The following definitions are in common usage in the Alaska Area:

A. ATHC Tribal Restricted Share - Used in Alaska to refer to those retained Tribal shares all compacting Tribes jointly initially agreed to leave in the Area Office in support of Alaska Area state wide PSFAs. Pursuant to Section 325 of PL 105-83, these shares now are in the Alaska Native Tribal Health Consortium (ANTHC) FA or are used for transitional federal PSFAs.

B. Buyback - The process by which Co-Signers use cash to purchase Area services from the Area Office. Requires accurate description and pricing of service, and mechanism for Area to invoice and receive payment.

C. Co-Signer Restricted Shares - Used in Alaska to refer to "retained Tribal shares" that have been left at the Area Office or Headquarters on an individual basis by a Co-Signer to allow the Area, Headquarters or ANTHC to provide specific services to the Co-Signer. Pursuant to Section 325 of PL 105-83, these Area shares now are in the ANTHC FA or are used for transitional federal PSFAs.

D. Residual - The resources necessary to support the PSFAs required for the United

A. OFFICE OF THE DIRECTOR

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Director	Provides overall executive direction and support on behalf of the Secretary.	R	1
Deputy Director, Chief Medical Officer	Provides public health advocacy; clinical consultation (CMO); legally required certification of health aide credentials and oversight of CHAP certification process; consultation in CHAP/Rural Health program management.	R	1
Executive Officer	Serves as principal advisor to the Director on overall management policies and procedures.	R	1
Attorney	Provides Region X attorney support and consultation.	R	1
EEO	Provides EEO support. 1		
Support Staff	Secretarial, clerical and administrative support to inherent and transitional federal functions at all levels of the Area Office.	R T	3 1
Planning, Evaluation & Statistics	Prepare statistical reports and publications in support of planning, evaluation and resource allocation requirements.	R	2
	Total		10

The Office will provide the specific PSFAs defined below:

1. Executive direction on behalf of the Secretary to the remaining inherently federal functions.
2. Advocacy at national level on behalf of the Tribes of Alaska including: legislative, policy, resource allocation, and appropriation advocacy.
3. Policy formulation and interpretation; supervision of non-IPA/MOA federal employees; negotiate, execute and administer compacts and FAs; resource allocation.
4. Public health coordination with Tribal, state and federal governments.
5. Provide legal advice and consultation on behalf of the Secretary.
6. Provides representation on the Executive Committee and Planning Committee of the Alaska Federal Health Care Partnership (AFHCP). Through the government-to-government relationship with Tribes and Tribal organizations, provides the mechanism for Tribal membership on the AFHCP.
7. Eligibility determinations assistance.
8. Equal Employment Opportunity program management in support of federal employment rights.
9. Oversight of certification of Community Health Aides as outlined by law and the *IHS Community Health Aide Program Certification Board Standards and Procedures*.
10. Consultation and technical assistance to Tribes and Tribal organizations staff and programs including
    a. Program review or evaluation at the request of the Area Director or the invitation of Tribal programs;
    b. Submission of electronic health record data to IHS National Data Warehouse; and
    c. Maintain current Area statistics to provide statistical analysis in support of resource needs and allocations.

1 The EEO function is provided under an intra-agency agreement among the IHS Alaska, California and Portland Area Offices.

B. OFFICE OF ACQUISITION AND PROPERTY MANAGEMENT [2]

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Federal Contracting „ Personal Property, and FOIA Coordinatio n	Responsible for federal acquisitions to support the Alaska Area Office, including the federal credit card program. Maintains the federal personal property inventory. Provides or coordinates various administrative services for the Alaska Area Office.	R	1
	Total		1

The Office will provide the specific PSFAs defined below:

1. Negotiate, award and administer federal acquisitions.
2. Maintain or develop Alaska Area Interagency and Cooperative Agreements in close partnership with appropriate IHS or other federal, state or Tribal entity(s).
3. Coordinate various administration functions including Freedom of Information Act requests and IHS delegations and directives.
4. Maintain the federal personal property management inventory, including excess and disposal.
5. Provide technical assistance to Tribally managed facilities on procurement issues as requested regarding procurement issues and acquired federal excess property.
6. Maintain the federal credit card program.

2 Residual (1) FTE moved to Office of Tribal Programs in support of Title 1 contracts and audit resolution.

a. Overall direction of resources and related environmental surveillance for statewide public health impacts.

b. Continue to carry out functions related to serving as one of the health and medical representatives to the Alaska Federal Emergency Response Group.

c. Provide management and verification of tribal input data in the IHS Environmental Health Services data system known as the Web-based Environmental Health Reporting System (WebEHRS).

d. Provide safety assurance, compliance and reporting relating to federal workers, and professional programmatic support for staff.

e. In the event of a national disaster situation as defined in the Federal Response Plan, IHS is the lead agency for emergency response related to water and sewer damage assessment and mitigation.

3. Health Facilities: PSFAs include:

a. Perform budget allocation;

b. Support and approve project or resource allocations derived through a priority system developed through the Maintenance & Improvement Resource Allocation Committee (MIRAC) and ANTHC process consistent with IHS national project eligibility criteria. Verify data submittals and manage IHS facilities databases in conformance with IHS national project and health facilities space eligibility criteria.

c. Respond to Congressional inquiries;

d. Review Project Justification Document/Program Of Requirements (PJD/POR) documents prepared by others;

e. Review and approve national priority systems applications, including Tribal Equipment Funds and Dental Facilities Funds;

f. Maintenance of Alaska portion of the IHS Healthcare Facilities Data System (HFDS) including the Facilities Maintenance and Improvement/Equipment database for federally and Tribally owned health facilities;

g. Support for new health facility construction project funds distribution and project development;

h. Stewardship responsibility for oversight of environmental cleanup of federally owned real property;

i. Approve workload statistics;

j. Advocate statewide and nationally for the DEHE program and facilitates its implementation.

4. **Realty:** PSFAs include:

a. Monitor and manage real property assets in accordance with Executive Order 13327, "Federal Real Property Asset Management" and existing authority under law or by executive order for real property, capital improvements, square footage, use or disposal.

b. Maintain the IHS Real Property Inventory by updating the asset book values with costs relating to acquisition of real property, capital improvements, square footage, use or disposal.

c. Verify construction project closeout documentation for capital improvements made to federal facilities prior to adjusting the real property subsidiary ledger.

d. Perform annual review of real property.

e. Warranted Lease Contracting Officer authorized to lease Village Built Clinics

Co-Signers and contractors to maintain accurate records of funding allocations, reconciliations and cash management issues.

8. Reconciliation, billing and amendment management related to contractor and compactor use of federal resources including but not limited to IPA/MOA employees and the Village Built Clinic lease program. Reconciliation includes transaction verification of buyback services with corrections and reports.

9. Support withhold and buyback management including payment for continuing government contracts for goods and services, permanent change of station moves, etc.

10. Monthly general ledger reconciliation including cash management related to Prompt Pay Act, Treasury, cash and others.

11. Process reimbursement requests including Beneficiary Medical Program (BMP), Interagency Payment and Collections (IPAC), quarters collections, CHEF and others. Make deposits and transfers of such reimbursements to Co-Signers no less often than monthly.

12. Assist Tribes during annual Budget Formulation for the second succeeding year's annual budget, including preparation for the National Budget Formulation meeting.

E. OFFICE OF HUMAN RESOURCES

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Civil Service Staffing, Classification & Employee/ Labor Relations	Advertise and recruit for federal, direct and IPA/MOA replacements; process personnel and pay actions; provide job information; maintain official records; rate applicants, appoint new employees, and provide HR consultation; Title 38 and Physician's Comparability Allowance, Market Pay & Locality Pay maintenance; process Reduction in Force and counseling; provides transportation services and relocation assistance for federal employees and consultation re: Tribal direct hires as requested; administers Workers' Compensation program; grievances, discipline/adverse actions; Merit Systems Protection Board, appeals and agency representation; performance management; retirements; payroll; benefits; outside activities; ethics program; suitability adjudication; manage Federal Employee Assistance program and Family Medical Leave and Family Friendly Acts consultation; conducts desk audits; applies Classification Standards and consultation. Initiate and assure completion of suitability investigations as needed on federal employees and personal services contractors.	R T	2 0
	Total		2

Under the direction of the IHS Western Region Human Resources Director, the Office of Human Resources will provide the specific PSFAs defined below for the current approximately 340 federal employees employed either directly or through Civil Service IPAs (58) or Commissioned Corps MOAs (254):

1. Advertise and recruit for direct federal employees. Replacement IPA positions may be filled with a current IPA already on board (such as by reassignment) or a new or replacement MOA. Process Reductions In Force (RIF). Provide counseling on RIF.

2. Maintain official personnel files (electronic and paper) and records for Civil Service employees.

F. COMMISSIONED CORPS PERSONNEL[4]

P/S/F/A	MAJOR FUNCTIONS	Buyback	Staffing (FTE)
Commissioned Corps Personnel	Orient and assist officers and their families to include: recruitment support, liaison between areas, TRICARE advice, wage verifications, grievances, leave programs, COERs and COSTEP. As necessary, Corps-specific personnel discipline advice to CEOs and HR staff of 638 awardees with MOA assignees and supervisors of MOAs.	B	2
	Total		2

Under the direction of the IHS Division of Commissioned Personnel Support, the Commissioned Corps Personnel component will provide the specific PSFAs defined below for the approximately 259 USPHS Commissioned Officers in the Alaska Area:

1. Provide general orientation to new Commissioned Officers.
2. Counsel Commissioned Officers; provide Corps-specific discipline advice to appropriate Co-Signer managers.
3. Maintain unofficial files and records for Commissioned Officers.
4. Process required federal personnel actions for Commissioned Officers including orders for deployment.
5. Assist and consult with officers and their supervisors.

G. OFFICE OF TRIBAL PROGRAMS

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Director	Management of Area Title V responsibilities for Self-Governance and Title I review, approval and technical assistance. Managing CHEF submissions, and fund distribution; clerical and secretarial support.	T	1
Health Care (Management) Consultation	Title V compacts/FAs (including amendments and database management of same), cooperative agreements, and grants; negotiate and administer CSC funds.	T	3
Health Care [5] (Management) Consultation	Negotiate, manage, and execute Title I contracts. Review audit findings and work with Tribal contractors to resolve as needed.	R	1
	Total		5

The Office will provide the specific PSFAs defined below:

1. Provide or facilitate technical assistance to Tribes which may or may not lead to the preparation of proposal(s) to assume PSFAs for Title I contracting, Title V compacting and Tribal Management grants for Tribes and Tribal organizations
2. Evaluate P.L. 93-638 proposal(s) to determine acceptance, declination or rejection; if

4 During FY 2005 this PSFA was centralized under the Division of Commissioned Personnel Support at IHS Headquarters. Effective FY 2006, it is funded by assessing the locations that use Commissioned Officers. See, also, Appendix A.

5 Formally P/S/F/A: Federal Contracting Title I awards, (1) Residual FTE moved from the Office of Acquisition and Property Management; to support Title I contracts and audit resolution.

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S
Digitally signed by Evangelyn L. Dotomain -S
Date: 2021.04.27 16:06:22 -08'00'

Director
Alaska Area Native Health Service, IHS

Date: _____

Norton Sound Health Corporation
on Behalf of Itself and Certain Alaska Tribes,
Identified in Exhibit A to the Compact.

By: Angie Gorn

Angie Gorn, President/CEO
Norton Sound Health Corporation

Date: 10/30/2020

Appendix D
Buyback/Withhold Agreement
between
the Indian Health Service
and
Norton Sound Health Corporation

Section 1. Generally. Pursuant to Section 5.3 of the Funding Agreement between Certain Alaska Native Tribes Served by Norton Sound Health Corporation (hereinafter "NSHC") and the Secretary of the Department of Health and Human Services of the United States of America (hereinafter "Secretary"), NSHC has determined that it wishes to carry out its responsibility to provide certain programs, activities, functions or services (e.g. salaries of IPA/MOA employees, and Village Built Clinics Program) included in its Funding Agreement utilizing services, personnel or other resources of the Federal Government, (hereinafter "services") under Article V, section 22 of the Compact, as permitted by law. These services may include some that are expected to be used throughout the year and some incidental services to be identified by NSHC on an as needed basis, and provided by the Indian Health Service (hereinafter "IHS") when IHS has the capacity to do so. The cost of providing the purchased services to NSHC shall be determined under section 2 below. NSHC's purchase of services is contingent upon the availability of IHS resources to provide those services. In addition, services must be paid for in advance, in order to avoid violation of the Anti-Deficiency Act and are subject to full cost recovery in accord with 25 USC 458aaa-7(f) and 31 USC 9701.

Section 2. Determination of Cost.

2.1 Generally. NSHC may acquire services from the IHS by either providing for full year withhold (with appropriate reconciliation) under terms agreed upon in this funding agreement, in which case the administrative surcharge provided for under section 2.2.4 shall not apply. In the alternative, NSHC may acquire services by authorizing partial year withhold amounts, as provided for in section 2.2, in which case the payment schedule and administrative surcharge provided for in section 2.2.4 shall apply. Whether full or partial year withhold is authorized, the full costs of IPA/MOAs including those detailed in section 2.3, Determination of IPA/MOA Costs, shall be paid by NSHC.

2.2 Conditions for Partial Year Withhold and Buyback.

2.2.1 IPA/MOA.

2.2.1.1 Advance withhold. The funds for IPA/MOA salary and other costs detailed in section 2.3, "Determination of IPA/MOA Costs," will be paid as a lump sum in accord with Section 5(a) of the Funding Agreement, except that an amount equal to three monthly payments based on the initial mutually agreed upon estimate of the annual IPA/MOA salary costs and related surcharges, as provided in section 2.2.4, will be withheld and retained by the Indian Health Service pending final disbursement for the last three months of the fiscal year as provided in section 3.2.2.2.

services to NSHC.

2.3 Determination of IPA/MOA Costs.

2.3.1 List of Costs. It is agreed by the parties that the entire cost of IPA/MOA assignments, including costs associated with the initiation, maintenance, and termination of the assignments are the responsibility of NSHC. The IHS must be reimbursed for all such costs which include but are not limited to the following:

2.3.1.1 Permanent change of station costs including the cost of moving replacement IPAs from the lower forty-eight to Alaska and the cost of moving IPA employees who separate back to the lower forty-eight.

2.3.1.2 Recruitment, relocation and retention bonuses if such funds are necessary to attract or retain employees.

2.3.1.3 Severance pay for employees who are released by NSHC and separated without cause.

2.3.1.4 Payment of turnaround leave travel expenses. All individuals who are eligible for these expenses shall be identified in the IPA negotiated between the parties. The IHS will retain liability for existing IPAs. NSHC assumes the liability for new IPAs and upon renewal of an existing IPA.

2.3.1.5 Lump sum leave payments for employees who leave federal service. All leave accrued prior to the employee becoming employed by NSHC shall be identified in the IPA/MOA negotiated between the parties. The liability for accrued leave on existing, renewing, and new IPA/MOAs shall be the responsibility of NSHC.

2.3.1.6 Costs associated with settling or resolving employment related disputes, subject to the terms specified in section 2.3.2 below.

2.3.1.7 Centrally paid expenses, subject to the terms specified in section 2.3.3 below.

2.3.1.8 The cost of paying unemployment benefits assessed to the Area in FY 2002 and thereafter on behalf of an employee who was employed by NSHC under an IPA immediately prior to voluntary or involuntary separation from IHS regardless of the year in which unemployment benefits were paid. The NSHC is not responsible for unemployment costs that were assessed to the Area in Fiscal Years 2000 and 2001.

2.3.2 Costs Related to Employment Related Disputes.

2.3.2.1 Responsibilities of the IHS. The Indian Health Service shall be responsible for the payment of all costs of the IHS Office of Human Resources and any other section of the Indian Health Service, the Office of General Counsel, and the Department of

2.3.3 Costs Related to IPA/MOA Centrally Paid Expenses. Certain costs associated with IPA and MOA employees are paid centrally by Headquarters from Area funds. These include costs detailed in columns 6, 7, and 8 of the spreadsheet entitled "Allocation of Centrally Paid Expenses (Excluding FTS)," Corrected May 11, 1998, that was prepared by David Mather. These are costs associated with Commissioned Corps, Personnel and Payroll, and Balance of Human Resources. The Alaska Area Native Health Service may pay for or recover assessments from Headquarters to cover these identified costs by including in the monthly charge for each IPA or MOA the monthly cost to the IHS of such Centrally Paid Expenses. The cost charged NSHC for each IPA/MOA may not exceed the average cost per federal employee actually paid by IHS. For purposes of calculating the initial withhold amount and estimated monthly payments, the estimated average cost per month for each IPA or MOA is shown in Appendix A of the Funding Agreement.

2.4 Limitation on Obligations and Notice.

2.4.1 Obligations. IHS shall within 30 days provide notice to NSHC of the best available estimate of the costs that may be incurred under this Agreement of leases, contracts, salaries and related expenses and permanent change of station.

2.4.2 Content of Notices of Best Available Estimates and Costs. Notice of best available estimates under section 2.4.1 and full accounting of all costs due under section 3.3.1 shall include the amount, vendor and reason for obligation or expenditure, including the name of the employee, if any.

Section 3. Method of Payment.

3.1 Full Year Withhold. Payment for services being purchased from the IHS may be made by NSHC authorizing a withhold of the full year's initial mutually agreed upon estimate of the annual cost of each category of services NSHC proposes to purchase from the IHS. In such case, no monthly payments are due from NSHC. Upon periodic reconciliation, provided for under section 3.3.1, excess withheld funds will be paid by the IHS to NSHC and adjustments in the amount of withhold or payments needed to pay for all services NSHC has purchased, or proposes to purchase, will be made to the IHS by NSHC. *See* "Summary of Withhold/Buyback" page of Appendix A for calculation of the amount NSHC hereby authorizes for full year withhold, if any.

3.2 Purchases through Buyback under section 2.2.

3.2.1 Calculations.

3.2.1.1 Of Initial Estimated Monthly Payment. The initial estimated monthly payment is determined by estimating the annual cost of services to be purchased from IHS, including the surcharge on all services under section 2.2.4, and dividing by 12. *See* "Summary of Withhold/Buyback" page of Appendix A for calculation of the amount of the initial estimated monthly payment.

reconciliation is due any under recovery must be paid by NSHC.

3.3.2 For Administrative Surcharge.

3.3.2.1 Use and Rebate. The administrative surcharge shall be used exclusively for administration of the buyback provisions under this Buyback/Withholding Agreement. All income from the administrative surcharge will be accounted for separately and compared on an annual basis to the cost of administering buyback at the Area Office. This accounting and reconciliation shall be complete within 60 days of the end of the last day of the fiscal year. Any surplus in administrative surcharges shall be returned to the Co-Signers who participated in the buyback option on a pro rata basis depending on the amount of administrative surcharge paid.

3.3.3 Adjustment in Estimated Monthly Payment. In addition to adjustments in estimated payments that may occur under sections 3.3.1 and 3.3.2.1, the parties may at any time mutually agree, based on a change in circumstances, to change the estimated monthly payment due from NSHC.

3.4 Use of Other Funds Due NSHC to Avoid Default or Satisfy Obligations to IHS and other Remedies.

3.4.1 Avoiding Default. Default may be avoided to the extent funds are held by the IHS from other funds due to NSHC, which may be withheld to satisfy the amount of the payment, which would otherwise be in default or to satisfy amounts due IHS after reconciliation of costs and payments when an amount is due to IHS.

3.4.2 Recoupment. Any amount due to the IHS by reason of NSHC's failure to pay in full all amounts owing under the buyback provisions of the Funding Agreement for the immediately preceding fiscal year shall be recouped by the IHS from any funds due to NSHC under this funding agreement.

3.4.3 Full Year Withhold as Penalty for Default. Notwithstanding any other provision of this Buyback/Withholding Agreement, the IHS may require "full year withhold" as permitted herein as a condition of permitting a Co-Signer who was in arrears at the end of the immediately preceding fiscal year to buyback services from the IHS under the terms of this Agreement.

Section 4. Dispute Resolution. The parties shall endeavor to resolve any disputes concerning amounts due by NSHC under this Agreement in a manner agreeable to NSHC and to the IHS. In the event of a failure to reach agreement on the resolution of any such dispute, NSHC may, after providing written notice to the IHS, choose not to include the disputed amount in any subsequent payment due. Payment in such a manner shall not be considered as a resolution of the dispute. The parties shall thereafter attempt to resolve the dispute through Alternative Dispute Resolution following, as appropriate, the principles and processes set forth in Executive Order 12988 signed by President Clinton on February 5, 1996, and made effective as of May 5, 1996. NSHC shall have the option of resolving the dispute in accordance with Article

Funding Agreement Appendix E

P.O. BOX 966
NOME, ALASKA 99762
(907) 443-3311

NORTON SOUND HEALTH CORPORATION

Norton Sound Health Corporation

RESOLUTION # 2010-16
Services for Non-Eligible Individuals

WHEREAS, the Norton Sound Health Corporation (NSHC) is a tribal organization that is a Co-Signer of the Alaska Tribal Health Compact (ATHC) and has negotiated a Funding Agreement (FA) with the Indian Health Service (IHS) under Title V of the Self-Determination Education and Assistance Act (ISDEAA); and

WHEREAS, the ATHC authorizes Co-Signers to provide services to non-eligible individuals provided Section 813 of the Indian Health Care Improvement Act (IHCIA) is complied with (*See* ATHC Article III, Section 4), and Section 813, as amended at 25 U.S.C. § 1680c(c)(2), provides that a tribe or tribal organization which operates a health facility under an ISDEAA agreement may make its own determination whether to provide health services to persons not otherwise eligible (i.e. non-beneficiaries) to receive IHS-funded health services; and

WHEREAS, NSHC is authorized to determine whether it will provide health services under its IHS-funded programs to persons who are not eligible beneficiaries under federal law, provided that NSHC gives consideration to whether the provision of such services will result in a denial or diminution of health services to eligible beneficiaries; and

WHEREAS, NSHC has determined that the provision of health services on a fee-for-service basis to non-beneficiaries, in an amount not less than the actual costs of providing such services, will not result in a denial or diminution of health services to beneficiaries; and

NOW THEREFORE, BE IT RESOLVED, that NSHC has decided to extend all available health services under the ATHC and its FAs to non-beneficiaries on a fee-for-service basis; and

BE IT FURTHER RESOLVED, that whenever significant evidence is presented to NSHC Board of Directors that services to non-eligible, non-beneficiaries have resulted in a denial or diminution of health services to beneficiaries, NSHC may suspend the delivery of such services to non-beneficiaries.

DATED this 25 day of June, 2010.

CERTIFICATION

The above Resolution was passed at a regular meeting of the Norton Sound Health Corporation Executive Board held on this 25 day of June, 2010 at Nome, Alaska at which a quorum was present. 8 FOR, 0 AGAINST, 0 ABSTAIN.

Attest: _____ Attest: Berda Willson
Emily Hughes, Board Chair — Berda Willson, Board Secretary

"Serving the communities of: Brevig Mission, Council, Diomede, Elim, Gambell, Golovin, King Island, Koyuk, Mary's Igloo, Nome, St. Michael, Savoonga, Shaktoolik, Shishmaref, Solomon, Stebbins, Teller, Unalakleet, Wales, White Mountain"

Norton Sound Health Corporation

APPENDIX F

PROJECT SUMMARY DOCUMENT

requirements. Cite specific, code or JCAHO references by standard clause, chapter, paragraph, etc.]

III. DEFICIENCIES

The following deficiencies will be corrected as part of this project:

[List and describe only those facility deficiencies this project will address. The types of deficiencies include BEMAR, JCAHO, NFPA, HFPM, Public Law compliance items, ADA, etc.]

IV. COST ESTIMATE

Provide a budgetary cost estimate and the funding sources for the proposed project, including separate line items for design Architect/Engineer fees, project construction, construction contract administration fees, and project contingency.

V. PROJECT SCORE SHEET DOCUMENT (*only required for BEMAR competitive pool funds*)

Complete a project score sheet further detailing the scope, impact and benefits of this project. Provide the information required by the project score sheet.

VI. OTHER PROJECT ITEMS TO BE ADDRESSED

Supporting Documents: Drawings, Photos, Estimates, Etc.

Norton Sound Health Corporation

APPENDIX G

ENVIRONMENTAL INFORMATION AND DOCUMENTATION

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

6. Does the proposed action have significant adverse direct or indirect effects on park land, other public lands, or areas of recognized scenic or recreational value?	Yes or No. Explanation.
7. Does the proposed action include construction of a new municipal solid waste landfill at a new solid waste disposal site?	Yes or No. Explanation.
8. Will the proposed action create a need for additional capacity at solid waste disposal facilities?	Yes or No. Explanation.
9. Does the proposed action include construction of a new wastewater treatment facility that will discharge treated sewage effluent to the waters of the U.S.	Yes or No. Explanation.
10. Will the proposed action create a need for additional capacity at wastewater treatment facilities?	Yes or No. Explanation.
11. Will the proposed action create a need for additional capacity in the drinking water supply?	Yes or No. Explanation.
12. Are there other considerations about the proposed action that could adversely affect the environment and/or public health and safety?	Yes or No. Explanation.

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

19. Will the proposed action require major sedimentation and erosion control measures?	Yes or No. Explanation.
20. Will the proposed action violate a storm water permit or a wastewater discharge permit either for construction or on-going operations?	Yes or No. Explanation.
21. Safe Drinking Water Act: Will the proposed action impact an EPA designated sole source aquifer?	Yes or No. Explanation.
22. Wetlands and Water Resources (lakes, rivers, ponds, streams, etc.): Will the proposed action violate a Section 404 (Clean Water Act) permit for actions in a wetland and/or Section 10 (Rivers and Harbors Act) permit for actions in a stream or river?	Yes or No. Explanation.
23. Floodplains: a. Is the proposed action located in either a 100-year or, for critical actions, a 500-year floodplain? (If Flood Insurance Rate Maps do not exist for the project site, a floodplain survey or consultation may be required. Also may need to consider if the facility will require flood insurance).	Yes or No. Explanation.
b. Will the proposed action adversely impact flood flows in a floodplain or support development in a floodplain?	Yes or No. Explanation.

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

27. Does the proposed action involve the sale or transfer of real property, on which any hazardous substance was stored for one year or more, known to have been released, or disposed of? (Provide relevant documentation for any hazardous substance releases. See 40 CFR 373.2(b), 302.4, and 261.30 for reportable quantities.)	Yes or No. Explanation.
28. Does the proposed action involve the sale or transfer of real property, on which underground or above ground storage tanks are located?	Yes or No. Explanation.
29. Will the proposed action violate Tribal, local, state, or federal law on the use and storage of hazardous substances or the transportation, storage, and disposal of hazardous wastes or medical wastes? (Activities that may generate reportable quantities include air conditioning repair and service, pesticide application, motor pools, automobile repair, welding, landscaping, agricultural activities, print shops, hospitals, clinics, & medical centers. Repair, renovation, or demolition activities can generate waste that has asbestos-containing materials, asbestos, lead-based paint, PCBs, CFCs, etc.)	Yes or No. Explanation.

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

36. Wild and Scenic Rivers Act: Will the proposed action affect a wild, scenic, or recreational river area or create conditions inconsistent with the character of the river? (A consideration for activities that are in or near any wild and scenic waterway including construction of stream/river crossings, intake structures, outfalls, etc.)	Yes or No. Explanation.

I certify that to the best of my knowledge and ability the information presented above is true and correct. The record was examined to identify potential extraordinary or exceptional circumstances which would require further environmental review.

Review by:

Title Date Environmental Coordinator Date

Norton Sound Health Corporation

APPENDIX H

ACTIONS REQUIRING IHS ENVIRONMENTAL REVIEW AND DETERMINATION

[]	Pg 571 (K)(4): Those involving the use of technology where the possible effects are highly uncertain or involve unique or unknown risks and where such technology has not been assessed previously for environmental impact;
[]	Pg 571 (K)(5): Those which have adverse effects on unique geographic characteristics (e.g. historic, archeological, or cultural resources, park recreation or refuge lands, wilderness, areas, wild or scenic rivers, sole or principal drinking water aquifers, prime farmlands, wetlands, floodplains, coastal management zones, or ecological or critical areas including those listed on the Department of Interior National Register of National landmarks);
[]	Pg 571 (K)(6): Those which establish a precedent for future action or represent a decision in principle about future actions with potentially significant environmental effects;
[]	Pg 571 (K)(7): Those which have adverse effects on properties listed or eligible for listing on the National Register of Historic Places;
[]	Pg 571 (K)(8): Those which have adverse effects on species listed by the Federal Government as Endangered or Threatened Species, or which have adverse effects on any designated critical habitat for these species;
[]	Pg 571 (K)(9): Those which require assessment in accordance with Executive Order 11988 (Floodplain Management), or Executive Order 11990 (Protection of Wetlands), or the Fish and Wildlife Coordination Act; and
[]	Pg 572 (K)(10): Those which involve the use, transfer, or lease of real property which has been determined, after investigation in accordance with the provisions of CERCLA 120 (h), to have been used as a storage facility for hazardous waste for more than 1 year; and
[]	Pg 572 (K)(11): Construction projects which are significantly greater in scope or size than normally experienced for a particular category of action.

Any action NOT categorically excluded per Federal Register Vol. 58, No. 3, pg 569-572, dated January 6, 1993 attached hereto.	**The Environmental Review and Determination Process for this group of actions ranges from 60 to 180 days from the receipt by the IHS of the proposal package.**

* The time needed to complete Environmental Reviews is highly dependent on required consultations with other Federal and State Agencies. As an example, the NHPA Section 106 Process requires the State Historic Preservation Officer (SHPO) be allotted 30 days to review and comment on a proposed action (36 CFR Part 800.3(c)(4)). Furthermore, additional time beyond the 30 days may be required for consultation with SHPO to adequately review and determine the effects of the proposed action on existing historical resources. Coordination early in the planning phase of the project can help identify these potential issues and allow NSHC and IHS to resolve them early.

employed varies from Area to Area. Population, health indices, and facilities and services available from sources other than the IHS are evaluated to determine the methods IHS uses to provide services.

The IHS program consists of two major systems: (1) A Federal health care delivery system, administered by Federal employees, and (2) a tribal health delivery system, administered by tribes and tribal groups under grants, contracts or cooperative agreements. The categorical exclusions apply to IHS program actions whether carried out directly by the IHS, or funded or otherwise sponsored by the IHS. The IHS contracts, grants, and cooperative agreements are actions defined in NEPA and are subject to the IHS review procedures established to ensure NEPA compliance, including provisions covering extraordinary and exceptional circumstances. The NEPA compliance for the tribal health care delivery system is ensured through IHS administrative procedures for contracts, grants, and cooperative agreements.

The selection of IHS program actions to list as categorical exclusions has been determined, in part, by agency experience in complying with NEPA, during the past 10 years. Actions required to provide health care services will not have significant impact on the environment except when exceptional or extraordinary circumstances exist. The IHS has categorically excluded these actions, since enactment of NEPA; however, actions involving construction normally have required completion of an environmental review/assessment.

The IHS administers programs for the construction of domestic sanitation facilities (water, wastewater, and solid waste) for Indian homes and communities, construction of new or replacement health care facilities and staff quarters, and renovations to existing health care facilities and quarters units.

Environmental reviews/assessments of construction projects undertaken during the past 10 years have concluded that an EIS was not required for any of them. Approximately 2,300 sanitation facilities construction projects and fewer than 60 health care facilities/staff quarters construction projects have been approved during this time.

The type of program and procedures employed to administer the construction of sanitation facilities for Indian homes and communities, and the consistent determinations that these projects do not have a significant impact on the environment, are the basis for the decision to list most sanitation facilities projects as categorically excluded.

Factors considered in making this determination include:

1. Projects are undertaken to improve health and/or environment.

2. Projects are untaken at the request and with approval of the tribal governing body, which provides for discussion and evaluation of the project and its impacts.

3. Projects are normally constructed on tribally owned or individually owned tribal land within reservation boundaries.

4. Projects are constructed to comply with all current applicable environmental regulations and plans and specifications are submitted to State and Federal agencies as necessary for review and comment.

5. Projects are constructed to provide utilities (water, sewer, solid waste) either for existing American Indian or Alaska Native homes or for new homes constructed with Federal, tribal, State or other resources. New homes are constructed at sites and locations approved by the Tribal Governing Board. Utilities are not provided for future development or undeveloped parcels, and capacity provided is limited to that routinely provided by standard engineering practice for the current design population.

6. The IHS projects fall into the category of minor construction projects based on cost. During the last 10 years, 85 of the 2,300 projects exceeded $1 million, and the average estimated cost was $250,000.

7. Standard IHS procedures require documentation of an environmental review of each construction project to identify any exceptional or extraordinary circumstances and to ensure compliance with all environmental laws, regulations, and executive orders; e.g., those concerning floodplains, wetlands, endangered species, etc. This review is required early in the project planning process.

The categorical exclusion for construction of health care facilities and staff quarters has been limited to renovation or new construction at existing health care delivery sites, and construction or development of relatively small facilities at new locations. The procedures noted in item 7 above for sanitation facilities construction projects also apply to all health care facility and staff quarters construction projects. Most health care facility and staff quarters renovation projects can be classified as minor construction projects based on cost. Fewer than 200 major renovation projects have been undertaken and only a few were funded at a level exceeding $1 million.

Categorical Exclusions

A. Health Services

Direct delivery of medical, dental, nursing, and other related health services; e.g., patient care/counseling administered from hospitals, health centers, health stations, satellite clinics, and in private homes by IHS staff or contract providers to authorized recipients.

B. Research

Research activities that are consistent with the mission of IHS including: (a) Biological and behavioral studies conducted in laboratories, clinics, and the field; (b) studies on the development and delivery of prevention and treatment services and their administration and financing; and (c) evaluations of prevention and treatment.

C. Pesticides

Application of pesticides which are not classified for restricted use under provisions of the Federal Insecticide, Fungicide and Rodenticide Act when used for routine pest control purposes.

D. Contracts, Grants, and Cooperative Agreements

Contracts, grants, and cooperative agreements and continuations, supplements, extensions, and amendments of these documents for IHS programs or actions that are categorically excluded. (Includes Self-Determination Act contracts, Contract Health Care contracts, etc.)

E. Technical Assistance

Action involving the provision of technical assistance to American Indian and Alaska Native tribes and groups, other Federal agencies, State and local governments, and non-profit organizations are excluded. These actions include but are not limited to:

1. The provision of technical assistance to American Indian and Alaska Native tribes and groups for the purpose of developing management capabilities needed to enable eventual tribal assumption of health program operation;

2. The provision of technical assistance to American Indian and Alaska Native tribes and groups for the purpose of developing capabilities in the areas of epidemiology, disease reduction, injury prevention, environmental improvement, and the operation and maintenance of sanitation facilities; and

3. The assignment of IHS personnel to agencies/organizations for the purpose of providing technical expertise (e.g.,

Order 11990 (Protection of Wetlands), or the Fish and Wildlife Coordination Act; and

10. Those which involve the use, transfer, or lease of real property which has been determined, after investigation in accordance with the provisions of CERCLA 120 (h), to have been used as a storage facility for hazardous waste for more than 1 year; and

11. Construction projects which are significantly greater in scope or size than normally experienced for a particular category of action.

Dated: December 29, 1992.

Michel E. Lincoln,

Deputy Director.

[FR Doc. 93-173 Filed 1-5-93; 8:45 am]

BILLING CODE 4160-18-M

ADDENDUM I

MEMORIALIZATION OF HISTORICAL LEVEL OF PFSA'S PROVIDED BY ANMC AND AANHS TO THE NORTON SOUND HEALTH CORPORATION

The ANMC and the Alaska Area Native Health Services, Area Office, subject to available appropriations, has historically provided the following PFSAs to Norton Sound Health Corporation as of October 1, 1997 and continued to provide such services through December 31, 1998:

- Coordination and support for the NSHC dental clinic, including dental specialty referral services, and the annual Alaska dental chiefs meeting. Commissioned Corp recruitment assistance including transportation costs of the recruiter to and from Nome, any applicable documentation, award information for Commissioned Officer promotions, and career counseling for officers desiring long term affiliation with IHS.

- Specialty care field clinics, consultation to Norton Sound Health Corporation physicians, arrange contracts for reference laboratory services, routine reading of x-rays, medivacs support for neonatal emergencies patient travel support for NSHC patients returning home from treatment at the ANMC.

- Accepting all referrals of Alaskan Natives from the Norton Sound Regional Hospital.

- The ANMC EMS program provided specialized training such as ACLS, ATLS, PALS, including hypothermia, cold water drowning and frostbite.

- The NSHC Laboratory received the following services from ANMC: (a) pathologist consultation and visitation twice a year; (b) Anatomical tissue analysis and reporting; and (c) Access to TDY Services as needed and available.

- The ANMC provided consultation and informational support for the NSHC Social Services program, including JCAHO standards and other licensure issues.

- The ANMC provided support including screening, diagnosis, consultations, referrals, personnel training, information, network and recruitment assistance for the FAS program at NSHC and for its Maternal Child Health Program.

- The ANMC provided recruitment assistance to the Mental Health program as needed.

- STD/HIV testing, counseling, partner notification, education and consultation as requested by NSHC.

- Nutrition education and counseling services from the statewide Diabetes program based at ANMC.

- Environmental Health /Sanitation services including, but not limited to, appropriate village visits for environmental services, injury prevention, institutional services.

- Diabetes patients tracking and registration.

- Engineering services inclusive of maintenance and improvement for federal facilities and projects;

- Purchasing activities under GSA contracts;

- Office of Environmental Health Services and activities, health facilities support, real property support especially for village built clinics; projects for health facilities management, special projects and sanitations facilities.

- Administration and management of IPA/MOAs;

- Certain contract health services, not otherwise contracted under Title I;

- Region X legal consultation.

ADDENDUM II
NORTON SOUND HEALTH CORPORATION
MEMORIALIZATION OF MATTERS REMAINING IN DISPUTE

(1) Norton Sound Health Corporation (NSHC) does not agree with the IHS' position that Area Office tribal shares that were restricted by individual Co-Signer decision or by a consensus decision of all Co-Signers from FY 1995 through FY 2000 are not available for inclusion in FY 2002 because of Section 325, P.L. 105-83. NSHC believes it has the right to include such tribal shares in its FY 2002 funding agreements notwithstanding Section 325. NSHC reserves any remedies it may have under law.

ALASKA TRIBAL HEALTH COMPACT

BETWEEN

CERTAIN ALASKA NATIVE TRIBES

AND THE

UNITED STATES OF AMERICA

OCTOBER 1, 1994

—

AMENDED AND RESTATED

OCTOBER 1, 2017

ALASKA TRIBAL HEALTH COMPACT

OCTOBER 1, 1994

AMENDED AND RESTATED
OCTOBER 1, 2017

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ALASKA TRIBAL HEALTH COMPACT
BETWEEN
CERTAIN ALASKA NATIVE TRIBES
AND THE
UNITED STATES OF AMERICA
OCTOBER 1, 1994
AMENDED AND RESTATED
OCTOBER 1, 2010

This Compact of Self-Governance, which under Title III of Public Law No. 93-638, as amended, became effective October 1, 1994, was amended and restated effective October 1, 1995, October 1, 1996, October 1, 1997, October 1, 1998, October 1, 2000, and was further amended and restated in FY 2001, effective October 1, 2000, to conform with Public Law 106-260, Title V of the Indian Self-Determination and Education Assistance Act, as amended (hereinafter Title V), October 1, 2003, October 1, 2006, October 1, 2008, and October 1, 2010 is made and entered into by and between the Secretary of Health and Human Services of the United States of America, represented by the Director of the Indian Health Service, and certain Alaska Native Tribes recognized by the United States acting collectively, and the Alaska Native Tribal Health Consortium, as set forth in Exhibit A. This Compact is entered into under the Title V, which authorizes the Secretary to enter into Compacts and Funding Agreements with the governing bodies of participating Tribal governments. The Secretary has delegated the authority to enter into this Compact and funding agreements to the Director, Indian Health Service (hereinafter IHS). This Compact reflects the United States' special trust responsibility and legal obligations to Indians and Alaska Natives, as stated in 25 U.S.C. section 1602, and the unique tribal cooperation that has developed in Alaska to assure that all Alaska Natives have access to a comprehensive, integrated, and tribally-controlled health care delivery system. The parties are committed to ensuring that the essential statewide functions of the Alaska Native Medical Center in Anchorage remain intact, whether operated by the Indian Health Service, the Alaska Native Tribal Health Consortium or by Alaska Native Tribes recognized by the United States.

WITNESSETH:

WHEREAS, the Alaska Native people have governed themselves and lived in the area known as Alaska since time immemorial;

WHEREAS, federally recognized tribal governments in the State of Alaska

> . . . have the same governmental status as other federally acknowledged Indian tribes by virtue of their status as Indian tribes with a government-to-government relationship with the United States; are entitled to the same protection, immunities, privileges as other acknowledged tribes; have the right, subject to general principles of Federal Indian law, to exercise the same inherent and delegated authorities available to other tribes; and are subject to the same limitations imposed by law on other tribes;

(*Indian Entities Recognized and Eligible to Receive Services from the United States Bureau of Indian Affairs*, 58 Fed. Reg. 54364 (October 21, 1993));

WHEREAS, for the purposes of ensuring that all Alaska Natives and America Indians in Alaska can receive the services provided by the Federal Government through an Alaska Native provider, the Congress has defined the term, "Indian Tribe," to mean:

> . . . any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(Indian Self-Determination and Education Assistance Act, as amended, 25 U.S.C. § 450b(e));

WHEREAS, to prioritize between the entities eligible to authorize contracting under the Indian Self-Determination and Education Assistance Act, as amended, the Indian Health Service has established in the Alaska Area the following order of preference:

> If there is an Indian Reorganization Act (IRA) Council, and it provides governmental functions for the village, it will be recognized.
>
> If there is no IRA Council, or it does not provide governmental functions, then the traditional village council will be recognized.
>
> If there is no IRA Council and no traditional village council, then the village profit corporation will be recognized.
>
> If there is no IRA Council, no traditional village council, and no village profit corporation, then the regional profit corporation will be recognized for that particular village.

(*Alaska Area Guidelines for Tribal Clearances for Indian Self-Determination Contracts*, 46 Fed.

Reg. 27178);

WHEREAS, the United States of America has recognized certain entities in Alaska as American Indian Tribes for purposes of the Indian Self-Determination and Education Assistance Act (*See* 25 U.S.C. § 450b(e); *Indian Entities Recognized and Eligible To Receive Services from the United States Bureau of Indian Affairs*, 58 Fed. Reg. 54364 (October 21, 1993); and *Alaska Area Guidelines for Tribal Clearances for Indian Self-Determination Contracts*, 46 Fed. Reg. 27178, (hereinafter "the Tribes");

WHEREAS, certain Tribes of Alaska have formed and authorized certain Tribal Organizations and Inter-Tribal Consortia as defined in 25 U.S.C. § 450b(*l*) and section 501(a)(5) of Title V, for the purpose of providing health care to Alaska Natives and to contract with the Indian Health Service and other federal and non-tribal agencies for such purpose as well as to provide health care to the other residents of their respective service areas, as permitted by section 813 of the Indian Health Care Improvement Act, as amended, or other applicable law;

WHEREAS, the Congress has declared its commitment to the maintenance of the Federal Government's unique and continuing relationship with, and responsibility to, Alaska Native and American Indian Tribes and to the Alaska Native and American Indian people as a whole through the permanent establishment of a meaningful Indian self-governance policy, which will permit an orderly transition from the federal domination of programs for, and services to, Alaska Natives and American Indians to effective and meaningful participation by the Alaska Native and American Indian people in the planning, conduct, and administration of those programs and services; 25 U.S.C. § 458aaa(note);

WHEREAS, the Congress has declared its commitment to strengthening the government-to-government relationship and to supporting and assisting Alaska Native and American Indian Tribes in the orderly transition from the federal domination of programs and services to provide Alaska Native and American Indian Tribes with meaningful authority, control, funding and discretion to plan, conduct, redesign and administer programs, services, functions and activities (or portions thereof) that meet the needs of the individual tribal communities, 25 U.S.C. § 458aaa(note);

WHEREAS, Federal health services to maintain and improve the health of the Indians and Alaska Natives are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian and Alaska Native people, 25 U.S.C.§§ 1601(1), (2);

WHEREAS, in accordance with 25 U.S.C. § 1601(2) a major national goal of the United States is to provide resources, processes and structures that will enable Indians and Alaska Natives to obtain the quality and quantity of health care services and opportunities that will eradicate health disparities between Indians and Alaska Natives and the general population of the United States;

WHEREAS, the Congress has declared that it is the policy of the United States as stated in 25 U.S.C. § 1602, in fulfillment of its special trust responsibilities and legal obligations to the American Indian and Alaska Native people, to ensure the highest possible health status for Indians

and Alaska Natives and to provide all resources necessary to effect that policy; to raise the health status of Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives; and also the ensure maximum Indian and Alaska Native participation in the direction of health care services so as to render the person administering such services and the services themselves more responsive to the needs and desires of Indian and Alaska Native communities;

WHEREAS, for the purposes of this Compact,

"ANTHC" shall mean only the Alaska Native Tribal Health Consortium;

"Co-Signer" shall mean all Tribes and tribal organizations or Inter-Tribal Consortia, including the ANTHC, participating in the Compact;

"Signatory Tribe(s)" shall mean all Tribes participating in the Compact either directly or through a tribal organization or Inter-Tribal Consortium that has been authorized to participate by resolution;

"Tribal Co-Signer" shall mean only those Tribes, tribal organizations and Inter-Tribal Consortia authorized by resolution of a Tribe, as defined in 25 U.S.C. § 450b(*l*) and sections 501(a)(5) and (b) of Title V, to participate in the Compact and shall not include the ANTHC; and

WHEREAS, under authority from the Tribes, certain Tribal Organizations and Inter-Tribal Consortia in Alaska have provided health services for many years under self-determination contracts with the Indian Health Service and have been recognized by the Indian Health Service as tribally-operated service units;

WHEREAS, pursuant to section 325 of P.L. 105-83, the Alaska Native Tribal Health Consortium (herein "ANTHC"), a tribal organization and Inter-tribal Consortium, as defined in section 501(a)(5) of Title V, was organized and is controlled by the Alaska Native tribes and tribal organizations which are represented on its Board of Directors;

WHEREAS, Tribes, Tribal Organizations and Inter-Tribal Consortia throughout Alaska are reliant on the services to be provided by the ANTHC;

WHEREAS, participation by the ANTHC in the Alaska Tribal Health Compact promotes the commitment of Alaska Native Tribes, Tribal Organizations and Inter-Tribal Consortia to maintain the unique tribal cooperation that has developed in Alaska to assure that all Alaska Natives have access to a comprehensive, integrated, organized, tribally controlled health care delivery system in which Alaska tribal health providers participate in numerous joint activities including utilization review and provide their health services in a clinically integrated care setting in which individuals typically receive health care from more than one of these Alaska tribal providers;

WHEREAS, in furtherance of the federal policy of Alaska Native and American Indian tribal self-determination and self-governance, Congress has directed the Secretary of Health and Human Services (herein the "Secretary") to carry out the Tribal Self-Governance Program under Title V.;

WHEREAS, Congress, in Title V, has authorized the Secretary to negotiate and implement a Compact of Self-Governance and Funding Agreements with the governing bodies of participating Tribal governments of qualified Alaska Native and American Indian Tribes that have completed a planning activity;

WHEREAS, Congress has directed that the Funding Agreements, which the Secretary negotiates with Alaska Native and American Indian tribes, shall authorize the Co-Signers to plan, conduct, consolidate, administer, receive full tribal shares of funding, redesign programs, and reallocate funds for programs, services, functions and activities as provided in sections 505(b)(1) and, (b)(2) and 506 (e) of Title V;

WHEREAS, each Funding Agreement shall specify the programs, services, functions or activities to be performed or administered, the funds to be provided, and the responsibilities of the Co-Signer and the Secretary in accordance with section 505 of Title V;

WHEREAS, the Funding Agreement shall specify the authority of the Co-Signer to redesign or consolidate programs, functions, services and activities (or portions thereof) and to reallocate or redirect funds or modify budget allocations pursuant to section 506(e) of Title V;

WHEREAS, to the extent to which, funding is provided to a Co-Signer, as authorized by Alaska Native Tribes, pursuant to a Funding Agreement, such Co-Signer shall be responsible for administration of programs, services, functions and activities pursuant to the Agreement, consistent with section 505 of Title V;

WHEREAS, nothing in this Compact or associated Funding Agreements shall be construed to limit or reduce in any way the funding for any program, project or activity serving an Indian Tribe under Title V or any other applicable Federal law, pursuant to section 515(a) of Title V;

WHEREAS, in Title V, Congress has directed that the Funding Agreements, which the Secretary negotiates with Co-Signers shall contain certain provisions and, at the option of the Co-Signers, apply to certain programs, activities, functions and services of the Indian Health Service (including construction) as specified in sections 505, 507(a)(2)(A), and 509 of Title V;

WHEREAS, Congress has directed that, at the request of the governing body of qualifying Tribes and the ANTHC and under the terms of a Funding Agreement, the Secretary shall provide funding to the Tribes and the ANTHC to implement the Funding Agreement in accordance with section 508 of Title V;

WHEREAS, Congress has directed that the Secretary shall interpret federal laws and regulations in a manner that will facilitate the implementation of a Compact of Self-Governance and Funding Agreement authorized by section 512(a) of Title V;

WHEREAS, Congress has directed that the Secretary shall interpret federal laws and regulations in a manner that will facilitate the inclusion of activities, programs, services, and functions (or portions thereof) in Compacts of Self-Governance and Funding Agreements authorized by section 512(a) of Title V;

WHEREAS, it is the intent of certain Alaska Native Tribes to collectively enter into a single Compact with the Secretary. To carry out that intent, such Tribes (hereafter referred to as signatory Tribes) enter into this Compact either by individual signature or by means of a delegation of signature authority as authorized by resolution of the Tribal government. Such resolutions are attached as Exhibit "A".

WHEREAS, it is the intent of the signatory Tribes that this Compact will be carried out either by the Tribe itself, by tribal organizations or Inter-Tribal Consortia, as authorized by resolution of Tribe(s) as defined by 25 USC § 450b(e), section 501(b), and by the ANTHC under section 325 of P.L. 105-83. These Tribes, tribal organizations and Inter-Tribal Consortia, including the ANTHC, are bound by the terms of this Compact and are signing separately as Co-Signers.

WHEREAS, it is the intent of the parties that each Tribal Co-Signer Funding Agreement entered into under this Compact shall be executed by the Tribes, either by individual signature or by means of a delegation of signature authority as authorized by resolution of the Tribal government. Each such Funding Agreement also will be signed by a Tribal Co-Signer, designated by the Tribal governing body. The Tribal Co-Signer will carry out the terms of the Funding Agreement for the signatory Tribe(s) from which it has obtained a resolution of authority and be bound by its terms;

WHEREAS, the ANTHC may enter into this Compact and into Funding Agreements under this Compact as authorized by the Board of Directors of the Alaska Native Tribal Health Consortium; and

WHEREAS, for purposes of clarification, and to recognize the government to government relationship between the signatory Tribes and the Secretary, the parties agree that the signatory Tribes, by entering into this Compact, do not relinquish any aspects of Tribal sovereignty to the Co-Signers. The Tribal Co-Signers act only for and on behalf of the signatory Tribe(s) within the scope of the authority granted to them by tribal resolution or by law and the ANTHC has only the authority granted to it under section 325 of P.L. 105-83. Tribal Co-Signers and the ANTHC by carrying out the terms of this Compact and the associated Funding Agreements do not gain the status of a sovereign tribal government;

WHEREAS, the parties have determined that all of the provisions of this Compact are authorized by Title V or other provisions of federal law and the parties have executed this Compact in reliance on this representation;

NOW, THEREFORE, the Secretary, signatory Tribes and the Co-Signers do hereby agree to enter into, undertake, and be bound by this Compact in accordance with the foregoing principles.

ARTICLE I — AUTHORITY AND PURPOSE

Section 1 – Authority. This Compact of Self-Governance, which became effective October 1, 1994, was amended and restated effective October 1, 1995, October 1, 1996, October 1, 1997, October 1, 1998, and October 1, 2000, and was further amended and restated in FY 2001 effective October 1, 2000, to conform with Title V, October 1, 2003, October 1, 2006, October 1,

2008, and October 1, 2010 (hereinafter the "Compact"), is authorized by Title V of the Indian Self-Determination and Education Assistance Act, as amended, and is hereby entered into by the Secretary of the Department of Health and Human Services of the United States of America (hereinafter the "Secretary"), represented by the Director of the Indian Health Service, certain Alaska Native Tribes, as identified in Exhibit A, recognized by the United States, acting individually or collectively, and the Alaska Native Tribal Health Consortium (hereinafter the "ANTHC"). The Director of the Indian Health Service by signing this Compact commits the Secretary to the extent and within the scope of the Secretary's delegation of authority to enter into Compacts and Funding Agreements pursuant to Title V or as otherwise authorized.

Section 2 – Purpose. This Compact shall be liberally construed to achieve its purposes:

(a) This Compact is to carry out a Self-Governance Program authorized by Title V, and is intended to transfer to tribal governments, at a tribe's request, the power to decide how federal programs, services, functions and activities (or portions thereof) shall be funded and carried out. Title V is meant to strengthen the government-to-government relationship and to uphold the United States trust responsibility for each Indian Tribe. This Compact promotes the autonomy of the Tribes in Alaska in the realm of health care.

(b) This Compact is to enable the signatory Tribes and the Co-Signers to re-design health programs, activities, functions, and services of the Indian Health Service; to reallocate funds for programs, activities, functions, or services according to the priorities of the signatory Tribes and Co-Signers; to enhance the effectiveness and long-term financial stability of the Tribes and the Co-Signers; and to streamline the federal Indian Health Service bureaucracy.

(c) This Compact is to enable the United States to maintain and improve its unique and continuing relationship with, and special trust responsibilities and legal obligations, pursuant to 25 U.S.C. 1602 of the IHCIA, to the Tribes through tribal self-governance and to permit an orderly transition from federal domination of programs and services.

(d) This Compact and Funding Agreement shall transfer to signatory Tribes, acting individually or collectively, and the ANTHC the responsibility for the programs, activities, functions and services of the Indian Health Service included in the Funding Agreement. This Compact allows signatory Tribes, acting individually or collectively, and the ANTHC to exercise meaningful authority to plan, conduct, and administer those programs and services to meet the health care needs of the Alaska Native Tribes. In fulfilling its responsibilities under the Compact and consistent with 25 U.S.C. §§ 1602(5), (6), and the November 5, 2009 Memorandum for the Heads of Executive Departments and Agencies, the April 29, 1994, Memorandum from the President of the United States of America for the Heads of Executive Departments and Agencies, attached hereto as Exhibit B, Executive Order 13175 on Consultation and Coordination with Indian Tribal Governments, the September 23, 2004, Memorandum from the President of the United States of America for the Heads of Executive Departments and Agencies, and the Department of Health and Human Services Tribal Consultation Policy, the Secretary hereby pledges that the Indian Health Service will conduct all relations with the Tribes on a government-to-government basis.

ARTICLE II — TERMS, PROVISIONS AND CONDITIONS

Section 1 – Term and Resolutions.

(a) Term. The term of this Compact begins as to each Co-Signer on the effective date of the Co-Signer's first Funding Agreement and shall extend thereafter as to each Co-Signer throughout the period authorized by Title V of the Indian Self-Determination and Education Assistance Act, and any subsequent amendment thereto, provided the Co-Signer has a Funding Agreement in effect, and shall remain in effect for so long as is permitted by Federal law or until terminated by mutual written agreement, retrocession, or reassumption pursuant to section 504(d) of Title V.

(b) Resolutions from Signatory Tribes. Those Tribes which intend to participate in this Compact and the applicable Funding Agreement through delegation of signature authority as provided in this Compact must have issued a written resolution authorizing the Tribal Co-Signer, on their behalf, to enter into this Compact and Funding Agreement on or before the date the Compact and the applicable Funding Agreement is signed by the Tribal Co-Signer for that Tribe, provided that if a Tribal Co-Signer negotiates a Funding Agreement prior to obtaining an authorizing resolution from a Tribe, nothing herein shall be construed to limit or impair in any way a tribal government's sovereign right to decide whether or not to sign such a resolution.

(c) Resolution from the Board of the ANTHC. The ANTHC may participate in this Compact and the applicable Funding Agreement upon receipt of an authorizing resolution of the Board of Directors of the ANTHC, attached hereto as a part of Exhibit A.

Section 2 – Effective Date.

(a) Once this Compact and the Funding Agreements, attached hereto as Exhibit C, are approved and signed by the Co-Signers and the Secretary, they shall be effective as of October 1, 2008. Subsequent Funding Agreements will be effective on the date signed by the Secretary and Co-Signer or another date mutually agreed upon.

(b) During the term of this Compact any Co-Signer which has not previously negotiated a Funding Agreement may do so. All Funding Agreements shall be subject to, and all the activities thereunder shall be governed by, the terms of this Compact to the same extent as the initial Funding Agreements. New Funding Agreements will be effective on the date signed by the Secretary and Co-Signer or another date mutually agreed upon.

(c) Each Funding Agreement and subsequent Funding Agreement of a Co-Signer is deemed to be incorporated, as negotiated, by reference into this Compact, for the purposes only of that Co-Signer and the United States. In the event of inconsistency between the Compact and any subsequent Funding Agreement, the provisions of the Compact shall prevail.

Section 3 – Funding Amount. Subject only to the appropriation of funds by the Congress of the United States and in accordance with section 508 of Title V, the Secretary shall provide the total amounts specified in the Funding Agreements.

Section 4 – Payment.

(a) Payment Schedule. Payment shall be made expeditiously and shall include financial arrangements to cover funding during periods under continuing resolutions to the extent permitted by such resolutions. For each fiscal year covered by the Compact, the Secretary shall make available the funds specified for that fiscal year under the Funding Agreements by paying the respective total amount as provided for in each Funding Agreement in advance lump sum, as permitted by law, or such other payments as provided in the schedule set forth in each Funding Agreement. The first payment shall be made on or before ten calendar days after the date on which the Office of Management and Budget (hereinafter "OMB") apportions the appropriations for that fiscal year for the programs, activities, functions and services subject to the Compact. The Prompt Payment Act, Chapter 39 of Title 31, United States Code, shall apply to the payment of funds due under this Compact and to each Funding Agreement negotiated thereunder.

(b) Interest on Advances. Co-Signers receiving funds under applicable Funding Agreements pursuant to this Compact shall be permitted to retain interest earned on funds advanced pending disbursement as authorized by law. Interest earned on advances shall not diminish the amount of funds the Co-Signer is authorized to receive under its Funding Agreement in the year earned or in any subsequent fiscal year. All funds transferred under Funding Agreements pursuant to this Compact shall be managed using the prudent investment standard pursuant to section 508(h) of Title V.

Section 5 – Reports to Congress. In accordance with section 514 of Title V, the Secretary shall submit to the Senate Committee on Indian Affairs and the House Resources Committee a written report not later than January 1 of each year on the administration of Title V. Each report shall include a detailed analysis on the level of need being presently funded or unfunded for each signatory Tribe and Co-Signer. The contents of each report shall comply with section 514(b). In compiling the reports, the Secretary may not impose any reporting requirements on Co-Signers not otherwise provided in Title V. The Secretary shall provide each Co-Signer with a draft of each report required to be submitted to Congress under this provision for a thirty (30) day comment period prior to the submission of the report to Congress so that the Co-Signers may comment on the report. The Secretary shall include each Co-Signer's comments in the final report to Congress.

Section 6 – Audits

(a) Single Audit. Each Co-Signer that has executed a Funding Agreement pursuant to this Compact shall provide to the National External Audit Review Center (or its successor), which is the designee of the Secretary for the purposes of this section, an annual single organization-wide audit as prescribed by the Single Audit Act of 1984, as amended, 31 U.S.C. § 7501, *et seq*. A copy of this audit will be sent simultaneously to the Indian Health Service Area Office, the cognizant agency, and the Federal Audit Clearinghouse.

(b) Cost Principles. Each Co-Signer shall apply cost principles under the applicable OMB Circular, except as modified by section 106(k) of the Indian Self-Determination and Education Assistance Act, as amended, which section is hereby incorporated into this Compact, or by any exemptions subsequently granted by OMB. To the extent that OMB Circular A-87 or its successor, or other applicable circulars, permit agency pre-approval of allowable costs,

the agency hereby grants that pre-approval. The Secretary will assist the Co-Signers in obtaining such additional waivers from OMB as are requested by the Co-Signers. No other audit or accounting standards shall be required by the Secretary. Any claim by the Federal Government against any Co-Signer receiving funds under a Funding Agreement based on any audit under this section shall be subject to the provisions of section 106(f) of the Indian Self-Determination and Education Assistance Act, as amended.

Section 7 – Records. Each Co-Signer's practices relating to document disclosure and record-keeping associated with this Compact shall, in accordance with applicable law, be set forth in the respective Funding Agreement.

Section 8 – Property.

(a) In General. The provisions of section 512(c) and section 1(b)(8) of the Model Agreement set forth in section 108(c) of the Indian Self-Determination and Education Assistance Act, as amended, are hereby incorporated into this Compact.

(b) Property Management. Management of property under this Compact shall be in accordance with additional provisions included in each Co-Signer's Funding Agreement.

(c) Access to Property Subject to Destruction. Prior to the destruction of federal property which would otherwise be declared surplus or excess and which is located within the service area of a Co-Signer, the Secretary, if previously requested by the Co-Signer, shall provide notice of such proposed destruction to the Co-Signer. Such notice shall inform the Co-Signer of the name and address of the official responsible for determining whether such property will be destroyed or declared surplus or excess. If the Secretary is the responsible official, the Secretary will consider information provided by the Co-Signer regarding transfer of the property, rather than destruction, and, if not the responsible official, the Secretary will assist the Co-Signer in communicating information to the responsible official.

(d) Leases. Upon the request of a Co-Signer, the Secretary shall enter into a lease with the Co-Signer in accordance with section 105(*l*) of the Indian Self-Determination and Education Assistance Act, as amended.

Section 9 – Regulatory Authority. The Secretary and the Co-Signers agree to utilize the following procedures governing the establishment and application of program rules and regulations under this Compact:

(a) Program Rules. No Co-Signer is required to comply with any agency circular, policy, manual, guidance or rule adopted by the Indian Health Service other than those identified in this section or expressly incorporated by reference in the individual Co-Signer's Funding Agreement in carrying out the programs, services, activities and functions under the Compact, except for the eligibility provisions of section 105(g) of the Indian Self-Determination and Education Assistance Act, as amended, and regulations promulgated under section 517 of Title V.

(b) Federal Regulations.

(1) Applicable Federal Regulations. The Co-Signers, in carrying out the provisions of this Compact and applicable Funding Agreements, will be required to comply only with applicable federal regulations, which include regulations promulgated under section 517 of Title V unless waived as provided in section 512(b) of Title V.

(2) Waiver of Federal Regulations.

(A) The Secretary and the Co-Signer will seek to identify federal regulations promulgated pursuant to section 517 or under the authorities specified in section 512(b) of Title V which may require waiver in order to effectively carry out this Compact or any Funding Agreement.

(B) Waivers of regulations shall be submitted and addressed in accordance with the procedures set forth in section 512(b).

(c) Title I Section Incorporated by Reference. Section 105(a)(1) of the Indian Self-Determination and Education Assistance Act, as amended, 25 U.S.C. § 450j(a)(1), is hereby incorporated in this Compact and shall have the same force and effect as if it were set forth in full in Title V of the Act.

Section 10 – Disputes.

(a) All disputes between the Indian Health Service and any Co-Signer or between the Indian Health Service and all Co-Signers under this Compact shall be subject to Title V and the provisions of section 110 of the Indian Self-Determination and Education Assistance Act, as amended, and all remedies provided for therein shall be available to each Co-Signer of this Compact. Actions and proceedings to enforce the Co-Signer's rights and the Secretary's obligations under this Compact shall be subject to the Equal Access to Justice Act, Public Law 96-481, as amended, to the same extent as are actions and proceedings involving Public Law 93-638 contracts.

(b) In the alternative, the Indian Health Service and the Co-Signers may use the processes authorized and encouraged in the Administrative Dispute Resolution Act, 5 U.S.C. § 581 note, for more informal resolution of disputes arising under this Compact and associated Funding Agreements.

Section 11 – Retrocession and Withdrawal

(a) Retrocession. Section 506(f) of the Act is herein adopted. A Co-signer may retrocede, fully or partially, to the Secretary programs, services, functions, or activities (or portions thereof) included in the compact or funding agreement. Unless the Co-signer rescinds the request for retrocession, such retrocession will become effective within the timeframe specified by the parties in the compact or funding agreement. In the absence of such a specification, such retrocession shall become effective on

(1) the earlier of

(A) one year after the date of submission of such request; or

(B) the date on which the funding agreement expires; or

(2) such date as may be mutually agreed upon by the Secretary and the Co-signer.

(b) Withdrawal. Section 506(g) of the Act is herein adopted. Unless prohibited by law and in accordance with Section 506(g) of the Act, a Tribe may fully or partially withdraw from a participating inter-tribal consortium or tribal organization its share of any program, function, service, or activity (or portions thereof) included in a compact or funding agreement. The withdrawal shall become effective within the timeframe specified in the resolution which authorizes transfer to the participating tribal organization or inter-tribal consortium. In the absence of a specific timeframe set forth in the resolution, such withdrawal shall become effective on

(1) the earlier of

(A) one year after the date of submission of such request; or

(B) the date on which the funding agreement expires; or

(2) such date as may be mutually agreed upon by the Secretary, the withdrawing Indian tribe, and the participating tribal organization or inter-tribal consortium that has signed the compact or funding agreement on behalf of the withdrawing Indian tribe, inter-tribal consortium, or tribal organization.

Section 12 – Discontinuance. Co-signer may discontinue its participation in the Alaska Tribal Health Compact after written notice to each authorizing Tribe or Village and the IHS. Notice must be provided one year in advance of the effective date of the request except that the effective date of a request may be less than one year upon approval of all authorizing Tribes and Villages and the IHS.

Section 13 – Subsequent Funding Agreements.

(a) Negotiations for subsequent Funding Agreements, as provided for in Article VI, section 2, shall begin no later than 120 days in advance of the conclusion of the preceding Funding Agreement. Each Co-Signer is hereby assured that future funding of the Co-Signer's subsequent Funding Agreements shall only be reduced pursuant to the provisions of section 508(d) of Title V provided, however, that future funding for each Co-Signer's non-recurring funds and tribal shares shall be subject to adjustments in accordance with a yearly reallocation decision by the Co-Signers. The Secretary agrees to prepare and supply relevant information, and promptly to comply with the Co-Signers' requests for information reasonably needed to determine the funds that may be available for a subsequent Funding Agreement as provided for in Article VI, Section 2 of this Compact.

(b) If the parties are unable to conclude negotiation of a subsequent Funding Agreement, the terms of this Compact and the existing Funding Agreement shall, at the option of the Co-Signer, continue on in 30-day, 90-day or longer increments until a subsequent Funding Agreement is agreed to. As provided in section 505(e) of Title V, the terms of the subsequent Funding Agreement will become retroactive to the end of the term of the preceding Funding Agreement. Any increases in funding to which Tribes are entitled by law or which have been made available by Congress, or increases which Co-Signers subsequently negotiate, shall be included in each Co-Signer's subsequent Funding Agreement.

Section 14 – Health Status Reports. In accordance with section 507(a)(1), Co-Signers shall provide the Secretary a health status and service delivery report to the extent that relevant data is not otherwise available to the Secretary and specific funds for this purpose are provided to the Co-Signer in its Funding Agreement. Such reporting may impose only minimal burdens on the Co-Signer and shall be consistent with regulations promulgated under section 517 of Title V.

Section 15 – Secretarial Approval. For the term of the Compact, the provisions of 25 U.S.C. § 81 and 25 U.S.C. § 476 shall not apply to attorney and other professional contracts of signatory tribal governments of Alaska Native Tribes operating under the Compact pursuant to section 511(b) of Title V.

Section 16 – Transportation and Other Supply Sources.

(a) Use of Motor Vehicles. Subject to agreement of the General Services Administration, the Secretary hereby authorizes each Co-Signer to obtain Interagency Motor Pool vehicles and related services for performance of any programs, activities, functions and services under this Compact.

(b) Other Supply Sources. Federal supply sources (including lodging, airline transportation, and other means of transportation) shall be available to each Co-Signer in accordance with sections 508(e) and 516(a) of Title V.

Section 17 – Limitation of Costs. Each Co-Signer shall not be obligated to continue performance that requires an expenditure of funds in excess of funds awarded under the Funding Agreement. In accordance with section 508(k), if, at any time the Co-Signer has reason to believe that the total amount required for performance of a Funding Agreement, or a specific activity conducted under the Funding Agreement, would be greater than the amount of funds awarded under the Funding Agreement, the Co-Signer shall provide reasonable notice to the Indian Health Service and affected Tribes and tribal organizations. If the Indian Health Service does not take such action as may be necessary to increase the amount of funds awarded under the Funding Agreement, the Co-Signer may suspend performance of the Funding Agreement until such time as additional funds are transferred.

ARTICLE III — OBLIGATIONS OF EACH CO-SIGNER

Section 1 – Consolidation. Each Co-Signer will be responsible for performing the health programs, activities, functions and services as specified in Section 3 of this Article III and in their respective Funding Agreements, as provided for in Article VI, Section 2 of this Compact. To the extent a program, activity, function, or service included within a contract or grant entered into pursuant to sections 102 or 103 of the Indian Self-Determination and Education Assistance Act, as amended, is included within a Funding Agreement, that contract or grant shall be modified or terminated as appropriate. The parties' obligations shall be governed by this Compact and all funds previously obligated under contracts or grants (including carry-over funds) will be re-obligated to the Co-Signer under the applicable Funding Agreement. Such terminated contracts shall be identified by contract number in each Funding Agreement.

Section 2 – Amount of Funds. The total amount of funds covered by the consolidation and redesign provided for in Section 1 of this Article that the Secretary shall make available to the Co-Signers shall be determined in accordance with section 508(c) of Title V and shall be set forth in the respective Funding Agreements between the Secretary and each Co-Signer.

Section 3 – Compact Programs. The health programs, activities, functions and services will be the responsibility of each Co-Signer under this Compact and shall be identified in each Co-Signer's Funding Agreement.

Section 4 – Eligibility for Services. In determining eligibility for services, the Co-Signers shall comply with applicable eligibility provisions set forth in the Indian Health Care Improvement Act, as amended, applicable regulations, and other statutory law.

Section 5 – Reallocation, Redesign and Consolidation. In accordance with section 506(e) of Title V, a Co-Signer may redesign or consolidate programs, services, functions, and activities (or portions thereof) included in a Funding Agreement and reallocate or redirect funds for such programs, services, functions, and activities (or portions thereof) in any manner in which the Co-Signer deems to be in the best interest of the health and welfare of the Indian community being served, only if the redesign or consolidation does not have the effect of denying eligibility for services to population groups otherwise eligible to be served under applicable federal law.

Section 6 – Consolidation with Other Programs. Each Co-Signer may consolidate programs, services, functions, and activities and associated funds identified in its funding agreement with other programs, services, functions, and activities provided with its own funds or funds from other sources, provided that the programs, services, functions, and activities are allowable for inclusion in a funding agreement under Section 505 of Title V. When programs, services, functions, and activities are consolidated in a funding agreement by a Co-Signer in accordance with the terms of the Funding Agreement and Title V, the Co-signer and its employees carrying out those programs, services, functions, and activities may receive Federal Tort Claims Act coverage in accordance with the statutory provisions and regulations cited in the Compact. Whether the Federal Tort Claims Act applies in any particular case is decided on an individual case-by-case basis by the United States Department of Justice and subsequently by the Federal courts. In cases in which a Co-Signer consolidates programs, services, functions, and activities under this section, the Co-Signer shall not be required to separate dollars or programs, services, functions, and activities so long as the Co-Signer can provide sufficient data to permit an acceptable program and financial audit to be conducted.

Section 7 – Program Income, including Medicare/Medicaid. All Medicare, Medicaid or other program income earned by a Co-Signer shall be treated as additional supplemental funding to that negotiated in the Funding Agreement and the Co-Signer may retain all such income, including Medicare/Medicaid, and expend such funds in the current year or in future years, nor shall such funds result in any off-set or reduction in the negotiated amount of the Funding Agreement. Medicare/Medicaid collections of a Co-Signer under Title IV of Public Law 94-437, as amended, shall be used by the Co-Signer in accordance with any applicable statutory restrictions on the use of such funds.

Section 8 – Carry-over. Congressionally appropriated funds allocated in accordance with

a Funding Agreement under this Compact are "no year" funds and may be expended by the Co-Signer in accordance with its budget for the year for which the funds are appropriated or carried over and expended in any subsequent fiscal year, and such carry-over shall not diminish the amount of funds the Co-Signer is authorized to receive under its Funding Agreement for any such subsequent fiscal year.

Section 9 – Matching Funds. Funds may be used to meet matching and other cost participation requirements under any other federal or non-federal programs pursuant to section 512(d) of Title V.

ARTICLE IV — OBLIGATIONS OF THE UNITED STATES

Section 1 – Trust Responsibility. In accordance with sections 507(g) and 515(b) of Title V, nothing in this Compact waives, modifies, or diminishes in any way the trust responsibility of the United States with respect to the Alaska Native Tribes or individual Alaska Natives and American Indians which exists under treaty, executive orders, and acts of Congress.

Section 2 – Programs Retained.

(a) The Secretary hereby retains the responsibility for the programs, activities, functions and services with respect to the signatory Tribes that are not specifically assumed by the signatory Tribes, acting individually or collectively, or by the ANTHC through their applicable Funding Agreements and they shall continue to be entitled to the full benefit of those programs, activities, functions, and services retained by the Indian Health Service. In accordance with section 506(h), each Co-Signer shall be eligible for new programs, activities, functions and services of the Secretary and the Indian Health Service on the same basis as other Tribes and Tribal Organizations. The Indian Health Service, in consultation with the Tribes, may reorganize to sustain its ability to provide, in the most effective and efficient manner, all programs, activities, functions, and services that have not been included in the Funding Agreement.

(b) No later than 120 days prior to the end of each fiscal year, the Indian Health Service shall provide each signatory Tribe and Co-Signer with a written list of the retained programs, activities, functions, and services relevant to Native health care in Alaska for the upcoming fiscal year. To the fullest extent permitted by law, the Secretary shall provide any requesting signatory Tribe and Co-Signer access to, and copies of, all documents and other information relevant to any ongoing retained programs, activities, functions, or services, and shall cooperate with any evaluation which the Co-Signer or signatory Tribe may wish to conduct. The Secretary will cooperate with each Tribe and Co-Signer to facilitate the inclusion of programs, activities, functions and services in future Funding Agreements of those Tribes and Co-Signer.

Section 3 – Financial and Other Information.

(a) To assist the Tribes and Co-Signers in monitoring compliance with section 508(c) of the Indian Self-Determination and Education Assistance Act, as amended, the Secretary shall provide to Co-Signers:

(1) all monthly reports of obligations and allowances, including all reports from Central Office, Headquarters, the Office of Tribal Self-Governance and the Alaska Area Office, concerning funds provided to support programs, activities, functions and services provided by Tribes or Tribal Organizations under this Compact and funds retained by the Indian Health Service to support programs, activities, functions and services retained by the Indian Health Service; and

(2) prompt notice of any new programs, activities, functions and services for which the Tribes or Co-Signers are eligible, including the funding available for such programs, activities, functions and services.

(b) The Secretary shall prepare and promptly supply relevant financial information and comply with each Co-Signer's request for information needed to determine funds that may be available for a successor Funding Agreement.

Section 4 - Savings. If the programs, services, functions and activities carried out under Title V Funding Agreements and this Compact result in a reduction to the administrative or other responsibilities of the Secretary, with respect to the operation of Indian programs, and thereby result in saving that have not otherwise been included in the amount of tribal shares and other funds determined under section 508(c) of Title V, the Secretary shall make such savings available to the Co-Signers for the provision of additional services in accordance with section 507(f) of Title V.

ARTICLE V — OTHER PROVISIONS

Section 1 – Designated Officials/Agent.

(a) Parties. On or before the effective date of this Compact, both the Secretary and each Co-Signer shall provide a written designation of an individual as their representative/liaison. The Secretary shall direct all communications about the Compact, and relevant Funding Agreement to the Co-Signer's designee, except in the case where the Compact or Funding Agreement requires notice to the signatory Tribes, in which case notice shall also be sent to the Tribes. Reference herein to Co-Signers or the Secretary shall include the respective Designated Official thereof.

(b) Agent for Notice. If Co-Signers assign an agent to accept and distribute notices, those Co-Signers shall provide the name and address of the agent and a description of the limited powers and duties of the agent.

Section 2 – Indian Preference in Employment, Contracting and Sub-Contracting. The Co-Signers will comply with the Indian and Alaska Native preference provisions of sections 7(b) and 7(c) of the Indian Self-Determination and Education Assistance Act, as amended. The parties agree that any Co-Signer may comply with any Indian or Alaska Native preference established by their respective Tribes, including preference based on tribal affiliation.

Section 3 – Federal Tort Claims Act Coverage; Insurance.

(a) The Tribes and Co-Signers are deemed by statute to be part of the Public Health

Service (PHS), and the employees of the Tribes and Co-Signers are deemed by statute to be part of or employed by the Public Health Service, for purposes of coverage under the Federal Tort Claims Act, while performing programs, activities, functions or services under this Compact and described in the Co-Signer's Funding Agreement (including new and existing programs, services, functions and activities as provided under Article III, Section 5 or 6, or supported with income received in accordance with Article III, Section 7), including coverage for claims of medical malpractice, as is more fully described in 25 C.F.R. Part 900 Subpart M, attached hereto as Exhibit E, and incorporated by reference herein, and section 102(d) of the Indian Self-Determination and Education Assistance Act, as amended, as required by section 516(a).

(b) The above status of a Tribe or Co-Signer, or an employee's status as an employee of a Tribe or employee of a Co-Signer, is not affected by the source of the funds used by the Tribe or Co-Signer to carry out the programs, services, functions or activities or to pay the employee's salary and benefits as long as the employee does not receive any additional compensation for the performance of covered services from anyone other than the Tribe or Co-Signer.

(c) The Tribe's employee or the Co-Signer's employee may, while performing under this Compact and any applicable Co-Signer's Funding Agreement and as a condition of employment, be required by the Tribe or Co-Signer to provide services to non-Indian Health Service beneficiaries in order to meet the obligations under this Compact either in facilities of the Tribe or Co-Signer or in facilities other than those of the Tribe or Co-Signer.

(d) Funds provided under a Funding Agreement may be used to purchase such additional liability and other insurance as is prudent in the judgment of a Co-Signer performing under this Compact and Funding Agreement for its protection and the protection of its employees.

(e) Personal services contracts shall be covered under this provision to the extent provided under section 102(d) of the Indian Self-Determination and Education Assistance Act, as amended.

(f) Coverage shall also apply in accordance with Section 813(e) of the IHCIA, as amended.

Section 4 – Compact Modifications or Amendments.

(a) Any request for a modification of this Compact must be communicated in writing to all signatory Tribes and Co-Signers and to the Indian Health Service. To be effective any modifications of this Compact shall be in the form of a written amendment to the Compact, and shall require written consent of each of the signatory Tribes, acting directly or through an agent authorized by resolution, and the Secretary.

(b) This provision shall not apply to amendment of the Compact to include additional Tribes and/or Co-Signers. Such amendment shall only require the concurrence of the additional Tribe and/or Co-Signer, and the Secretary.

Section 5 – Construction. This Compact shall apply to funds included in the facilities category of Indian Health Service appropriations. A Co-signer may assume construction projects or programs in accordance with Titles I or V or P.L. 86-121. In doing so, the Co-Signer elects to comply with the regulations of the elected statutory provision.

Section 6 – Officials Not To Benefit. No member of or delegate to Congress shall be admitted to any share or part of any Compact executed pursuant to this Compact, or to any benefit that may arise there from; but this provision shall not be construed to extend to any contract under this Compact if made with a corporation for its general benefit.

Section 7 – Covenant Against Contingent Fees. The parties warrant that no person or selling agency has been employed or retained to solicit or secure any contract executed pursuant to this Compact upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial or selling agencies maintained by the contractor for the purpose of securing business.

Section 8 – Penalties. The parties agree that the criminal penalties set forth in 25 U.S.C. § 450d apply to all activities conducted pursuant to this Compact.

Section 9 – Use of Federal Employees. Section 104 of the Indian Self-Determination and Education Assistance Act, as amended, shall apply to this Compact and to any individuals assigned or detailed to any Co-Signer performing functions under this Compact or leaving federal employment to perform services under this Compact, including assignments either on detail or on leave without pay and with or without reimbursement by the Co-Signer for the travel and transportation expenses to or from the place of assignment and for the pay, or supplemental pay, or a part thereof, of the employee during assignment.

Section 10 – Extraordinary or Unforeseen Events. This Compact is intended to obligate each Co-Signer to carry out all usual and ordinary functions respecting the programs, activities, functions and services that it is undertaking to assume responsibility for under its Funding Agreement. In the event major unforeseen or extraordinary events occur, as jointly identified by each Co-Signer and the Secretary, with consequences beyond the control of the Co-Signer, that the Co-Signer shall have access to additional services and funding amounts for its Funding Agreement as described in its Funding Agreement. The parties will seek to ensure that funds available to the Co-Signer to deal with the unforeseen circumstance will not be less than would have been available to non-Compact Tribes or the Indian Health Service had they encountered a similar circumstance. Each Co-Signer's participation in the Indian Health Service Catastrophic Health Emergency Funds will be identified in the Co-Signer's Funding Agreement.

Section 11 – Mature Contractor Status upon Compact Termination. In accordance with section 506(g)(3) of Title V, should any signatory Tribe, tribal organization at the direction of a signatory Tribe or Tribes, or the ANTHC, elect to convert all or some of the programs operated under the Compact back to contract status under Public Law 93-638, as amended, such conversion shall not affect the Co-Signer's or the Tribe's status as having operated a mature contract within the meaning of section 4(h) of the Indian Self-Determination and Education Assistance Act, as amended. Such conversion would occur only at the end of the Compact term, on another date mutually acceptable to the Tribe, the Co-Signer and the Secretary, or as otherwise provided in this Compact, and will be implemented in a manner which avoids any interruption of services to

individual tribal members. If the Compact is terminated or a Tribe determines that it will retrocede any program, activity, function or service operated under the Compact, neither the Tribe nor the Co-Signer shall lose its mature contractor status under section 4(h) as provided above.

Section 12 – Startup Costs. In accordance with section 508(c) of Title V, startup costs may be separately negotiated by each Co-Signer and shall be included in each Co-Signer's Funding Agreement, if available. Startup costs are designed to compensate the Tribe for costs associated with implementing this Compact which the Co-Signer would not normally incur. Upon agreement to such costs on an annual basis, funds for such costs shall be included in the Funding Agreement, if available.

Section 13 – Limitation of Liability. Any liability to the United States or to any third party incurred by a Co-Signer arising out of its performance of or expenditure of funds under this Compact and each Co-Signer's Funding Agreement shall be the obligation only of that Co-Signer and shall not be the obligation of any Co-Signer of this Compact which did not participate in such performance or expenditure.

Section 14 – Contracting Rights. Nothing in this Compact or in any Funding Agreement shall be construed to preclude a Co-Signer from contracting with the Secretary to perform a program, activity, function, or service under Title I of P.L. 93-638, as amended, subject, however, to constraints against duplication pursuant to section 506(h) of Title V.

Section 15 – Sovereign Immunity. Nothing in this Compact or in any Funding Agreement shall be construed to affect the sovereign immunity, to the extent that it may exist, of any Tribe or Co-Signer.

Section 16 – Interpretation of Federal Law. In the implementation of this Compact, the Secretary, to the extent feasible, shall interpret all federal laws, executive orders, and regulations and this Compact in a manner that effectuates and facilitates the purposes of this Compact and achievement of the Co-Signers' health goals and objectives in accordance with section 512(a) of Title V.

Section 17 – Inadequacy of Program Funding. The parties to this Compact understand that the Indian Health Service budget is inadequate to fully meet the special responsibilities and legal obligations of the United States to assure the highest possible health status for American Indians and Alaska Natives and that, accordingly, the funds provided to the Co-Signers are inadequate to permit the Co-Signers to achieve this goal. The Secretary commits to advocate for increases in the Indian Health Service budget to further the ability of the Co-Signers to provide the full range of services that are the responsibility and obligation of the United States to make available to American Indian and Alaska Native people and to meet the goals of the Indian Health Care Improvement Act.

Section 18 – Effect on Non-Signatory Tribes.

(a) Nothing in this Compact or associated Funding Agreements shall be construed to limit or reduce in any way the service, contracts or funds that any Indian tribe, inter-tribal

consortium or tribal organization is eligible to receive. It is the intent of the parties to this Compact that the Compact will not have an adverse impact on any tribe choosing not to participate in this Compact directly or through a tribal organization.

(b) The Compact shall not be construed to limit or curtail the right of any Tribe to pursue a contract under Title I of the Indian Self-Determination and Education Assistance Act, as amended, individual participation in this Compact under Title V, or an independent compact under Title V.

Section 19 – Gaining Mature Contractor Status. Subject to Secretarial approval, a tribe that participates in this Compact by authorizing a tribal organization or inter-tribal consortium to be a Co-signer and receive funds on its behalf, which enters into a Memorandum of Agreement with the Co-Signer, for three years manages a program, activity, function or service identified in the Co-Signer's Funding Agreement and obtains three audits with no material unresolved audit exceptions, shall be deemed a mature contractor for all purposes, including entering into a Compact under section 503(c) of Title V. Nothing in this section precludes the right of a tribe to become a mature contractor under other provisions of law.

Section 20 – Severability. This Compact shall not be considered invalid, void or voidable if any section or provision of this Compact is found to be invalid, unlawful or unenforceable by a court of competent jurisdiction. Should such a court make such a finding, the parties will seek agreement to amend, revise or delete any such invalid, unlawful or unenforceable section or provision, in accordance with the provisions of this Compact.

Section 21 – Applicability of Title I Provisions. At the request of a Co-Signer, any provision of Title I, not already specified in section 516(a) of Title V, to the extent such provision does not conflict with a provision in Title V, shall be made a part of a Funding Agreement. The Secretary is obligated to include such provision at the option of the Co-Signer. If such provision is incorporated it shall have the same force and effect as if it were set out in full in Title V and in the Funding Agreement. Should the Co-Signer request such an incorporation sometime other than during the negotiation stage of the Funding Agreement, the Co-Signer will present the proposed incorporated Section to the Indian Health Service, OTSG, with a copy to the Alaska Area IHS Director. The Director of the Indian Health Service shall approve a written addendum to the Funding Agreement within 30 days after verifying that the provision is in Title I. In the case of any such provision, it shall be deemed incorporated in the Funding Agreement at the end of the 30 day period unless the Co-Signer receives a written notice from the Indian Health Service stating that the provision is not in Title I. In the event a Co-Signer requests such incorporation at the negotiation stage of this Compact or a Funding Agreement, such incorporation shall be deemed effective immediately and shall control the negotiation and resulting Compact and Funding Agreement.

Section 22 — Purchases from the Indian Health Service. With respect to functions transferred by the Indian Health Service to a Co-Signer under this Compact or an applicable Funding Agreement, the Indian Health Service shall provide goods and services to the Co-Signer, on a reimbursable basis, including payment in advance with subsequent adjustment. The reimbursements received from those goods and services, along with the funds received from the Co-Signer pursuant to this section, may be credited to the same or subsequent appropriation account which provided the funding, such amounts to remain available until expended.

ARTICLE VI — ATTACHMENTS

Section 1 – Approval of Compact. The resolutions of the Tribes approving this Compact for each Co-Signer are attached as part of Exhibit A. Additional resolutions for each Co-Signer may be filed with the Indian Health Service and included in Exhibit A up to the effective date of each Co-Signer's Funding Agreement. The resolution of the Board of Directors of the ANTHC is attached as part of Exhibit A.

Section 2 – Funding Agreements. Each Co-Signer's Funding Agreement shall be attached hereto as Exhibit C.

ARTICLE VII — COUNTERPART SIGNATURES

This Compact may be signed in counterparts.

CITY OF NOME
ADMINSTRATIVE REVIEW AND APPEAL FORM

Appeal #: 26

This form is for you to appeal the assessed valuation on your property. Complete Sections 1, 2 and 3. Retain a copy for your records, and return or mail the original copy to the City Clerk's Office. Appeals must be returned or postmarked no later than the date indicated on the Assessment Notice. The Assessor will contact you regarding your appeal.

****

RECEIVED
APR 21 2022
CITY OF NOME
CLERKS DEPARTMENT

1) I appeal the value of tax parcel #: 0 0 1 . 1 1 5 . 0 1

Property legal description: Block 116, Lot 1A, Mineral Survey _____, Other _____

Print Owner's Name: Norton Sound Health Corporation

Owner's Mailing Address: PO Box 966, Day Phone: ( ) 443-3337

Nome, AK 99762, Evening Phone: ( ) _____-_____

Address to which all correspondence should be mailed (if different than above): _____

Please also email all information to: dpardee@nshcorp.org

****

2)

Assessor's Value	Land:	Bldg:	Total:	Purchase Date:
	$1,105,400	$1,718,500	$2,823,900	
Owner's Estimate of Value	$0.00	$0.00	exempt	

Owner's reason for estimate of value (including inventory corrections, sales of comparable properties, and property income statements, if appropriate). The Appellant bears the burden of proof. Grounds for adjustment of assessment are proof of unequal, excessive, improper, or under-valuation based on facts that are stated in a valid written appeal or proven at the appeal hearing.

Appeal based on AS 29.45.030 (a)(3), Hospital, Charitable Activities and Federal Law. Assessment is improper.

See attached

(PLEASE ATTACH STATEMENT IF YOU NEED MORE SPACE)

****

3) I hereby affirm that the foregoing information is true and correct, that I have read and understand the guidelines above, and that I am the owner or owner's authorized agent of the property described above.

Angie Gom — **Signature of owner or authorized agent**

4/20/22 — Date signed

Angie Gom — Print Name (if different form item # 1)

SUBSCRIBED and SWORN to before me this 20 day of April, 2022

NOTARY PUBLIC in and for the STATE of ALASKA: Meredith Ahmasuk

Commission Expires: 2026. Jan 5

Seal:

STATE OF ALASKA
NOTARY PUBLIC
Meredith Ahmasuk
My Commission Expires Jan 5, 2026

Appeal#: 26

4)

Assessor's Decision	From:	Land:	Building:	Total:
	To:			

Assessor's Reason for Decision: _____

(PLEASE ATTACH STATEMENT IF YOU NEED MORE SPACE)

Date Rec'd	Decision made by	Date	Approved by	Date	Date mailed

5) **Appellant's Response**:

☐ **I ACCEPT** the assessor's decision in Block 4 above and hereby withdraw my appeal.

☒ **I DO NOT ACCEPT** the assessor's decision and desire to have my appeal presented to the Board of Equalization.

Signature of owner or authorized agent	Date	Printed Name
	4/19/2022	Geoffrey D. Strommer

6)

BOARD OF EQUALIZATION DECISION	LAND:	BUILDING:	TOTAL:

Date Received	Date Heard	Certified (Chairman or Clerk of Board)	Date	Date Mailed

2022 BOARD OF EQUALIZATION DATE: MAY 4, 5, & 6 2022

THE FINAL DAY TO APPEAL (April 25, 2022) IS 30 DAYS AFTER THE POSTMARK OF YOUR ASSESSMENT NOTICE (*March 25, 2022*)

Attachment to Administrative Review and Appeal Form
Block 116, Lot 1A, 704 E. N. Street ("Hostel")

I. Property Use Description

1. General Scope of Activities on Hospital-Owned Properties.

The Norton Sound Health Corporation (NSHC) is a tribally owned and operated, independent, not-for-profit healthcare organization founded in 1970 to meet the healthcare needs of the Inupiat, Siberian Yup'ik, and Yup'ik people of the Bering Strait region. NSHC is governed by a 22-member board of directors who represent all communities and areas of the Bering Strait region, a 44,000 square-mile section of Northwestern Alaska. The NSHC service area encompasses these 44,000 square miles. NSHC is the only regional health system serving Northwestern Alaska.

The NSHC healthcare system includes a tribally owned regional hospital which is operated pursuant to an Indian Self-Determination and Education Assistance Act (ISDEAA) agreement. NSHC operates health facilities and provides health care services to Alaska Natives and other beneficiaries pursuant to the Alaska Tribal Health Compact (ATHC), a multi-tribe self-governance compact with the Indian Health Service (IHS) under Title V of the ISDEAA, 25 U.S.C. § 5381, et seq., and funding agreements (FAs), which include program funding amounts that are negotiated for each fiscal year between the IHS and NSHC to fund the programs, functions, services, and activities (PFSAs) that NSHC performs on behalf of IHS. IHS funds the administration of the PFSAs, including the operation of the hospital facilities in Nome, that NSHC has contracted to perform on behalf of IHS.[1]

NSHC is an "instrumentality" of the United States in providing healthcare services under Title V of the ISDEAA. Healthcare services are federal PFSAs provided under the ISDEAA pursuant to the federal trust responsibility to Indians for health care.[2]

The ISDEAA deems tribes and tribal organizations carrying out ISDEAA agreements to be federal executive agencies for purposes of coverage under the Federal Tort Claims Act (FTCA) and access to federal sources of supply.[3] NSHC employees, like employees of other tribal entities operating agreements with IHS under the ISDEAA, are similarly equally covered by the FTCA and are "federal employees" for these purposes.[4] The ISDEAA also authorizes tribal contractors and compactors to perform personal services otherwise performed by federal employees in determining eligibility for IHS services and benefits, the amounts of such services and benefits, and how such services and benefits should be provided.[5] In addition, tribal

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[1] 25 U.S.C. § 5325; 25 U.S.C. § 5396(a) (mandatory application of § 5325 to Title V agreements).

[2] 25 U.S.C. § 1602.

[3] 25 U.S.C. §§ 450f(d) and 450j(k).

[4] *See* 25 U.S.C. §§ 5321(d) and 5396(a); *M.J. ex rel. Beebe v. United States*, 721 F.3d 1079, 1084 (9th Cir. 2013).

[5] 25 USC § 450j(g).

facilities operated under the ISDEAA are interpreted by the Centers for Medicare and Medicaid Services as IHS facilities for purposes of the 100 percent Federal Medical Assistance Percentage under Section 1905 of the Social Security Act.[6]

The ATHC expressly provides that ATHC co-signers, such as NSHC, "are deemed by statute to be part of the Public Health Service (PHS), and the employees of the Tribes and Co-Signers are deemed by statute to be part of or employed by the Public Health Service, for purposes of coverage under the [FTCA]," while performing PFSAs under the ATHC's compact and as described in its Funding Agreement.[7] The current NSHC Funding Agreement expressly provides that "support services required to support the provision of health services," including human resources activities, administration and board support, performance management, financial functions, and the provision of staff housing, are part of the scope of work,[8] as is the training of community health aides;[9] emergency medical services training for staff and community members throughout the region;[10] and the provision of lodging for patients, family members of patients, and their escorts.[11]

2. Specific Use of Hostel.

This lot includes a building used entirely for patient housing, called the "hostel." (See attached blueprint). It is comprised of a west wing and east wing. The east wing has been historically devoted to pre-admission maternity patients. However, to address the COVID-19 public health emergency, the east wing has been used for isolation and quarantine of COVID-19 patients. This will continue through the duration of the public health emergency. The west wing is used for general pre-admission patients but is also being used at times for isolation of COVID-19 patients as need arises.

The purpose of the patient hostel is devoted entirely to housing patients, predominantly all of whom must travel from the outlying villages to receive care at the NSHC facilities. Most of the patients are Medicaid and IHS patients who lack the resources to pay for a hotel room or have no alternative place to stay close to the facility when they are being provided care at NSHC. There is a very high demand for patient housing and the hostel is always full. Patients at the hostel receive pre- and post-admission support, including three meals per day provided by the hospital. The hostel also facilitates patients' medical needs, providing them immediate access to medical care. The patient hostel is directly across the street from the hospital. The average length of occupancy is two (2) to three (3) days.

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[6] 42 U.S.C. § 1396(d).

[7] *See* ATHC Article V Sec. 3(a).

[8] Funding Agreement Between Certain Alaska Native Tribes Served By The Norton Sound Health Corporation And The Secretary Of Human Health And Human Services Of The United States of America Fiscal Years 2018-2020 § 3.5.

[9] *Id.* §§ 3.4.4, 3.4.5.

[10] *Id.* § 3.4.7.

[11] *Id.* at § 3.2.14.

As the NSHC Community Health Needs Assessment indicates (attached), the NSHC service area encompasses 44,000 square miles and serves the entire community of the Bering Strait region, not just Nome. NSHC is the only regional health system serving Northwestern Alaska. Without the ability to house patients from this service area, NSHC would be unable to provide care to the community it serves. Put another way, if NSHC cannot house its regional patients, it cannot fulfill its charitable purpose as a hospital or carry out its scope of work under its ISDEAA agreement.

II. NSHC Enjoys the Sovereign Immunity of its Member Tribes and is Immune from Suits to Collect Taxes

Tribal healthcare entities like NSHC performing self-determination contracts under the ISDEAA for health services enjoy sovereign immunity,[12] including those operating off-reservation.[13] "Indian tribes have long been recognized as possessing the common-law immunity from suit traditionally enjoyed by sovereign powers."[14] "As a matter of federal law, an Indian tribe is subject to suit only where Congress has authorized the suit or the tribe has waived its immunity."[15] "[T]ribal immunity is a matter of federal law and is not subject to diminution by the States."[16] Tribal immunity extends to tribal governing bodies and to tribal agencies or entities that act as an "arm of the tribe."[17] Lastly, "[i]t is settled that a waiver of [tribal] sovereign immunity cannot be implied but must be unequivocally expressed."[18]

In *Barron v. Alaska Native Tribal Health Consortium*, the U.S. District Court for the District of Alaska held a tribal health consortium organization enjoyed sovereign immunity where the organization was formed by Alaska Native tribes; its creation was authorized pursuant to the ISDEAA; it received federal funding to conduct activities that benefitted tribal members; the structure of its board placed control over its ownership and management in representatives of the Alaska Native tribes; its purpose of entering into self-determination and self-governance agreements was "core to the notion of sovereignty"; and it received federal funding "to carry out governmental functions critical to Alaska Native tribes," i.e., healthcare services.[19] Like the entity in *Barron*, and as more fully discussed below, NSHC shares these same attributes.

Tribal immunity extends to suits to collect unpaid taxes. This is because, as the U.S. Supreme Court noted in *Oklahoma Tax Commission v. Citizen Band Potawatomi Indian Tribe of Oklahoma*, "[a]lthough Congress has occasionally authorized limited classes of suits against Indian tribes, *it has never authorized suits to enforce tax assessments*."[20]

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[12] *Manzano v. S. Indian Health Council, Inc.*, No. 20-cv-02130-BAS-BGS, 2021 WL 2826072, at *1 (S.D. Cal. July 7, 2021) (non-profit healthcare corporation formed by membership of seven tribes entitled to sovereign immunity).
[13] *See Pink v. Modoc Indian Health Proj., Inc.*, 157 F.3d 1185, 1189 (9th Cir. 1998) (nonprofit corporation created and controlled by two tribes entitled to sovereign immunity).
[14] *Santa Clara Pueblo v. Martinez*, 436 U.S. 49, 58 (1978).
[15] *Kiowa Tribe of Okla.* v. *Mfg. Techs., Inc.*, 523 U.S. 751, 754 (1998) (citations omitted).
[16] *Id.* at 756 (citations omitted).
[17] *Cook v. AVI Casino Enters., Inc.*, 548 F.3d 718, 725 (9th Cir. 2008).
[18] *Santa Clara Pueblo*, 436 U.S. at 58 (citation omitted) (internal quotation omitted).
[19] 373 F.Supp.3d 1232, 1239–40 (D. Alaska 2019).
[20] 498 U.S. 505, 510 (1991) (emphasis added).

In *Matter of 1981–85 Delinquent Property Taxes Owed to the City of Nome, Alaska*, the Supreme Court of Alaska held that the Indian Reorganization Act (IRA) barred a city from foreclosing on lands held by groups of Alaska Natives organized under Section 16 of the IRA on the basis of non-payment of local property taxes.[21] In that case, the city sought to foreclose on two tracts owed by the Alaska Native group which were "purchased in part with funds from a federal grant under the [ISDEAA]."[22] In that case, the Court found the IRA was "intended to promote tribal self-government and conserve Indian lands and resources," and that had any doubt remained, the Court "would rest on the settled principle that, in Indian law, all ambiguities must be resolved in favor of the Indians."[23]

In the U.S. Circuit Court of Appeals for the Ninth Circuit, where NSHC is located, courts look to the following factors to determine whether a tribal entity functions as an "arm of the tribe" and is therefore entitled to share in the tribe's sovereign immunity: "(1) the method of creation of the economic entities; (2) their purpose; (3) their structure, ownership, and management, including the amount of control the tribe has over the entities; (4) the tribe's intent with respect to the sharing of its sovereign immunity; and (5) the financial relationship between the tribe and the entities."[24] In *White v. University of California*, the Ninth Circuit upheld the district court's application of this test to hold that a tribal repatriation committee formed by twelve tribes was entitled to sovereign immunity because it was created by resolution of each of the tribes; comprised solely of tribal members appointed by each tribe; funded exclusively by the tribes; and its purpose, "to recover remains and educate the public, [was] 'core to the notion of sovereignty.'"[25] And in *Pink v. Modoc Indian Health Project, Inc.*, the court held that a subsidiary tribal entity established and controlled by several tribes to provide health care services was protected by sovereign immunity.[26]

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[21] 780 P.2d 363 (Alaska 1989).
[22] *Id.* at 364.
[23] *Id.* at 367 (citation omitted).
[24] *White v. Univ. of Cal.*, 765 F.3d at 1025 (2014) (citation omitted). Although not included in the Ninth Circuit's "arm of the tribe" test, an additional factor is examined by the Tenth Circuit: "the policies underlying tribal sovereign immunity and its connection to tribal economic development, and whether those policies are served by granting immunity to the economic entities." *Breakthrough Mgmt. Grp., Inc. v. Chukchansi Gold Casino and Resort*, 629 F.3d 1173, 1187 (2010).
Here, a grant of immunity to NSHC furthers the policies underlying tribal sovereign immunity. The doctrine of tribal sovereign immunity exists in order to avoid "interference with tribal autonomy and self-government," *Santa Clara Pueblo*, 436 U.S. at 59, and "infringe[ment] on the right of the Indians to govern themselves." *Williams v. Lee*, 358 U.S. 217, 223 (1959). Like the doctrine of tribal sovereign immunity, the fundamental policy underlying the ISDEAA is to enhance tribal autonomy and control in the provision of services to tribal communities. *See, e.g.*, 25 U.S.C. § 5302(a) (declaring that policy of ISDEAA is to assure "maximum Indian participation in the direction of educational as well as other Federal services to Indian communities so as to render such services more responsive to the needs and desires of those communities"). NSHC has taken on the entire federal responsibility for health care services for its member tribes. The essential federal-tribal nature of the ISDEAA program and the fact ISDEAA programs are funded by the federal resources that would have been spent on programs serving those tribes shows that NSHC is completely financially dependent on the tribes' right to ISDEAA funding, and has stepped into the tribes' shoes and operates as the "health arm" of its member tribes. Because NSHC has stepped into the shoes of its member tribes as the "health arm" of those tribes in order to enter a government-to-government relationship with the United States, NSHC's immunity from suit protects the tribal autonomy of NSHC's member governments.
[25] *White*, 765 F.3d at 1025.
[26] 157 F.3d at 1188–89.

1. NSHC's method of creation supports immunity.

NSHC was incorporated on November 27, 1970 under the Alaska Non-Profit Corporation Act. Article VII of the NSHC Articles of Incorporation names three individuals representing the Alaska Native villages of Shaktoolik, Gambell, and Teller to the initial Board of Directors, and Article VIII shows the same three Village representatives as the initial incorporators. The formation and governance of NSHC was thereby tied directly to the member Villages. Article I and Article III of the Articles of Incorporation also provide that NSHC shall be "non-profit in nature," weighing in favor of treating it as an arm of the tribes. It is clear that NSHC's member tribes have delegated their governmental, rather than commercial, responsibility to provide health care to NSHC, which is not a for-profit venture but a vehicle for providing government health services.

2. NSHC's purpose to provide governmental health care supports immunity.

NSHC's Bylaws, adopted in 1977 and revised in 1978–79, expressly establish the Corporations purposes as follows:

1. To establish and maintain facilities, including but not limited to hospital and clinics, for the care of people suffering from injury, illness or disability requiring medical and hospital services and utilizing both inpatient and outpatient facilities and services, such care to be given regardless of the person's race, color, creed, age, sex, nationality or ability to pay.
2. To participate, so far as the circumstances may warrant, in any activity to promote the general health of the principal area.
3. To carry on educational programs, including the training of healing arts personnel, relating to rendering care to the sick and the promotion of health and the maintenance of high health care standards.
4. To advance general community understanding of, confidence in and proper use of the total program of health services.
5. To carry out the foregoing purposes [through the receipt and disbursement of funds and assets].

Each of these purposes reflects the delegation from the member tribes of their respective governmental health care responsibilities to NSHC. Indeed, the purpose of NSHC is to "step into the shoes" of the federal government to carry out, through the ISDEAA, the United States' responsibility to provide health care for Alaska Native and American Indian people.[27]

3. The tribal governments' close ownership, and management and control of NSHC support immunity.

NSHC is structured such that NSHC's member tribes directly control the governance of NSHC. Article IV of the Bylaws established a Board of Directors of 22 elected directors. Each of the 16 member villages elects one representative to the Board of Directors, and the Nome Eskimo Community elects two directors. The Nome City Council may elect one director, and

[27] *See* 25 U.S.C. § 5302.

the Board of Directors, among themselves, elects three additional directors representing Nome. Article V provides that the NSHC officers, including the Chairman, are elected from among the Board of Directors.

To this point, in 1980, the United States Department of the Interior unequivocally determined, based on the member tribal organizations' direct control of NSHC, that NSHC is an arm of the member tribes.[28]

In his Memorandum, Alaska Regional Solicitor Dennis J. Hopewell informed the BIA Area Director, Juneau Area Office that "[NSHC] is not only considered the 'health arm' of the Bering Straits Native Corporation . . . which is a recognized Indian tribe . . . but the Norton Sound Health Corporation is controlled, sanctioned and chartered by other tribal governing bodies." Hopewell considered the NSHC Bylaws to be conclusive evidence of NSHC's direct control by its member tribal entities, stating "[s]ince the Bylaws for the [NSHC] also spell out that '[t]he management of the property, funds, affairs and business of this Corporation shall be vested in a Board of Directors consisting of ...' the members listed above, there can be no doubt that the corporation is controlled by tribal governing bodies." Hopewell found that NSHC "in addition to being controlled by, is also sanctioned and chartered by such tribal governing bodies," and "[t]his representation also shows that the operation and management of [NSHC] includes the maximum participation of Indians in all phases of its activities."

4. The tribal governments intended that NSHC share in their tribal sovereign immunity.

In 1975, Congress signed the ISDEAA (Pub. L. No. 93-638) into law. In 1978 and 1979, NSHC's member Alaska Native Villages each executed resolutions authorizing NSHC to enter contracts and grants with the United States on their behalf.[29] In 1994, the member Villages executed additional resolutions, which provide the current authority for NSHC to enter into the compact and funding agreements.[30]

Each resolution acknowledged that Congress enacted the ISDEAA as a "far reaching Indian Self-Determination Policy" that "grants Alaska Native villages the *sovereign right to designate tribal organizations which shall have the authority to provide services through contracts or grants with the Federal Government* under Public Law 93-638 for the provision of Government services to Native peoples."[31] The resolutions further note that NSHC "has village representation and traditionally provided information both to and from the village on health related matters" and that NSHC "is controlled and operated by a Board of Directors appointed by the tribal governments" of its member communities.[32]

In recognition of the foregoing, the resolutions authorize NSHC "to apply for, negotiate, appeal from adverse decisions, and secure contracts and grants with the Indian Health Service of

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[28] Status of Norton Sound Health Corporation As A Tribal Organization Pursuant to P.L. 93-638.
[29] A representative resolution from the Native Village of Elim is attached [hereafter Elim Resolution].
[30] A representative resolution from the Native Village of Diomede is attached.
[31] *See, e.g.,* Elim Resolution at 1 (emphasis added).
[32] *Ibid.*

the Department of Health, Education and Welfare for health care and related programs serving Native people" in the region.[33] The resolutions further authorize NSHC and its Board of Directors "to act on behalf of this village on health and related services" and "to accept funding for health and related service projects for this village from all funding agencies private and public."[34] The United States Supreme Court has noted that "[t]he common law sovereign immunity possessed by the Tribe is a necessary corollary to Indian sovereignty and self-governance."[35] The resolutions' provisions that NSHC would "act on behalf" of the villages as their health arm and delegation of governmental duties to NSHC reflects their intent that NSHC would share in the "corollary" privilege of immunity from suit in carrying out those functions.

5. NSHC is wholly financially dependent on the member tribes' assignment of their right to contract with IHS to provide health services to their members.

Under the ATHC, all Alaska tribes participate in the delivery of health care services to their members and other beneficiaries in accordance with the principles of tribal self-governance. The Compact allowed NSHC, on behalf of its member tribes, to enter into a government-to-government relationship with the United States. Since 1994, NSHC has participated each year with other co-signers and the IHS in the negotiation of annual funding agreements and amendments to the ATHC.

The funding agreement (FA) NSHC negotiates annually with IHS on behalf of the member tribes includes a broad scope of work covering a wide variety of health care services, from hospital and clinic services to long-term care, from dental services to lodging for patients.[36] In fact, while NSHC is the *signatory* to the funding agreement, the *parties* to the FA are the HHS Secretary and NSHC's member villages themselves. The 2018 Funding Agreement, titled, "Funding Agreement Between Certain Alaska Native Tribes Served by the Norton Sound Health Corporation and the Secretary Of Health And Human Services Of The United States Of America," states:

> This Funding Agreement is entered into by and between certain Alaska Native Tribes in the Bering Straits region of the Norton Sound Service Unit, as identified on the signature page herein, and the Secretary of the Department of Health and Human Services. These Tribes have authorized the Norton Sound Health Corporation to sign this Funding Agreement for them and to be responsible for and carry out the terms of this Funding Agreement.[37]

Section 2.1 of the 2018 FA "obligates NSHC to be responsible for and to provide health PSFAs identified in Section 3 [Tribal Programs and Budget], utilizing the resources transferred under this FA and other funds as they may become available to NSHC." Section 5.2 provides

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[33] *Ibid.*
[34] *Ibid.*
[35] *Three Affiliated Tribes of Fort Berthold Reservation v. Wold Eng'g*, 476 U.S. 877, 890 (1986) (emphasis added).
[36] Funding Agreement Between Certain Alaska Native Tribes Served By The Norton Sound Health Corporation And The Secretary Of Health And Human Services Of The United States Of America Fiscal Years 2018-2020 §§ 3.2, 3.4.1, and 3.2.14.
[37] *Id.* at 1.

these resources represent the entirety of the member Tribes' entitlement to these funds: "NSHC will be paid 100 percent of Headquarters and Area Tribal Shares in its initial lump sum payment, as negotiated in this FA." Section 4 of the 2018 FA describes the total FY 2018 funding made available to NSHC from funds that would otherwise be allocated to NSHC's member tribes. Without the Compact and Funding Agreements, through which NSHC performs governmental functions for their member villages, NSHC would be unable to function. Accordingly, the financial relationship between NSHC and the tribal entities supports NSHC's immunity.[38]

In substance and in form, NSHC serves as an arm of its member tribes. NSHC is dependent on the authorization and support of its member tribal governments to operate, and it fills a critically under-resourced governmental function–far different from a private, for-profit economic venture or other state-incorporated non-profits that may operate in the public sector but are not fulfilling government functions. NSHC shares in the sovereign immunity of its member tribes, and this immunity from suit extends to suits to collect unpaid taxes. This sovereign immunity operates unless specifically and unequivocally waived, and NSHC has not waived its immunity.

III. The City's Taxation is Preempted by Federal Law

Alaska Statute 29.45.030(a)(8) exempts from tax, "property of a political subdivision, agency, corporation, or other entity of the United States to the extent required by federal law..." The city of Nome's tax on all real property owned by NSHC is preempted by federal law.

In *United States v. New Mexico*, the U.S. Supreme Court announced a rule to apply generally to determine immunity from state and local taxation under the supremacy doctrine:

> [T]ax immunity is appropriate in only one circumstance; when the levy falls on the United States itself, or on an agency or *instrumentality* so closely connected to the Government that the two cannot realistically be viewed as separate entities, *at least insofar as the activity being taxed is concerned.*[39]

Under the implied federal preemption doctrine, space that is used to carry out federal programs and that is subject to comprehensive and pervasive federal oversight is exempt from state or local taxation.[40]

In *Ketchikan Gateway Borough v. Ketchikan Indian Corporation*, the Alaska Supreme Court upheld application of the implied federal preemption doctrine to exempt from borough taxes "*all space in a building that contains a tribally operated clinic.*"[41] In that case, the tribally operated clinic was funded by the IHS and operated on land conveyed by the United States.[42] The only space held not to be exempt from taxation was "space not committed to use by the

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[38] *See White*, 765 F.3d at 1025 (fact that entity was funded solely by the tribe supported determination that entity was an "arm of the tribe" entitled to immunity).
[39] 455 U.S. 720, 735 (1982) (emphasis added).
[40] *Ketchikan Gateway Borough v. Ketchikan Indian Corp.*, 75 P.3d 1042, 1048 (Alaska 2003).
[41] *Id.* at 1044 (emphasis added).
[42] *Ibid.*

clinic," because it was "uncertain how the uncommitted space would be used" and it "appear[ed] that at least for near-term purposes it [would] either be leased to others or used for other [i.e., non-clinic-related] programs of [the Indian corporation]."[43]

This property is integral to the provision of healthcare under NSHC's ISDEAA agreement. As programs and services that support the healthcare operations are included under the scope of work as defined in NSHC's Funding Agreement, all areas used for human resources, administration and board support, performance management, training, medical personnel housing, patient housing, and financial function are integral to NSHC's healthcare operations under the ISDEAA.

The Alaska Supreme Court, in *Ketchikan Gateway Borough,* acknowledged that federal law preempts state taxation where the activity is subject to comprehensive and pervasive federal oversight.[44]

The federal and tribal interests in the instant case are clear and strong. Provision of Indian health care services is comprehensively and pervasively regulated; this is manifest both in the ISDEAA and in the Indian Health Care Improvement Act (IHCIA). Congress expressed its intention in the ISDEAA that those operating under self-determination contracts receive the same amount of funding as would the federal government if one of its departments was still providing the services in question. NSHC is subject to comprehensive and pervasive oversight by virtue of its operation under the ISDEAA. Accordingly, the city's tax is preempted.[45]

Although tribes step into the shoes of the IHS when carrying out programs and providing services under the ISDEAA, the ultimate responsibility for those programs and services remains with IHS, which therefore retains a pervasive oversight role. Participation in the self-governance program requires a rigorous planning process and demonstration of financial stability and financial management capability for three (3) years.[46] ISDEAA contractors are subject to annual audits, with penalties for noncompliance with applicable cost principles.[47] And every ISDEAA agreement must, by law, include a provision allowing the Secretary to reassume operation of a program, and the associated funding, if the agency finds gross mismanagement or imminent danger to public health.[48] The regulations at 25 C.F.R. Part 900 and 42 C.F.R. Part 137 elaborate these and other limitations. As noted above, nothing in the ISDEAA abrogates or weakens the trust responsibility to tribes and individual Indians,[49] and IHS consequently retains comprehensive and pervasive oversight.

In *Ketchikan Gateway Borough*, the Alaska Supreme Court noted that while the rule of strict construction requires that "[t]axpayer exemptions are strictly construed against the taxpayer

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[43] *Id.* at 1049; 1048 n.27.
[44] *Id.* at 1048.
[45] *Ketchikan Gateway Borough*, 75 P.3d at 1048.
[46] 25 U.S.C. § 5383(c)(1)(C).
[47] *Id.* § 5386(c).
[48] *Id.* § 5387(a)(2).
[49] *E.g.*, *id.* § 5332(2); *id.* § 5329(c), Model Agreement § (d)(1) ("The United States reaffirms the trust responsibility of the United States" to the contracting tribe); *id.* § 5395(b) ("Nothing in this chapter shall be construed to diminish in any way the trust responsibility of the United States to Indian tribes and individual Indians . . .").

and in favor of the taxing authority . . . . where the question is whether federal law requires the exemption of tribal interests from taxation, ambiguities in federal law should be resolved *in favor of the tribe.*"[50]

IV. Alaska Law Exempts All Hospital Property from Taxation

1. The Subject Property Constitutes a "Hospital."

The Alaska Constitution provides that: "All, or any portion of, property used exclusively for non-profit religious, charitable, cemetery, or educational purposes, as defined by law, shall be exempt from taxation."[51] Pursuant to this provision, Alaska Statute (AS) 29.45.030(a)(3) provides that "property used exclusively for nonprofit religious, charitable, cemetery, hospital, or educational purposes" is exempt from general taxation.

The meaning of "hospital" is generally understood to include the structures operated as part of a hospital complex in addition to the limited area at which care is directly provided to patients.[52] In this opinion, the Alaska A.G. cites the Alaska Hospital and Medical Facilities Survey and Construction Act ("Construction Act") for the definition of "hospital", although the issue at hand did not directly implicate the Construction Act. The Alaska A.G found as follows:

> 'hospital' includes a public health center and general, tuberculosis, mental, chronic disease, and other type of hospital, and related facilities, including laboratory, outpatient department, nurses' homes, and training facilities, and central services facilities operated in connection with a hospital, but does not include a hospital furnishing primarily domiciliary care.[53]

Accordingly, the housing structure is by definition a "hospital" for purposes of AS 29.45.030(a)(3).

2. The Subject Property is Exclusively Used for NSHC's Exempt Purposes.

Constitutional or statutory provisions exempting real property used exclusively for hospital purposes have been interpreted by multiple courts, including in Alaska, to include hospital-owned residential facilities maintained for members of its staff or patients as tax exempt.

Interpreting constitutional and statutory provisions that exempted real property used exclusively for hospital purposes from taxation to include any facility reasonably necessary to accomplish a hospital purpose, the court in *Cedars of Lebanon Hospital v County of Los Angeles* 35 Cal.2d 729, 221 P.2d 31 (Cal. 1950), held that hospital-owned buildings used to house hospital staff were exempt. Resident physicians, interns, nurses, student nurses, supervisory and

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[50] *Id.* at 1045 (citing *Cotton Petroleum Corp. v. New Mexico*, 490 U.S. 163, 177 (1989)).

[51] Alaska Const. art. IX, § 4.

[52] AK Office of Attorney General Opinion, 1981 WL 38838 (Alaska A.G.) (1981) (hereinafter "A.G. Opinion").

[53] A.G. Opinion (citing AS 18.20.210(3)).

maintenance personnel, and other employees lived in various buildings that several hospitals maintained for their staffs. Describing a building immediately adjacent to one of the hospitals, which housed nurses who paid nominal rent as typical of the quarters at issue, the court pointed out that housing employees on or near hospital property was necessary to cope with emergency situations requiring extra personnel and to otherwise conduct an efficient operation.

On two occasions, Alaska courts have distinguished the *Cedars of Lebanon* ruling because of factual differences. In *Harmon v. North Pacific Union Conference Association of Seventh Day Adventists*, 462 P.2d 432 (Alaska 1969), the *Cedars* case was found to be inapplicable because the *Harmon* matter involved a specific statutory exemption for the residences of clergy, and not a question of use of property by a hospital.[54] In *Greater Anchorage Area Borough v. Sisters of Charity of the House of Providence*, 553 P.2d 467 (Alaska 1976), the issue concerned office buildings owned by the hospital and being used for the private practice of medical providers and which were not being used by the hospital. The court found *Cedars* to be inapplicable to situations where the property is being leased out for private use.[55] Those distinctions do not apply in the instant case. The patients in this residential facility are being cared for at the NSHC hospital facility and do not pay to stay there.

This case presents the situation where the use of the property is entirely integrated with the provision of care. For instance, the court in *Abbott-Northwestern Hospital, Inc. v County of Hennepin*, 389 N.W.2d 916 (Minn. 1986), recognized that the exemption was broad enough to include auxiliary property reasonably necessary to effectuate hospital purposes and held that a hospital-owned facility providing temporary lodging for patients, medical personnel, and others was exempt. As part of its complex, a public hospital, which had been organized to provide health care services, maintained low-cost temporary housing for preadmission patients, outpatients, patients' families, and medical personnel attending seminars at the hospital. The building included such features as handicap accessibility, indoor access to all medical facilities, and late checkout to coordinate with hospital schedules. The court acknowledged the increasing role of family members in patient treatment and recovery and pointed out that the facility's major advantage over hospital rooms and hotels was cost containment.

Similarly in the instant case, the hostel accomplishes the following hospital functions:

1. Patient housing is necessary because patients travel from the 44,000 square mile area of the Bering Strait community to receive care at NSHC, which is the only hospital within the region and which is obligated to serve the citizens of this geographic area (See Community Health Needs Assessment).
2. Patient housing is integrated into the medical care of the patient, providing regular meals, easy hospital and provider access, and handicap and other supportive infrastructure.
3. Patients who travel from the outlying villages for care at NSHC have inadequate resources to pay for temporary housing while receiving essential care at NSHC, and

[54] *Id.* at 438.

[55] *Sisters of Charity*, 553 P.2d at 470.

there are inadequate lodging options in Nome for patients who often have special needs.

4. NSHC's funding agreement requires it to provide housing for patients.

The use of this property by NSHC is distinguishable from uses that merely promote the charitable activity. *See, e.g., Evangelical Covenant Church of America v. City of Nome,* 394 P.2d 882 (Alaska 1964) (revenue from church's operation of radio station supported the charitable purposes but was not itself the direct and primary purpose of the church). NSHC occupies and operates these properties as an integral part of its operation, without which it could not provide medical care. This is use which is directly for the charitable purposes for which NSHC was incorporated and is not use for the primary purpose of production of income. *Matanuska-Susitna Borough v. King's Lake Camp,* 439 P.2d 441, 445 (Alaska 1968) (distinguishing *Evangelical Covenant Church*, income from participant camp fees were "incidental to and reasonably necessary for the carrying out of the primary charitable purposes of the camp"). NSHC cannot accomplish the charitable purposes for which it was organized without these properties and is, in fact, legally obligated to provide this housing. As the Alaska court stated in *Sisters of Charity,* exemption is warranted when the property must be provided and utilized for purposes necessary to the functioning of the hospital. 553 P.2d at 471 n.12.

3. Assessor's Reliance on the "Vitally Necessary" Standard is Misplaced and Misconstrued.

The assessor appears to rely upon the case of *City of Nome v. Catholic Bishop of Northern Alaska*, 707 P.2d 870 (Alaska 1985), to deny tax exemptions to these properties. The *Catholic Bishop* case entailed an interpretation of AS 29.53.020(a)(3) (repealed and replaced by AS 29.45.030(a)(3)) with respect to use of certain church properties. The assessor suggests that the standard for determining whether property is "exclusively used" for exempt purposes is set forth in *Catholic Bishop* as whether the use of the property is "vitally necessary" to the hospital's exempt purposes. This is a misinterpretation of *Catholic Bishop* and is not the applicable standard.

The *Catholic Bishop* court stated that the standard for interpreting "exclusive use" is whether the use is "direct and primary" to the exempt purposes:

> We have interpreted "exclusive use" in accord with our rule of strict construction. In *Harmon v. North Pacific Union Conference Association of Seventh Day Adventists,* 462 P.2d 432 (Alaska 1969), we decided that "[e]ven when the uses of a piece of property are highly related to the primarily exempted activity, the exemption will not apply when the statute requires 'exclusive' use." 462 P.2d at 437. All uses of the property must be for the "direct and primary" exempt purpose. *Evangelical Covenant Church v. City of Nome,* 394 P.2d 882, 883 (Alaska 1964) (citing Annot., 154 A.L.R. 895, 898 (1945)). *See Matanuska-Susitna Borough v. King's Lake Camp,* 439 P.2d 441, 445 (Alaska 1968).[56]

[56] 707 P.2d. at 879.

The "vitally necessary" test was first referenced in *Harmon* for purposes of interpreting a different statutory exemption from the instant case, the religious parsonage exemption under AS 29.10.336 (now AS 29.45.030(b)). The church in *Harmon* sought to exempt buildings used for the residences of church administrators, teachers, and visiting church staff members. The buildings were also used for counseling and church social gatherings. The court stated that it must strictly construe whether property is used "exclusively for religious purposes" based on the legislative intent to narrowly define the type of residence which qualifies for exemption.[57]

Similarly, in *Catholic Bishop*, the court addressed the same parsonage exemption under AS 29.53.020(b)(1) (now AS 29.45.030(b)(1)). The court stated that it recognizes a narrow exception to the exclusive-use standard when evaluating the parsonage allowance, as follows:

> Residences that are not exempt under AS 29.53.020(b)(1) may still be exempt if their use was directly incidental to and vitally necessary for the exempt use **of other church property**.[58]

In *Catholic Bishop,* three churches sought to exempt religious residences, administrative offices, sanctuaries, and property used for both religious educational and charitable purposes. They also sought to exempt properties used as support for exempt properties, and church property leased to other nonprofit organizations. With respect to the residence of a religious worker/volunteer, the court evaluated this as "other property" not specifically listed in the applicable statute (i.e., residence of bishop, pastor, priest, rabbi, minister), and applied the narrow "vitally necessary" alternative standard to exclusive use. The *Catholic Bishop* court explained that the "vitally necessary" standard applies only to use of other [church] property and does not supplant the "direct and primary" exclusive-use standard for property used directly with the particular exempt activity.[59]

NSHC submits that the *Catholic Bishop* "vitally necessary" standard does not apply outside of interpreting the special definition of "exclusive religious use" for housing ministers, pastors, et al., under AS 29.45.030(b). Even if *Catholic Bishop* were found to be controlling in the instant matter, the case confirms that the test for determining "exclusive use" is whether the use is direct and primary to the exempt purposes.[60] NSHC's patient hostel is "used directly" with its exempt activity of the hospital. The *Catholic Bishop* court acknowledges that residential accommodations which are "institutionally necessary" to the operation of a hospital are exempt.[61]

Since *Catholic Bishop,* Alaska courts have confirmed that "direct and primary" is the standard for evaluating exclusive use:

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[57] *Harmon*, 462 P.2d at 436.

[58] 707 P.2d at 880, 884-85 (emphasis added).

[59] *Id.* at 880.

[60] *Id.* at 879.

[61] *Id.* at 880-881.

> Most of our charitable-purposes tax exemption cases revolve around the second part of the analysis: whether the property is being used exclusively for a charitable purpose. We have interpreted "exclusive use" to require that all uses of the property be for the "direct and primary" exempt purpose.[62]

The *Dená Nená Henash* court declined to use the "vitally necessary" standard when determining whether property used to house, in part, fundraising activities for non-exempt purposes was an "exclusive" charitable use.[63]

This is not a case of "other property" discrete from the hospital being used for ancillary purposes or purposes outside of the statutory definition of hospital use. This building is operated in connection with the hospital and, as such, meets the definition of "hospital." The property uses are institutionally necessary to the operation of the hospital and legally required for its operation. The properties are used directly for the charitable purposes for which NSHC was incorporated and not used for the primary purpose of production of income or some other ancillary or incidental purpose.

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[62] *Fairbanks North Star Borough v. Dená Nená Henash*, 88 P.3d 124 (2004).

[63] *Id.* at 141.

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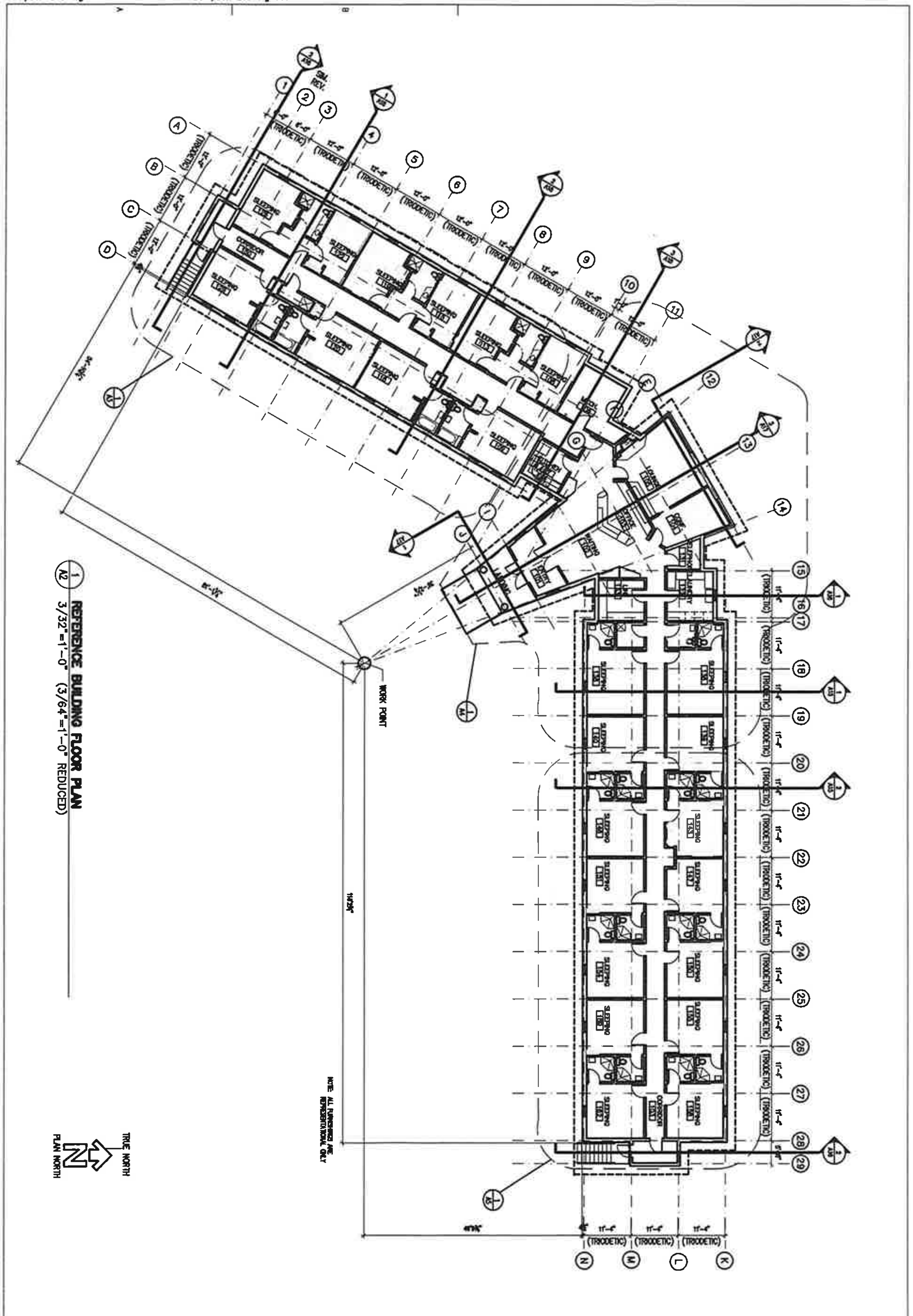

NORTON SOUND HEALTH CORPORATION

HOSTEL

NOME, ALASKA

Discipline A

Sheet No. 2

Sheet Contents: REFERENCE BUILDING FLOOR PLAN

Architects Alaska

Community Health Needs Assessment Survey Report

Norton Sound Health Corporation

January 2021

For additional information regarding the Norton Sound Health Corporation Community Health Needs Assessment, contact Quality Improvement at (907) 443-4501.

EXECUTIVE SUMMARY

Norton Sound Regional Hospital

Norton Sound Health Corporation (NSHC) is a tribally owned and operated, independent, not-for profit health care organization, founded in 1970 to meet the health care needs of the Inupiat, Siberian Yup'ik and Yup'ik people of the Being Strait region. NSHC is governed by a 22-member board of directors who represent all communities and areas of the Bering Strait region, a 44,000 square-mile section of northwestern Alaska.

Norton Sound Health Corporation puts the patient first. This principle applies equally at the new Norton Sound Regional Hospital and at the 15 village clinics managed by NSHC.

Every day, NSHC's approximately 750 employees – about 62% of them Alaska Native – demonstrate their commitment to our mission: providing quality health services and promoting wellness within our people and environment. NSHC strives to train local people to deliver and manage its services. NSHC offers a 2-year Registered Nurse Program through the University of Alaska Anchorage, a Certified Nursing Assistant Course, and other local trainings in partnership with the local Nome Northwest Campus and the region's partners.

In 2019, Norton Sound Health Corporation was recognized as one of the nation's top clinically performing community health centers. HRSA named NSHC as a "gold tier" Health Center Quality Leader awardee, meaning that the organization is among the top 10% of health centers to achieve best overall clinical performance nationwide. NSHC improved on measures such as tobacco intervention, colorectal cancer screening, and childhood immunization status.

The organization also increased the level of medical and mental health care provided to patients. Significant steps have been taken by NSHC to ensure that whole-person care is being delivered; behavioral health services have been prioritized, and resources have been increased. Full-time psychiatry services were implemented to better meet the needs of our patients. In FY19, NSHC opened a drug rehabilitation program, known as the "day shelter", which utilizes the skills of recovery coaches to facilitate lifestyle changes. The resource and recovery program has resulted in guests securing jobs, housing, reducing emergency department visits, and achieving GED status. The day shelter is just one of the critical steps necessary to enhance the behavioral health continuum of care model.

The goal to increase access to care for all communities is being realized; village visits have doubled and more mid-level providers have been hired to provide higher level care in the village clinics, to provide relief to health aides, and to facilitate additional on-call coverage. A Population Health Department was implemented to coordinate prevention care and to ensure clinical standards of care are being met for patients. An In-home support program was also initiated, in which NSHC will administer the Personal Care Attendant (P.C.A) Program for the region with the goal to offer end-of-life care for families who need the services.

In January 2019, NSHC started offering MRI services locally, with its new state-of-the-art MRI machine, the only one of its kind in Alaska and in the nation serving rural health needs. A staff neurologist was also hired. NSHC continued to offer tribal healing services and acupuncture services to compliment its pain management services.

NSHC continues to promote state-of-the-art facilities. Since 2017, NSHC has completed the construction of four new health clinics located in Savoonga, Gambell, Shaktoolik, and Little Diomede. The construction of two new health clinics are underway in St. Michael and Shishmaref, and a new clinic with staffing housing is under design for the village of Wales. NSHC has made village-based housing a priority to ensure the staff who work at the clinic have adequate housing available. New housing has been constructed in St. Michael, Savoonga, and Golovin to-date. The responsibility for the maintenance and oversight of the village-based facilities has also improved through NSHC's ability to establish 105(l) leases with the Indian Health Services.

Although significant improvements been made in health care delivery, five of the fifteen villages remain without water and sewer. One of NSHC's highest priorities is to continue to strengthen the region's best practice scores to remain eligible for water and sewer capital infrastructure funding. A sanitation engineer was hired in FY19 to manage and coordinate the region's water and sewer goals and objectives.

NSHC is excited to open its new Wellness and Training Center in June 2021; the new facility will include a sobering center with integrated wellness services to facilitate sobriety. The new training facility will provide expanded classroom space to train the organization's health aide workforce. It

Norton Sound Health Corporation is a model of how Indian Self-Determination is meant to work, with tribes taking responsibility for their own health and well-being.

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BACKGROUND INFORMATION

In 1969, the Alaska Federation of Natives (AFN) sought a demonstration project to give Alaska Natives greater power in health care decisions. Norton Sound was selected for development of a model for community-based health care services as an alternative to regional, hospital-based care. Norton Sound Health Corporation (NSHC) was incorporated November 27, 1970. The first board had just three directors: William Takak of Shaktoolik, president; Winfred James of Gambell, treasurer; and Dorothy Isabell of Teller, secretary.

That first NSHC Board of Directors faced a formidable task: Bring health care services to a remote area with limited resources. At the time, northwest Alaskans had little access to health care, and getting medical treatment often meant traveling long distances to regional hospitals. One of the first initiatives NSHC launched was the health aide program, established in 1971. While health aides continue to be the backbone of the NSHC organization today, more than 40 years later, NSHC's services have expanded to include clinic travel clerks, village-based counselors, patient benefit coordinators, dental health therapists and nurse practitioners in all the villages served.

At its first meeting in November 1970, the NSHC Board of Directors established its highest goal: provide a "comprehensive and quality inpatient facility in Nome." That year, NSHC opened its first office in the basement of Maynard-McDougall Memorial Hospital in Nome, with a budget of $143,000. Six years later, NSHC purchased the hospital, and in 1978 Norton Sound Regional Hospital opened in Nome. It was quickly followed by Unalakleet' s sub-regional health clinic, staffed by a physician assistant and community health aides serving four villages.

In 1975, NSHC became the first Native health corporation to become independent of AFN and contract directly with the Indian Health Service. The following year, the board assumed responsibility for regional environmental health services through assignment of a federal Public Health Service sanitarian.

Over the years, NSHC's board focused on expanding patient care in the Bering Strait region of Alaska, adding basic services in 15 villages throughout the Norton Sound area as well as specialty clinics in Nome. In 2008, the Board of Directors opened The Patient Hostel, a 38-bed facility, located on the east side of Nome and positioned close to where the new facility would be constructed someday.

Another milestone was reached in 2009, when Indian Health Services awarded NSHC full funding to complete a new hospital building in Nome. Construction began in October 2009 and was completed in 2012. The first patients were seen at the new Norton Sound Regional Hospital and Quyanna Care Center in March 2013.

In October 2014, NSHC went live with its new electronic medical record, "Cerner" and completed the renovation for the Wales clinic and replaced the Shishmaref clinic. In 2015, NSHC initiated a village clinic improvement program and assumed oversight and responsibility for nearly all village clinics and hired housekeepers and maintenance workers to keep the clinics maintained in all the villages. The Nome outpatient clinic received a HRSA new access point grant and was integrated with the village primary health care services for the first time.

In 2016, NSHC began an ambitious mission to replace and/or update aging clinic facilities throughout the region. In 2017, saw NSHC's Nome Primary Care Center receive recognition as a Patient Centered Medical Home by the National Committee on Quality Assurance. New clinics were completed in the villages of Gambell, Savoonga, and Shaktoolik. Village-based housing projects were also completed in Savoonga and Golovin.

In 2018 an MRI was added to the NSHC hospital to further advanced our diagnostic capabilities and a new health clinic for the village of Shakoolik was opened.

In 2020, NSHC achieved its vision to complete construction for a new health clinic for the remote village of Little Diomede.

In 2021, NSHC expects to open the long- awaited Wellness and Training Center which will create the first sobering center in the region as well as add intensive outpatient mental health services to our comprehensive service wrap around services.

The COVID-19 pandemic saw Norton Sound Health Corporation face the challenge of the generations while minimizing morbidity and mortality, supporting communities in mitigation and suppression methods while retaining high quality preventative, chronic and emergency care.

NORTON SOUND HEALTH CORPORATION: MISSION, VISION, AND VALUES

Our purpose, core values and vision for the future are built on our commitment to providing the Native people of the Norton Sound region with the highest quality health care possible.

Our mission:
Providing quality health services and promoting wellness within our people and environment.

Our core values:

- Integrity
- Cultural sensitivity and respect for traditional values
- Always learning and improving
- Compassion
- Teamwork
- Pride

Our vision for the future:

- We will ensure that all patients receive quality and respectful health care.
- We will educate our patients and communities to be proactive in caring for themselves and promoting wellness.
- We will listen to, honor, and respect our elders, preserve their right to speak, and ensure they receive the best care in gratitude for their leadership.
- We will increase wellness efforts to reduce addictive behaviors and to raise the quality of life among our people and communities.
- We will advocate that our environment (air, land and water) will be clean, and our water and waste disposal systems are safe and affordable, in order to ensure our subsistence way of life.

- We will assert and implement tribal self-governance to achieve our vision through effective leadership.
- We will hire and support our tribal members to deliver and manage our services.
- We will develop state of the art and efficient health care facilities throughout the region.
- We will be financially strong through aggressive, effective and efficient financial management.
- We will support and develop our youth to pursue higher education and health care careers to ensure there is future tribal leadership.

SCOPE OF THE STUDY

The purpose of the 2020 Norton Sound Health Corporation Community Health Needs Assessment is to collect data on specific information regarding community perception of the Use of Healthcare Services, Awareness of Services, Community Health, and Health Insurance. Additionally, data were collected regarding the demographics of survey responders. The data are presented in a format that can be useful to Norton Sound Health Corporation board of directors, administration, health care providers and community.

METHODOLOGY

A comprehensive survey was developed by the Quality Assurance/Performance Improvement Team "Aquutaq". The survey was loaded electronically into Microsoft Forms. It was distributed electronically via advertisement, QR code, email, public information, Facebook, community meetings and other avenues. Paper copies of the form were also mailed to all box holders in the region as well as made available at all clinics and within the Nome hospital site. The survey was also distributed at various Health Forums held within the region.

Data collection began in early 2019 and continued until early 2020 with a goal of at least 1000 responses. Processing of data and this report was delayed due to reallocation of staff during the pandemic and completed in 2021. The survey was closed for responses in January 2020, after 1004 responses had been received, (32.4% of households in the region). The data was entered into a Microsoft Forms/ Microsoft Excel database and are presented in the Survey Results section of this report. At the time of survey closure, data was first prepared and shared with the NSHC Board of Directors, final report was completed on January 26, 2021.

Population Data

PEOPLE		
Population		
Population estimates, July 1, 2019, (V2019)	**10,004**	**731,545**
Population estimates base, April 1, 2010, (V2019)	9,492	710,249
Population, percent change - April 1, 2010 (estimates base) to July 1, 2019, (V2019)	5.4%	3.0%
Population, Census, April 1, 2010	9,492	710,231
Age and Sex		
Persons under 5 years, percent	10.0%	7.0%
Persons under 18 years, percent	34.6%	24.6%
Persons 65 years and over, percent	8.0%	12.5%
Female persons, percent	47.4%	47.9%
Race and Hispanic Origin		
White alone, percent	15.7%	65.3%
Black or African American alone, percent(a)	0.9%	3.7%
American Indian and Alaska Native alone, percent(a)	75.3%	15.6%
Asian alone, percent(a)	1.5%	6.5%
Native Hawaiian and Other Pacific Islander alone, percent(a)	0.2%	1.4%
Two or More Races, percent	6.5%	7.5%
Hispanic or Latino, percent(b)	2.9%	7.3%
White alone, not Hispanic or Latino, percent	14.9%	60.2%
Population Characteristics		
Veterans, 2015-2019	394	65,186
Foreign born persons, percent, 2015-2019	2.5%	7.8%
Housing		
Housing units, July 1, 2019, (V2019)	4,100	319,854
Owner-occupied housing unit rate, 2015-2019	60.5%	64.3%
Median value of owner-occupied housing units, 2015-2019	$154,600	$270,400
Median selected monthly owner costs -with a mortgage, 2015-2019	$1,470	$1,933
Median selected monthly owner costs -without a mortgage, 2015-2019	$469	$582
Median gross rent, 2015-2019	$1,287	$1,244
Building permits, 2019	6	1,680
Families & Living Arrangements		
Households, 2015-2019	2,844	253,346
Persons per household, 2015-2019	3.30	2.80
Living in same house 1 year ago, percent of persons age 1 year+, 2015-2019	84.1%	82.1%

Language other than English spoken at home, percent of persons age 5 years+, 2015-2019	31.0%	16.1%
Computer and Internet Use		
Households with a computer, percent, 2015-2019	90.7%	94.1%
Households with a broadband Internet subscription, percent, 2015-2019	74.1%	85.5%
Education		
High school graduate or higher, percent of persons age 25 years+, 2015-2019	84.6%	92.8%
Bachelor's degree or higher, percent of persons age 25 years+, 2015-2019	16.1%	29.6%
Health		
With a disability, under age 65 years, percent, 2015-2019	6.8%	8.9%
Persons without health insurance, under age 65 years, percent	18.4%	13.9%
Economy		
In civilian labor force, total, percent of population age 16 years+, 2015-2019	64.8%	65.5%
In civilian labor force, female, percent of population age 16 years+, 2015-2019	66.8%	63.1%
Total accommodation and food services sales, 2012 ($1,000)(c)	14,821	2,221,335
Total health care and social assistance receipts/revenue, 2012 ($1,000)(c)	D	6,375,483
Total manufacturers shipments, 2012 ($1,000)(c)	D	D
Total merchant wholesaler sales, 2012 ($1,000)(c)	D	5,216,303
Total retail sales, 2012 ($1,000)(c)	78,672	10,474,275
Total retail sales per capita, 2012(c)	$7,935	$14,320
Transportation		
Mean travel time to work (minutes), workers age 16 years+, 2015-2019	6.7	19.1
Income & Poverty		
Median household income (in 2019 dollars), 2015-2019	$61,048	$77,640
Per capita income in past 12 months (in 2019 dollars), 2015-2019	$23,581	$36,787
Persons in poverty, percent	20.7%	10.1%
BUSINESSES		
Businesses		
Total employer establishments, 2018	168	21,293
Total employment, 2018	2,119	261,053
Total annual payroll, 2018 ($1,000)	121,975	15,732,010
Total employment, percent change, 2017-2018	-2.9%	-0.4%
Total nonemployer establishments, 2018	551	57,391

All firms, 2012	676	68,032
Men-owned firms, 2012	380	35,402
Women-owned firms, 2012	212	22,141
Minority-owned firms, 2012	381	13,688
Nonminority-owned firms, 2012	264	51,147
Veteran-owned firms, 2012	61	7,953
Nonveteran-owned firms, 2012	578	56,091

GEOGRAPHY		
Geography		
Population per square mile, 2010	0.4	1.2
Land area in square miles, 2010	22,961.76	570,640.95
FIPS Code	02180	02

About datasets used in this table

Value Notes

Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable.

The vintage year (e.g., V2019) refers to the final year of the series (2010 thru 2019). *Different vintage years of estimates are not comparable.*

Fact Notes

- (a)Includes persons reporting only one race
- (b)Hispanics may be of any race, so also are included in applicable race categories
- (c)Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

Value Flags

- -Either no or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest or upper interval of an open ended distribution.
- D- Suppressed to avoid disclosure of confidential information

QuickFacts data are derived from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area Health Insurance Estimates, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits.

Source: US Department of Commerce. US Census Bureau

http://quickfacts.census.gov/qfd/index.html

BEHAVIORAL RISK FACTOR DATA

Alaska Behavioral Risk Factor Surveillance System

2018 Nome Region

Risk Fact	Nome (%)	Alaska (%)
Health Status: General Health Excellent/Very Good	41.7	51.3
Health Status: Poor physical health	18.0	16.4
Health Status: Frequent mental distress	18.8	11.3
Thoughts of Suicide in past 12 months (2013)	5.0	4.2
Ever told had depressive disorder	15.4	21.2
HTN: Ever told HTN (2017)	25.7	29.9
CVD: Ever told heart attack	3.7	4.4
CVD: Diagnosis of Angina or Coronary Heart Disease	1	2.8
COPD	4.6	5.3
Cancer: Any type	4.2	7.8
Weight Status: Severely Obese (BM>40)	10.3	7.8
Weight Status: Obese (BMI 30-39.9)	26.5	31.2
Weight Status: Overweight	28.1	35.1
Weight Status: Underweight	0.6	1.8
Seen a provider in the last 12 months	56.0	69.3
Access: No Health Care Coverage	6.1	9.1
Follow Subsistence Lifestyle (2017)	79.7	30.2
Rent Home	20.3	27.2
Believe currently get enough physical activity (2015)	59.7	46.9
Activity Time: Adequate Aerobic Physical Activity (at least 150 minutes per week) (2017)	86.9	56.7
Activity Time: Adequate Aerobic Physical Activity (at least 300 minutes per week) (2017)	69.9	36.2
Received Food Assistance from Community Program(s) (2013)	14.7	7
Received Food Assistance from Government Program(s) (2013)	34.9	15.6
Less than 3 vegetables and 2 fruits per day	81.5	93.8
Sweetened carbonated beverages 1+ per day (2017)	27.5	13.2
Sweetened non-carbonated beverages 1+ per day (2017)	45.4	12.1
Cigarette Smoking: Current Smoker Everyday (2018)	30.3	17.1
Cigarette Smoking: Former Smoking (2018)	27.7	28.3
Cigarette Smoking: Never Smoked (2018)	42.1	54.6
Tobacco Use (not including e-cig) (2018)	63.4	25.2
Current Marijuana Use (2018)	44.6	17.3
Current Alcohol Use (2018)	34.9	58.6
Binge Drinking (2018)	13.4	16.4
Before age 18, lived with problem drinker/alcoholic/drugs/rx med (2015)	47.4	32.3
Seat Belt Use: always use a seatbelt (2018)	73.1	83.0
Hurt by intimate partner last 5 years (2017)	15.2	6.6

NOME CA MAPP: BRFSS DATA: 2015-2018: MIXED

COMMUNITY HEALTH NEEDS SURVEY RESULTS (as of 1/26/2021) (1004 households reporting)

Norton Sound Health Corporation

*NOTE SOME TOTALS MAY NOT EQUAL TO 100% DUE TO ROUNDING AND ALLOWANCE FOR MULTIPLE RESPONSES PER ITEM. ALSO NUMBER OF RESPONSES DIFFERS TO EACH ITEM ALLOWING FOR NON-RESPONDERS AND MULTIPLE RESPONSES TO SOME ITEMS.

Section A: Please tell us about yourself

1. What is your zip code?

Village	Zip Code	Number	Percentage
Nome, Golovin, Diomede	99762	481	47.91%
Brevig	99785	28	2.79%
Elim	99739	73	7.27%
Gambell	99742	55	5.48%
Koyuk	99753	25	2.49%
St. Michael	99659	15	1.49%
Savoonga	99769	31	3.09%
Shaktoolik	99771	17	1.69%
Shishmaref	99772	56	5.58%
Stebbins	99671	49	4.88%
Teller	99778	16	1.59%
Unalakleet	99684	96	9.56%
Wales	99783	9	0.90%
White Mountain	99784	29	2.89%
OTHER		11	1.10%
NO RESPONSE		13	1.29%
Total		**1004**	**100%**

2. What is your gender?

Gender	Number	Percentage
Male	295	29.38%
Female	679	67.63%
Transgender	2	0.20%
Other	1	0.10%
Prefer not to answer	27	2.69%
Total	**1004**	**100.0%**

3. What is your age range?

Age	Number	Percentage
18-25	100	9.96%
26-35	260	25.90%
36-45	163	16.24%
46-55	164	16.33%
56-65	197	19.62%
66-75	79	7.87%
76-85	21	2.09%
86+	1	0.10%
Unanswered/Prefer not to say	19	1.89%
Total	**1004**	**100.0%**

4. Are you an IHS beneficiary?

Response	Count	Percentages
Yes	660	65.74%
No	286	28.49%
Unanswered/Prefer not to say	58	5.78%
Total	**800**	**100%**

5. How many people, including yourself, live in your household?

Number	Count	Percentage
1	141	14.04%
2	196	19.52%
3	167	16.63%
4	150	14.94%
5	118	11.75%
6	75	7.47%
7	61	6.08%
8	38	3.78%
9	16	1.59%
10+	30	3%
Unanswered/ Prefer not to say	12	1.2%
Total	**1004**	**100%**

6. How many children under the age of 18 live in your household?

Number	Count	Percentage
0	425	42.37%
1	164	16.35%
2	160	15.95%
3	110	10.97%
4	61	6.08%
5	37	3.69%
6	18	1.79%
7	7	0.70%
8	1	0.10%
9+	2	0.20%
Unanswered/ Prefer not to say	19	1.89%
Total	**1004**	**100%**

7. What is your employment status?

Response	Count	Percentage
Work full-time	529	52.69%
Work part-time	129	12.85%
Retired	116	11.55%
Unemployed and looking for employment	103	10.26%
Not currently seeking employment	69	6.87%
Disabled	25	2.49%
Student	21	2.09%
Unanswered/Prefer not to say	12	1.20%
Total	**1004**	**100%**

8. Do you access the internet in your home?

Response	Count	Percentages
Yes	646	64.34%
No	343	34.16%
Unanswered/Prefer not to say	15	1.49%
Grand Total	**1004**	**100.00%**

9. Do you have plumbed drinking water in your home?

Response	Count	Percentages
No	180	17.93%
Yes	813	80.98%
Unanswered/Prefer not to say	11	1.10%

Grand Total	1004	100.00%

10. Do you have plumbed septic/sewer in your home?

Response	Count	Percentages
No	203	20.22%
Yes	789	78.59%
Unanswered/Prefer not to say	12	1.20%
Grand Total	**1004**	**100.00%**

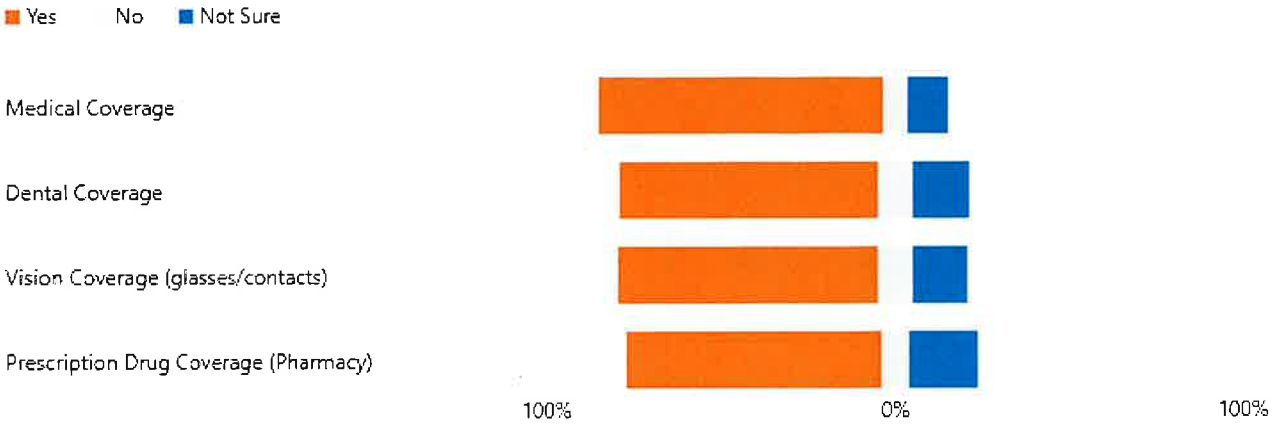
11. What is the best way for NSHC to communicate with you? (Preferential choice ranking, only first preference listed below)

Response	Count	Percentage
Email	112	11.16%
Mail	90	8.96%
Phone	156	25%
Text Message	366	36.45%
Other Media	11	1.1%
Unanswered/Prefer not to say	296	29.48%
Total	**1004**	**100%**

12. What type(s) of health care coverage do you have? (Multiple responses allowed).

Response	Count	Percentage
Indian Health Services (IHS)	507	33.82%
Employer Sponsored	494	32.96%
Medicaid	259	17.28%
Medicare	111	7.40%
No coverage	38	3.78%
VA/Military	20	1.33%
Health Savings Account	9	0.60%
Other	38	3.78%
Unanswered/Prefer not to say	11	1.01%
Total	1004	100%

13. What types of coverage do you have?



Section B: Tell us about your healthcare experience

1. Have you used any Norton Sound Health Corporation facilities?

Response	Count	Percentages
Yes	943	93.92%
No	38	3.78%
Unanswered/Prefer not to say	23	2.29
Total	**1004**	**100%**

2. Why do you choose to use NSHC facilities?
(multiple responses allowed)

Response	Count
Only clinic available	759
Has services I need	264
Needed medication refefilled	187
Emergency, no other choices	185
Provider listens to me	126
Provider knows me by name	119
Referred	92
Great experiences prior	89
Short waiting time	87
Hospital/Clinic reputation for quality	70
Required by my insurance	46
Recommended by family/friends	42
Cost of Care	35
n/a, I NEVER use NSHC facilities	18
Other, free text responses	17
VA/Military requirement	6

3. If you ever choose not to use NSHC facilities, why not?
(multiple responses allowed)

Response	Count	Percentage
n/a, I ONLY use NSHC	336	27.77%
Service I needed was unavailable	213	17.60%
Lack of privacy/confidentiality	83	6.86%
Costs too much money	77	6.36%
No appointment available in a timely manner	77	6.36%
Did not trust the provider	63	5.21%
Unsure if service I need is available	62	5.12%
Not treated with respect	52	4.30%
Do not like provider	50	4.13%
Appointments do not fit my schedule	46	3.80%
My insurance would not cover my care	30	2.48%
Provider is my co-worker/relative	26	2.15%
Other – free text response	66	5.45%
Unanswered/Prefer not to say	191	19.02%

4. In the past 12 months, was there a time when you or someone living in your home needed medical care from NSHC but were not seen?

Response	Count	Percentages
Yes	202	20%
No	731	73%
Other	39	4%
Unanswered/Prefer not to say	32	3%
Total	**788**	**100%**

5. If you answered "yes" above, what service were you not able to use:

Response	Count
Nome Hospital	20
Nome Clinic	45
Village Clinic	80
BHS Nome	11
BHS Village	4
Other	41

6. Check any of the reasons below that help explain why you were not seen. (multiple responses allowed)

Reason	Count
Clinic is too far away	3
Costs too much money	19
Did not trust the provider	21
Do not like provider (MD, DO, PA, NP, Health Aide)	14
Had no one to watch kids	6
Lack of privacy/confidentiality	21
Language barrier	0
My insurance would not cover	8
No appointment available in a timely manner	73
No appointments that fit my schedule	26
No transportation	14
Not treated with respect	25
Other	47
Provider is my co-worker/relative	7
Too afraid or nervous	7
Unsure if service I need is available	11
Service I needed was unavailable	40

7. In the past 12 months, check all of the health care providers you or anyone living your home has seen: (multiple responses allowed)

Provider	Count
General practice provider (MD, DO, PA, NP)	646
Dentist/DHAT	488
Optometrist (Eye doctor)	420
Health Aide	394
Audiologist (hearing)	276
Pediatrician	212
Physical Therapist	179
Behavioral Health Clinician/Therapist	164
ENT Specialist (ear, nose, throat specialist)	156
Obstetrician/Gynecologist (female reproductive specialist)	134
Tribal Healer	128
Orthopedist (bone/joint specialist)	93
Cardiologist (heart specialist)	89
Dietitian	73
Neurologist (brain/nerve specialist)	72
Urologist (kidney/bladder/male reproductive specialist)	69
Surgeon	68
Diabetes Specialist	66
Psychiatrist	61
Rheumatologist (arthritis specialist)	42
Dermatologist (skin specialist)	35
Oncologist (cancer specialist)	34
Chiropractor	33
Social Worker	31
Tobacco Counselor	31
Pulmonologist (lung specialist)	30
Infant Learning Program	30
Podiatrist (foot/ankle specialist)	23
Allergy Specialist	23
Substance Abuse Counselor	15
Other (Free text)	44

8. How long did you have to wait to see the specialist from the time you were referred or requested an appointment?

Column1	Count	Percentage
1 month	240	23.90%
2 months	102	10.16%
3 months	60	5.98%
4 months	24	2.39%
5 months	13	1.29%
6 moths or more	50	4.98%
Unanswered/choose not to respond	515	51.29%
Total	**1004**	**100%**

9. Please rate the following services Norton Sound Health Corporation offers and tell where you used that service most:

	Excellent	Good	Fair	Poor
Emergency Room	44.20%	43.30%	7.59%	4.91%
Inpatient (Acute Care)	16.57%	40.51%	35.54%	7.38%
QCC (Quyanna Care Center, Nursing Home)	31.76%	44.12%	20.00%	4.12%
Nome Primary Care	25.48%	52.71%	18.59%	3.22%
Village Clinic	32.13%	44.68%	20.91%	2.28%
Laboratory	33.28%	47.68%	17.50%	1.54%
Physical Therapy	33.04%	46.67%	17.39%	2.90%
Eye Care Clinic (Optometry)	42.48%	42.48%	12.07%	2.98%
Audiology	38.39%	47.16%	12.32%	2.13%
Dental	39.55%	42.93%	13.67%	3.86%
Behavioral Health	27.09%	44.15%	21.40%	7.36%
Case Management	22.87%	40.96%	23.55%	12.63%
CAMP Program	36.33%	39.45%	19.92%	4.30%
Tribal Healing	50.76%	36.64%	9.54%	3.05%
Infant Learning Program	34.68%	42.74%	18.55%	4.03%
Radiology/Diagnostic Imaging	39.64%	44.42%	13.44%	2.51%
EMS-Medevac Team	57.38%	32.07%	10.13%	0.42%
WIC Program	42.93%	41.46%	13.66%	1.95%
Environmental Health (OEH)	27.93%	45.95%	22.52%	3.60%
Respiratory Therapy	33.74%	51.53%	12.88%	1.84%
Medical Records/HIM	27.73%	45.48%	21.81%	4.98%
Billing Department	27.38%	38.39%	22.32%	11.90%
Human Resources Department	24.91%	37.37%	24.57%	13.15%
Patient Driver	39.21%	40.84%	14.15%	5.80%
Patient Advocate	33.69%	36.56%	19.71%	10.04%
Administration	29.52%	38.10%	21.59%	10.79%

10. Have you or anyone in your household been affected by these community issues:

	% Yes
Elder abuse	5.87%
Child Abuse	7.39%
Domestic Violence	17.54%
Drug Abuse	17.87%
Alcohol Abuse	29.63%
Tobacco Use	44.82%
Chronic Disease	22.83%
Obesity	28.12%
Heart Disease	19.98%
Diabetes	22.05%
Stroke	13.74%
Cancer	26.08%
Teen Pregnancy	10.23%
Sexually Transmitted Infections	17.16%
Suicide	23.58%
Lack of Access to Healthcare	19.41%
Lack of Access to Medications	15.47%
Lack of Quality childcare	19.41%
Lack of Quality Schooling	14.67%
Lack of Quality Housing	31.62%
Lack of Strong Family Support	14.51%
Lack of Safety	11.89%
Lack of Good Jobs	34.26%
Lack of Food due to expense	28.37%
Lack of healthy food available	36.08%
Lack of Native/Traditional foods	24.80%
Lack of Indoor Exercise Facilities	37.66%
Lack of Outdoor Recreational Spaces (parks, walking paths, etc)	24.85%
Lack of Running Water/Sewer	22.20%
Lack of Sobering Center	20.82%
Lack of Homeless Shelter	19.11%
Lack of Law Enforcement	30.87%

11. What would improve your access to care? (multiple responses allowed)

	Count
More providers/health aides	352
More specialty clinics	309
End of Life Care Program	126
Prescription deliver	127
Home visits by providers/health aides	164
Longer hours at the clinics	145
Telemedicine availability	67
Personal Care Attendants	152
Transportation to clinic or hospital	152
Assisted Living Center	171
Availability of Long Term Care	109
Financial Support for Out of Region	91
Other (free text)	

Nurse Call Line

12. Have you ever used the NSHC Nurse Call Line, and based on your experience, how would you rate it? (1 – Excellent, 5 - poor)

Row Labels	Count of ID	Sum of ID
No - but I've head of it	**103**	**18.35%**
1	28	6.47%
2	16	3.21%
3	38	5.12%
4	7	1.28%
5	14	2.28%
No - but I've heard of it	**3**	**1.08%**
1	3	1.08%
No - Never heard of it	**8**	**1.26%**
1	1	0.22%
2	2	0.53%
3	3	0.37%
5	2	0.13%
Yes, I have used the Nurse Call Line	**392**	**79.31%**
1	108	22.31%
2	75	14.64%
3	101	19.89%
4	46	9.87%
5	62	12.60%
Grand Total	**506**	**100.00%**

Performance Improvement Goals Summary

Over the next three years, NSHC will strive to:

1) Improve Communication with Patients by asking the patient what their preferred method of communication is and utilizing it to provide meaningful feedback to patients.

2) Improve Access to Care for Patient by ensuring the NSHC Primary Care System has both appointments available for patients to accommodate same-day access to care when needed.

3) Improve Notification and Reminders to Patients about scheduled appointments.

4) Improve customer service by training staff on phone etiquette and by improving the switchboard operator experience.

5) Improve the quality of patient care by performing audits of patients who present to NSHC's outpatient clinics for care on a frequent basis; reports will be made to the HRSA quality committee to ensure there is accountability.

6) Continue the initiatives of the Population Health Department to ensure patients are receiving coordinated care and referrals for prevention tests and receiving care that meets clinical standards for disease states.

7) Continue to strengthen the nurse call line by listening to consumer feedback; share success stories when possible.

8) Ensure patient privacy and confidentiality is preserved at all times by providing training to all staff at regular intervals.

9) Continue to focus on Tobacco cessation counseling and prevention activities, substance abuse treatment programs, and suicide prevention activities.

10) Improve access to healthy foods region-wide by collaborating with village leadership.

11) Increase access to indoor workout space region-wide by working with local leaders to develop partnerships for solutions.

12) Continue to develop and expand NSHC's in-home support program to provide personal care attendant services (PCA Program) and to offer end-of-life care for family's in the region at all locations.

13) Continue to provide patient transport services in all locations and to deliver prescription medications.

FUNDING AGREEMENT
BETWEEN CERTAIN ALASKA NATIVE TRIBES
SERVED BY THE
NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
OF THE
UNITED STATES OF AMERICA
FISCAL YEARS 2018-2020

This Funding Agreement is entered into by and between certain Alaska Native Tribes in the Bering Straits region of the Norton Sound Service Unit, as identified on the signature page herein, and the Secretary of the Department of Health and Human Services. These Tribes have authorized the Norton Sound Health Corporation to sign this Funding Agreement for them and to be responsible for and carry out the terms of this Funding Agreement.

Section 1 – Obligations of the IHS.

1.1 Generally. Under the authority of Section 325 of P.L. 105-83, and P.L. 93-638 as amended, non-residual programs, services, functions and activities (PSFAs) of the Alaska Area Office and the Alaska Native Medical Center (ANMC) have been transferred to tribal management.

Delivery of PSFAs shall be consistent with each Co-Signer's Funding Agreement (FA). The Indian Health Service (IHS) shall remain responsible for performing all federal residual PSFAs. The IHS shall remain responsible for negotiating assurances with the Alaska Native Tribal Health Consortium (ANTHC) and Southcentral Foundation (SCF) on behalf of Alaska Natives and American Indians to the effect that Co-Signers continue to receive non-residual PSFAs from the ANMC and Area Office and provided by ANTHC and SCF at a minimum at the level that such PSFAs were provided by the IHS as of October 1, 1997, to the extent permitted by Section 325 of P.L. 105-83. To the extent authorized by federal law, the IHS will respond to written Co-Signer concerns about the extent with which such assurances have not been complied and take appropriate action. IHS shall further be responsible for performing its special trust responsibilities and legal obligations as provided in the Indian Health Care Improvement Act, the Indian Self-Determination and Education Assistance Act, and other applicable provisions of federal law.

This FA obligates the IHS to provide funding and services identified herein and as provided in the Alaska Tribal Health Compact (ATHC) between the Norton Sound Health Corporation (NSHC) and certain other Co-Signers thereof and the United States in Fiscal Years 2018-2020.

The "Memorandum of Agreement Describing the Continuing Services of the IHS, Alaska Area Native Health Service" among the Co-Signers and the Alaska Area Native Health Service

(AANHS) reflects the understanding of the parties regarding services to be provided by the AANHS to Co-Signers. This document, attached as Appendix C, is hereby incorporated by reference.[1]

In addition, although funds are provided from Headquarters and Area Office in support of this ATHC, the IHS will agree to continue to make available to NSHC PSFAs from both Area Office and Headquarters unless 100 percent of the tribal shares for these PSFAs have been specifically included in this FA. In cases where a portion of tribal shares has been transferred, there may be some diminishment in the level of PSFAs provided by IHS. Furthermore, the IHS will reorganize both Headquarters and the Area Office to continue to provide the remaining PSFAs which have not been included in this FA, in the most effective and efficient manner possible, provided that the decisions about the array and level of PSFAs to be offered by the IHS shall be made in consultation with Alaska Tribes. The IHS PSFAs not negotiated into or listed in Appendix A are the responsibility of the IHS.

Unless funds are specifically provided from Headquarters, Headquarters retains all PSFAs and NSHC will not be denied access to, or services from, Headquarters. Specifically, NSHC will receive the following services from IHS Headquarters:

1.1.1 Information Services. IHS will provide the full range of Office of Information Technology (OIT) national support to ANTHC and ANMC OIT will provide specified services directly to NSHC. In addition, OIT will provide support to ANTHC to assist it to carry out its responsibility to provide day-to-day technical support, user support, distribution of software and files and other typical information technology support to Co-Signers as defined in the Assurances Appendix to the ANTHC FA. Upon request of ANTHC, after good faith efforts to resolve NSHC's technical issue, OIT's support of NSHC will include technical support needed on-site by NSHC. A list of the services due under this paragraph, with identification of the method of delivery, is shown below.

Office of Information Technology Provides:	Directly to ANTHC	Directly to Co-Signer	Indirectly to Cosigner through ANTHC
National Database Services			
100% Data Center Services	X		
Process Data exports into National Database		X	
Evaluate, correct, convert site data for National Database		X	
Telecommunications Management Services			
100% Telecommunications Management Services	X		
Maintain IHS to Alaska connection		X	
Email transfer and global address listing		X	
SMTP Gateway		X	
Intranet and Internet Access (to available bandwidth)		X	
Antivirus Software			X

[1] All references to Appendix A and Appendix C in this FA are to the Appendix for the applicable fiscal year.

Office of Information Technology Provides:	Directly to ANTHC	Directly to Co-Signer	Indirectly to Cosigner through ANTHC
Software Development and Maintenance			
100% Software Development and Maintenance	X		
Use of IHS contract vehicles		X	
RPMS Integrated Commercial-Off-The-Shelf packages (Average Wholesale Prices, CPT, ICD-9, Immunization Algorithm) licenses (This does not include licenses for stand-alone or interfaced commercial software.)			X
RPMS Package Support/Installation			X
System Support and Training			
100% System Support and Training	X		
Nationally Available OIT Training instruction (as available)		X	
Alaska On-site training instruction (four annual classes)			X
Hardware and Operating System Support			X
Cache Upgrade (initial installations)			X
National Patient File (2000) conversion			X
Envoy (WebMD) installation			X
Additional Services - Fee for Service	X	X	X

1.1.2 Access to Training and Technical Assistance. To the extent funds are identified by the IHS, NSHC shall have access to training, continuing education, and technical assistance in the manner and to the same extent NSHC would have received such services if it were not a Self-Governance Co-Signer.

1.1.3 Intellectual Property. In the course of administering federal contracts, grants, subgrants, and other agreements, IHS acquired various copyrights and licenses, including licenses pursuant to 45 CFR § 74.36 and 45 CFR § 92.34, in works which the IHS possessed, reproduced, published and otherwise used and allowed others to possess, reproduce, publish, and otherwise use. To carry out the PSFAs assumed by NSHC under this and previous FAs and contracts NSHC has the delegated authority and permission from IHS to use and allow others to reproduce, publish, and otherwise make use of these works to the same extent as IHS, consistent with the copyrights or licenses acquired by IHS in such works.

1.1.4 HIPAA Compliance. IHS retains the responsibility for complying with the Health Insurance Portability and Accountability Act of 1996 for retained IHS health care component activities.

1.2 Historical PSFAs. NSHC has historically received certain PSFAs from ANMC and AANHS. Responsibility for these PSFAs has been transferred to ANTHC by ANMC and AANHS prior to the transfer of management to ANTHC and SCF, NSHC attached to its FY 2002 FA Addendum I entitled "Memorialization of Historical Level of PSFAs provided by ANMC and AANHS." The PSFAs listed in this addendum are taken from NSHC's FY 1999 Annual FA. The addendum was attached to the FY 2002 FA only for the purpose of identifying historical levels of PSFAs received by the NSHC from ANMC and AANHS, and is specifically not made part of this

FA.

1.3 Community Health Aide Program Certification. The IHS retains the responsibility, pursuant to Section 119 of the Indian Health Care Improvement Act, as amended, to maintain the IHS Community Health Aide Program Certification Board (CHAPCB), which was established by and is under the direct control and supervision of IHS, to accredit training for and to certify community health aides, which includes community health aides/practitioners, dental health aides, and behavioral health aides/practitioners.

Section 2 – Obligations of the Co-Signer.

2.1 Generally. This FA obligates NSHC to be responsible for and to provide health PSFAs identified in Section 3 [Tribal Programs and Budget], utilizing the resources transferred under this FA and other funds as they may become available to NSHC. This FA further authorizes NSHC to consolidate and redesign PSFAs as provided in the Act and the ATHC. Whether providing, purchasing, or authorizing health care services described in the Compact and this Funding Agreement, in accordance with Section 2901(b) of Pub. L. 111-148, the Affordable Care Act, and as otherwise provided in law, NSHC shall be the payer of last resort. NSHC is committed to and will strive to provide quality health services and will strive to meet standards NSHC believes to be appropriate and applicable to the delivery of those health services.

2.2 Tribal Facilities and Locations. NSHC operates the programs described in this FA out of more than one facility or location. These include, but are not limited to the facilities and locations listed in Appendix B, which will be submitted prior to the effective date of this FA, and will be incorporated by reference herein. The Area Division of Planning Evaluation and Health Statistics shall compile from this Appendix a list of all health facilities identified in the Appendix and forward that list annually to the Headquarters' Office of Program Statistics, which shall include each of these facilities and locations in the annual list it must provide to the Centers for Medicare and Medicaid Services (CMS) (formerly Health Care Financing Administration) pursuant to the Memorandum of Agreement between the Health Care Financing Administration and the IHS (December 19, 1996).

Section 3 – Tribal Programs and Budget.

The NSHC agrees to be responsible for the health PSFAs identified below in accordance with the ATHC and this FA, including administration of the Norton Sound Service Unit of the IHS, a tribally operated Service Unit of the IHS. NSHC provides and facilitates a range of services directly, and in cooperation with ANMC, ANTHC, SCF and other Co-signers, through field clinics, referrals to ANMC, and other arrangements with tribal health organizations. Any PSFA described in this section 3 [Tribal Programs and Budget] may be performed by any organizational unit of NSHC at NSHC's discretion. For the purposes of this FA, the NSHC's General Budget Categories consolidate related health PSFAs as listed below.

3.1 Executive Leadership. NSHC through its Board of Directors and administration provides policy and administrative/executive/legal direction and oversight for all PSFAs in this FA. Board members, officers, General Counsel, and staff represent NSHC on the local, regional,

state and national committees and boards to provide for advocacy, negotiations, coordination, consultation, development of new programs and information activities.

3.2 Hospital and Clinic Services. NSHC is committed to providing quality patient care achieved through maintaining qualified staff, physical plant, and adequate supply of medical provisions. Under a comprehensive health care delivery plan NSHC provides the following direct patient care services:

3.2.1 Acute patient care swing-bed;

3.2.2 Twenty-four hour emergency services, including those associated with being a Level IV trauma center;

3.2.3 Ambulatory care services, including after-hour nursing phone triage service;

3.2.4 Medevac/air ambulance services;

3.2.5 Referral/transport system from the villages and/or Nome to and from the next higher level of care (e.g. travel coordination and authorization, patient transport vehicle, medivac transport and patient transportation, including adult escort, health professional and other escort as NSHC deems appropriate and emergency or non-emergency air transportation where ground transportation is not feasible and transportation by private vehicle where no other means is available, including specially-equipped vehicle and ambulance) subject to available funding. NSHC may provide the above described patient transportation services in accordance with Section 213 of the Indian Health Care Improvement Act as amended at 25 U.S.C. § 1621*l*;

3.2.6 Specialty clinic support;

3.2.7 Sexual Assault Response Team (SART), including forensic exams and counseling of victims;

3.2.8 Comprehensive health care nursing services for the elderly, disabled and others needing long term health care services as defined by Section 205(a)(4) of the Indian Health Care Improvement Act, as amended, and in accordance with Section 205(c) of such Act. Such services will include but not be limited to the nursing facility services of Quyanna Care Center;

3.2.9 Emergency and minor surgery within the expected capability of Medical Practitioners;

3.2.10 Services associated with training medical students, residents, physician assistant students, nursing students, and allied health provider students from accredited institutions, under supervision of appropriate staff;

3.2.10.1 Physician coverage for services provided in the hospital and villages in person and through daily contact by telephone and/or video telemedicine equipment as needed with the physician assistants and/or Community Health Aides/Practitioners in the villages, and for teleradiology services;

3.2.11 Comprehensive, well person, emergency, acute and chronic care and preventive services at the subregional/community health centers and surrounding village clinics. These services include, but are not limited to, Early Periodic Screening, Diagnosis and Treatment (EPSDT), immunizations, maternal and child health services including family planning, prenatal care and case management of care provided to children and other high-risk individuals; urgent care services 24 hours a day; and specialty clinics, dental services, optometry services, diagnostic imaging services, laboratory services, and telemedicine, telehealth, telepharmacy, teleradiology, telepsychiatry services, dialysis, and mammography, colonoscopy and other cancer screenings, and cancer

treatment;

3.2.12 Diabetes prevention program, including community exercise and activity programs, such as "Summercise" programs, community health fairs, and water aerobics. As authorized under Section 204(d) of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621c, NSHC provides dialysis services and is committed to and shall provide quality dialysis services that will at all times meet standards applicable to such services;

3.2.13 Ancillary services will be maintained at levels sufficient to support medical diagnosis, including but not limited to physical therapy, smoking cessation, respiratory therapy, diagnostic imaging, laboratory, pharmacy, social services, nutrition services, and point of care testing;

3.2.14 Provide lodging for patients, family members of patients, and/or their escorts, including but not limited to housing at the patient hostel, and elder housing;

3.2.15 Coordination with, support of, and assistance to tribal and non-profit entities with their provision of health and social services; and

3.2.16 Provides training and continuing education for NSHC employees and NSHC beneficiaries, and, subject to availability of funding, provides limited financial support for NSHC beneficiaries to assist them to be prepared to pursue health related careers. NSHC also provides a nursing educational program.

3.3 Behavioral Health Services. Provides behavioral health services including, but not limited to:

3.3.1 Substance Abuse Services. Provide services to reduce and prevent substance abuse and associated problems through in/outpatient services, prevention/education, referral services, transitional/residential care services, outreach services, and community involvement, diagnostic and primary alcoholism and drug abuse treatment services, including individual assessment and referrals, individual and group counseling, detoxification services, case management, and substance abuse education classes and Alcoholics Anonymous and/or Narcotics Anonymous meeting sponsorship.

3.3.2 Mental Health Service. Provides professional and paraprofessional staff that travel within the Norton Sound Service Unit, and provides family, child, adolescent and community mental health programs. As needed, a psychiatrist provides mental health services in the hospital. Services include but are not limited to assessment and diagnostic services, individual and group therapy, crisis intervention services, suicide prevention and psychological testing, and telebehavioral health.

3.3.3 Village Based Counseling Program. Provides supportive counseling to identified clients, including abused children, children with behavioral health problems, families in crisis, adults and adolescents with substance abuse and/or mental health issues, and the chronically mentally ill. This program works in conjunction with the substance abuse and mental health program and includes the services of behavioral health aides.

3.3.4 Rainbow Services. Provides services to clients with developmental disabilities. The program assists clients to remain in their homes and communities by developing skills to increase self-control and participation in the community. When this is not possible, the

program assists families to find appropriate treatment and services outside the home for the client.

3.3.5 Transitional Living Services. Provides transitional living services, including residential programs, to assist clients in maintaining sobriety while attending outpatient substance abuse treatment, and after completion of treatment until the client is ready to return to his/her home community.

3.3.6 Fetal Alcohol Spectrum Disorder Prevention Services. Provides education and assistance regarding Fetal Alcohol Spectrum Disorder, targeting pregnant women with substance abuse issues to educate them about the effects of substance abuse on children and families.

3.3.7 Children's Services. Provides intensive outpatient behavioral health services to high risk clients with severe emotional problems ages 9-20 and their families. The program aims to help youth succeed at school, home and in the community while eliminating the need to send them elsewhere. Children's services also may include a full array of behavioral health prevention, early intervention, and treatment programs, including recreational and activity programs and residential and day camps. Providing culturally relevant services involving the community in the treatment process.

3.4 Other Health Services. Provides other health services, including but not limited to:

3.4.1 Dental Services. Provides services at the hospital and in field clinics to raise dental health and lower the incidence of dental disease. The field dental program offers visits to all the villages. Dental services may include dental health aide and dental health aide therapist, training, supervision, and services under the Standards and Procedures approved by the IHS Community Health Aide Program Certification Board.

3.4.2 Audiology. Audiology Services will be delivered, both at the hospital and through field clinics throughout the Norton Sound Service Unit.

3.4.3 Optometry Services. Optometry Services will be provided consistent with the needs of the patients, both in Nome and through field clinics throughout the region.

3.4.4 Village Health Services. Provides training, supervision and services of Community Health Aides/Practitioners (CHA/Ps) and the Clinic Travel Clerks who act as support staff to the village clinics. The Community Health Aide Program will be carried out under the Standards and Procedures approved by the IHS Community Health Aide Program Certification Board.

3.4.5 Health Aide Training. Provides Community Health Aide Program training to trainees from throughout Alaska.

3.4.6 Traditional and Alternative Medicine. Provides traditional healing-services in coordination with existing western medicine services; and alternative healing practices only upon a referral from a provider credentialed in accord with the standards cited in Section 8 of this FA.

These services will be provided in accordance with Section 831 of the Indian Health Care Improvement Act, amended at 25 U.S.C. § 1680u.

3.4.7 Emergency Medical Services. NSHC will maintain Emergency Medical Services (EMS) to lower the incidence of death and disability by providing air ambulance services. The NSHC departments also provide various levels of EMS and injury prevention training for staff and community members throughout the region. NSHC participates in EMS delivery in cooperative with community fire departments, other emergency response, and rescue services throughout the region.

3.4.8 Maternal and Child Health Program. Provides:

3.4.8.1 Prematernal home care for village women awaiting delivery in Norton Sound Regional Hospital;
3.4.8.2 Prenatal, family planning and newborn patient education; and
3.4.8.3 Assistance in risk screening and coordination of prenatal care.

3.4.9 Office of Environmental Health. Provides inspections of the hospital and clinics; technical assistance, training and research to help protect the public from illness and injury related to problems with water, waste, food, air, pests, safety, hazardous waste sites and bioterrorism. Technical assistance is provided to local, state and federal officials as necessary to assist with funding processes and the development of local environmental programs. Training is provided to regional water/wastewater operators and utility managers as needed to ensure safe operation and management of environmental systems.

3.4.10 Public Health Nursing. Provides public health nursing services, including but not limited to consultation to CHA/Ps in the villages, child health and developmental screening, prenatal care, EPSDT, school screenings, immunizations, and tuberculosis and other infectious disease screening and monitoring.

3.4.11 Research and Prevention. Participate in research activities to determine whether genetic factors predispose Alaska Natives to disease.

3.4.12 Home Care and Other Community Based Services. Through a combination of western methods and traditional modalities, provides home care and other community based services, which includes but is not limited to assistance with activities of daily living such as bathing, dressing, laundry, light housekeeping, cooking, vital signs, and medication reminders. These services are provided to all individuals throughout the Bering Straits region who are unable to perform their activities of daily living on their own, or when the families are unable to meet their needs. Home and Community Based Services also provides palliative care and other end-of-life services, such as hospice care, respite, chore, nutrition, transportation, and other supportive services including various senior programs and activities. Such services may also include Assisted Living Services. NSHC will provide home and community based services, hospice and assisted living in accordance with the requirements at § 205 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621d.

3.4.13 Nutrition Services for Women, Young Children, and Infants. Provides supplemental foods, and nutritional education, counseling and other services to women, infants and young children who are at nutritional risk.

3.4.14 Infant and Young Child Developmental Program. Provides services that promote growth and development of infants and young children. Children who qualify for services may have been born prematurely, have delays in their development, or have a diagnosed disability such as Down's syndrome or cerebral palsy. Other child development and family services include, but are not limited to, health-oriented education; socialization; health screening; growth and nutritional assessment; individualized culturally-appropriate child development services; family services; and family involvement.

3.4.15 Injury Prevention Services. Provides services to lower the incidence of death and disability, including but not limited to, the provision of safety information, equipment, and training.

3.4.16 HIV Services. Provides testing, referrals, data collection, and training end education.

3.4.17 Purchased/Referred Care Services. Purchases services, which are not otherwise available or accessible to eligible beneficiaries, on a contractual or open-market basis within funds available. NSHC agrees to be bound by 42 C.F.R. Part 136, subpart I, in the administration and provision of Purchased/Referred Care (PRC) services carried out under this Agreement. Accordingly, NSHC has opted to pay at Medicare Like Rates for PRC in accordance with that subpart of the regulations.

3.4.18 Morgue. Provides morgue services in each village.

3.5 Support Services. Support services required to support the provision of health services, including, but not limited, to plant operations, biomedical services, housekeeping and linen/laundry services, security (for patients and staff), human resources, information systems, administration and board support, corporate planner, grant management, compliance officer and performance improvement, material management (procurement, receiving, processing and distribution), central sterile supply, infection control/employee health, and financial, including business office functions, coding and medical records, planning and implementation of an electronic health records system, patient benefits coordinator, and the provision of staff housing.

3.6 Capital Projects. Provides technical assistance, planning, design, engineering, management and general contracting for construction, maintenance and operation of all facilities used by NSHC, including both federal facilities and those leased or owned by NSHC. This program also provides technical assistance and construction related services to other tribes and tribal organizations inside and outside NSHC's service area.

3.7 Village Built Clinic (VBC) Lease Program. Provides funds to eligible entities to

support the rental of CHA/P clinic space. NSHC will operate this program directly with all VBC lessees, who so elect, including the provision of support services and technical assistance. NSHC will ensure that each lessee is in compliance with the standards referenced in the VBC lease.

3.8 Public Health and Epidemiology. Directly and/or through ANTHC, including its Epidemiology Center,[2] NSHC carries out public health, epidemiology and health research functions. These activities include, but are not limited to: collecting and receiving personally identifiable health information for the purpose of

3.8.1 preventing or controlling disease, injury, or disability;

3.8.2 reporting disease, injury, and vital events such as birth and death; and

3.8.3 the conduct of public health and epidemiological investigations, surveillance, and interventions, including the maintenance of disease and injury registries.

3.9 Other Programs/Services Funded.

3.9.1 Generally. This FA includes programs, functions, services and activities resulting from tribal redesign, or consolidation, reallocation or redirection of funds, including its own funds or funds from other sources, provided that such consolidation, redesign, or reallocation or redirection of funds results in carrying out programs, functions, services and activities that may be included in the FA pursuant to section 505 of Title V and Article III, Section 6 [Consolidation with Other Programs] of the ATHC. This includes any other new health care programs, including, but not limited to, those identified in the Indian Health Care Improvement Act funded during the fiscal years.

3.9.2 Non-IHS Funding. NSHC will complement and supplement the PSFAs described throughout Section 3 [Tribal Programs and Budget] with funding from sources other than the IHS through this Funding Agreement, subject to the availability of such other funding sources. Consistent with Article III, Section 5 [Reallocation], 6 [Merging with Other Programs], and 7 [Program Income] of the ATHC, non-IHS funds will be added to or merged with funds provided by the IHS through this FA.

3.10 FTCA. The Federal Tort Claims Act applies to NSHC's PSFAs under this FA as provided in Section 516(a) of Title V (which incorporates Section 102(d) of Title I of the Act and Section 314 of P.L. 101-512). The extent of Federal Tort Claims Act coverage is described more particularly in 25 C.F.R. Sections §§ 900-180-900.210.

Section 4 – Amounts Available During the Term of the FA

4.1 The following amounts shall be available to NSHC pursuant to the ATHC and Title V of the Act and are subject to reductions only in accordance with Section 508(d) of Title V and Section 106 of Title I of the Act.[3]

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[2] The ANTHC Epidemiology Center was previously operated by the Alaska Native Health Board.

[3] A breakout of these funds is shown in Appendix A, which cites the source document used to determine the amount. These amounts are subject to change under the Act and as provided in this FA. For other fiscal

Recurring Base: Inclusive of all recurring funding, including recurring contract support funds and Village Built Clinic Funds of $425,417.[4]	$48,467,747
Non-recurring funds: inclusive of all non-recurring contract support funds and such other funding which may be added to the contract.[5]	$13,954,404
Subtotal: (This amount is subject to amendments in accordance with Section 14 [Amendment or Modification of this FA])[6]	$62,422,151
Area "Tribal" share to include funding identified from the Area Office and identified in Appendix A to this Agreement.[7]	$1,031,630
Headquarters-tribal share: "Tribal Size Adjustment Pool," including all funds identified in Appendix A. The amount identified is exclusive of funds for which distribution amount has not been determined. The final amount due shall be determined as set forth in this FA or Appendix A.[8]	$731,037
Headquarters-Tribal share: "Program Formula Pool" – to include all funds identified in Appendix A, and such additional funds which the IHS may make available on a program formula basis during the year based on the programs accepted for this allocation in Appendix A.	$0

years to which this FA may be applicable, the replacement Appendix A will be negotiated between IHS and NSHC for the respective year and amended to this FA and incorporated by reference, accordingly.

4 A breakout of these recurring costs is found in Appendix A, fully incorporated herein and citing the actual documents used to determine the amount. *See* Footnote 3.

5 These non-recurring funds include contract support costs and routine Maintenance and Improvement funds available at the beginning of the fiscal year. *See* Footnote 3.

6 The Radiologist Consultation funds in the amount of $195,131 and Biomed funds in the amount of $67,102 are not included in this amount (neither of these amounts include any adjustments for mandatory increases). These recurring funds and any mandatories associated with them are in the ANTHC FA and will be negotiated annually as a flow-thru from the ANTHC, in accordance with the interpretation of Section 325 of P.L. 105-83 by the IHS.

7 Funds from the Alaska Area were distributed according to methods agreed upon in a caucus open to all Alaska Tribes and tribal organizations. The specific methodology is identified in Appendix A.

8 Headquarters tribal shares were allocated according to the following process, which was adopted in a caucus open to all Alaska tribal organizations: The Alaska Area Tribal shares of Headquarters was first defined using the national IHS recommended methodology. The total Alaska Area Tribal shares was then reallocated to each Co-Signer according to the agreed upon Alaska Area methodology, which is identified specifically for each line in Appendix A.

Subtotal – Tribal Shares[9]	$1,762,667
TOTAL ATHC FUNDING	**$64,184,818**

These amounts are subject to additions for other reimbursements, and for new funds received during the term of this Agreement including amounts that have historically been distributed as non-recurring funds under the Act. Any amounts remaining unspent under the prior FA, after adjustments and services, as of the previous fiscal year, shall be included and spent under this FA.

Of the amount shown above for non-recurring program funds, $1,211,108 are for Routine Maintenance and Improvement (M&I); the Routine M&I amount paid as a part of the lump sum due NSHC was determined by multiplying the FY 2017 Routine M&I amount paid to the Co-Signer by 90%. The final Routine M&I amounts paid in FYs 2018-2020 will be based on the final 2018-2020 Routine M&I allocations. If the final Routine M&I amounts, as determined by the final FYs 2018-2020 Routine M&I allocations, is less than the 90% calculation, NSHC will return the difference to the IHS. See also Appendix A, footnote to line 19 on page 6.

Of the amount shown above for Headquarters Tribal Share "Program Formula," $141,878 are for Equipment Replacement, the Equipment Replacement amount paid as part of the lump sum due NSHC was determined by multiplying the FY 2017 Equipment Replacement amount paid to NSHC by 90%. The final Equipment Replacement amounts paid in FYs 2018-2020 will be based on the final FYs 2018-2020 Equipment Replacement allocations. If the final Equipment Replacement amounts, as determined by the final FYs 2018-2020 Equipment Replacement allocations, is less than the 90% calculation, NSHC will return the difference to the IHS. See also Appendix A, footnote to line 22 on page 6.

The Recurring Base amount shown above includes $291,158 that NSHC received, recurring in FY 2006 for Congressionally earmarked alcohol funds. Such funds are subject to "Adjustments Due to Congressional Actions" as described herein in Section 6 as well as any conditions on those funds that may be described in the FYs 2018-2020 Interior Appropriations Acts (Act) or Congressional Reports. After each Act is passed into law, such conditions, including Congressionally-directed reporting requirements, will be added by amendment not requiring NSHC's signature as described in Section 14 [Amendment or Modification of this FA].

The parties agree Section 505(b)(2) of Title V provides, among other things, that grants administered by the Department of Health and Human Services through the IHS may be added to NSHC's FA after award of such grants. In accordance with this provision of Title V and its implementing regulations, the Secretary will add NSHC's diabetes grants and any other statutorily mandated grant(s) administered by the Department through the IHS to this FA after such grant(s) have been awarded. Grant funds will be paid to NSHC as a lump sum advance payment through the PMS grants payment system as soon as practicable after award of the grant. NSHC will use interest

[9] The subtotal of Tribal shares does not include certain Headquarters for which the amount or availability has not been determined. This amount will be adjusted to make available all Tribal shares for which NSHC is eligible. IHS will pay mandatory increases on some Headquarters Tribal shares, subject to appropriations.

earned on such funds to enhance the purposes of the grant including allowable administrative costs. NSHC will comply with all terms and conditions of the grant award, including reporting requirements, and will not reallocate grant funds nor redesign the grant program, except as provided in the implementing regulations or the terms of the grant.

4.2 Contract Support Costs. Contract support costs (CSC) will be paid in accordance with 25 U.S.C. § 5325 and § 5388(c). The parties agree that, according to the best data available as of the date of execution of this agreement, the amount to be paid under FY 2018, which represents the parties' estimate of the Tribe's full CSC requirement pursuant to 25 U.S.C. § 5325, is $16,798,500, including $4,197,082 for direct CSC and $12,601,418 for indirect or indirect-like CSC.[10] This estimate shall be recalculated as necessary as additional data becomes available including information regarding the direct cost base, pass throughs and exclusions, and the indirect cost rates to reflect the full CSC required under 25 U.S.C. § 5325. The parties will cooperate in updating the relevant data to make any agreed upon adjustments. In the event the parties disagree on the CSC amounts estimated and paid pursuant to this paragraph and the Tribe's full CSC requirement under the ISDEAA, the parties may pursue any remedies available to them under the ISDEAA, the Compact, and the Contract Disputes Act, 41 U.S.C. §7101 et seq.

4.3 Base Budgets.

4.3.1 Categories and Base Year. At the end of the first period of the base budget option, the IHS and Co-Signers agreed to extend the three year (FY1998-FY2000) base budgets implemented for the ATHC for an additional two years (FY2001-FY2002). IHS and NSHC have subsequently agreed to additional extensions through FY 2009. The IHS and Co-Signers have agreed to further extend the base budget period at the Co-Signer's option. The following categories are subject to base budgeting for the base year period and the period, as noted below.

Category of Funding	Base Period for Base Funding	Extended through:
Headquarters TSA amounts[11]	FY 97	FY 2020
Equipment Replacement Funding	Not Included	N/A
Area Tribal Share	Not Included	N/A

4.3.2 Adjustments. Adjustments to base funding shall be permitted in direct proportion to changes in appropriated amounts (by sub-activity), as provided under Section 6.1 of this FA titled "Adjustments, Due to Congressional Actions." Adjustments shall also be permitted for the addition of new Co-Signers to the ATHC and when current Co-Signers add or retrocede PSFAs,

10 For other fiscal years to which this FA is applicable, the CSC estimates will be negotiated between the IHS and NSHC for the respective year and amended to this FA in Appendix A.

11 ATHC base budgets for TSA amounts shall be considered as a whole (entire ATHC amount) and shall be subject to adjustment of the internal allocation subject to ATHC agreements.

as provided in Section 14.4 [Due to Addition of New Programs].[12] Adjustments also shall be permitted when Co-Signer chooses to restrict or un-restrict previously "restricted" or "un-restricted" categories, provided that restrictions shall be changed only during annual negotiations. NSHC shall also be eligible for funding for new service increases, mandatories, specific Congressional appropriation for population growth, health services priority system, contract support costs and other increases in resources on the same basis as all other Tribes. Adjustments for changes required when a Tribe joins or withdraws from a Tribal consortium shall also be permitted, as provided under Section 10.3 [Withdrawal Procedures] of this FA. Co-Signers shall also remain eligible for the distribution of additional Tribal shares for Assessments, Workers Compensation, Emergency Reserve, Management Initiatives, and other PSFAs from Headquarters.

Section 5 – Methods of Payment.

5.1 Payment Schedule. Except as provided in subsection 5.2 [Availability of Tribal Shares], 5.3 [Buyback/Withholding], and 5.4 [Periodic Payments] of this Section, all funds identified in Section 4 [Amounts Available During the Term of the FA] of this FA shall be paid to NSHC, in accordance with Article II, Section 4(a) [Payment Schedule] of the ATHC; payment to NSHC to be made as follows: One annual lump sum payment to be made in advance.

5.2 Availability of Tribal Shares. NSHC will be paid 100 percent of Headquarters and Area Tribal Shares in its initial lump sum payment, as negotiated in this FA, for each year under the term of this FA.

5.3 Buyback/Withholding. NSHC may carry out its responsibility to provide certain PSFAs included in this FA by using services or other resources of the Federal government under Article V, Section 22 [Purchases from the IHS] of the ATHC, as permitted by law. Except as provided herein, the cost of such services and the terms under which they may be available to NSHC are set forth in the Buyback/Withhold Agreement between the IHS and NSHC, which is attached as Appendix D to this FA and incorporated by reference herein. The administrative surcharge provided for in Section 2.2.4 of the Buyback/Withhold Agreement for FY 2018 shall be .285 percent. During the term of this FA, the Administrative surcharge rates will be negotiated annually. Notwithstanding Section 5 of the Buyback/Withhold Agreement, upon the request of the IHS or any Co-Signer, such FA will be negotiated for future fiscal years annually during negotiation of this FA.

5.4 Periodic Payments. Payment of funds otherwise due to NSHC under this FA, which are added or identified after the initial payment is made, shall be made promptly upon request of NSHC by check or wire transfer.

Section 6 – Adjustments.

[12] This includes addition of new facilities when the addition of these facilities includes an increase in equipment funds identified for the new facilities.

6.1 Due to Congressional Actions. The parties to this FA recognize that the total amount of the funding in this FA is subject to adjustment due to Congressional action in appropriations Acts or other law affecting availability of funds to the IHS and the Department of Health and Human Services. Upon enactment of any such Act or law, the amount of funding provided to NSHC in this FA shall be adjusted as necessary, after NSHC has been notified of such pending action and subject to any rights which NSHC may have under this FA, the ATHC, or the law.

6.2 Proposals by Authorizing Tribes. Should any authorizing Tribe assume responsibility for PSFAs (or portions thereof) under a contract or annual FA pursuant to the Act, adjustment to funding amounts under this FA will be negotiated.

Section 7 – Records.

7.1 Incorporation of the Privacy Act. Pursuant to Section 506(d)(1) of Title V, records acquired, generated or maintained by NSHC shall not be treated as Federal records under chapter 5 of title 5 of the United States Code, except that:

7.1.1 Patient medical, financial records and personnel records may be disclosed only in accordance with 5 U.S.C § 552a(b); and

7.1.2 Medical records generated by NSHC shall be eligible for storage in Federal Records Centers at NSHC's option in accordance with Section 105(o) of Title I.

7.2 Confidentiality Standards. NSHC will seek to comply with the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including, but not limited to, privacy, security, transactions, and code set regulations, codified at 45 CFR Parts 160, 162, and 164. If a record is not subject to HIPAA, NSHC will maintain the confidentiality of its records in accordance with policies and procedures adopted by its Governing Body, which will be consistent with the purposes and guidelines of HIPAA and the Federal Privacy Act of 1974.

7.3 Quality Assurance Records. NSHC operates a medical quality assurance program and treats the records of such program as confidential and privileged in accordance with section 805 of the Indian Health Care Improvement Act as amended at 25 U.S.C. § 1674.

Section 8 – Program Rules.

NSHC in carrying out the PSFAs in this FA agrees to comply only with those guidelines, manuals, and policy directives that are listed below: Joint Commission (formerly known as JCAHO) standards, as applicable, and Community Health Aide/Practitioner certification standards.

Except as specifically set forth in this Section, pursuant to Section 517(e) of Title V, NSHC does not agree to be subject to any agency circular, policy, manual, guidance or rule adopted by the IHS, except for the eligibility provisions of Section 105(g) and the regulations promulgated under Section 517 of Title V, unless otherwise waived.

Section 9 - Real Property Reporting Requirements

9.1 Leases. The IHS must report on its federally leased facilities. NSHC agrees to notify the AANHS of changes of occupancy, size, use, and general condition of Village Built Clinic (VBC) leased facilities in locations where NSHC has bought back services from the IHS. IHS will annually, or upon renegotiation, provide to NSHC a copy of each VBC lease. No increase in the amount due to the lessor pursuant to a lease will be negotiated by IHS without advance notice to NSHC. In administering these leases, the IHS will work with NSHC to ensure that each lease is in compliance with the standards referenced in the VBC lease.

9.2 Maintenance and Improvement Funds. NSHC agrees to use maintenance and improvement funds received through this FA in accordance with the appropriation language for Indian Health Facilities in the Department of Interior and Related Agencies Appropriation Act for FYs 2018-2020 or any comparable Act of Congress that contains the subject appropriation and in accordance with 41 U.S.C. § 12 to the extent applicable.

Section 10 – Services to Non-Beneficiaries.

Section 813 of the Indian Health Care Improvement Act, as amended, 25 U.S.C. 1680c, (Section 813), authorizes the governing body of a Tribal Organization carrying out health services of the IHS under the Indian Self-Determination and Education Assistance Act to determine whether health services should be provided under the Tribal Organization's FA with the IHS "to individuals who are not eligible for such health services under any other subsection of this section or under any other provision of law", 25 U.S.C. 1680c(c). The NSHC Board of Directors has made such determination consistent with Section 813, and provides for its findings in Resolution No. 2010-16. Resolution No. 2010-16 is attached as Appendix E and incorporated by reference herein. NSHC may provide services under this FA to "non-beneficiaries" as described in Resolution No. 2010-16. In addition services may be provided to U.S. Public Health Service Commissioned Corps Officers and their dependents.

Section 11 – Retrocession and Discontinuance.

11.1 Retrocession. The retrocession provisions of Section 506(f) of the Act are herein adopted, except that the effective date from a retrocession request of the ATHC and FA, in whole or in part, shall be one year from the date of the request by an authorizing Tribe or Village, except as provided below. Retrocession may be effective with less then one years notice, providing the Tribe or Village requesting retrocession, NSHC and the IHS agree to an effective date of less than one year from the date of retrocession request.

11.2 Discontinuance. NSHC may discontinue its participation in the ATHC after written notice to each authorizing Tribe or Village and the IHS. Notice must be provided one year in advance of the effective date of the request except that the effective date of a request may be less than one year upon approval of all authorizing Tribes and Villages and the IHS.

11.3 Withdrawal Procedures.

11.3.1 Process. Unless prohibited by law and in accordance with § 506(g) of Title V, an Indian tribe may fully or partially withdraw from a participating inter-tribal consortium or tribal organization its share of any program, function, service or activity (or portions thereof) included in the ATHC or FA, and any such withdrawal will become effective within the time frame specified in the resolution which authorized transfer to the participating inter-tribal consortium or tribal organization, provided that in the absence of a specific time frame being set forth in the resolution, such withdrawal shall become effective on -

11.3.1.1 The earlier of

11.3.1.1.1 One year after the date of submission of such request; or

11.3.1.1.2 The date on which the FA expires, or

11.3.1.2 Such date as may be mutually agreed upon by the Secretary, the withdrawing Indian tribe, and the participating tribal organization or inter-tribal consortium that has signed the ATHC or FA on behalf of the withdrawing Indian tribe, inter-tribal consortium, or tribal organization.

11.3.2 Distribution of Funds. In accordance with Sections 503(b) and 506(g) of the Act, when a tribe proposing to enter into a contract under Title I or a compact and FA under Title V fully or partially withdraws from a participating tribal organization, the withdrawing Tribe shall, upon written request, be entitled to be paid its tribal share of funds supporting those PSFAs (or portions thereof) which it will be carrying out under its own contract or compact and FA, and such funds shall be removed from the FA of the tribal organization and awarded to the Tribe upon approval of a Title I contract or compact and FA. The IHS shall retain any funds removed, but not awarded in a Title I contract or compact and FA.

Section 12 – Memorandum of Agreement with Member Village.

Funds provided under this FA may be allocated to and expended by an Alaska Native Village ("Village") which is party to this FA in accordance with the terms of the ATHC, this FA and a Memorandum of Agreement (MOA) approved by NSHC and the Village. The Federal Tort Claims Act shall apply to PSFAs carried out by the Village under such MOA and to the Village and its employees to the same extent as if they had been carried out directly by NSHC. Such an MOA may include provisions for the assignment of federal employees under IPA assignment or Commissioned Corps detail. Such assignment shall be subject to the approval of the AANHS Director. NSHC shall be responsible for assuring compliance by the Village with the ATHC, this FA and the MOA.

Section 13 – Consolidation of Contract and Previous Annual FAs.

The contracts listed below and all previous Annual FAs shall be amended or terminated, as appropriate to transfer applicable contract funds into this FA for services, materials and activities, programs, functions and facilities provided to the Tribes represented by NSHC: Title I, P.L. 93-638 Contract #243-89-0011, as modified.

Section 14 – Amendment or Modification of this FA.

14.1 Form of Amendments. Except as otherwise provided by this FA, the ATHC, or by law, any modifications of this FA shall be in the form of a written amendment and shall require written consent of each of the signatory Tribes, acting directly or through NSHC as authorized by resolution, the NSHC, and the United States. Participation or written consent of Tribes and Co-Signers not subject to the terms of this FA shall not be required.

14.2 Funding Increases.

14.2.1 Written consent of NSHC shall only be required for issuing amendments for those funds which:

14.2.1.1 require a change to Section 3 [Tribal Programs and Budget];

14.2.1.2 require a specific commitment by NSHC (*e.g.*, Maintenance & Improvement projects and prior fiscal year Sanitation Facility Construction projects); or

14.2.1.3 reduce funding other than changes in Congressional appropriations pursuant to Section 6.1 [Adjustments Due to Congressional Actions].

14.2.2 Amendments not requiring written consent may include, but are not limited to:

14.2.2.1 Program/Area/HQ Mandatories;

14.2.2.2 Program/Area/HQ End-of-Year Distributions;

14.2.2.3 CHEF, subject to the condition that if a case initially qualifying for reimbursement is paid (in whole or in part) by an alternate resource or cancels for any reason, NSHC will return the unused amount to the IHS CHEF account;

14.2.2.4 PRC Deferred Services;

14.2.2.5 Routine Maintenance & Improvement; or

14.2.2.6 Collections and reimbursements.

14.2.3 Amendments reflecting payment of these funds shall be provided to NSHC after any such funds are added to the FA. NSHC retains the right to reject the addition of such funds to the FA and return the funds to the IHS.

14.3 Services from IHS. Should NSHC determine that it wishes the IHS to provide PSFAs included in this FA for which funding has been identified but not provided, the parties shall negotiate an amendment to the FA to reflect the transfer of responsibilities from NSHC back to the IHS and the pro-rata share of funding for that program, services, function or activity shall be retained by the IHS. Unless otherwise negotiated, IHS will not transfer centrally paid expenses including but not limited to Workers Compensation to any ATHC Co-Signer.

14.4 Due to the Addition of New Programs. Should NSHC determine that it wishes to provide a program, service, function or activity of the IHS not included in this FA, NSHC shall submit a proposal to the IHS to provide such program, service, function or activity. The parties agree to negotiate such a proposal and, should the parties fail to reach agreement, NSHC may submit a final offer in accordance with the Title V procedures set forth in Sections 507(b)-(d) of Title V. A

proposal submitted pursuant to this section shall be treated as a request for amendment to the FA and, once approved by the IHS, the Alaska Area Office shall prepare within 30 days an amendment to this FA and the amendment shall be executed through the Area Office and added to the FA.

14.5 Due to Availability of Additional Funding. NSHC shall be eligible for any increases in funding or funding for Medicaid, Medicare, maintenance and improvement, other reimbursements and new programs for which it would have been eligible had it been administering programs under a self-determination contract, rather than under the ATHC and this FA, and for any other funds that are not restricted by appropriations language for which any Alaska Tribe or tribal organizations may be eligible, including any new funds appropriated for IHS Headquarters and funds passed to Alaska Area as recurring or non recurring funds, and this FA shall be amended to provide for timely payment of such new funds to NSHC. Such amendment shall be originated and prepared within 30 days by the Alaska Area Office and executed through the Area Office in consultation with the Co-Signer.

14.6 Other Adjustments. Upon written authorization by NSHC and agreed to by the IHS, the IHS may reallocate funds retained by the IHS, which are obligated to NSHC, for the purpose of reimbursing the IHS for services or equipment provided to NSHC to assist NSHC in carrying out the terms of the ATHC and this FA.

14.7 General Procedures for Amending or Modifying this FA. Amendments or modifications proposed by NSHC shall be submitted in writing to the IHS Alaska Area Director with a copy to the Office of Tribal Self Governance at IHS. Except as provided with respect to the incorporation of a provision of Title I under Article V, Section 21 [Applicability of Title I Provisions] of the ATHC, or as provided above in paragraphs .1, .2, .3 and .4 of this Section 14 [Amendment or Modification of this FA], a request to amend or modify this FA submitted by NSHC shall be processed in accordance with Sections 507(b)-(d) of Title V and all provisions of those identified sub-sections are incorporated herein for this purpose.

Section 15 – Third Party Recoveries.

Any funds recovered by NSHC through the filing, litigating, or settling a claim against a third party to require that third party to pay for services previously provided to IHS-eligible beneficiaries by NSHC, or for such services previously provided by the IHS in a PSFA now operated by NSHC, shall be the property of the Co-Signer and shall be considered program income to be utilized by NSHC as provided in Article III, Section 7 [Program Income] of the ATHC. Any prospective recovery of funds for such services shall likewise be considered program income to be utilized pursuant to Article III, Section 7 [Program Income] of the ATHC.

Section 16 – Severability.

This FA shall not be considered invalid, void or voidable if any section or provision of this FA is found to be invalid, unlawful or unenforceable by a court of competent jurisdiction. Should such a court make such a finding, the parties will seek agreement to amend, revise or delete any such

invalid, unlawful or unenforceable section or provision, in accordance with the provisions of the ATHC.

Section 17 – Memorializing Disputes.

The parties to this FA may have failed to reach agreement on certain matters which remain unresolved and in dispute. Such matters may be addressed through the process set forth in Sections 507(b)-(d) of Title V, or, at the option of NSHC, may be set forth in Addendum II to this FA, which shall be identified as "Memorialization of Matters Remaining in Dispute." This attachment shall not be considered a part of this FA but is attached for the purpose of recording matters in dispute for future reference, discussion and resolution as appropriate. The NSHC does not waive any remedy it may have under the law with regard to these issues and any others not listed herein.

Section 18 – Title I Provisions Applicable to This FA. As authorized in 25 U.S.C. § 5396(b), NSHC exercises its option to include the following provisions of Title I of the Act as part of this FA, and these provisions shall have the force and effect as if they were set out in full in Title V of the Act.

18.1. 25 U.S.C. § 5304(e) (definition of "Indian Tribe");

18.2. 25 U.S.C. § 5322(b) (related to grants for health facility construction and planning, training and evaluation);

18.3. 25 U.S.C. § 5322(d)(1) (related to duty of IHS to provide technical assistance);

18.4. 25 U.S.C. § 5324(a)(1) (exemption from Federal procurement and other contracting laws and regulations);

18.5. 25 U.S.C. § 5328(b), (conflicting provisions of law);

18.6. 25 U.S.C. § 5329(c), section 1(b)(8)(F) (screener identification);

18.7. 25 U.S.C. § 5329(c), section 1(b)(9) (availability of funds);

18.8. 25 U.S.C. § 5329(c), section 1(d)(1)(B) (construction of contract);

18.9. 25 U.S.C. § 5329(c), section 1(d)(2) (good faith).

Section 19 – Exemption from Licensing Fees.

In accordance with Section 124 of the IHCIA, as amended at 25 U.S.C. 1616q, employees of the NSHC health programs shall be exempt from payment of licensing, registration, and any other fees imposed by a federal agency to the same extent that officers of the Public Health Service commissioned corps and other employees of the Indian Health Service are exempt from such fees.

Section 20 – Licensure.

Licensed NSHC health professionals will be licensed in accordance with section 221 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621t.

Section 21 – Purchase of Health Coverage.

NSHC may use federal funds for purchase of health care coverage in accordance with section

402 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1642.

Section 22 – Medicare & Medicaid Reimbursements.

22.1 Medicare & Medicaid. NSHC has elected to directly collect Medicare and Medicaid payments as provided in 25 U.S.C. § 1641, as amended. NSHC is obligated and entitled to directly collect and retain reimbursement for Medicare and Medicaid and any other third party payers for services provided under this Agreement in accordance with section 401 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1641 and section 206 of such Act, 25 U.S.C. § 1621e, as amended.

22.2 Recovery Right. NSHC has the right to recover reimbursement from certain third parties of the reasonable charges for health services in accordance with section 206 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621e.

Section 23 – Federal Insurance. IHS will assist NSHC to obtain information about the coverage, rights and benefits available for its employees under chapters 87 and 89 of title 5, United States Code, the cost of such coverage, rights and benefits (including any options in coverage, rights and benefits that may be available), and the procedures by which NSHC may exercise its rights under Section 409 of the IHCIA, as amended, to have access to such Federal insurance for its employees.

Section 24 – Environmental and Cultural Resources. The National Environmental Policy Act (NEPA), National Historic Preservation Act (NHPA), and related provisions of law require the IHS to review and approve actions resulting in the use or commitment of IHS funds or that affect IHS property, and which may significantly impact the environment or cultural resources. Unless NSHC has assumed these responsibilities under a construction project agreement in accordance with Section 509 of Title V and 42 C.F.R. § 137.285-312, the IHS must carry out these responsibilities and has elected to utilize Appendix H. Where NSHC plans to undertake an action, as described in Appendix H, on IHS owned real property or utilizing IHS funds received through this Funding Agreement, and NSHC has not assumed these responsibilities, NSHC will provide the IHS with a Project Summary Document (see Appendix F) and a completed Environmental Information and Documentation Form (see Appendix G) so that the IHS can accomplish these requirements, and issue a Determination Document (Categorical Exclusion (CATEX) or Finding of No Significant Impact (FONSI)), as soon as possible. All documentation shall be submitted to the IHS as early as possible in the planning phase of the project to prevent delays in the action. No irreversible action can be taken by NSHC until the IHS completes its compliance responsibilities and so advises NSHC with a Determination Document. Pending resource availability, the IHS is available for education and consultation on NEPA, NHPA, and related provisions of law on an as needed basis.

Section 25 – Effective Date and Duration.

This Funding Agreement becomes effective on October 1, 2017, and will remain in effect through the 2020 Federal Fiscal Year or until a subsequent agreement is negotiated and becomes effective pursuant to Article II, Section 12 [Subsequent Funding Agreements] of the ATHC.

United States of America
Secretary of Department of Health and Human Services

By: P. Re Sta
Director, Indian Health Service

Date: 6-14-2019

Norton Sound Health Corporation On Behalf of Itself and Certain Alaska Native Tribes, Identified in Exhibit A of the Compact.

By: Angie Gorn
Angie Gorn
President/CEO

JUN 14 2019

Date:

FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

Amendment Effective October 1, 2018

In accordance with Section 14.1 of the Norton Sound Health Corporation (NSHC) FYs 2018-2020 Multi-Year Funding Agreement (MFA), NSHC's MFA is hereby amended as follows:

1. Section 3.2.9 is amended as follows: "Emergency surgery, and minor and other outpatient day surgery, within the scope of qualified ~~expected capability of~~ Medical Practitioners;"

2. Section 3.3.4 is amended to change the title from "Rainbow Services" to "Developmental Disability Program."

3. Appendix B, the list of facilities in which Norton Sound is carrying out health services, is amended as follows:

   In the portion pertaining to "Nome and all Villages," change the Facility Name to add the underlined language: "staff housing owned/rented including "Lawyer's apts," St. Michael Triplex, Golovin 2-bedroom home, and Savoogna duplexes".

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

By: Angie Gorn
Angie Gorn, President/CEO

6/4/2019
Date

United States of America
Secretary of
Department of Health and Human Services

By:
Director, Indian Health Service

8/2/2019
Date

FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

In accordance with Section 14.1 of the FYs 2018-2020 Funding Agreement made and entered into by Norton Sound Health Corporation (NSHC) and the Secretary of the Department of Health and Human Services of the United States of America, effective October 1, 2017, the Funding Agreement, as amended, is hereby further amended as follows:

1. **Appendices.** The following appendices are incorporated by reference and attached:

   - Appendix A (Financial Summary Agreement) FY 2021
   - Appendix B (Facility List) FY 2021

2. **Effective Date**. This amendment is effective October 1, 2020.

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

Angie Gorn

By: _____ 4/30/2021
Angie Gorn, President/CEO Date

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S Digitally signed by Evangelyn L. Dotomain -S Date: 2022.03.11 16:22:11 -09'00'
Alaska Area Director, Indian Health Service Date

Norton Sound Health Corporation

Appendix A - Financial Summary Tribal Shares Funding Agreement - FY 2021

Tribal Share Summary Norton Sound Health Corporation	FY 2021 Negotiated Amount	NSHC Restricted	Total Due NSHC	Initial Lump Sum Payment
Area TS Amount	$1,094,886	$45,473	$1,049,412	$1,049,412
	0		0	0
Subtotal Area TS Amount	$1,094,886	$45,473	$1,049,412	$1,049,412
Headquarters TSA Amount	$828,953	$93,107	$735,846	$735,846
Headquarters Other Program Formula (OEHE)	$48,412	$48,412	$0	$0
Subtotal Headquarters TS amounts	$877,365	$141,519	$735,846	$735,846
Total Tribal Shares	$1,972,250	$186,992	$1,785,258	$1,785,258

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Driving Variables Norton Sound Health Corporation	FY 2021
Population (2010 Census AN/AI population)	7749
Tribes (Federally Recognized Tribes)	20
Recurring Base - FY 2013 (less VBC)	$34,794,479
Percentage of Total Area TS (of all Alaska Tribes)	8.12295%
Percentage of ATHC (of all Title V Alaska Tribes)	8.22359%
Number of MOA employees	3
Number of IPA employees	0

Individually Restricted Items Norton Sound Health Corporation	FY 2021
Area Office (Individual Restricted Only)	
Supply Service Center	YES
Emergency Medical Services	NO
Village Clinic Leasing Management	YES
Headquarters (ATHC Restricted Only)	
ACOG	YES
OIT - Negotiated Alaska Plan	YES
Clinical Sup. Ctr. (Inc. CME Cert.)	YES

Appendix A - Financial Summary for Funding Agreement-Area Tribal Shares
Norton Sound Health Corporation

Line #	FY 2021 Budget Activity/Service	Total Area Budget	Residual Amount	ATHC restricted		Total AO Tribal Shares	NSHC AK Dist.	NSHC Retained	NSHC Total TS Due
				Trans. Fed.	ANTHC				
		(Column 1)	*(Column 2)*	*(Column 3)*	*(Column 4)*	*(Column 5)*	*(Column 6)*	*(Column 7)*	*(Column 8)*
1	TRIBAL SHARE FUNDS	$11,900,108	$0		$0	$11,900,108	$966,640		$966,640
2									
3	AREA OFFICE PFSAs (excluding OEHE)								
4	Area Office PFSA's	$4,193,809	$2,442,960	$681,500	$1,069,349	$0	$0		$0
5	Lease Costs-	$1,657,267	$185,820	$193,220	$1,278,227	$0	$0		$0
5a	Space Costs- negotiations	$19,000	$0	$19,000					
6	Area Director's Reserve	$100,000	$0	$100,000	$0	$0	$0		$0
7	Headquarters Assessments	$488,590	$54,720	$230,202	$203,668	$0	$0		$0
8	Human Resources	$849,441	$210,962	$356,311	$282,168	$0	$0		$0
9	Human Resources (ANMC) funds	$0	$0	$0	$0	$0	$0		$0
10	Area PFSA transferred to ANTHC	$3,028,546	$0	$0	$3,028,546	$0	$0		$0
11	CHC Reserve	$1,555,064	$0	$0	$1,555,064	$0	$0		$0
12	Area Managed Care	$723,423	$0	$0	$723,423	$0	$0		$0
13	ANHB (inc. tobacco funds)	$389,983	$0	$0	$389,983	$0	$0		$0
14	Supply Service Center	$853,749	$0	$0	$335,598	$518,151	$42,089	$42,089	$0
15	Epidemiologists	$196,885	$0	$0	$0	$196,885	$15,993		$15,993
16	EMS program at ANMC	$195,140	$0		$0	$195,140	$15,851	*$0*	$15,851
17	Centers for Disease Control	$282,902	$0	$0	$282,902	$0	$0		$0
18	Subtotal Area PFSAs (ex. OEHE)	$14,533,798	$2,894,462	$1,580,233	$9,148,927	$910,176	$73,933	$42,089	$31,844
19									
20	OFFICE OF ENVIRONMENTAL HEALTH AND DESIGN								
21	Office of Envir. Hlth and Eng.-.(EH	$5,961,749	$244,466		$5,127,476	$589,807	$47,910		$47,910
22	Real Property/Realty (FSA)	$148,888	$92,682		$14,547	$41,659	$3,384	$3,384	$0
23	Health Facilities/Main./ Spec. Pro	$1,368,036	$114,204		$1,216,669	$37,163	$3,019		$3,019
24	Subtotal OEHE	$7,478,673	$451,352	$0	$6,358,692	$668,629	$54,312	$3,384	$50,928
25	**TOTAL AREA OFFICE**	$33,912,579	$3,345,814	$1,580,233	$15,507,619	$13,478,914	$1,094,886	$45,473	$1,049,412

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General Notes on Alaska Area Office Tribal Shares

Column 1 - Includes all FY17 changes allocated to TS, Residual, & Transitional as of FY17. In FY 2019 TS changes will be added as received.

Column 2 - Residual includes no changes in residual functions. Based on FY2018 Area approved residual budgets.
Remaining funds at 9/30 distributed (Non-Recurring) to all Alaska Area health programs based on recurring base.

Column 3 - Transitional funds agreed by co-signers to remain at Area Office. Based on FY2018 approved transitional budget.

Column 4 - Restricted by all co-signers & transferred to the ANTHC to provide "Area PSFAs" .

Column 5 - Includes Area TS for all Alaska Tribes, including Title I & Title V. FY19 mandatories to be added if received.

Column 6 - Available Tribal shares for Co-Signer (amounts for ANTHC include pass-through to awardees with shares captured by Sec. 325).
Distributed by the approved ATHC methodology of - 30% # of Tribes / 35% 2010 Census Pop. / 35% 2013 Rec. Base (less VBC).
All Area TS for Services line items will be recurring, Area TS for Facilities will be non recurring.

Column 7 - Items restricted by individual co-signer to pay for continued services from ANTHC. (Restricted amounts are added to ANTHC FA.)

Column 8 - The agreed upon amount due (col. 6 - col. 7) to the co-signer after all retained shares are withheld.

Line 1 - All TS funds for non-OEHE Area Office PSFAs except where co-signers have individually decided to retain certain PSFAs at the ANTHC or AANHS.

Line 5 - Lease on Inuit Building.

Line 5a - $20,000 (less sequester) from transitional funding held by IHS to rent space for annual negotiations. Funds transferred to ANTHC upon confirmation of space availa

Line 7 - Centrally paid expenses, including personnel & finance support for Area positions, costs & funds for departmental assessments.

Line 8 - Area Human Resources functions (previously Office of Personnel & Training).

Line 9 - Funding originally from ANMC - have all been returned to SCF/ANTHC as IPA/MOAs were reduced.

Line 10 - Includes funding for Area PSFAs transferred to ANTHC under Section 325.

Line 11 - Funds to ANTHC to support the statewide Contract Health Services reserve program.

Line 12 - Funds to ANTHC to support specialized services in Barrow, NSHC, & BBAHC & certain statewide laboratory contracts.

Line 13 - ANHB funds from Loc 77 including previous tobacco prevention funding.

Line 14 - Supply Service Center individually withheld amounts retained for ANTHC for all co-signers except YKHC, Seldovia, & Eklutna.

Line 15 - Funds distributed to support the Epidemiology Center distributed to co-signers for individual payment to ANTHC.

Line 16 - Funds for EMS training. Retained by IHS for transfer to ANTHC for Maniilaq, BBAHC, & Chugachmiut for EMS training at ANMC.

Line 18 - Does not include funds from surcharge, assessments, or other services purchased through Area Office.

Line 22 - Funds retained for ANTHC for all co-signers except YKHC, SCF, & KIC.

Line 24 - Does not include NR SFC funds for Health Facilities design and construction oversight.

Appendix A - Financial Summary for Annual Funding Agreement - Headquarters Tribal Shares
Norton Sound Health Corporation

Sub Act.	Line Item	Account	TSA	PF	BB	National FY 2021 TSA Pool	Chickaloon inc in All AK	Knik in All AK	All Alaska	ATHC Eligible Shares Total ATHC TS	NSHC Eligible shares	Co - Signer 0% Retained	Co - Signer 0 Due	
						Column 1				*Column 2*	*Column 3*	*Column 4*	*Column 5*	
Hospitals and Clinics														
	101	Emergency Fund		x		$3,956,016			$462,063	462,063	End of year funds to be dist. on AK TSA formula.			
	104	Inter-Agency Agreements				$0			$138,380	138,380	$11,380	$0	$11,380	
	105	Management Initiatives		x		$2,049,512			$239,383	239,383	End of year funds to be dist. on AK. TSA formula.			
	106	A.C.O.G. Contract	x			$98,592			11,209	11,209	$922	$922	$0	
	107	H.P./D.P. Initiatives	x			$3,484,867			200,844	200,844	$16,517	$0	$16,517	
	110	N.E.C.I.	x			$1,107,951			124,173	124,173	$10,211	$0	$10,211	
	111	Nurse Initiatives	x			$1,287,656			140,892	140,892	$11,586	$0	$11,586	
	112	Nursing Co-steps	x			$648,528			72,677	72,677	$5,977	$0	$5,977	
	113	Chief Clinical Consultant	x			$277,340			31,086	31,086	$2,556	$0	$2,556	
	115	Emer. Medical Svcs	x			$465,222			41,980	41,980	$3,452	$0	$3,452	
	117	Traditional Advocacy Prog.	x			$100,578			11,272	11,272	$927	$0	$927	
	118	Research Projects	x			$1,283,252			143,088	143,088	$11,767	$0	$11,767	
	119	A.A.I.P. Contract	x			$26,731			2,994	2,994	$246	$0	$246	
	120	Clinical Support Center-Phoenix	x			$1,744,883			204,917	204,917	$16,852	$2,549	$14,302	
	121	Co-steps Non-physicians	x			$81,839			9,159	9,159	$753	$0	$753	
	123	Physician Residency	x			$277,416			31,093	31,093	$2,557	$0	$2,557	
	124	Recruitment/Retention	x			$2,057,393			230,592	230,592	$18,963	$0	$18,963	
	125	U.S.U.H.S., etc.	x			$3,071,317			344,246	344,246	$28,309	$0	$28,309	
	126	DIR Support Fund	x			$24,915,898			2,762,946	2,762,946	$227,213	$63,165	$164,048	
	127	Evaluation	x			$1,063,992			119,272	119,272	$9,808	$0	$9,808	
	128	National Indian Health Board	x			$459,114			51,111	51,111	$4,203	$0	$4,203	
	129	Albq./HQ Administration	x			$892,404			112,813	112,813	$9,277	$0	$9,277	
	130	Nutrition Training Center	x			$345,053			41,806	41,806	$3,438	$0	$3,438	
	131	Diabetes Program- Albq./HQ	x			$1,295,589			151,342	151,342	$12,446	$0	$12,446	
	132	Cancer Prevention- Albq./HQ	x			$716,968			84,278	84,278	$6,931	$0	$6,931	
	133	Health Records	x			$136,277			12,043	12,043	$990	$0	$990	
	134	AIDS Program	x			$422,971			78,823	78,823	$6,482	$0	$6,482	
	135	Handicapped Children	x			$346,083			40,775	40,775	$3,353	$0	$3,353	
	137	National OIT Sup.- Albq./HQ	x			$8,292,508			925,939	925,939	$76,145	$21,168	$54,977	
	154	Prescription Drug Monitoring	x			$1,002,361			$115,171	115,171	$9,471	$0	$9,471	
Dental Health														
	201	IHS Dental Program	x			$2,505,120			$300,609	300,609	$24,721	$0	$24,721	
	202	IHS Dental Program- Program formula		x		$5,269,192					$0	$0	$0	
Mental Health														
	301	MH/SS Tech. Asst.	x			$1,542,507			$174,272	174,272	$14,331	$0	$14,331	
	302	C.M.I. Grants	x			$628,310			$70,130	70,130	$5,767	$0	$5,767	
	303	National Conference	x			$107,552			$11,990	11,990	$986	$0	$986	
Alcohol/Sub. Abuse														
	401	Clinical Advocacy	x			$3,148,617			$516,623	516,623	$42,485	$0	$42,485	
	402	Collaborative Initiatives	x			$848,033			$48,451	48,451	$3,984	$0	$3,984	

Appendix A - Financial Summary for Annual Funding Agreement - Headquarters Tribal Shares
Norton Sound Health Corporation

Sub Act.	Line Item	Account	TSA	PF	BB	National FY 2021 TSA Pool	Chickaloon inc in All AK	Knik in All AK	All Alaska	ATHC Eligible Shares Total ATHC TS	ATHC Eligible Shares NSHC Eligible shares	Co - Signer 0% Retained	Co - Signer 0 Due
						Column 1				*Column 2*	*Column 3*	*Column 4*	*Column 5*
Contract Health Care													
	501	Fiscal Immediary		x						$0	$0	$0	$0
	504	C.H.S. Reserve & Undistrib.	x			$3,377,832			$361,250	361,250	$29,708	$0	$29,708
Public Health Nursing													
	601	Preventive Health Initiatives	x			$951,210			$103,180	103,180	$8,485	$0	$8,485
	602	Preventive H. Init. - Prog. Formula		x							$0	$0	$0
Health Education													
	701	IHS Health Education Program	x			$1,133,793			$127,796	127,796	$10,509	$0	$10,509
CHR													
	801	IHS CHR Program	x			$2,412,266			$267,854	267,854	$22,027	$0	$22,027
Direct Operations													
	1301	Direct Operations	x			$13,847,784			$1,557,559	1,557,559	$128,087	$0	$128,087
	1301a	Direct Operations- OIT	x			$2,716,551			$305,550	305,550	$25,127	$5,302	$19,825
	1302	Direct Ops Dental	x			$0			$0	-	$0	$0	$0
Facilities and Environmental Health Services													
	2401	Sanitation Fac. Construction Sup.		x		$6,761,916				$325,101	$0	$0	$0
	2402	Environmental Health Ser. Support		x		$5,114,837				$197,905	$25,264	$25,264	$0
	2403	Facilities & Property Support		x		$24,019,205				$221,409	$17,947	$17,947	$0
	2404	Facilities Engineering Support		x						$0	$0	$0	$0
	2405	Engineering Services Support		x						$51,699	$5,201	$5,201	$0
TOTAL TSA AMOUNT						$89,122,358	$0	$0	$10,080,185	10,080,185	$828,953	$93,107	$735,846
TOTAL PROGRAM FORMULA AMOUNT						$47,170,678				$1,497,560	48,412	$48,412	$0
TOTAL HEADQUARTERS TRIBAL SHARE						$136,293,036				$11,577,745	$877,365	$141,519	$735,846

Column 1 - All numbers are based on HQ PFSAs for FY20 Table #4 dated 1/13/20 & FY21 Table 4F dated 7/16/20 (facilities)
Column 2 - All numbers are based on HQ PFSAs for FY20 Table #4 dated 1/13/20 & FY21 Table 4F dated 7/16/20 (facilities)

Column 3 - Individual Co-Signer share of column 2.
Column 4 - Co-Signer amounts left with (retained by) IHS to provide service- If service is not available IHS shall pay to each Co-Signer amount provided.
Column 5 - This column (col. 3 - col. 4) is the HQ. TS funds due to Co-Signer, calculated by Alaska TSA formula.
All Headquarters Tribal Shares shall be recurring except for Facilities (lines 2401 -2405) and funds in lines 101 and 105.
Line 101 - Any funds remaining will be distributed non recurring on 9/30 (from HQ by TSA formula) and to each Co-Signer on ATHC distribution method.
Line 105 - Any funds remaining will be distributed non recurring on 9/30 (from HQ by TSA formula) and to each Co-Signer on ATHC distribution method.
Line 106 - All Alaska Co-Signers restricted all funds to continued advanced OB training opportunities for all Alaska Area physicians.
Line 120 -Alaska Co-Signers restricted a total of $31,000 dollars for the clinical support center for CME certification and "IHS Provider" magazine.
Line 124 - BBAHC, EAT, Chugachmiut, Eyak, and Maniilaq retrocede 50% of line 124 to IHS in exchange for use of recruitment website ihs.gov/jobs.
Line 126, 137 -DIR withheld were computed at 27.8% of each Co-Signer on ATHC proposal. See Section 1 of the Funding Agreement.
Line 0154 New line for Prescription Drug monitoring. Full share included in co-signers TS.
Line 201 - Dental Program - approximately $800,000 transferred to line 1302 in Direct Ops Dental. No impact on TS.
Line 1301a - DIR Withheld was computed at 21.1% of each Co-Signer share based on continuing agreements with Dir. DIR.
Linr 1302 - Direct Ops Dental is now in line 201
Lines 2401-2405 - Funds available for OEHE support functions (from table 4f) provided based on national formula at tribal option.

Name of Tribe/Tribal Org. **Norton Sound Health Corporation** **58G950016**

Contract/Compact Period **October 1, 2020 through September 30, 2021**

	Budget Activity	Initial Negotiated Annual Funding Agreement					
		Program/Service Unit Base		Area Tribal Share	Headquarter Tribal Share	Contract (Reductions)	Net Annual Payment Obligation
		Recurring	Non-Recurring	0.081229506		IPA/MOA	
		(1)	(2)	(3)	(4)	(5)	1+2+3+4+5=(6)
1	Hospitals & Clinics	$23,213,352		$275,437	$424,929	($224,613)	$23,689,105
2	Dental	$2,533,887		$17,016	$24,721	$0	$2,575,624
3	Mental Health	$765,746		$104,878	$21,085		$891,708
4	Alcohol & Substance Abuse	$1,174,320		$69,541	$46,469		$1,290,330
5	Public Health Nursing	$1,063,687		$9,956	$8,485		$1,082,128
6	Health Education	$117,928		$20,402	$10,509		$148,840
7	Community Health Representativ	$329,970		$7,517	$22,027		$359,515
8	Immunization (AK only)	$10,316		$28,276	$0	$0	$38,592
9	Direct Operations	$40,186		$347,386	$147,913		$535,484
10							
11							
12	Self-Governance				$0		$0
13	Other, Services (Annual)						
14	TOTAL, Services (Annual)	$29,249,392	$0	$880,409	$706,138	($224,613)	$30,611,327
15	Purchased/Referred Care	$13,412,656		$118,066	$29,708		$13,560,429
16	Operational Cost for Tribal Clinics					0	$0
17	Environmental Health Support	$661,707		$47,910			$709,617
18	Facilities Support	$1,828,331		$3,028			$1,831,359
19	OEHE Support				$0		$0
20	Maintenance & Improvement		$1,462,821		$0		$1,462,821
21	Sanitation Facilities - Housing				$0		$0
22	Sanitation Facilities - Regular				$0		$0
23	Equipment		$180,666				$180,666
24	TOTAL, Facilities	$2,490,038	$1,643,487	$50,937	$0	$0	$4,184,463
25	Current year CSC Direct	$4,630,788					$4,630,788
26	Current year CSC Indirect		$12,264,014				$12,264,014
27							
28	Other (*See* Remarks)						$0
29	TOTAL, CSC	$4,630,788	$12,264,014	$0	$0	$0	$16,894,802
30	Quarters						$0
31	Contract Health Services (Prior Year)						$0
32	Indian Health Facilities (Prior Year)						$0
33	Others						
34	TOTAL, Other	$0	$0	$0	$0	$0	$0
35					$0		$0
36	**GRAND TOTAL, AFA**	**$49,782,874**	**$13,907,501**	**$1,049,412**	**$735,846**	**($224,613)**	**$65,251,021**

Footnotes:

The FA program funding amount in column 1 and 2 are as of FA 12 dated 7/31/2020

The FA funding also includes all funds from Diomede ISDA TI agreement transferred in FY15.

Line 20 and 23 - Routine M&I and Equipment funding is estimated at 90% of prior FY amount for lump sum payment -subject to adjustm with Sec. 4 of the FA.

d Health Corporation

Norton Sound Health Corporation
Withhold Calculation

The Co-Signer will "withhold" 100% of all estimated costs for IPA/MOA, SSC, VBC, **No** (Yes or No)

surcharge **0.285%**

The Co-Signer will "withhold" the minimum initial amount for IPA, etc., and "buyback" services. **Yes** (Yes or No)

0.285%

Service	Annual Amount (1)	(2)	(3)	Total Annual Estimated Costs	Est. Monthly Payment	Initial Auth. Withhold
	(1)	(2)	(3)	1+2+3=(4)	(4)/12=(5)	*see* Footnotes
H & C						
IPA/MOA Personnel Costs	$566,729	18,731	$1,615	$587,076	$48,923	$195,692
VBC	$0		$0	$0	$0	$0
Other	$86,516		$247	$86,763	$7,230	$28,921
SUBTOTAL H & C	$653,245	$18,731	$1,862	$673,838	$56,153	$224,613
DENTAL						
IPA/MOA personnel costs			$0	$0	$0	$0
Supply Service Center		$0	$0	$0	$0	$0
All other costs-			$0	$0	$0	$0
SUBTOTAL DENTAL	$0	$0	$0	$0	$0	$0
IMMUNIZATION						
IPA/MOA personnel costs			$0	$0	$0	$0
Supply Service Center		$0	$0	$0	$0	$0
Village Clinic Leases			$0	$0	$0	$0
All other costs-			$0	$0	$0	$0
SUBTOTAL IMMUNIZATION	$0	$0	$0	$0	$0	$0
T-CLINIC						
VBC Increases			$0	$0	$0	$0
		$0	$0	$0	$0	$0
			$0	$0	$0	$0
SUBTOTAL T-CLINIC	$0	$0	$0	$0	$0	$0
Withhold Total	$653,245	$18,731	$1,862	$673,838	$56,153	$224,613

Footnotes:

Column 2 - IPA/MOA Centrally Paid Expenses are estimated at $588 for each IPA and $6,243.81 for each MOA.

Column 2 - IPA/MOA Centrally Paid Expenses are estimated at $588 for each IPA and $5,293.74 for each MOA.
Employee Dispute Pool Costs are no longer charged in advance (*see* Section 2.3.2.3 of Buyback Agreement).

Column 3 - Surcharge for all Co-Signers using buyback is .285%

This sheet not to be included in Appendix A - Provided to assist in completing Section 4 of the FA then disca

Norton Sound Health Corporation	
Recurring base	$49,782,874
Non Recurring base	$13,907,501
Subtotal recurring and non recurrir	$63,690,375
Area tribal Share	$1,049,412
HDQ TSA Tribal Share	$735,846
HDQ program formula tribal share	**$0**
Subtotal tribal shares	$1,785,258
TOTAL Funding Agreement	$65,475,634

non recurring includes M & I $1,462,821

FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

Amendment Effective December 30, 2018

In accordance with Section 14.1 of the Norton Sound Health Corporation (NSHC) FYs 2018-2020 Multi-Year Funding Agreement (MFA), as amended, the NSHC and IHS agree to the following revision:

> Appendix B (as previously amended) is hereby further amended and restated by the version of Appendix B attached.

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

Angie Gorn 12/9/20

By: _____ _____
Angie Gorn, President/CEO Date

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S Digitally signed by Evangelyn L. Dotomain -S Date: 2021.01.05 14:53:56 -09'00' _____
Director, Indian Health Service Date

Norton Sound Health Corporation Funding Agreement - Appendix B
Fiscal Years 2018-2020

This non-exhaustive list of Tribal Facilities and Locations identifies the sites where Norton Sound Health Corporation owns, leases, occupies, or otherwise used real property to carry out its responsibilities under the Alaska Tribal Health Compact and its Funding Agreement. Each description of facilities and locations is intended to include surrounding and adjacent grounds.

Additionally, the cross references to specific PSFAs are not intended to limit the scope of PSFAS that may be performed at a facility or for which a facility may be used; rather, cross references are intended as an example of the type of PSFA that may be performed at the facility or of the manner in which a facility may be utilized. Cross references are not exhaustive and may not be construed to be exclusory of other PSFAs that may be performed at a facility or of the uses of the facility.

LOCATION	FACILITY NAME	TRIBAL PROGRAMS (including but not limited to)
Nome	Norton Sound Regional Hospital-Main Campus (Replacement Facility)	Section 3.1; Sections 3.2.1-3.2.7; Sections 3.2.9-3.2.13; Section 3.2.15; Section 3.2.16; Section 3.3.6; Sections 3.4.1-3.4.4; Sections 3.4.6-3.4.8; Sections 3.4.11-3.4.14; Section 3.5; Section 3.6; Section 3.7; Section 3.8.
Nome	Quyanna Care Center	Section 3.2.8
Nome	Hostel	Section 3.2.14
Nome	BIA EMT Training Center/Drug and Alcohol Rehabilitation Center	Section 3.2.13; Sections 3.3.1-3.3.3, 3.3.5-3.3.7; Section 3.4.6, 3.4.12
Nome	Kusgi House	Section 3.3.5, 3.3.6
Nome 607 Division Street	NSHC Behavioral Health Clinic	Section 3.3.1-3.3.3, 3.3.5-3.3.7; Section 3.4.10; Section 3.8
Nome	Health Aide Training	Section 3.4.5
Brevig Mission	Brevig Mission Clinic	Section 3.2.5, 3.2.10, 3.2.11; Section 3.3.1-3.3.3; Section 3.4.1-3.4.4, 3.4.12; Section 3.7; Section 3.8
Diomede	Diomede Clinic	Section 3.2.5, 3.2.10, 3.2.11; Section 3.3.1-3.3.3; Section 3.4.1-3.4.4, 3.4.12; Section 3.7; Section 3.8

All Villages	Village-Based Counselor Office Space	Section 3.3
All Villages	Village Based Morgues	Section 3.4.17

AMENDMENT TO
FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

In accordance with Section 14.1 of the FY's 2018-2020 Funding Agreement made and entered into by Norton Sound Health Corporation and the Secretary of the Department of Health and Human Services of the United States of America, effective October 1, 2017, the funding agreement, as amended, is hereby further amended as follows:

1. **Appendices.** The following appendices are incorporated by reference and attached:

   - Appendix C – FY 2020 Continuing Services Agreement

2. **Effective Date**. This amendment is effective October 1, 2019.

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

By: Angie Gorn
Angie Gorn, President/CEO

3/29/21
Date

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S
Digitally signed by Evangelyn L. Dotomain -S
Date: 2021.04.27 16:07:52 -08'00'
Director, Indian Health Service

Date

MEMORANDUM OF AGREEMENT DESCRIBING THE CONTINUING SERVICES OF THE INDIAN HEALTH SERVICE, ALASKA AREA NATIVE HEALTH SERVICE TO NORTON SOUND HEALTH CORPORATION FOR FY 2020

I. INTRODUCTION

This agreement provides for the continuation by the Indian Health Service (IHS) of certain services from the Alaska Area Office for the benefit of Norton Sound Health Corporation under its Funding Agreement (FA) under the Alaska Tribal Health Compact (ATHC) Self-Governance Compact.

This agreement is limited to the programs, services, functions, and activities (PSFAs) performed by the residual and transitional federal staff of the Alaska Area Office.

This agreement should be interpreted in conjunction with Norton Sound Health Corporation's FA and Appendix A to that FA, which may provide for additional detail on "restrictions" of funds at the Area or Headquarters level to ensure that specific services are continued to the individual Co-Signer.

In FY 2020, funding for these continuing services and activities will be from the funds, which have been designated as residual and from funds, which have been designated in support of temporary transitional federal PSFAs. In addition funding to purchase specific services, i.e., use of IPA/MOA assignees and Village Built Clinic leases, may be provided through reimbursement by Norton Sound Health Corporation to the IHS.

II. DEFINITIONS

The following definitions are in common usage in the Alaska Area:

A. ATHC Tribal Restricted Share - Used in Alaska to refer to those retained Tribal shares all compacting Tribes jointly initially agreed to leave in the Area Office in support of Alaska Area state wide PSFAs. Pursuant to Section 325 of PL 105-83, these shares now are in the Alaska Native Tribal Health Consortium (ANTHC) FA or are used for transitional federal PSFAs.

B. Buyback - The process by which Co-Signers use cash to purchase Area services from the Area Office. Requires accurate description and pricing of service, and mechanism for Area to invoice and receive payment.

C. Co-Signer Restricted Shares - Used in Alaska to refer to "retained Tribal shares" that have been left at the Area Office or Headquarters on an individual basis by a Co-Signer to allow the Area, Headquarters or ANTHC to provide specific services to the Co-Signer. Pursuant to Section 325 of PL 105-83, these Area shares now are in the ANTHC FA or are used for transitional federal PSFAs.

D. Residual - The resources necessary to support the PSFAs required for the United

A. OFFICE OF THE DIRECTOR

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Director	Provides overall executive direction and support on behalf of the Secretary.	R	1
Deputy Director, Chief Medical Officer	Provides public health advocacy; clinical consultation (CMO); legally required certification of health aide credentials and oversight of CHAP certification process; consultation in CHAP/Rural Health program management.	R	1
Executive Officer	Serves as principal advisor to the Director on overall management policies and procedures.	R	1
Attorney	Provides Region X attorney support and consultation.	R	1
EEO	Provides EEO support. 1		
Support Staff	Secretarial, clerical and administrative support to inherent and transitional federal functions at all levels of the Area Office.	R T	3 1
Planning, Evaluation & Statistics	Prepare statistical reports and publications in support of planning, evaluation and resource allocation requirements.	R	2
	Total		10

The Office will provide the specific PSFAs defined below:

1. Executive direction on behalf of the Secretary to the remaining inherently federal functions.
2. Advocacy at national level on behalf of the Tribes of Alaska including: legislative, policy, resource allocation, and appropriation advocacy.
3. Policy formulation and interpretation; supervision of non-IPA/MOA federal employees; negotiate, execute and administer compacts and FAs; resource allocation.
4. Public health coordination with Tribal, state and federal governments.
5. Provide legal advice and consultation on behalf of the Secretary.
6. Provides representation on the Executive Committee and Planning Committee of the Alaska Federal Health Care Partnership (AFHCP). Through the government-to-government relationship with Tribes and Tribal organizations, provides the mechanism for Tribal membership on the AFHCP.
7. Eligibility determinations assistance.
8. Equal Employment Opportunity program management in support of federal employment rights.
9. Oversight of certification of Community Health Aides as outlined by law and the *IHS Community Health Aide Program Certification Board Standards and Procedures.*
10. Consultation and technical assistance to Tribes and Tribal organizations staff and programs including
    a. Program review or evaluation at the request of the Area Director or the invitation of Tribal programs;
    b. Submission of electronic health record data to IHS National Data Warehouse; and
    c. Maintain current Area statistics to provide statistical analysis in support of resource needs and allocations.

1 The EEO function is provided under an intra-agency agreement among the IHS Alaska, California and Portland Area Offices.

B. OFFICE OF ACQUISITION AND PROPERTY MANAGEMENT [2]

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Federal Contracting ,, Personal Property, and FOIA Coordinatio n	Responsible for federal acquisitions to support the Alaska Area Office, including the federal credit card program. Maintains the federal personal property inventory. Provides or coordinates various administrative services for the Alaska Area Office.	R	1
	Total		1

The Office will provide the specific PSFAs defined below:

1. Negotiate, award and administer federal acquisitions.
2. Maintain or develop Alaska Area Interagency and Cooperative Agreements in close partnership with appropriate IHS or other federal, state or Tribal entity(s).
3. Coordinate various administration functions including Freedom of Information Act requests and IHS delegations and directives.
4. Maintain the federal personal property management inventory, including excess and disposal.
5. Provide technical assistance to Tribally managed facilities on procurement issues as requested regarding procurement issues and acquired federal excess property.
6. Maintain the federal credit card program.

2 Residual (1) FTE moved to Office of Tribal Programs in support of Title 1 contracts and audit resolution.

a. Overall direction of resources and related environmental surveillance for statewide public health impacts.

b. Continue to carry out functions related to serving as one of the health and medical representatives to the Alaska Federal Emergency Response Group.

c. Provide management and verification of tribal input data in the IHS Environmental Health Services data system known as the Web-based Environmental Health Reporting System (WebEHRS).

d. Provide safety assurance, compliance and reporting relating to federal workers, and professional programmatic support for staff.

e. In the event of a national disaster situation as defined in the Federal Response Plan, IHS is the lead agency for emergency response related to water and sewer damage assessment and mitigation.

3. **Health Facilities:** PSFAs include:

a. Perform budget allocation;

b. Support and approve project or resource allocations derived through a priority system developed through the Maintenance & Improvement Resource Allocation Committee (MIRAC) and ANTHC process consistent with IHS national project eligibility criteria. Verify data submittals and manage IHS facilities databases in conformance with IHS national project and health facilities space eligibility criteria.

c. Respond to Congressional inquiries;

d. Review Project Justification Document/Program Of Requirements (PJD/POR) documents prepared by others;

e. Review and approve national priority systems applications, including Tribal Equipment Funds and Dental Facilities Funds;

f. Maintenance of Alaska portion of the IHS Healthcare Facilities Data System (HFDS) including the Facilities Maintenance and Improvement/Equipment database for federally and Tribally owned health facilities;

g. Support for new health facility construction project funds distribution and project development;

h. Stewardship responsibility for oversight of environmental cleanup of federally owned real property;

i. Approve workload statistics;

j. Advocate statewide and nationally for the DEHE program and facilitates its implementation.

4. **Realty:** PSFAs include:

a. Monitor and manage real property assets in accordance with Executive Order 13327, "Federal Real Property Asset Management" and existing authority under law or by executive order for real property, capital improvements, square footage, use or disposal.

b. Maintain the IHS Real Property Inventory by updating the asset book values with costs relating to acquisition of real property, capital improvements, square footage, use or disposal.

c. Verify construction project closeout documentation for capital improvements made to federal facilities prior to adjusting the real property subsidiary ledger.

d. Perform annual review of real property.

e. Warranted Lease Contracting Officer authorized to lease Village Built Clinics

Co-Signers and contractors to maintain accurate records of funding allocations, reconciliations and cash management issues.

8. Reconciliation, billing and amendment management related to contractor and compactor use of federal resources including but not limited to IPA/MOA employees and the Village Built Clinic lease program. Reconciliation includes transaction verification of buyback services with corrections and reports.

9. Support withhold and buyback management including payment for continuing government contracts for goods and services, permanent change of station moves, etc.

10. Monthly general ledger reconciliation including cash management related to Prompt Pay Act, Treasury, cash and others.

11. Process reimbursement requests including Beneficiary Medical Program (BMP), Interagency Payment and Collections (IPAC), quarters collections, CHEF and others. Make deposits and transfers of such reimbursements to Co-Signers no less often than monthly.

12. Assist Tribes during annual Budget Formulation for the second succeeding year's annual budget, including preparation for the National Budget Formulation meeting.

E. OFFICE OF HUMAN RESOURCES

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Civil Service Staffing, Classification & Employee/ Labor Relations	Advertise and recruit for federal, direct and IPA/MOA replacements; process personnel and pay actions; provide job information; maintain official records; rate applicants, appoint new employees, and provide HR consultation; Title 38 and Physician's Comparability Allowance, Market Pay & Locality Pay maintenance; process Reduction in Force and counseling; provides transportation services and relocation assistance for federal employees and consultation re: Tribal direct hires as requested; administers Workers' Compensation program; grievances, discipline/adverse actions; Merit Systems Protection Board, appeals and agency representation; performance management; retirements; payroll; benefits; outside activities; ethics program; suitability adjudication; manage Federal Employee Assistance program and Family Medical Leave and Family Friendly Acts consultation; conducts desk audits; applies Classification Standards and consultation. Initiate and assure completion of suitability investigations as needed on federal employees and personal services contractors.	R T	2 0
	Total		2

Under the direction of the IHS Western Region Human Resources Director, the Office of Human Resources will provide the specific PSFAs defined below for the current approximately 340 federal employees employed either directly or through Civil Service IPAs (58) or Commissioned Corps MOAs (254):

1. Advertise and recruit for direct federal employees. Replacement IPA positions may be filled with a current IPA already on board (such as by reassignment) or a new or replacement MOA. Process Reductions In Force (RIF). Provide counseling on RIF.

2. Maintain official personnel files (electronic and paper) and records for Civil Service employees.

F. COMMISSIONED CORPS PERSONNEL[4]

P/S/F/A	MAJOR FUNCTIONS	Buyback	Staffing (FTE)
Commissioned Corps Personnel	Orient and assist officers and their families to include: recruitment support, liaison between areas, TRICARE advice, wage verifications, grievances, leave programs, COERs and COSTEP. As necessary, Corps-specific personnel discipline advice to CEOs and HR staff of 638 awardees with MOA assignees and supervisors of MOAs.	B	2
	Total		2

Under the direction of the IHS Division of Commissioned Personnel Support, the Commissioned Corps Personnel component will provide the specific PSFAs defined below for the approximately 259 USPHS Commissioned Officers in the Alaska Area:

1. Provide general orientation to new Commissioned Officers.
2. Counsel Commissioned Officers; provide Corps-specific discipline advice to appropriate Co-Signer managers.
3. Maintain unofficial files and records for Commissioned Officers.
4. Process required federal personnel actions for Commissioned Officers including orders for deployment.
5. Assist and consult with officers and their supervisors.

G. OFFICE OF TRIBAL PROGRAMS

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Director	Management of Area Title V responsibilities for Self-Governance and Title I review, approval and technical assistance. Managing CHEF submissions, and fund distribution; clerical and secretarial support.	T	1
Health Care (Management) Consultation	Title V compacts/FAs (including amendments and database management of same), cooperative agreements, and grants; negotiate and administer CSC funds.	T	3
Health Care [5] (Management) Consultation	Negotiate, manage, and execute Title I contracts. Review audit findings and work with Tribal contractors to resolve as needed.	R	1
	Total		5

The Office will provide the specific PSFAs defined below:

1. Provide or facilitate technical assistance to Tribes which may or may not lead to the preparation of proposal(s) to assume PSFAs for Title I contracting, Title V compacting and Tribal Management grants for Tribes and Tribal organizations
2. Evaluate P.L. 93-638 proposal(s) to determine acceptance, declination or rejection; if

4 During FY 2005 this PSFA was centralized under the Division of Commissioned Personnel Support at IHS Headquarters. Effective FY 2006, it is funded by assessing the locations that use Commissioned Officers. See, also, Appendix A.

5 Formally P/S/F/A: Federal Contracting Title I awards, (1) Residual FTE moved from the Office of Acquisition and Property Management; to support Title I contracts and audit resolution.

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S Digitally signed by Evangelyn L. Dotomain -S Date: 2021.04.27 16:06:22 -08'00'

Director
Alaska Area Native Health Service, IHS

Date: _____

Norton Sound Health Corporation
on Behalf of Itself and Certain Alaska Tribes,
Identified in Exhibit A to the Compact.

By: Angie Gorn

Angie Gorn, President/CEO
Norton Sound Health Corporation

Date: 10/30/2020

Appendix D
Buyback/Withhold Agreement
between
the Indian Health Service
and
Norton Sound Health Corporation

Section 1. Generally. Pursuant to Section 5.3 of the Funding Agreement between Certain Alaska Native Tribes Served by Norton Sound Health Corporation (hereinafter "NSHC") and the Secretary of the Department of Health and Human Services of the United States of America (hereinafter "Secretary"), NSHC has determined that it wishes to carry out its responsibility to provide certain programs, activities, functions or services (e.g. salaries of IPA/MOA employees, and Village Built Clinics Program) included in its Funding Agreement utilizing services, personnel or other resources of the Federal Government, (hereinafter "services") under Article V, section 22 of the Compact, as permitted by law. These services may include some that are expected to be used throughout the year and some incidental services to be identified by NSHC on an as needed basis, and provided by the Indian Health Service (hereinafter "IHS") when IHS has the capacity to do so. The cost of providing the purchased services to NSHC shall be determined under section 2 below. NSHC's purchase of services is contingent upon the availability of IHS resources to provide those services. In addition, services must be paid for in advance, in order to avoid violation of the Anti-Deficiency Act and are subject to full cost recovery in accord with 25 USC 458aaa-7(f) and 31 USC 9701.

Section 2. Determination of Cost.

2.1 Generally. NSHC may acquire services from the IHS by either providing for full year withhold (with appropriate reconciliation) under terms agreed upon in this funding agreement, in which case the administrative surcharge provided for under section 2.2.4 shall not apply. In the alternative, NSHC may acquire services by authorizing partial year withhold amounts, as provided for in section 2.2, in which case the payment schedule and administrative surcharge provided for in section 2.2.4 shall apply. Whether full or partial year withhold is authorized, the full costs of IPA/MOAs including those detailed in section 2.3, Determination of IPA/MOA Costs, shall be paid by NSHC.

2.2 Conditions for Partial Year Withhold and Buyback.

2.2.1 IPA/MOA.

2.2.1.1 Advance withhold. The funds for IPA/MOA salary and other costs detailed in section 2.3, "Determination of IPA/MOA Costs," will be paid as a lump sum in accord with Section 5(a) of the Funding Agreement, except that an amount equal to three monthly payments based on the initial mutually agreed upon estimate of the annual IPA/MOA salary costs and related surcharges, as provided in section 2.2.4, will be withheld and retained by the Indian Health Service pending final disbursement for the last three months of the fiscal year as provided in section 3.2.2.2.

services to NSHC.

2.3 Determination of IPA/MOA Costs.

2.3.1 List of Costs. It is agreed by the parties that the entire cost of IPA/MOA assignments, including costs associated with the initiation, maintenance, and termination of the assignments are the responsibility of NSHC. The IHS must be reimbursed for all such costs which include but are not limited to the following:

2.3.1.1 Permanent change of station costs including the cost of moving replacement IPAs from the lower forty-eight to Alaska and the cost of moving IPA employees who separate back to the lower forty-eight.

2.3.1.2 Recruitment, relocation and retention bonuses if such funds are necessary to attract or retain employees.

2.3.1.3 Severance pay for employees who are released by NSHC and separated without cause.

2.3.1.4 Payment of turnaround leave travel expenses. All individuals who are eligible for these expenses shall be identified in the IPA negotiated between the parties. The IHS will retain liability for existing IPAs. NSHC assumes the liability for new IPAs and upon renewal of an existing IPA.

2.3.1.5 Lump sum leave payments for employees who leave federal service. All leave accrued prior to the employee becoming employed by NSHC shall be identified in the IPA/MOA negotiated between the parties. The liability for accrued leave on existing, renewing, and new IPA/MOAs shall be the responsibility of NSHC.

2.3.1.6 Costs associated with settling or resolving employment related disputes, subject to the terms specified in section 2.3.2 below.

2.3.1.7 Centrally paid expenses, subject to the terms specified in section 2.3.3 below.

2.3.1.8 The cost of paying unemployment benefits assessed to the Area in FY 2002 and thereafter on behalf of an employee who was employed by NSHC under an IPA immediately prior to voluntary or involuntary separation from IHS regardless of the year in which unemployment benefits were paid. The NSHC is not responsible for unemployment costs that were assessed to the Area in Fiscal Years 2000 and 2001.

2.3.2 Costs Related to Employment Related Disputes.

2.3.2.1 Responsibilities of the IHS. The Indian Health Service shall be responsible for the payment of all costs of the IHS Office of Human Resources and any other section of the Indian Health Service, the Office of General Counsel, and the Department of

2.3.3 Costs Related to IPA/MOA Centrally Paid Expenses. Certain costs associated with IPA and MOA employees are paid centrally by Headquarters from Area funds. These include costs detailed in columns 6, 7, and 8 of the spreadsheet entitled "Allocation of Centrally Paid Expenses (Excluding FTS)," Corrected May 11, 1998, that was prepared by David Mather. These are costs associated with Commissioned Corps, Personnel and Payroll, and Balance of Human Resources. The Alaska Area Native Health Service may pay for or recover assessments from Headquarters to cover these identified costs by including in the monthly charge for each IPA or MOA the monthly cost to the IHS of such Centrally Paid Expenses. The cost charged NSHC for each IPA/MOA may not exceed the average cost per federal employee actually paid by IHS. For purposes of calculating the initial withhold amount and estimated monthly payments, the estimated average cost per month for each IPA or MOA is shown in Appendix A of the Funding Agreement.

2.4 Limitation on Obligations and Notice.

2.4.1 Obligations. IHS shall within 30 days provide notice to NSHC of the best available estimate of the costs that may be incurred under this Agreement of leases, contracts, salaries and related expenses and permanent change of station.

2.4.2 Content of Notices of Best Available Estimates and Costs. Notice of best available estimates under section 2.4.1 and full accounting of all costs due under section 3.3.1 shall include the amount, vendor and reason for obligation or expenditure, including the name of the employee, if any.

Section 3. Method of Payment.

3.1 Full Year Withhold. Payment for services being purchased from the IHS may be made by NSHC authorizing a withhold of the full year's initial mutually agreed upon estimate of the annual cost of each category of services NSHC proposes to purchase from the IHS. In such case, no monthly payments are due from NSHC. Upon periodic reconciliation, provided for under section 3.3.1, excess withheld funds will be paid by the IHS to NSHC and adjustments in the amount of withhold or payments needed to pay for all services NSHC has purchased, or proposes to purchase, will be made to the IHS by NSHC. *See* "Summary of Withhold/Buyback" page of Appendix A for calculation of the amount NSHC hereby authorizes for full year withhold, if any.

3.2 Purchases through Buyback under section 2.2.

3.2.1 Calculations.

3.2.1.1 Of Initial Estimated Monthly Payment. The initial estimated monthly payment is determined by estimating the annual cost of services to be purchased from IHS, including the surcharge on all services under section 2.2.4, and dividing by 12. *See* "Summary of Withhold/Buyback" page of Appendix A for calculation of the amount of the initial estimated monthly payment.

reconciliation is due any under recovery must be paid by NSHC.

3.3.2 For Administrative Surcharge.

3.3.2.1 Use and Rebate. The administrative surcharge shall be used exclusively for administration of the buyback provisions under this Buyback/Withholding Agreement. All income from the administrative surcharge will be accounted for separately and compared on an annual basis to the cost of administering buyback at the Area Office. This accounting and reconciliation shall be complete within 60 days of the end of the last day of the fiscal year. Any surplus in administrative surcharges shall be returned to the Co-Signers who participated in the buyback option on a pro rata basis depending on the amount of administrative surcharge paid.

3.3.3 Adjustment in Estimated Monthly Payment. In addition to adjustments in estimated payments that may occur under sections 3.3.1 and 3.3.2.1, the parties may at any time mutually agree, based on a change in circumstances, to change the estimated monthly payment due from NSHC.

3.4 Use of Other Funds Due NSHC to Avoid Default or Satisfy Obligations to IHS and other Remedies.

3.4.1 Avoiding Default. Default may be avoided to the extent funds are held by the IHS from other funds due to NSHC, which may be withheld to satisfy the amount of the payment, which would otherwise be in default or to satisfy amounts due IHS after reconciliation of costs and payments when an amount is due to IHS.

3.4.2 Recoupment. Any amount due to the IHS by reason of NSHC's failure to pay in full all amounts owing under the buyback provisions of the Funding Agreement for the immediately preceding fiscal year shall be recouped by the IHS from any funds due to NSHC under this funding agreement.

3.4.3 Full Year Withhold as Penalty for Default. Notwithstanding any other provision of this Buyback/Withholding Agreement, the IHS may require "full year withhold" as permitted herein as a condition of permitting a Co-Signer who was in arrears at the end of the immediately preceding fiscal year to buyback services from the IHS under the terms of this Agreement.

Section 4. Dispute Resolution. The parties shall endeavor to resolve any disputes concerning amounts due by NSHC under this Agreement in a manner agreeable to NSHC and to the IHS. In the event of a failure to reach agreement on the resolution of any such dispute, NSHC may, after providing written notice to the IHS, choose not to include the disputed amount in any subsequent payment due. Payment in such a manner shall not be considered as a resolution of the dispute. The parties shall thereafter attempt to resolve the dispute through Alternative Dispute Resolution following, as appropriate, the principles and processes set forth in Executive Order 12988 signed by President Clinton on February 5, 1996, and made effective as of May 5, 1996. NSHC shall have the option of resolving the dispute in accordance with Article

Funding Agreement Appendix E

P.O. BOX 966
NOME, ALASKA 99762
(907) 443-3311

NORTON SOUND HEALTH CORPORATION

Norton Sound Health Corporation

RESOLUTION # 2010-16
Services for Non-Eligible Individuals

WHEREAS, the Norton Sound Health Corporation (NSHC) is a tribal organization that is a Co-Signer of the Alaska Tribal Health Compact (ATHC) and has negotiated a Funding Agreement (FA) with the Indian Health Service (IHS) under Title V of the Self-Determination Education and Assistance Act (ISDEAA); and

WHEREAS, the ATHC authorizes Co-Signers to provide services to non-eligible individuals provided Section 813 of the Indian Health Care Improvement Act (IHCIA) is complied with (*See* ATHC Article III, Section 4), and Section 813, as amended at 25 U.S.C. § 1680c(c)(2), provides that a tribe or tribal organization which operates a health facility under an ISDEAA agreement may make its own determination whether to provide health services to persons not otherwise eligible (i.e. non-beneficiaries) to receive IHS-funded health services; and

WHEREAS, NSHC is authorized to determine whether it will provide health services under its IHS-funded programs to persons who are not eligible beneficiaries under federal law, provided that NSHC gives consideration to whether the provision of such services will result in a denial or diminution of health services to eligible beneficiaries; and

WHEREAS, NSHC has determined that the provision of health services on a fee-for-service basis to non-beneficiaries, in an amount not less than the actual costs of providing such services, will not result in a denial or diminution of health services to beneficiaries; and

NOW THEREFORE, BE IT RESOLVED, that NSHC has decided to extend all available health services under the ATHC and its FAs to non-beneficiaries on a fee-for-service basis; and

BE IT FURTHER RESOLVED, that whenever significant evidence is presented to NSHC Board of Directors that services to non-eligible, non-beneficiaries have resulted in a denial or diminution of health services to beneficiaries, NSHC may suspend the delivery of such services to non-beneficiaries.

DATED this 25 day of June, 2010.

CERTIFICATION

The above Resolution was passed at a regular meeting of the Norton Sound Health Corporation Executive Board held on this 25 day of June, 2010 at Nome, Alaska at which a quorum was present. 8 FOR, 0 AGAINST, 0 ABSTAIN.

Attest: _____ Attest: Berda Willson
Emily Hughes, Board Chair — Berda Willson, Board Secretary

"Serving the communities of: Brevig Mission, Council, Diomede, Elim, Gambell, Golovin, King Island, Koyuk, Mary's Igloo, Nome, St. Michael, Savoonga, Shaktoolik, Shishmaref, Solomon, Stebbins, Teller, Unalakleet, Wales, White Mountain"

Norton Sound Health Corporation

APPENDIX F

PROJECT SUMMARY DOCUMENT

requirements. Cite specific, code or JCAHO references by standard clause, chapter, paragraph, etc.]

III. DEFICIENCIES

The following deficiencies will be corrected as part of this project:

[List and describe only those facility deficiencies this project will address. The types of deficiencies include BEMAR, JCAHO, NFPA, HFPM, Public Law compliance items, ADA, etc.]

IV. COST ESTIMATE

Provide a budgetary cost estimate and the funding sources for the proposed project, including separate line items for design Architect/Engineer fees, project construction, construction contract administration fees, and project contingency.

V. PROJECT SCORE SHEET DOCUMENT (*only required for BEMAR competitive pool funds*)

Complete a project score sheet further detailing the scope, impact and benefits of this project. Provide the information required by the project score sheet.

VI. OTHER PROJECT ITEMS TO BE ADDRESSED

Supporting Documents: Drawings, Photos, Estimates, Etc.

Norton Sound Health Corporation

APPENDIX G

ENVIRONMENTAL INFORMATION AND DOCUMENTATION

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

6. Does the proposed action have significant adverse direct or indirect effects on park land, other public lands, or areas of recognized scenic or recreational value?	Yes or No. Explanation.
7. Does the proposed action include construction of a new municipal solid waste landfill at a new solid waste disposal site?	Yes or No. Explanation.
8. Will the proposed action create a need for additional capacity at solid waste disposal facilities?	Yes or No. Explanation.
9. Does the proposed action include construction of a new wastewater treatment facility that will discharge treated sewage effluent to the waters of the U.S.	Yes or No. Explanation.
10. Will the proposed action create a need for additional capacity at wastewater treatment facilities?	Yes or No. Explanation.
11. Will the proposed action create a need for additional capacity in the drinking water supply?	Yes or No. Explanation.
12. Are there other considerations about the proposed action that could adversely affect the environment and/or public health and safety?	Yes or No. Explanation.

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

19. Will the proposed action require major sedimentation and erosion control measures?	Yes or No. Explanation.
20. Will the proposed action violate a storm water permit or a wastewater discharge permit either for construction or on-going operations?	Yes or No. Explanation.
21. Safe Drinking Water Act: Will the proposed action impact an EPA designated sole source aquifer?	Yes or No. Explanation.
22. Wetlands and Water Resources (lakes, rivers, ponds, streams, etc.): Will the proposed action violate a Section 404 (Clean Water Act) permit for actions in a wetland and/or Section 10 (Rivers and Harbors Act) permit for actions in a stream or river?	Yes or No. Explanation.
23. Floodplains: a. Is the proposed action located in either a 100-year or, for critical actions, a 500-year floodplain? (If Flood Insurance Rate Maps do not exist for the project site, a floodplain survey or consultation may be required. Also may need to consider if the facility will require flood insurance).	Yes or No. Explanation.
b. Will the proposed action adversely impact flood flows in a floodplain or support development in a floodplain?	Yes or No. Explanation.

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

27. Does the proposed action involve the sale or transfer of real property, on which any hazardous substance was stored for one year or more, known to have been released, or disposed of? (Provide relevant documentation for any hazardous substance releases. See 40 CFR 373.2(b), 302.4, and 261.30 for reportable quantities.)	Yes or No. Explanation.
28. Does the proposed action involve the sale or transfer of real property, on which underground or above ground storage tanks are located?	Yes or No. Explanation.
29. Will the proposed action violate Tribal, local, state, or federal law on the use and storage of hazardous substances or the transportation, storage, and disposal of hazardous wastes or medical wastes? (Activities that may generate reportable quantities include air conditioning repair and service, pesticide application, motor pools, automobile repair, welding, landscaping, agricultural activities, print shops, hospitals, clinics, & medical centers. Repair, renovation, or demolition activities can generate waste that has asbestos-containing materials, asbestos, lead-based paint, PCBs, CFCs, etc.)	Yes or No. Explanation.

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

36. Wild and Scenic Rivers Act: Will the proposed action affect a wild, scenic, or recreational river area or create conditions inconsistent with the character of the river? (A consideration for activities that are in or near any wild and scenic waterway including construction of stream/river crossings, intake structures, outfalls, etc.)	Yes or No. Explanation.

I certify that to the best of my knowledge and ability the information presented above is true and correct. The record was examined to identify potential extraordinary or exceptional circumstances which would require further environmental review.

Review by:

Title Date Environmental Coordinator Date

Norton Sound Health Corporation

APPENDIX H

ACTIONS REQUIRING IHS ENVIRONMENTAL REVIEW AND DETERMINATION

[]	Pg 571 (K)(4): Those involving the use of technology where the possible effects are highly uncertain or involve unique or unknown risks and where such technology has not been assessed previously for environmental impact;
[]	Pg 571 (K)(5): Those which have adverse effects on unique geographic characteristics (e.g. historic, archeological, or cultural resources, park recreation or refuge lands, wilderness, areas, wild or scenic rivers, sole or principal drinking water aquifers, prime farmlands, wetlands, floodplains, coastal management zones, or ecological or critical areas including those listed on the Department of Interior National Register of National landmarks);
[]	Pg 571 (K)(6): Those which establish a precedent for future action or represent a decision in principle about future actions with potentially significant environmental effects;
[]	Pg 571 (K)(7): Those which have adverse effects on properties listed or eligible for listing on the National Register of Historic Places;
[]	Pg 571 (K)(8): Those which have adverse effects on species listed by the Federal Government as Endangered or Threatened Species, or which have adverse effects on any designated critical habitat for these species;
[]	Pg 571 (K)(9): Those which require assessment in accordance with Executive Order 11988 (Floodplain Management), or Executive Order 11990 (Protection of Wetlands), or the Fish and Wildlife Coordination Act; and
[]	Pg 572 (K)(10): Those which involve the use, transfer, or lease of real property which has been determined, after investigation in accordance with the provisions of CERCLA 120 (h), to have been used as a storage facility for hazardous waste for more than 1 year; and
[]	Pg 572 (K)(11): Construction projects which are significantly greater in scope or size than normally experienced for a particular category of action.

Any action NOT categorically excluded per Federal Register Vol. 58, No. 3, pg 569-572, dated January 6, 1993 attached hereto.	**The Environmental Review and Determination Process for this group of actions ranges from 60 to 180 days from the receipt by the IHS of the proposal package.**

* The time needed to complete Environmental Reviews is highly dependent on required consultations with other Federal and State Agencies. As an example, the NHPA Section 106 Process requires the State Historic Preservation Officer (SHPO) be allotted 30 days to review and comment on a proposed action (36 CFR Part 800.3(c)(4)). Furthermore, additional time beyond the 30 days may be required for consultation with SHPO to adequately review and determine the effects of the proposed action on existing historical resources. Coordination early in the planning phase of the project can help identify these potential issues and allow NSHC and IHS to resolve them early.

employed varies from Area to Area. Population, health indices, and facilities and services available from sources other than the IHS are evaluated to determine the methods IHS uses to provide services.

The IHS program consists of two major systems: (1) A Federal health care delivery system, administered by Federal employees, and (2) a tribal health delivery system, administered by tribes and tribal groups under grants, contracts or cooperative agreements. The categorical exclusions apply to IHS program actions whether carried out directly by the IHS, or funded or otherwise sponsored by the IHS. The IHS contracts, grants, and cooperative agreements are actions defined in NEPA and are subject to the IHS review procedures established to ensure NEPA compliance, including provisions covering extraordinary and exceptional circumstances. The NEPA compliance for the tribal health care delivery system is ensured through IHS administrative procedures for contracts, grants, and cooperative agreements.

The selection of IHS program actions to list as categorical exclusions has been determined, in part, by agency experience in complying with NEPA, during the past 10 years. Actions required to provide health care services will not have significant impact on the environment except when exceptional or extraordinary circumstances exist. The IHS has categorically excluded these actions, since enactment of NEPA; however, actions involving construction normally have required completion of an environmental review/assessment.

The IHS administers programs for the construction of domestic sanitation facilities (water, wastewater, and solid waste) for Indian homes and communities, construction of new or replacement health care facilities and staff quarters, and renovations to existing health care facilities and quarters units.

Environmental reviews/assessments of construction projects undertaken during the past 10 years have concluded that an EIS was not required for any of them. Approximately 2,300 sanitation facilities construction projects and fewer than 60 health care facilities/staff quarters construction projects have been approved during this time.

The type of program and procedures employed to administer the construction of sanitation facilities for Indian homes and communities, and the consistent determinations that these projects do not have a significant impact on the environment, are the basis for the decision to list most sanitation facilities projects are categorically excluded.

Factors considered in making this determination include:

1. Projects are undertaken to improve health and/or environment.

2. Projects are untaken at the request and with approval of the tribal governing body, which provides for discussion and evaluation of the project and its impacts.

3. Projects are normally constructed on tribally owned or individually owned tribal land within reservation boundaries.

4. Projects are constructed to comply with all current applicable environmental regulations and plans and specifications are submitted to State and Federal agencies as necessary for review and comment.

5. Projects are constructed to provide utilities (water, sewer, solid waste) either for existing American Indian or Alaska Native homes or for new homes constructed with Federal, tribal, State or other resources. New homes are constructed at sites and locations approved by the Tribal Governing Board. Utilities are not provided for future development or undeveloped parcels, and capacity provided is limited to that routinely provided by standard engineering practice for the current design population.

6. The IHS projects fall into the category of minor construction projects based on cost. During the last 10 years, 85 of the 2,300 projects exceeded $1 million, and the average estimated cost was $250,000.

7. Standard IHS procedures require documentation of an environmental review of each construction project to identify any exceptional or extraordinary circumstances and to ensure compliance with all environmental laws, regulations, and executive orders; e.g., those concerning floodplains, wetlands, endangered species, etc. This review is required early in the project planning process.

The categorical exclusion for construction of health care facilities and staff quarters has been limited to renovation or new construction at existing health care delivery sites, and construction or development of relatively small facilities at new locations. The procedures noted in item 7 above for sanitation facilities construction projects also apply to all health care facility and staff quarters construction projects. Most health care facility and staff quarters renovation projects can be classified as minor construction projects based on cost. Fewer than 200 major renovation projects have been undertaken and only a few were funded at a level exceeding $1 million.

Categorical Exclusions

A. Health Services

Direct delivery of medical, dental, nursing, and other related health services; e.g., patient care/counseling administered from hospitals, health centers, health stations, satellite clinics, and in private homes by IHS staff or contract providers to authorized recipients.

B. Research

Research activities that are consistent with the mission of IHS including: (a) Biological and behavioral studies conducted in laboratories, clinics, and the field; (b) studies on the development and delivery of prevention and treatment services and their administration and financing; and (c) evaluations of prevention and treatment.

C. Pesticides

Application of pesticides which are not classified for restricted use under provisions of the Federal Insecticide, Fungicide and Rodenticide Act when used for routine pest control purposes.

D. Contracts, Grants, and Cooperative Agreements

Contracts, grants, and cooperative agreements and continuations, supplements, extensions, and amendments of these documents for IHS programs or actions that are categorically excluded. (Includes Self-Determination Act contracts, Contract Health Care contracts, etc.)

E. Technical Assistance

Action involving the provision of technical assistance to American Indian and Alaska Native tribes and groups, other Federal agencies, State and local governments, and non-profit organizations are excluded. These actions include but are not limited to:

1. The provision of technical assistance to American Indian and Alaska Native tribes and groups for the purpose of developing management capabilities needed to enable eventual tribal assumption of health program operation;

2. The provision of technical assistance to American Indian and Alaska Native tribes and groups for the purpose of developing capabilities in the areas of epidemiology, disease reduction, injury prevention, environmental improvement, and the operation and maintenance of sanitation facilities; and

3. The assignment of IHS personnel to agencies/organizations for the purpose of providing technical expertise (e.g.,

Order 11990 (Protection of Wetlands), or the Fish and Wildlife Coordination Act; and

10. Those which involve the use, transfer, or lease of real property which has been determined, after investigation in accordance with the provisions of CERCLA 120 (h), to have been used as a storage facility for hazardous waste for more than 1 year; and

11. Construction projects which are significantly greater in scope or size than normally experienced for a particular category of action.

Dated: December 29, 1992.

Michel E. Lincoln,

Deputy Director.

[FR Doc. 93-173 Filed 1-5-93; 8:45 am]

BILLING CODE 4160-16-M

ADDENDUM I

MEMORIALIZATION OF HISTORICAL LEVEL OF PFSA'S PROVIDED BY ANMC AND AANHS TO THE NORTON SOUND HEALTH CORPORATION

The ANMC and the Alaska Area Native Health Services, Area Office, subject to available appropriations, has historically provided the following PFSAs to Norton Sound Health Corporation as of October 1, 1997 and continued to provide such services through December 31, 1998:

- Coordination and support for the NSHC dental clinic, including dental specialty referral services, and the annual Alaska dental chiefs meeting. Commissioned Corp recruitment assistance including transportation costs of the recruiter to and from Nome, any applicable documentation, award information for Commissioned Officer promotions, and career counseling for officers desiring long term affiliation with IHS.

- Specialty care field clinics, consultation to Norton Sound Health Corporation physicians, arrange contracts for reference laboratory services, routine reading of x-rays, medivacs support for neonatal emergencies patient travel support for NSHC patients returning home from treatment at the ANMC.

- Accepting all referrals of Alaskan Natives from the Norton Sound Regional Hospital.

- The ANMC EMS program provided specialized training such as ACLS, ATLS, PALS, including hypothermia, cold water drowning and frostbite.

- The NSHC Laboratory received the following services from ANMC: (a) pathologist consultation and visitation twice a year; (b) Anatomical tissue analysis and reporting; and (c) Access to TDY Services as needed and available.

- The ANMC provided consultation and informational support for the NSHC Social Services program, including JCAHO standards and other licensure issues.

- The ANMC provided support including screening, diagnosis, consultations, referrals, personnel training, information, network and recruitment assistance for the FAS program at NSHC and for its Maternal Child Health Program.

- The ANMC provided recruitment assistance to the Mental Health program as needed.

- STD/HIV testing, counseling, partner notification, education and consultation as requested by NSHC.

- Nutrition education and counseling services from the statewide Diabetes program based at ANMC.

- Environmental Health /Sanitation services including, but not limited to, appropriate village visits for environmental services, injury prevention, institutional services.

- Diabetes patients tracking and registration.

- Engineering services inclusive of maintenance and improvement for federal facilities and projects;

- Purchasing activities under GSA contracts;

- Office of Environmental Health Services and activities, health facilities support, real property support especially for village built clinics; projects for health facilities management, special projects and sanitations facilities.

- Administration and management of IPA/MOAs;

- Certain contract health services, not otherwise contracted under Title I;

- Region X legal consultation.

ADDENDUM II
NORTON SOUND HEALTH CORPORATION
MEMORIALIZATION OF MATTERS REMAINING IN DISPUTE

(1) Norton Sound Health Corporation (NSHC) does not agree with the IHS' position that Area Office tribal shares that were restricted by individual Co-Signer decision or by a consensus decision of all Co-Signers from FY 1995 through FY 2000 are not available for inclusion in FY 2002 because of Section 325, P.L. 105-83. NSHC believes it has the right to include such tribal shares in its FY 2002 funding agreements notwithstanding Section 325. NSHC reserves any remedies it may have under law.

ALASKA TRIBAL HEALTH COMPACT

BETWEEN

CERTAIN ALASKA NATIVE TRIBES

AND THE

UNITED STATES OF AMERICA

OCTOBER 1, 1994

—

AMENDED AND RESTATED

OCTOBER 1, 2017

ALASKA TRIBAL HEALTH COMPACT

OCTOBER 1, 1994

AMENDED AND RESTATED
OCTOBER 1, 2017

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ALASKA TRIBAL HEALTH COMPACT
BETWEEN
CERTAIN ALASKA NATIVE TRIBES
AND THE
UNITED STATES OF AMERICA
OCTOBER 1, 1994
AMENDED AND RESTATED
OCTOBER 1, 2010

This Compact of Self-Governance, which under Title III of Public Law No. 93-638, as amended, became effective October 1, 1994, was amended and restated effective October 1, 1995, October 1, 1996, October 1, 1997, October 1, 1998, October 1, 2000, and was further amended and restated in FY 2001, effective October 1, 2000, to conform with Public Law 106-260, Title V of the Indian Self-Determination and Education Assistance Act, as amended (hereinafter Title V), October 1, 2003, October 1, 2006, October 1, 2008, and October 1, 2010 is made and entered into by and between the Secretary of Health and Human Services of the United States of America, represented by the Director of the Indian Health Service, and certain Alaska Native Tribes recognized by the United States acting collectively, and the Alaska Native Tribal Health Consortium, as set forth in Exhibit A. This Compact is entered into under the Title V, which authorizes the Secretary to enter into Compacts and Funding Agreements with the governing bodies of participating Tribal governments. The Secretary has delegated the authority to enter into this Compact and funding agreements to the Director, Indian Health Service (hereinafter IHS). This Compact reflects the United States' special trust responsibility and legal obligations to Indians and Alaska Natives, as stated in 25 U.S.C. section 1602, and the unique tribal cooperation that has developed in Alaska to assure that all Alaska Natives have access to a comprehensive, integrated, and tribally-controlled health care delivery system. The parties are committed to ensuring that the essential statewide functions of the Alaska Native Medical Center in Anchorage remain intact, whether operated by the Indian Health Service, the Alaska Native Tribal Health Consortium or by Alaska Native Tribes recognized by the United States.

WITNESSETH:

WHEREAS, the Alaska Native people have governed themselves and lived in the area known as Alaska since time immemorial;

WHEREAS, federally recognized tribal governments in the State of Alaska

> . . . have the same governmental status as other federally acknowledged Indian tribes by virtue of their status as Indian tribes with a government-to-government relationship with the United States; are entitled to the same protection, immunities, privileges as other acknowledged tribes; have the right, subject to general principles of Federal Indian law, to exercise the same inherent and delegated authorities available to other tribes; and are subject to the same limitations imposed by law on other tribes;

(*Indian Entities Recognized and Eligible to Receive Services from the United States Bureau of Indian Affairs*, 58 Fed. Reg. 54364 (October 21, 1993));

WHEREAS, for the purposes of ensuring that all Alaska Natives and America Indians in Alaska can receive the services provided by the Federal Government through an Alaska Native provider, the Congress has defined the term, "Indian Tribe," to mean:

> . . . any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(Indian Self-Determination and Education Assistance Act, as amended, 25 U.S.C. § 450b(e));

WHEREAS, to prioritize between the entities eligible to authorize contracting under the Indian Self-Determination and Education Assistance Act, as amended, the Indian Health Service has established in the Alaska Area the following order of preference:

> If there is an Indian Reorganization Act (IRA) Council, and it provides governmental functions for the village, it will be recognized.
>
> If there is no IRA Council, or it does not provide governmental functions, then the traditional village council will be recognized.
>
> If there is no IRA Council and no traditional village council, then the village profit corporation will be recognized.
>
> If there is no IRA Council, no traditional village council, and no village profit corporation, then the regional profit corporation will be recognized for that particular village.

(*Alaska Area Guidelines for Tribal Clearances for Indian Self-Determination Contracts*, 46 Fed.

Reg. 27178);

WHEREAS, the United States of America has recognized certain entities in Alaska as American Indian Tribes for purposes of the Indian Self-Determination and Education Assistance Act (*See* 25 U.S.C. § 450b(e); *Indian Entities Recognized and Eligible To Receive Services from the United States Bureau of Indian Affairs*, 58 Fed. Reg. 54364 (October 21, 1993); and *Alaska Area Guidelines for Tribal Clearances for Indian Self-Determination Contracts*, 46 Fed. Reg. 27178, (hereinafter "the Tribes");

WHEREAS, certain Tribes of Alaska have formed and authorized certain Tribal Organizations and Inter-Tribal Consortia as defined in 25 U.S.C. § 450b(*l*) and section 501(a)(5) of Title V, for the purpose of providing health care to Alaska Natives and to contract with the Indian Health Service and other federal and non-tribal agencies for such purpose as well as to provide health care to the other residents of their respective service areas, as permitted by section 813 of the Indian Health Care Improvement Act, as amended, or other applicable law;

WHEREAS, the Congress has declared its commitment to the maintenance of the Federal Government's unique and continuing relationship with, and responsibility to, Alaska Native and American Indian Tribes and to the Alaska Native and American Indian people as a whole through the permanent establishment of a meaningful Indian self-governance policy, which will permit an orderly transition from the federal domination of programs for, and services to, Alaska Natives and American Indians to effective and meaningful participation by the Alaska Native and American Indian people in the planning, conduct, and administration of those programs and services; 25 U.S.C. § 458aaa(note);

WHEREAS, the Congress has declared its commitment to strengthening the government-to-government relationship and to supporting and assisting Alaska Native and American Indian Tribes in the orderly transition from the federal domination of programs and services to provide Alaska Native and American Indian Tribes with meaningful authority, control, funding and discretion to plan, conduct, redesign and administer programs, services, functions and activities (or portions thereof) that meet the needs of the individual tribal communities, 25 U.S.C. § 458aaa(note);

WHEREAS, Federal health services to maintain and improve the health of the Indians and Alaska Natives are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian and Alaska Native people, 25 U.S.C.§§ 1601(1), (2);

WHEREAS, in accordance with 25 U.S.C. § 1601(2) a major national goal of the United States is to provide resources, processes and structures that will enable Indians and Alaska Natives to obtain the quality and quantity of health care services and opportunities that will eradicate health disparities between Indians and Alaska Natives and the general population of the United States;

WHEREAS, the Congress has declared that it is the policy of the United States as stated in 25 U.S.C. § 1602, in fulfillment of its special trust responsibilities and legal obligations to the American Indian and Alaska Native people, to ensure the highest possible health status for Indians

and Alaska Natives and to provide all resources necessary to effect that policy; to raise the health status of Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives; and also the ensure maximum Indian and Alaska Native participation in the direction of health care services so as to render the person administering such services and the services themselves more responsive to the needs and desires of Indian and Alaska Native communities;

WHEREAS, for the purposes of this Compact,

"ANTHC" shall mean only the Alaska Native Tribal Health Consortium;

"Co-Signer" shall mean all Tribes and tribal organizations or Inter-Tribal Consortia, including the ANTHC, participating in the Compact;

"Signatory Tribe(s)" shall mean all Tribes participating in the Compact either directly or through a tribal organization or Inter-Tribal Consortium that has been authorized to participate by resolution;

"Tribal Co-Signer" shall mean only those Tribes, tribal organizations and Inter-Tribal Consortia authorized by resolution of a Tribe, as defined in 25 U.S.C. § 450b(*l*) and sections 501(a)(5) and (b) of Title V, to participate in the Compact and shall not include the ANTHC; and

WHEREAS, under authority from the Tribes, certain Tribal Organizations and Inter-Tribal Consortia in Alaska have provided health services for many years under self-determination contracts with the Indian Health Service and have been recognized by the Indian Health Service as tribally-operated service units;

WHEREAS, pursuant to section 325 of P.L. 105-83, the Alaska Native Tribal Health Consortium (herein "ANTHC"), a tribal organization and Inter-tribal Consortium, as defined in section 501(a)(5) of Title V, was organized and is controlled by the Alaska Native tribes and tribal organizations which are represented on its Board of Directors;

WHEREAS, Tribes, Tribal Organizations and Inter-Tribal Consortia throughout Alaska are reliant on the services to be provided by the ANTHC;

WHEREAS, participation by the ANTHC in the Alaska Tribal Health Compact promotes the commitment of Alaska Native Tribes, Tribal Organizations and Inter-Tribal Consortia to maintain the unique tribal cooperation that has developed in Alaska to assure that all Alaska Natives have access to a comprehensive, integrated, organized, tribally controlled health care delivery system in which Alaska tribal health providers participate in numerous joint activities including utilization review and provide their health services in a clinically integrated care setting in which individuals typically receive health care from more than one of these Alaska tribal providers;

WHEREAS, in furtherance of the federal policy of Alaska Native and American Indian tribal self-determination and self-governance, Congress has directed the Secretary of Health and Human Services (herein the "Secretary") to carry out the Tribal Self-Governance Program under Title V.;

WHEREAS, Congress, in Title V, has authorized the Secretary to negotiate and implement a Compact of Self-Governance and Funding Agreements with the governing bodies of participating Tribal governments of qualified Alaska Native and American Indian Tribes that have completed a planning activity;

WHEREAS, Congress has directed that the Funding Agreements, which the Secretary negotiates with Alaska Native and American Indian tribes, shall authorize the Co-Signers to plan, conduct, consolidate, administer, receive full tribal shares of funding, redesign programs, and reallocate funds for programs, services, functions and activities as provided in sections 505(b)(1) and, (b)(2) and 506 (e) of Title V;

WHEREAS, each Funding Agreement shall specify the programs, services, functions or activities to be performed or administered, the funds to be provided, and the responsibilities of the Co-Signer and the Secretary in accordance with section 505 of Title V;

WHEREAS, the Funding Agreement shall specify the authority of the Co-Signer to redesign or consolidate programs, functions, services and activities (or portions thereof) and to reallocate or redirect funds or modify budget allocations pursuant to section 506(e) of Title V;

WHEREAS, to the extent to which, funding is provided to a Co-Signer, as authorized by Alaska Native Tribes, pursuant to a Funding Agreement, such Co-Signer shall be responsible for administration of programs, services, functions and activities pursuant to the Agreement, consistent with section 505 of Title V;

WHEREAS, nothing in this Compact or associated Funding Agreements shall be construed to limit or reduce in any way the funding for any program, project or activity serving an Indian Tribe under Title V or any other applicable Federal law, pursuant to section 515(a) of Title V;

WHEREAS, in Title V, Congress has directed that the Funding Agreements, which the Secretary negotiates with Co-Signers shall contain certain provisions and, at the option of the Co-Signers, apply to certain programs, activities, functions and services of the Indian Health Service (including construction) as specified in sections 505, 507(a)(2)(A), and 509 of Title V;

WHEREAS, Congress has directed that, at the request of the governing body of qualifying Tribes and the ANTHC and under the terms of a Funding Agreement, the Secretary shall provide funding to the Tribes and the ANTHC to implement the Funding Agreement in accordance with section 508 of Title V;

WHEREAS, Congress has directed that the Secretary shall interpret federal laws and regulations in a manner that will facilitate the implementation of a Compact of Self-Governance and Funding Agreement authorized by section 512(a) of Title V;

WHEREAS, Congress has directed that the Secretary shall interpret federal laws and regulations in a manner that will facilitate the inclusion of activities, programs, services, and functions (or portions thereof) in Compacts of Self-Governance and Funding Agreements authorized by section 512(a) of Title V;

WHEREAS, it is the intent of certain Alaska Native Tribes to collectively enter into a single Compact with the Secretary. To carry out that intent, such Tribes (hereafter referred to as signatory Tribes) enter into this Compact either by individual signature or by means of a delegation of signature authority as authorized by resolution of the Tribal government. Such resolutions are attached as Exhibit "A".

WHEREAS, it is the intent of the signatory Tribes that this Compact will be carried out either by the Tribe itself, by tribal organizations or Inter-Tribal Consortia, as authorized by resolution of Tribe(s) as defined by 25 USC § 450b(e), section 501(b), and by the ANTHC under section 325 of P.L. 105-83. These Tribes, tribal organizations and Inter-Tribal Consortia, including the ANTHC, are bound by the terms of this Compact and are signing separately as Co-Signers.

WHEREAS, it is the intent of the parties that each Tribal Co-Signer Funding Agreement entered into under this Compact shall be executed by the Tribes, either by individual signature or by means of a delegation of signature authority as authorized by resolution of the Tribal government. Each such Funding Agreement also will be signed by a Tribal Co-Signer, designated by the Tribal governing body. The Tribal Co-Signer will carry out the terms of the Funding Agreement for the signatory Tribe(s) from which it has obtained a resolution of authority and be bound by its terms;

WHEREAS, the ANTHC may enter into this Compact and into Funding Agreements under this Compact as authorized by the Board of Directors of the Alaska Native Tribal Health Consortium; and

WHEREAS, for purposes of clarification, and to recognize the government to government relationship between the signatory Tribes and the Secretary, the parties agree that the signatory Tribes, by entering into this Compact, do not relinquish any aspects of Tribal sovereignty to the Co-Signers. The Tribal Co-Signers act only for and on behalf of the signatory Tribe(s) within the scope of the authority granted to them by tribal resolution or by law and the ANTHC has only the authority granted to it under section 325 of P.L. 105-83. Tribal Co-Signers and the ANTHC by carrying out the terms of this Compact and the associated Funding Agreements do not gain the status of a sovereign tribal government;

WHEREAS, the parties have determined that all of the provisions of this Compact are authorized by Title V or other provisions of federal law and the parties have executed this Compact in reliance on this representation;

NOW, THEREFORE, the Secretary, signatory Tribes and the Co-Signers do hereby agree to enter into, undertake, and be bound by this Compact in accordance with the foregoing principles.

ARTICLE I — AUTHORITY AND PURPOSE

Section 1 – Authority. This Compact of Self-Governance, which became effective October 1, 1994, was amended and restated effective October 1, 1995, October 1, 1996, October 1, 1997, October 1, 1998, and October 1, 2000, and was further amended and restated in FY 2001 effective October 1, 2000, to conform with Title V, October 1, 2003, October 1, 2006, October 1,

2008, and October 1, 2010 (hereinafter the "Compact"), is authorized by Title V of the Indian Self-Determination and Education Assistance Act, as amended, and is hereby entered into by the Secretary of the Department of Health and Human Services of the United States of America (hereinafter the "Secretary"), represented by the Director of the Indian Health Service, certain Alaska Native Tribes, as identified in Exhibit A, recognized by the United States, acting individually or collectively, and the Alaska Native Tribal Health Consortium (hereinafter the "ANTHC"). The Director of the Indian Health Service by signing this Compact commits the Secretary to the extent and within the scope of the Secretary's delegation of authority to enter into Compacts and Funding Agreements pursuant to Title V or as otherwise authorized.

Section 2 – Purpose. This Compact shall be liberally construed to achieve its purposes:

(a) This Compact is to carry out a Self-Governance Program authorized by Title V, and is intended to transfer to tribal governments, at a tribe's request, the power to decide how federal programs, services, functions and activities (or portions thereof) shall be funded and carried out. Title V is meant to strengthen the government-to-government relationship and to uphold the United States trust responsibility for each Indian Tribe. This Compact promotes the autonomy of the Tribes in Alaska in the realm of health care.

(b) This Compact is to enable the signatory Tribes and the Co-Signers to re-design health programs, activities, functions, and services of the Indian Health Service; to reallocate funds for programs, activities, functions, or services according to the priorities of the signatory Tribes and Co-Signers; to enhance the effectiveness and long-term financial stability of the Tribes and the Co-Signers; and to streamline the federal Indian Health Service bureaucracy.

(c) This Compact is to enable the United States to maintain and improve its unique and continuing relationship with, and special trust responsibilities and legal obligations, pursuant to 25 U.S.C. 1602 of the IHCIA, to the Tribes through tribal self-governance and to permit an orderly transition from federal domination of programs and services.

(d) This Compact and Funding Agreement shall transfer to signatory Tribes, acting individually or collectively, and the ANTHC the responsibility for the programs, activities, functions and services of the Indian Health Service included in the Funding Agreement. This Compact allows signatory Tribes, acting individually or collectively, and the ANTHC to exercise meaningful authority to plan, conduct, and administer those programs and services to meet the health care needs of the Alaska Native Tribes. In fulfilling its responsibilities under the Compact and consistent with 25 U.S.C. §§ 1602(5), (6), and the November 5, 2009 Memorandum for the Heads of Executive Departments and Agencies, the April 29, 1994, Memorandum from the President of the United States of America for the Heads of Executive Departments and Agencies, attached hereto as Exhibit B, Executive Order 13175 on Consultation and Coordination with Indian Tribal Governments, the September 23, 2004, Memorandum from the President of the United States of America for the Heads of Executive Departments and Agencies, and the Department of Health and Human Services Tribal Consultation Policy, the Secretary hereby pledges that the Indian Health Service will conduct all relations with the Tribes on a government-to-government basis.

ARTICLE II — TERMS, PROVISIONS AND CONDITIONS

Section 1 – Term and Resolutions.

(a) Term. The term of this Compact begins as to each Co-Signer on the effective date of the Co-Signer's first Funding Agreement and shall extend thereafter as to each Co-Signer throughout the period authorized by Title V of the Indian Self-Determination and Education Assistance Act, and any subsequent amendment thereto, provided the Co-Signer has a Funding Agreement in effect, and shall remain in effect for so long as is permitted by Federal law or until terminated by mutual written agreement, retrocession, or reassumption pursuant to section 504(d) of Title V.

(b) Resolutions from Signatory Tribes. Those Tribes which intend to participate in this Compact and the applicable Funding Agreement through delegation of signature authority as provided in this Compact must have issued a written resolution authorizing the Tribal Co-Signer, on their behalf, to enter into this Compact and Funding Agreement on or before the date the Compact and the applicable Funding Agreement is signed by the Tribal Co-Signer for that Tribe, provided that if a Tribal Co-Signer negotiates a Funding Agreement prior to obtaining an authorizing resolution from a Tribe, nothing herein shall be construed to limit or impair in any way a tribal government's sovereign right to decide whether or not to sign such a resolution.

(c) Resolution from the Board of the ANTHC. The ANTHC may participate in this Compact and the applicable Funding Agreement upon receipt of an authorizing resolution of the Board of Directors of the ANTHC, attached hereto as a part of Exhibit A.

Section 2 – Effective Date.

(a) Once this Compact and the Funding Agreements, attached hereto as Exhibit C, are approved and signed by the Co-Signers and the Secretary, they shall be effective as of October 1, 2008. Subsequent Funding Agreements will be effective on the date signed by the Secretary and Co-Signer or another date mutually agreed upon.

(b) During the term of this Compact any Co-Signer which has not previously negotiated a Funding Agreement may do so. All Funding Agreements shall be subject to, and all the activities thereunder shall be governed by, the terms of this Compact to the same extent as the initial Funding Agreements. New Funding Agreements will be effective on the date signed by the Secretary and Co-Signer or another date mutually agreed upon.

(c) Each Funding Agreement and subsequent Funding Agreement of a Co-Signer is deemed to be incorporated, as negotiated, by reference into this Compact, for the purposes only of that Co-Signer and the United States. In the event of inconsistency between the Compact and any subsequent Funding Agreement, the provisions of the Compact shall prevail.

Section 3 – Funding Amount. Subject only to the appropriation of funds by the Congress of the United States and in accordance with section 508 of Title V, the Secretary shall provide the total amounts specified in the Funding Agreements.

Section 4 – Payment.

(a) Payment Schedule. Payment shall be made expeditiously and shall include financial arrangements to cover funding during periods under continuing resolutions to the extent permitted by such resolutions. For each fiscal year covered by the Compact, the Secretary shall make available the funds specified for that fiscal year under the Funding Agreements by paying the respective total amount as provided for in each Funding Agreement in advance lump sum, as permitted by law, or such other payments as provided in the schedule set forth in each Funding Agreement. The first payment shall be made on or before ten calendar days after the date on which the Office of Management and Budget (hereinafter "OMB") apportions the appropriations for that fiscal year for the programs, activities, functions and services subject to the Compact. The Prompt Payment Act, Chapter 39 of Title 31, United States Code, shall apply to the payment of funds due under this Compact and to each Funding Agreement negotiated thereunder.

(b) Interest on Advances. Co-Signers receiving funds under applicable Funding Agreements pursuant to this Compact shall be permitted to retain interest earned on funds advanced pending disbursement as authorized by law. Interest earned on advances shall not diminish the amount of funds the Co-Signer is authorized to receive under its Funding Agreement in the year earned or in any subsequent fiscal year. All funds transferred under Funding Agreements pursuant to this Compact shall be managed using the prudent investment standard pursuant to section 508(h) of Title V.

Section 5 – Reports to Congress. In accordance with section 514 of Title V, the Secretary shall submit to the Senate Committee on Indian Affairs and the House Resources Committee a written report not later than January 1 of each year on the administration of Title V. Each report shall include a detailed analysis on the level of need being presently funded or unfunded for each signatory Tribe and Co-Signer. The contents of each report shall comply with section 514(b). In compiling the reports, the Secretary may not impose any reporting requirements on Co-Signers not otherwise provided in Title V. The Secretary shall provide each Co-Signer with a draft of each report required to be submitted to Congress under this provision for a thirty (30) day comment period prior to the submission of the report to Congress so that the Co-Signers may comment on the report. The Secretary shall include each Co-Signer's comments in the final report to Congress.

Section 6 – Audits

(a) Single Audit. Each Co-Signer that has executed a Funding Agreement pursuant to this Compact shall provide to the National External Audit Review Center (or its successor), which is the designee of the Secretary for the purposes of this section, an annual single organization-wide audit as prescribed by the Single Audit Act of 1984, as amended, 31 U.S.C. § 7501, *et seq*. A copy of this audit will be sent simultaneously to the Indian Health Service Area Office, the cognizant agency, and the Federal Audit Clearinghouse.

(b) Cost Principles. Each Co-Signer shall apply cost principles under the applicable OMB Circular, except as modified by section 106(k) of the Indian Self-Determination and Education Assistance Act, as amended, which section is hereby incorporated into this Compact, or by any exemptions subsequently granted by OMB. To the extent that OMB Circular A-87 or its successor, or other applicable circulars, permit agency pre-approval of allowable costs,

the agency hereby grants that pre-approval. The Secretary will assist the Co-Signers in obtaining such additional waivers from OMB as are requested by the Co-Signers. No other audit or accounting standards shall be required by the Secretary. Any claim by the Federal Government against any Co-Signer receiving funds under a Funding Agreement based on any audit under this section shall be subject to the provisions of section 106(f) of the Indian Self-Determination and Education Assistance Act, as amended.

Section 7 – Records. Each Co-Signer's practices relating to document disclosure and record-keeping associated with this Compact shall, in accordance with applicable law, be set forth in the respective Funding Agreement.

Section 8 – Property.

(a) In General. The provisions of section 512(c) and section 1(b)(8) of the Model Agreement set forth in section 108(c) of the Indian Self-Determination and Education Assistance Act, as amended, are hereby incorporated into this Compact.

(b) Property Management. Management of property under this Compact shall be in accordance with additional provisions included in each Co-Signer's Funding Agreement.

(c) Access to Property Subject to Destruction. Prior to the destruction of federal property which would otherwise be declared surplus or excess and which is located within the service area of a Co-Signer, the Secretary, if previously requested by the Co-Signer, shall provide notice of such proposed destruction to the Co-Signer. Such notice shall inform the Co-Signer of the name and address of the official responsible for determining whether such property will be destroyed or declared surplus or excess. If the Secretary is the responsible official, the Secretary will consider information provided by the Co-Signer regarding transfer of the property, rather than destruction, and, if not the responsible official, the Secretary will assist the Co-Signer in communicating information to the responsible official.

(d) Leases. Upon the request of a Co-Signer, the Secretary shall enter into a lease with the Co-Signer in accordance with section 105(*l*) of the Indian Self-Determination and Education Assistance Act, as amended.

Section 9 – Regulatory Authority. The Secretary and the Co-Signers agree to utilize the following procedures governing the establishment and application of program rules and regulations under this Compact:

(a) Program Rules. No Co-Signer is required to comply with any agency circular, policy, manual, guidance or rule adopted by the Indian Health Service other than those identified in this section or expressly incorporated by reference in the individual Co-Signer's Funding Agreement in carrying out the programs, services, activities and functions under the Compact, except for the eligibility provisions of section 105(g) of the Indian Self-Determination and Education Assistance Act, as amended, and regulations promulgated under section 517 of Title V.

(b) Federal Regulations.

(1) Applicable Federal Regulations. The Co-Signers, in carrying out the provisions of this Compact and applicable Funding Agreements, will be required to comply only with applicable federal regulations, which include regulations promulgated under section 517 of Title V unless waived as provided in section 512(b) of Title V.

(2) Waiver of Federal Regulations.

(A) The Secretary and the Co-Signer will seek to identify federal regulations promulgated pursuant to section 517 or under the authorities specified in section 512(b) of Title V which may require waiver in order to effectively carry out this Compact or any Funding Agreement.

(B) Waivers of regulations shall be submitted and addressed in accordance with the procedures set forth in section 512(b).

(c) Title I Section Incorporated by Reference. Section 105(a)(1) of the Indian Self-Determination and Education Assistance Act, as amended, 25 U.S.C. § 450j(a)(1), is hereby incorporated in this Compact and shall have the same force and effect as if it were set forth in full in Title V of the Act.

Section 10 – Disputes.

(a) All disputes between the Indian Health Service and any Co-Signer or between the Indian Health Service and all Co-Signers under this Compact shall be subject to Title V and the provisions of section 110 of the Indian Self-Determination and Education Assistance Act, as amended, and all remedies provided for therein shall be available to each Co-Signer of this Compact. Actions and proceedings to enforce the Co-Signer's rights and the Secretary's obligations under this Compact shall be subject to the Equal Access to Justice Act, Public Law 96-481, as amended, to the same extent as are actions and proceedings involving Public Law 93-638 contracts.

(b) In the alternative, the Indian Health Service and the Co-Signers may use the processes authorized and encouraged in the Administrative Dispute Resolution Act, 5 U.S.C. § 581 note, for more informal resolution of disputes arising under this Compact and associated Funding Agreements.

Section 11 – Retrocession and Withdrawal

(a) Retrocession. Section 506(f) of the Act is herein adopted. A Co-signer may retrocede, fully or partially, to the Secretary programs, services, functions, or activities (or portions thereof) included in the compact or funding agreement. Unless the Co-signer rescinds the request for retrocession, such retrocession will become effective within the timeframe specified by the parties in the compact or funding agreement. In the absence of such a specification, such retrocession shall become effective on

(1) the earlier of

(A) one year after the date of submission of such request; or

(B) the date on which the funding agreement expires; or

(2) such date as may be mutually agreed upon by the Secretary and the Co-signer.

(b) Withdrawal. Section 506(g) of the Act is herein adopted. Unless prohibited by law and in accordance with Section 506(g) of the Act, a Tribe may fully or partially withdraw from a participating inter-tribal consortium or tribal organization its share of any program, function, service, or activity (or portions thereof) included in a compact or funding agreement. The withdrawal shall become effective within the timeframe specified in the resolution which authorizes transfer to the participating tribal organization or inter-tribal consortium. In the absence of a specific timeframe set forth in the resolution, such withdrawal shall become effective on

(1) the earlier of

(A) one year after the date of submission of such request; or

(B) the date on which the funding agreement expires; or

(2) such date as may be mutually agreed upon by the Secretary, the withdrawing Indian tribe, and the participating tribal organization or inter-tribal consortium that has signed the compact or funding agreement on behalf of the withdrawing Indian tribe, inter-tribal consortium, or tribal organization.

Section 12 – Discontinuance. Co-signer may discontinue its participation in the Alaska Tribal Health Compact after written notice to each authorizing Tribe or Village and the IHS. Notice must be provided one year in advance of the effective date of the request except that the effective date of a request may be less than one year upon approval of all authorizing Tribes and Villages and the IHS.

Section 13 – Subsequent Funding Agreements.

(a) Negotiations for subsequent Funding Agreements, as provided for in Article VI, section 2, shall begin no later than 120 days in advance of the conclusion of the preceding Funding Agreement. Each Co-Signer is hereby assured that future funding of the Co-Signer's subsequent Funding Agreements shall only be reduced pursuant to the provisions of section 508(d) of Title V provided, however, that future funding for each Co-Signer's non-recurring funds and tribal shares shall be subject to adjustments in accordance with a yearly reallocation decision by the Co-Signers. The Secretary agrees to prepare and supply relevant information, and promptly to comply with the Co-Signers' requests for information reasonably needed to determine the funds that may be available for a subsequent Funding Agreement as provided for in Article VI, Section 2 of this Compact.

(b) If the parties are unable to conclude negotiation of a subsequent Funding Agreement, the terms of this Compact and the existing Funding Agreement shall, at the option of the Co-Signer, continue on in 30-day, 90-day or longer increments until a subsequent Funding Agreement is agreed to. As provided in section 505(e) of Title V, the terms of the subsequent Funding Agreement will become retroactive to the end of the term of the preceding Funding Agreement. Any increases in funding to which Tribes are entitled by law or which have been made available by Congress, or increases which Co-Signers subsequently negotiate, shall be included in each Co-Signer's subsequent Funding Agreement.

Section 14 – Health Status Reports. In accordance with section 507(a)(1), Co-Signers shall provide the Secretary a health status and service delivery report to the extent that relevant data is not otherwise available to the Secretary and specific funds for this purpose are provided to the Co-Signer in its Funding Agreement. Such reporting may impose only minimal burdens on the Co-Signer and shall be consistent with regulations promulgated under section 517 of Title V.

Section 15 – Secretarial Approval. For the term of the Compact, the provisions of 25 U.S.C. § 81 and 25 U.S.C. § 476 shall not apply to attorney and other professional contracts of signatory tribal governments of Alaska Native Tribes operating under the Compact pursuant to section 511(b) of Title V.

Section 16 – Transportation and Other Supply Sources.

(a) Use of Motor Vehicles. Subject to agreement of the General Services Administration, the Secretary hereby authorizes each Co-Signer to obtain Interagency Motor Pool vehicles and related services for performance of any programs, activities, functions and services under this Compact.

(b) Other Supply Sources. Federal supply sources (including lodging, airline transportation, and other means of transportation) shall be available to each Co-Signer in accordance with sections 508(e) and 516(a) of Title V.

Section 17 – Limitation of Costs. Each Co-Signer shall not be obligated to continue performance that requires an expenditure of funds in excess of funds awarded under the Funding Agreement. In accordance with section 508(k), if, at any time the Co-Signer has reason to believe that the total amount required for performance of a Funding Agreement, or a specific activity conducted under the Funding Agreement, would be greater than the amount of funds awarded under the Funding Agreement, the Co-Signer shall provide reasonable notice to the Indian Health Service and affected Tribes and tribal organizations. If the Indian Health Service does not take such action as may be necessary to increase the amount of funds awarded under the Funding Agreement, the Co-Signer may suspend performance of the Funding Agreement until such time as additional funds are transferred.

ARTICLE III — OBLIGATIONS OF EACH CO-SIGNER

Section 1 – Consolidation. Each Co-Signer will be responsible for performing the health programs, activities, functions and services as specified in Section 3 of this Article III and in their respective Funding Agreements, as provided for in Article VI, Section 2 of this Compact. To the extent a program, activity, function, or service included within a contract or grant entered into pursuant to sections 102 or 103 of the Indian Self-Determination and Education Assistance Act, as amended, is included within a Funding Agreement, that contract or grant shall be modified or terminated as appropriate. The parties' obligations shall be governed by this Compact and all funds previously obligated under contracts or grants (including carry-over funds) will be re-obligated to the Co-Signer under the applicable Funding Agreement. Such terminated contracts shall be identified by contract number in each Funding Agreement.

Section 2 – Amount of Funds. The total amount of funds covered by the consolidation and redesign provided for in Section 1 of this Article that the Secretary shall make available to the Co-Signers shall be determined in accordance with section 508(c) of Title V and shall be set forth in the respective Funding Agreements between the Secretary and each Co-Signer.

Section 3 – Compact Programs. The health programs, activities, functions and services will be the responsibility of each Co-Signer under this Compact and shall be identified in each Co-Signer's Funding Agreement.

Section 4 – Eligibility for Services. In determining eligibility for services, the Co-Signers shall comply with applicable eligibility provisions set forth in the Indian Health Care Improvement Act, as amended, applicable regulations, and other statutory law.

Section 5 – Reallocation, Redesign and Consolidation. In accordance with section 506(e) of Title V, a Co-Signer may redesign or consolidate programs, services, functions, and activities (or portions thereof) included in a Funding Agreement and reallocate or redirect funds for such programs, services, functions, and activities (or portions thereof) in any manner in which the Co-Signer deems to be in the best interest of the health and welfare of the Indian community being served, only if the redesign or consolidation does not have the effect of denying eligibility for services to population groups otherwise eligible to be served under applicable federal law.

Section 6 – Consolidation with Other Programs. Each Co-Signer may consolidate programs, services, functions, and activities and associated funds identified in its funding agreement with other programs, services, functions, and activities provided with its own funds or funds from other sources, provided that the programs, services, functions, and activities are allowable for inclusion in a funding agreement under Section 505 of Title V. When programs, services, functions, and activities are consolidated in a funding agreement by a Co-Signer in accordance with the terms of the Funding Agreement and Title V, the Co-signer and its employees carrying out those programs, services, functions, and activities may receive Federal Tort Claims Act coverage in accordance with the statutory provisions and regulations cited in the Compact. Whether the Federal Tort Claims Act applies in any particular case is decided on an individual case-by-case basis by the United States Department of Justice and subsequently by the Federal courts. In cases in which a Co-Signer consolidates programs, services, functions, and activities under this section, the Co-Signer shall not be required to separate dollars or programs, services, functions, and activities so long as the Co-Signer can provide sufficient data to permit an acceptable program and financial audit to be conducted.

Section 7 – Program Income, including Medicare/Medicaid. All Medicare, Medicaid or other program income earned by a Co-Signer shall be treated as additional supplemental funding to that negotiated in the Funding Agreement and the Co-Signer may retain all such income, including Medicare/Medicaid, and expend such funds in the current year or in future years, nor shall such funds result in any off-set or reduction in the negotiated amount of the Funding Agreement. Medicare/Medicaid collections of a Co-Signer under Title IV of Public Law 94-437, as amended, shall be used by the Co-Signer in accordance with any applicable statutory restrictions on the use of such funds.

Section 8 – Carry-over. Congressionally appropriated funds allocated in accordance with

a Funding Agreement under this Compact are "no year" funds and may be expended by the Co-Signer in accordance with its budget for the year for which the funds are appropriated or carried over and expended in any subsequent fiscal year, and such carry-over shall not diminish the amount of funds the Co-Signer is authorized to receive under its Funding Agreement for any such subsequent fiscal year.

Section 9 – Matching Funds. Funds may be used to meet matching and other cost participation requirements under any other federal or non-federal programs pursuant to section 512(d) of Title V.

ARTICLE IV — OBLIGATIONS OF THE UNITED STATES

Section 1 – Trust Responsibility. In accordance with sections 507(g) and 515(b) of Title V, nothing in this Compact waives, modifies, or diminishes in any way the trust responsibility of the United States with respect to the Alaska Native Tribes or individual Alaska Natives and American Indians which exists under treaty, executive orders, and acts of Congress.

Section 2 – Programs Retained.

(a) The Secretary hereby retains the responsibility for the programs, activities, functions and services with respect to the signatory Tribes that are not specifically assumed by the signatory Tribes, acting individually or collectively, or by the ANTHC through their applicable Funding Agreements and they shall continue to be entitled to the full benefit of those programs, activities, functions, and services retained by the Indian Health Service. In accordance with section 506(h), each Co-Signer shall be eligible for new programs, activities, functions and services of the Secretary and the Indian Health Service on the same basis as other Tribes and Tribal Organizations. The Indian Health Service, in consultation with the Tribes, may reorganize to sustain its ability to provide, in the most effective and efficient manner, all programs, activities, functions, and services that have not been included in the Funding Agreement.

(b) No later than 120 days prior to the end of each fiscal year, the Indian Health Service shall provide each signatory Tribe and Co-Signer with a written list of the retained programs, activities, functions, and services relevant to Native health care in Alaska for the upcoming fiscal year. To the fullest extent permitted by law, the Secretary shall provide any requesting signatory Tribe and Co-Signer access to, and copies of, all documents and other information relevant to any ongoing retained programs, activities, functions, or services, and shall cooperate with any evaluation which the Co-Signer or signatory Tribe may wish to conduct. The Secretary will cooperate with each Tribe and Co-Signer to facilitate the inclusion of programs, activities, functions and services in future Funding Agreements of those Tribes and Co-Signer.

Section 3 – Financial and Other Information.

(a) To assist the Tribes and Co-Signers in monitoring compliance with section 508(c) of the Indian Self-Determination and Education Assistance Act, as amended, the Secretary shall provide to Co-Signers:

(1) all monthly reports of obligations and allowances, including all reports from Central Office, Headquarters, the Office of Tribal Self-Governance and the Alaska Area Office, concerning funds provided to support programs, activities, functions and services provided by Tribes or Tribal Organizations under this Compact and funds retained by the Indian Health Service to support programs, activities, functions and services retained by the Indian Health Service; and

(2) prompt notice of any new programs, activities, functions and services for which the Tribes or Co-Signers are eligible, including the funding available for such programs, activities, functions and services.

(b) The Secretary shall prepare and promptly supply relevant financial information and comply with each Co-Signer's request for information needed to determine funds that may be available for a successor Funding Agreement.

Section 4 - Savings. If the programs, services, functions and activities carried out under Title V Funding Agreements and this Compact result in a reduction to the administrative or other responsibilities of the Secretary, with respect to the operation of Indian programs, and thereby result in saving that have not otherwise been included in the amount of tribal shares and other funds determined under section 508(c) of Title V, the Secretary shall make such savings available to the Co-Signers for the provision of additional services in accordance with section 507(f) of Title V.

ARTICLE V — OTHER PROVISIONS

Section 1 – Designated Officials/Agent.

(a) Parties. On or before the effective date of this Compact, both the Secretary and each Co-Signer shall provide a written designation of an individual as their representative/liaison. The Secretary shall direct all communications about the Compact, and relevant Funding Agreement to the Co-Signer's designee, except in the case where the Compact or Funding Agreement requires notice to the signatory Tribes, in which case notice shall also be sent to the Tribes. Reference herein to Co-Signers or the Secretary shall include the respective Designated Official thereof.

(b) Agent for Notice. If Co-Signers assign an agent to accept and distribute notices, those Co-Signers shall provide the name and address of the agent and a description of the limited powers and duties of the agent.

Section 2 – Indian Preference in Employment, Contracting and Sub-Contracting. The Co-Signers will comply with the Indian and Alaska Native preference provisions of sections 7(b) and 7(c) of the Indian Self-Determination and Education Assistance Act, as amended. The parties agree that any Co-Signer may comply with any Indian or Alaska Native preference established by their respective Tribes, including preference based on tribal affiliation.

Section 3 – Federal Tort Claims Act Coverage; Insurance.

(a) The Tribes and Co-Signers are deemed by statute to be part of the Public Health

Service (PHS), and the employees of the Tribes and Co-Signers are deemed by statute to be part of or employed by the Public Health Service, for purposes of coverage under the Federal Tort Claims Act, while performing programs, activities, functions or services under this Compact and described in the Co-Signer's Funding Agreement (including new and existing programs, services, functions and activities as provided under Article III, Section 5 or 6, or supported with income received in accordance with Article III, Section 7), including coverage for claims of medical malpractice, as is more fully described in 25 C.F.R. Part 900 Subpart M, attached hereto as Exhibit E, and incorporated by reference herein, and section 102(d) of the Indian Self-Determination and Education Assistance Act, as amended, as required by section 516(a).

(b) The above status of a Tribe or Co-Signer, or an employee's status as an employee of a Tribe or employee of a Co-Signer, is not affected by the source of the funds used by the Tribe or Co-Signer to carry out the programs, services, functions or activities or to pay the employee's salary and benefits as long as the employee does not receive any additional compensation for the performance of covered services from anyone other than the Tribe or Co-Signer.

(c) The Tribe's employee or the Co-Signer's employee may, while performing under this Compact and any applicable Co-Signer's Funding Agreement and as a condition of employment, be required by the Tribe or Co-Signer to provide services to non-Indian Health Service beneficiaries in order to meet the obligations under this Compact either in facilities of the Tribe or Co-Signer or in facilities other than those of the Tribe or Co-Signer.

(d) Funds provided under a Funding Agreement may be used to purchase such additional liability and other insurance as is prudent in the judgment of a Co-Signer performing under this Compact and Funding Agreement for its protection and the protection of its employees.

(e) Personal services contracts shall be covered under this provision to the extent provided under section 102(d) of the Indian Self-Determination and Education Assistance Act, as amended.

(f) Coverage shall also apply in accordance with Section 813(e) of the IHCIA, as amended.

Section 4 – Compact Modifications or Amendments.

(a) Any request for a modification of this Compact must be communicated in writing to all signatory Tribes and Co-Signers and to the Indian Health Service. To be effective any modifications of this Compact shall be in the form of a written amendment to the Compact, and shall require written consent of each of the signatory Tribes, acting directly or through an agent authorized by resolution, and the Secretary.

(b) This provision shall not apply to amendment of the Compact to include additional Tribes and/or Co-Signers. Such amendment shall only require the concurrence of the additional Tribe and/or Co-Signer, and the Secretary.

Section 5 – Construction. This Compact shall apply to funds included in the facilities category of Indian Health Service appropriations. A Co-signer may assume construction projects or programs in accordance with Titles I or V or P.L. 86-121. In doing so, the Co-Signer elects to comply with the regulations of the elected statutory provision.

Section 6 – Officials Not To Benefit. No member of or delegate to Congress shall be admitted to any share or part of any Compact executed pursuant to this Compact, or to any benefit that may arise there from; but this provision shall not be construed to extend to any contract under this Compact if made with a corporation for its general benefit.

Section 7 – Covenant Against Contingent Fees. The parties warrant that no person or selling agency has been employed or retained to solicit or secure any contract executed pursuant to this Compact upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial or selling agencies maintained by the contractor for the purpose of securing business.

Section 8 – Penalties. The parties agree that the criminal penalties set forth in 25 U.S.C. § 450d apply to all activities conducted pursuant to this Compact.

Section 9 – Use of Federal Employees. Section 104 of the Indian Self-Determination and Education Assistance Act, as amended, shall apply to this Compact and to any individuals assigned or detailed to any Co-Signer performing functions under this Compact or leaving federal employment to perform services under this Compact, including assignments either on detail or on leave without pay and with or without reimbursement by the Co-Signer for the travel and transportation expenses to or from the place of assignment and for the pay, or supplemental pay, or a part thereof, of the employee during assignment.

Section 10 – Extraordinary or Unforeseen Events. This Compact is intended to obligate each Co-Signer to carry out all usual and ordinary functions respecting the programs, activities, functions and services that it is undertaking to assume responsibility for under its Funding Agreement. In the event major unforeseen or extraordinary events occur, as jointly identified by each Co-Signer and the Secretary, with consequences beyond the control of the Co-Signer, that the Co-Signer shall have access to additional services and funding amounts for its Funding Agreement as described in its Funding Agreement. The parties will seek to ensure that funds available to the Co-Signer to deal with the unforeseen circumstance will not be less than would have been available to non-Compact Tribes or the Indian Health Service had they encountered a similar circumstance. Each Co-Signer's participation in the Indian Health Service Catastrophic Health Emergency Funds will be identified in the Co-Signer's Funding Agreement.

Section 11 – Mature Contractor Status upon Compact Termination. In accordance with section 506(g)(3) of Title V, should any signatory Tribe, tribal organization at the direction of a signatory Tribe or Tribes, or the ANTHC, elect to convert all or some of the programs operated under the Compact back to contract status under Public Law 93-638, as amended, such conversion shall not affect the Co-Signer's or the Tribe's status as having operated a mature contract within the meaning of section 4(h) of the Indian Self-Determination and Education Assistance Act, as amended. Such conversion would occur only at the end of the Compact term, on another date mutually acceptable to the Tribe, the Co-Signer and the Secretary, or as otherwise provided in this Compact, and will be implemented in a manner which avoids any interruption of services to

individual tribal members. If the Compact is terminated or a Tribe determines that it will retrocede any program, activity, function or service operated under the Compact, neither the Tribe nor the Co-Signer shall lose its mature contractor status under section 4(h) as provided above.

Section 12 – Startup Costs. In accordance with section 508(c) of Title V, startup costs may be separately negotiated by each Co-Signer and shall be included in each Co-Signer's Funding Agreement, if available. Startup costs are designed to compensate the Tribe for costs associated with implementing this Compact which the Co-Signer would not normally incur. Upon agreement to such costs on an annual basis, funds for such costs shall be included in the Funding Agreement, if available.

Section 13 – Limitation of Liability. Any liability to the United States or to any third party incurred by a Co-Signer arising out of its performance of or expenditure of funds under this Compact and each Co-Signer's Funding Agreement shall be the obligation only of that Co-Signer and shall not be the obligation of any Co-Signer of this Compact which did not participate in such performance or expenditure.

Section 14 – Contracting Rights. Nothing in this Compact or in any Funding Agreement shall be construed to preclude a Co-Signer from contracting with the Secretary to perform a program, activity, function, or service under Title I of P.L. 93-638, as amended, subject, however, to constraints against duplication pursuant to section 506(h) of Title V.

Section 15 – Sovereign Immunity. Nothing in this Compact or in any Funding Agreement shall be construed to affect the sovereign immunity, to the extent that it may exist, of any Tribe or Co-Signer.

Section 16 – Interpretation of Federal Law. In the implementation of this Compact, the Secretary, to the extent feasible, shall interpret all federal laws, executive orders, and regulations and this Compact in a manner that effectuates and facilitates the purposes of this Compact and achievement of the Co-Signers' health goals and objectives in accordance with section 512(a) of Title V.

Section 17 – Inadequacy of Program Funding. The parties to this Compact understand that the Indian Health Service budget is inadequate to fully meet the special responsibilities and legal obligations of the United States to assure the highest possible health status for American Indians and Alaska Natives and that, accordingly, the funds provided to the Co-Signers are inadequate to permit the Co-Signers to achieve this goal. The Secretary commits to advocate for increases in the Indian Health Service budget to further the ability of the Co-Signers to provide the full range of services that are the responsibility and obligation of the United States to make available to American Indian and Alaska Native people and to meet the goals of the Indian Health Care Improvement Act.

Section 18 – Effect on Non-Signatory Tribes.

(a) Nothing in this Compact or associated Funding Agreements shall be construed to limit or reduce in any way the service, contracts or funds that any Indian tribe, inter-tribal

consortium or tribal organization is eligible to receive. It is the intent of the parties to this Compact that the Compact will not have an adverse impact on any tribe choosing not to participate in this Compact directly or through a tribal organization.

(b) The Compact shall not be construed to limit or curtail the right of any Tribe to pursue a contract under Title I of the Indian Self-Determination and Education Assistance Act, as amended, individual participation in this Compact under Title V, or an independent compact under Title V.

Section 19 – Gaining Mature Contractor Status. Subject to Secretarial approval, a tribe that participates in this Compact by authorizing a tribal organization or inter-tribal consortium to be a Co-signer and receive funds on its behalf, which enters into a Memorandum of Agreement with the Co-Signer, for three years manages a program, activity, function or service identified in the Co-Signer's Funding Agreement and obtains three audits with no material unresolved audit exceptions, shall be deemed a mature contractor for all purposes, including entering into a Compact under section 503(c) of Title V. Nothing in this section precludes the right of a tribe to become a mature contractor under other provisions of law.

Section 20 – Severability. This Compact shall not be considered invalid, void or voidable if any section or provision of this Compact is found to be invalid, unlawful or unenforceable by a court of competent jurisdiction. Should such a court make such a finding, the parties will seek agreement to amend, revise or delete any such invalid, unlawful or unenforceable section or provision, in accordance with the provisions of this Compact.

Section 21 – Applicability of Title I Provisions. At the request of a Co-Signer, any provision of Title I, not already specified in section 516(a) of Title V, to the extent such provision does not conflict with a provision in Title V, shall be made a part of a Funding Agreement. The Secretary is obligated to include such provision at the option of the Co-Signer. If such provision is incorporated it shall have the same force and effect as if it were set out in full in Title V and in the Funding Agreement. Should the Co-Signer request such an incorporation sometime other than during the negotiation stage of the Funding Agreement, the Co-Signer will present the proposed incorporated Section to the Indian Health Service, OTSG, with a copy to the Alaska Area IHS Director. The Director of the Indian Health Service shall approve a written addendum to the Funding Agreement within 30 days after verifying that the provision is in Title I. In the case of any such provision, it shall be deemed incorporated in the Funding Agreement at the end of the 30 day period unless the Co-Signer receives a written notice from the Indian Health Service stating that the provision is not in Title I. In the event a Co-Signer requests such incorporation at the negotiation stage of this Compact or a Funding Agreement, such incorporation shall be deemed effective immediately and shall control the negotiation and resulting Compact and Funding Agreement.

Section 22 — Purchases from the Indian Health Service. With respect to functions transferred by the Indian Health Service to a Co-Signer under this Compact or an applicable Funding Agreement, the Indian Health Service shall provide goods and services to the Co-Signer, on a reimbursable basis, including payment in advance with subsequent adjustment. The reimbursements received from those goods and services, along with the funds received from the Co-Signer pursuant to this section, may be credited to the same or subsequent appropriation account which provided the funding, such amounts to remain available until expended.

ARTICLE VI — ATTACHMENTS

Section 1 – Approval of Compact. The resolutions of the Tribes approving this Compact for each Co-Signer are attached as part of Exhibit A. Additional resolutions for each Co-Signer may be filed with the Indian Health Service and included in Exhibit A up to the effective date of each Co-Signer's Funding Agreement. The resolution of the Board of Directors of the ANTHC is attached as part of Exhibit A.

Section 2 – Funding Agreements. Each Co-Signer's Funding Agreement shall be attached hereto as Exhibit C.

ARTICLE VII — COUNTERPART SIGNATURES

This Compact may be signed in counterparts.

CITY OF NOME
ADMINSTRATIVE REVIEW AND APPEAL FORM

Appeal #: 27

This form is for you to appeal the assessed valuation on your property. Complete Sections 1, 2 and 3. Retain a copy for your records, and return or mail the original copy to the City Clerk's Office. Appeals must be returned or postmarked no later than the date indicated on the Assessment Notice. The Assessor will contact you regarding your appeal.

****

1) I appeal the value of tax parcel #: 0 0 1 . 2 4 1 . 5 4

RECEIVED
APR 21 2022
CITY OF NOME
CLERKS DEPARTMENT

Property legal description: Block 30, Lot 66&67, Mineral Survey _____, Other _____

Print Owner's Name: Norton Sound Health Corporation

Owner's Mailing Address: PO Box 966, Day Phone: ( ) _____-_____

Nome, AK 99762, Evening Phone: ( ) _____-_____

Address to which all correspondence should be mailed (if different than above): _____

Please also email all information to: dpardee@nshcorp.org

****

2)

Assessor's Value	Land:	Bldg:	Total:	Purchase Date:
	$37,700	$417,800	$455,500	
Owner's Estimate of Value	$0.00	$0.00	exempt	

Owner's reason for estimate of value (including inventory corrections, sales of comparable properties, and property income statements, if appropriate). The Appellant bears the burden of proof. Grounds for adjustment of assessment are proof of unequal, excessive, improper, or under-valuation based on facts that are stated in a valid written appeal or proven at the appeal hearing.

Appeal based on AS 29.45.030 (a)(3), Hospital, Charitable Activities and Federal Law. Assessment is improper.

See attached

(PLEASE ATTACH STATEMENT IF YOU NEED MORE SPACE)

****

3) I hereby affirm that the foregoing information is true and correct, that I have read and understand the guidelines above, and that I am the owner or owner's authorized agent of the property described above.

Angie Gorn — **Signature of owner or authorized agent**

4/20/22 — Date signed

Angie Gorn — Print Name (if different form item # 1)

SUBSCRIBED and SWORN to before me this 20 day of April, 2022

NOTARY PUBLIC in and for the STATE of ALASKA: Meredith Ahmasuk

Commission Expires: 2026, Jan. 5

Seal:

STATE OF ALASKA
NOTARY PUBLIC
Meredith Ahmasuk
My Commission Expires Jan 5, 2026

Appeal#: 27

4)

Assessor's Decision	From:	Land:	Building:	Total:
	To:			

Assessor's Reason for Decision: _____

(PLEASE ATTACH STATEMENT IF YOU NEED MORE SPACE)

Date Rec'd	Decision made by	Date	Approved by	Date	Date mailed

5) Appellant's Response:

☐ **I ACCEPT** the assessor's decision in Block 4 above and hereby withdraw my appeal.

☒ **I DO NOT ACCEPT** the assessor's decision and desire to have my appeal presented to the Board of Equalization.

Signature of owner or authorized agent	Date	Printed Name
	4-19-2022	Geoffrey D. Strommer

6)

BOARD OF EQUALIZATION DECISION	LAND:	BUILDING:	TOTAL:

Date Received	Date Heard	Certified (Chairman or Clerk of Board)	Date	Date Mailed

2022 BOARD OF EQUALIZATION DATE: MAY 4, 5, & 6 2022

THE FINAL DAY TO APPEAL (April 25, 2022) IS 30 DAYS AFTER THE POSTMARK OF YOUR ASSESSMENT NOTICE (*March 25, 2022*)

Attachment to Administrative Review and Appeal Form
Block 30, Lots 66 and 67, 200 W. 1st Avenue ("BIA")

I. Property Use Description

1. General Scope of Activities on Hospital-Owned Properties.

The Norton Sound Health Corporation (NSHC) is a tribally owned and operated, independent, not-for-profit healthcare organization founded in 1970 to meet the healthcare needs of the Inupiat, Siberian Yup'ik, and Yup'ik people of the Bering Strait region. NSHC is governed by a 22-member board of directors who represent all communities and areas of the Bering Strait region, a 44,000 square-mile section of Northwestern Alaska. The NSHC service area encompasses these 44,000 square miles. NSHC is the only regional health system serving Northwestern Alaska.

The NSHC healthcare system includes a tribally owned regional hospital which is operated pursuant to an Indian Self-Determination and Education Assistance Act (ISDEAA) agreement. NSHC operates health facilities and provides health care services to Alaska Natives and other beneficiaries pursuant to the Alaska Tribal Health Compact (ATHC), a multi-tribe self-governance compact with the Indian Health Service (IHS) under Title V of the ISDEAA, 25 U.S.C. § 5381, et seq., and funding agreements (FAs), which include program funding amounts that are negotiated for each fiscal year between the IHS and NSHC to fund the programs, functions, services, and activities (PFSAs) that NSHC performs on behalf of IHS. IHS funds the administration of the PFSAs, including the operation of the hospital facilities in Nome, that NSHC has contracted to perform on behalf of IHS.[1]

NSHC is an "instrumentality" of the United States in providing healthcare services under Title V of the ISDEAA. Healthcare services are federal PFSAs provided under the ISDEAA pursuant to the federal trust responsibility to Indians for health care.[2]

The ISDEAA deems tribes and tribal organizations carrying out ISDEAA agreements to be federal executive agencies for purposes of coverage under the Federal Tort Claims Act (FTCA) and access to federal sources of supply.[3] NSHC employees, like employees of other tribal entities operating agreements with IHS under the ISDEAA, are similarly equally covered by the FTCA and are "federal employees" for these purposes.[4] The ISDEAA also authorizes tribal contractors and compactors to perform personal services otherwise performed by federal employees in determining eligibility for IHS services and benefits, the amounts of such services and benefits, and how such services and benefits should be provided.[5] In addition, tribal

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[1] 25 U.S.C. § 5325; 25 U.S.C. § 5396(a) (mandatory application of § 5325 to Title V agreements).

[2] 25 U.S.C. § 1602.

[3] 25 U.S.C. §§ 450f(d) and 450j(k).

[4] *See* 25 U.S.C. §§ 5321(d) and 5396(a); *M.J. ex rel. Beebe v. United States*, 721 F.3d 1079, 1084 (9th Cir. 2013).

[5] 25 USC § 450j(g).

facilities operated under the ISDEAA are interpreted by the Centers for Medicare and Medicaid Services as IHS facilities for purposes of the 100 percent Federal Medical Assistance Percentage under Section 1905 of the Social Security Act.[6]

The ATHC expressly provides that ATHC co-signers, such as NSHC, "are deemed by statute to be part of the Public Health Service (PHS), and the employees of the Tribes and Co-Signers are deemed by statute to be part of or employed by the Public Health Service, for purposes of coverage under the [FTCA]," while performing PFSAs under the ATHC's compact and as described in its Funding Agreement.[7] The current NSHC Funding Agreement expressly provides that "support services required to support the provision of health services," including human resources activities, administration and board support, performance management, financial functions, and the provision of staff housing, are part of the scope of work,[8] as is the training of community health aides;[9] emergency medical services training for staff and community members throughout the region;[10] and the provision of lodging for patients, family members of patients, and their escorts.[11]

2. Specific Use of BIA Building.

This building is currently vacant. This property was deeded to NSHC by the HHS, a federal agency, in 2006. Covenants of use are placed on this property by the federal government which require it to be "used continuously for health purposes." This property has been used for health purposes through 2020 for behavioral services, including a day shelter and sobering center. Those functions have been moved to another hospital-owned building at Block 116, Lot 1A. The NSHC Board voted in November 2021 to deed the property back to HHS, which is expected to be complete by May of 2022. (See attached reversion letter).

II. NSHC Enjoys the Sovereign Immunity of its Member Tribes and is Immune from Suits to Collect Taxes

Tribal healthcare entities like NSHC performing self-determination contracts under the ISDEAA for health services enjoy sovereign immunity,[12] including those operating off-reservation.[13] "Indian tribes have long been recognized as possessing the common-law immunity from suit traditionally enjoyed by sovereign powers."[14] "As a matter of federal law,

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[6] 42 U.S.C. § 1396(d).

[7] *See* ATHC Article V Sec. 3(a).

[8] Funding Agreement Between Certain Alaska Native Tribes Served By The Norton Sound Health Corporation And The Secretary Of Human Health And Human Services Of The United States of America Fiscal Years 2018-2020 § 3.5.

[9] *Id.* §§ 3.4.4, 3.4.5.

[10] *Id.* § 3.4.7.

[11] *Id.* at § 3.2.14.

[12] *Manzano v. S. Indian Health Council, Inc.*, No. 20-cv-02130-BAS-BGS, 2021 WL 2826072, at *1 (S.D. Cal. July 7, 2021) (non-profit healthcare corporation formed by membership of seven tribes entitled to sovereign immunity).

[13] *See Pink v. Modoc Indian Health Proj., Inc.*, 157 F.3d 1185, 1189 (9th Cir. 1998) (nonprofit corporation created and controlled by two tribes entitled to sovereign immunity).

[14] *Santa Clara Pueblo v. Martinez*, 436 U.S. 49, 58 (1978).

an Indian tribe is subject to suit only where Congress has authorized the suit or the tribe has waived its immunity."[15] "[T]ribal immunity is a matter of federal law and is not subject to diminution by the States."[16] Tribal immunity extends to tribal governing bodies and to tribal agencies or entities that act as an "arm of the tribe."[17] Lastly, "[i]t is settled that a waiver of [tribal] sovereign immunity cannot be implied but must be unequivocally expressed."[18]

In *Barron v. Alaska Native Tribal Health Consortium*, the U.S. District Court for the District of Alaska held a tribal health consortium organization enjoyed sovereign immunity where the organization was formed by Alaska Native tribes; its creation was authorized pursuant to the ISDEAA; it received federal funding to conduct activities that benefitted tribal members; the structure of its board placed control over its ownership and management in representatives of the Alaska Native tribes; its purpose of entering into self-determination and self-governance agreements was "core to the notion of sovereignty"; and it received federal funding "to carry out governmental functions critical to Alaska Native tribes," i.e., healthcare services.[19] Like the entity in *Barron*, and as more fully discussed below, NSHC shares these same attributes.

Tribal immunity extends to suits to collect unpaid taxes. This is because, as the U.S. Supreme Court noted in *Oklahoma Tax Commission v. Citizen Band Potawatomi Indian Tribe of Oklahoma*, "[a]lthough Congress has occasionally authorized limited classes of suits against Indian tribes, *it has never authorized suits to enforce tax assessments*."[20]

In *Matter of 1981–85 Delinquent Property Taxes Owed to the City of Nome, Alaska*, the Supreme Court of Alaska held that the Indian Reorganization Act (IRA) barred a city from foreclosing on lands held by groups of Alaska Natives organized under Section 16 of the IRA on the basis of non-payment of local property taxes.[21] In that case, the city sought to foreclose on two tracts owed by the Alaska Native group which were "purchased in part with funds from a federal grant under the [ISDEAA]."[22] In that case, the Court found the IRA was "intended to promote tribal self-government and conserve Indian lands and resources," and that had any doubt remained, the Court "would rest on the settled principle that, in Indian law, all ambiguities must be resolved in favor of the Indians."[23]

In the U.S. Circuit Court of Appeals for the Ninth Circuit, where NSHC is located, courts look to the following factors to determine whether a tribal entity functions as an "arm of the tribe" and is therefore entitled to share in the tribe's sovereign immunity: "(1) the method of creation of the economic entities; (2) their purpose; (3) their structure, ownership, and management, including the amount of control the tribe has over the entities; (4) the tribe's intent with respect to the sharing of its sovereign immunity; and (5) the financial relationship between

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[15] *Kiowa Tribe of Okla.* v. *Mfg. Techs., Inc.*, 523 U.S. 751, 754 (1998) (citations omitted).
[16] *Id.* at 756 (citations omitted).
[17] *Cook v. AVI Casino Enters., Inc.*, 548 F.3d 718, 725 (9th Cir. 2008).
[18] *Santa Clara Pueblo*, 436 U.S. at 58 (citation omitted) (internal quotation omitted).
[19] 373 F.Supp.3d 1232, 1239–40 (D. Alaska 2019).
[20] 498 U.S. 505, 510 (1991) (emphasis added).
[21] 780 P.2d 363 (Alaska 1989).
[22] *Id.* at 364.
[23] *Id.* at 367 (citation omitted).

the tribe and the entities."[24] In *White v. University of California*, the Ninth Circuit upheld the district court's application of this test to hold that a tribal repatriation committee formed by twelve tribes was entitled to sovereign immunity because it was created by resolution of each of the tribes; comprised solely of tribal members appointed by each tribe; funded exclusively by the tribes; and its purpose, "to recover remains and educate the public, [was] 'core to the notion of sovereignty.'"[25] And in *Pink v. Modoc Indian Health Project, Inc.*, the court held that a subsidiary tribal entity established and controlled by several tribes to provide health care services was protected by sovereign immunity.[26]

1. NSHC's method of creation supports immunity.

NSHC was incorporated on November 27, 1970 under the Alaska Non-Profit Corporation Act. Article VII of the NSHC Articles of Incorporation names three individuals representing the Alaska Native villages of Shaktoolik, Gambell, and Teller to the initial Board of Directors, and Article VIII shows the same three Village representatives as the initial incorporators. The formation and governance of NSHC was thereby tied directly to the member Villages. Article I and Article III of the Articles of Incorporation also provide that NSHC shall be "non-profit in nature," weighing in favor of treating it as an arm of the tribes. It is clear that NSHC's member tribes have delegated their governmental, rather than commercial, responsibility to provide health care to NSHC, which is not a for-profit venture but a vehicle for providing government health services.

2. NSHC's purpose to provide governmental health care supports immunity.

NSHC's Bylaws, adopted in 1977 and revised in 1978–79, expressly establish the Corporations purposes as follows:

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[24] *White v. Univ. of Cal.*, 765 F.3d at 1025 (2014) (citation omitted). Although not included in the Ninth Circuit's "arm of the tribe" test, an additional factor is examined by the Tenth Circuit: "the policies underlying tribal sovereign immunity and its connection to tribal economic development, and whether those policies are served by granting immunity to the economic entities." *Breakthrough Mgmt. Grp., Inc. v. Chukchansi Gold Casino and Resort*, 629 F.3d 1173, 1187 (2010).
Here, a grant of immunity to NSHC furthers the policies underlying tribal sovereign immunity. The doctrine of tribal sovereign immunity exists in order to avoid "interference with tribal autonomy and self-government," *Santa Clara Pueblo*, 436 U.S. at 59, and "infringe[ment] on the right of the Indians to govern themselves." *Williams v. Lee*, 358 U.S. 217, 223 (1959). Like the doctrine of tribal sovereign immunity, the fundamental policy underlying the ISDEAA is to enhance tribal autonomy and control in the provision of services to tribal communities. *See, e.g.*, 25 U.S.C. § 5302(a) (declaring that policy of ISDEAA is to assure "maximum Indian participation in the direction of educational as well as other Federal services to Indian communities so as to render such services more responsive to the needs and desires of those communities"). NSHC has taken on the entire federal responsibility for health care services for its member tribes. The essential federal-tribal nature of the ISDEAA program and the fact ISDEAA programs are funded by the federal resources that would have been spent on programs serving those tribes shows that NSHC is completely financially dependent on the tribes' right to ISDEAA funding, and has stepped into the tribes' shoes and operates as the "health arm" of its member tribes. Because NSHC has stepped into the shoes of its member tribes as the "health arm" of those tribes in order to enter a government-to-government relationship with the United States, NSHC's immunity from suit protects the tribal autonomy of NSHC's member governments.
[25] *White*, 765 F.3d at 1025.
[26] 157 F.3d at 1188–89.

1. To establish and maintain facilities, including but not limited to hospital and clinics, for the care of people suffering from injury, illness or disability requiring medical and hospital services and utilizing both inpatient and outpatient facilities and services, such care to be given regardless of the person's race, color, creed, age, sex, nationality or ability to pay.
2. To participate, so far as the circumstances may warrant, in any activity to promote the general health of the principal area.
3. To carry on educational programs, including the training of healing arts personnel, relating to rendering care to the sick and the promotion of health and the maintenance of high health care standards.
4. To advance general community understanding of, confidence in and proper use of the total program of health services.
5. To carry out the foregoing purposes [through the receipt and disbursement of funds and assets].

Each of these purposes reflects the delegation from the member tribes of their respective governmental health care responsibilities to NSHC. Indeed, the purpose of NSHC is to "step into the shoes" of the federal government to carry out, through the ISDEAA, the United States' responsibility to provide health care for Alaska Native and American Indian people.[27]

3. The tribal governments' close ownership, and management and control of NSHC support immunity.

NSHC is structured such that NSHC's member tribes directly control the governance of NSHC. Article IV of the Bylaws established a Board of Directors of 22 elected directors. Each of the 16 member villages elects one representative to the Board of Directors, and the Nome Eskimo Community elects two directors. The Nome City Council may elect one director, and the Board of Directors, among themselves, elects three additional directors representing Nome. Article V provides that the NSHC officers, including the Chairman, are elected from among the Board of Directors.

To this point, in 1980, the United States Department of the Interior unequivocally determined, based on the member tribal organizations' direct control of NSHC, that NSHC is an arm of the member tribes.[28]

In his Memorandum, Alaska Regional Solicitor Dennis J. Hopewell informed the BIA Area Director, Juneau Area Office that "[NSHC] is not only considered the 'health arm' of the Bering Straits Native Corporation . . . which is a recognized Indian tribe . . . but the Norton Sound Health Corporation is controlled, sanctioned and chartered by other tribal governing bodies." Hopewell considered the NSHC Bylaws to be conclusive evidence of NSHC's direct control by its member tribal entities, stating "[s]ince the Bylaws for the [NSHC] also spell out that '[t]he management of the property, funds, affairs and business of this Corporation shall be vested in a Board of Directors consisting of ...' the members listed above, there can be no doubt that the corporation is controlled by tribal governing bodies." Hopewell found that NSHC "in

[27] *See* 25 U.S.C. § 5302.
[28] Status of Norton Sound Health Corporation As A Tribal Organization Pursuant to P.L. 93-638.

addition to being controlled by, is also sanctioned and chartered by such tribal governing bodies," and "[t]his representation also shows that the operation and management of [NSHC] includes the maximum participation of Indians in all phases of its activities."

4. The tribal governments intended that NSHC share in their tribal sovereign immunity.

In 1975, Congress signed the ISDEAA (Pub. L. No. 93-638) into law. In 1978 and 1979, NSHC's member Alaska Native Villages each executed resolutions authorizing NSHC to enter contracts and grants with the United States on their behalf.[29] In 1994, the member Villages executed additional resolutions, which provide the current authority for NSHC to enter into the compact and funding agreements.[30]

Each resolution acknowledged that Congress enacted the ISDEAA as a "far reaching Indian Self-Determination Policy" that "grants Alaska Native villages the *sovereign right to designate tribal organizations which shall have the authority to provide services through contracts or grants with the Federal Government* under Public Law 93-638 for the provision of Government services to Native peoples."[31] The resolutions further note that NSHC "has village representation and traditionally provided information both to and from the village on health related matters" and that NSHC "is controlled and operated by a Board of Directors appointed by the tribal governments" of its member communities.[32]

In recognition of the foregoing, the resolutions authorize NSHC "to apply for, negotiate, appeal from adverse decisions, and secure contracts and grants with the Indian Health Service of the Department of Health, Education and Welfare for health care and related programs serving Native people" in the region.[33] The resolutions further authorize NSHC and its Board of Directors "to act on behalf of this village on health and related services" and "to accept funding for health and related service projects for this village from all funding agencies private and public."[34] The United States Supreme Court has noted that "[t]he common law sovereign immunity possessed by the Tribe is a necessary corollary to Indian sovereignty and self-governance."[35] The resolutions' provisions that NSHC would "act on behalf" of the villages as their health arm and delegation of governmental duties to NSHC reflects their intent that NSHC would share in the "corollary" privilege of immunity from suit in carrying out those functions.

5. NSHC is wholly financially dependent on the member tribes' assignment of their right to contract with IHS to provide health services to their members.

Under the ATHC, all Alaska tribes participate in the delivery of health care services to their members and other beneficiaries in accordance with the principles of tribal self-governance.

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[29] A representative resolution from the Native Village of Elim is attached [hereafter Elim Resolution].
[30] A representative resolution from the Native Village of Diomede is attached.
[31] *See, e.g.*, Elim Resolution at 1 (emphasis added).
[32] *Ibid.*
[33] *Ibid.*
[34] *Ibid.*
[35] *Three Affiliated Tribes of Fort Berthold Reservation v. Wold Eng'g*, 476 U.S. 877, 890 (1986) (emphasis added).

The Compact allowed NSHC, on behalf of its member tribes, to enter into a government-to-government relationship with the United States. Since 1994, NSHC has participated each year with other co-signers and the IHS in the negotiation of annual funding agreements and amendments to the ATHC.

The funding agreement (FA) NSHC negotiates annually with IHS on behalf of the member tribes includes a broad scope of work covering a wide variety of health care services, from hospital and clinic services to long-term care, from dental services to lodging for patients.[36] In fact, while NSHC is the *signatory* to the funding agreement, the *parties* to the FA are the HHS Secretary and NSHC's member villages themselves. The 2018 Funding Agreement, titled, "Funding Agreement Between Certain Alaska Native Tribes Served by the Norton Sound Health Corporation and the Secretary Of Health And Human Services Of The United States Of America," states:

> This Funding Agreement is entered into by and between certain Alaska Native Tribes in the Bering Straits region of the Norton Sound Service Unit, as identified on the signature page herein, and the Secretary of the Department of Health and Human Services. These Tribes have authorized the Norton Sound Health Corporation to sign this Funding Agreement for them and to be responsible for and carry out the terms of this Funding Agreement.[37]

Section 2.1 of the 2018 FA "obligates NSHC to be responsible for and to provide health PSFAs identified in Section 3 [Tribal Programs and Budget], utilizing the resources transferred under this FA and other funds as they may become available to NSHC." Section 5.2 provides these resources represent the entirety of the member Tribes' entitlement to these funds: "NSHC will be paid 100 percent of Headquarters and Area Tribal Shares in its initial lump sum payment, as negotiated in this FA." Section 4 of the 2018 FA describes the total FY 2018 funding made available to NSHC from funds that would otherwise be allocated to NSHC's member tribes. Without the Compact and Funding Agreements, through which NSHC performs governmental functions for their member villages, NSHC would be unable to function. Accordingly, the financial relationship between NSHC and the tribal entities supports NSHC's immunity.[38]

In substance and in form, NSHC serves as an arm of its member tribes. NSHC is dependent on the authorization and support of its member tribal governments to operate, and it fills a critically under-resourced governmental function–far different from a private, for-profit economic venture or other state-incorporated non-profits that may operate in the public sector but are not fulfilling government functions. NSHC shares in the sovereign immunity of its member tribes, and this immunity from suit extends to suits to collect unpaid taxes. This sovereign immunity operates unless specifically and unequivocally waived, and NSHC has not waived its immunity.

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[36] Funding Agreement Between Certain Alaska Native Tribes Served By The Norton Sound Health Corporation And The Secretary Of Health And Human Services Of The United States Of America Fiscal Years 2018-2020 §§ 3.2, 3.4.1, and 3.2.14.

[37] *Id.* at 1.

[38] *See White*, 765 F.3d at 1025 (fact that entity was funded solely by the tribe supported determination that entity was an "arm of the tribe" entitled to immunity).

III. The City's Taxation is Preempted by Federal Law

Alaska Statute 29.45.030(a)(8) exempts from tax, "property of a political subdivision, agency, corporation, or other entity of the United States to the extent required by federal law…" The city of Nome's tax on all real property owned by NSHC is preempted by federal law.

In *United States v. New Mexico*, the U.S. Supreme Court announced a rule to apply generally to determine immunity from state and local taxation under the supremacy doctrine:

> [T]ax immunity is appropriate in only one circumstance; when the levy falls on the United States itself, or on an agency or *instrumentality* so closely connected to the Government that the two cannot realistically be viewed as separate entities, *at least insofar as the activity being taxed is concerned*.[39]

Under the implied federal preemption doctrine, space that is used to carry out federal programs and that is subject to comprehensive and pervasive federal oversight is exempt from state or local taxation.[40]

In *Ketchikan Gateway Borough v. Ketchikan Indian Corporation*, the Alaska Supreme Court upheld application of the implied federal preemption doctrine to exempt from borough taxes "*all space in a building that contains a tribally operated clinic*."[41] In that case, the tribally operated clinic was funded by the IHS and operated on land conveyed by the United States.[42] The only space held not to be exempt from taxation was "space not committed to use by the clinic," because it was "uncertain how the uncommitted space would be used" and it "appear[ed] that at least for near-term purposes it [would] either be leased to others or used for other [i.e., non-clinic-related] programs of [the Indian corporation]."[43]

This property is integral to the provision of healthcare under NSHC's ISDEAA agreement. As programs and services that support the healthcare operations are included under the scope of work as defined in NSHC's Funding Agreement, all areas used for human resources, administration and board support, performance management, training, medical personnel housing, patient housing, and financial function are integral to NSHC's healthcare operations under the ISDEAA.

The Alaska Supreme Court, in *Ketchikan Gateway Borough,* acknowledged that federal law preempts state taxation where the activity is subject to comprehensive and pervasive federal oversight.[44] However, the court was considering only whether preemption still applies to uncommitted, vacant property which will ultimately be put to non-exempt uses.[45] In *Ketchikan Gateway Borough*, the court distinguished the facts of that case with others where it is held that

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[39] 455 U.S. 720, 735 (1982) (emphasis added).
[40] *Ketchikan Gateway Borough v. Ketchikan Indian Corp.*, 75 P.3d 1042, 1048 (Alaska 2003).
[41] *Id.* at 1044 (emphasis added).
[42] *Ibid.*
[43] *Id.* at 1049; 1048 n.27.
[44] *Id.* at 1048.
[45] *Ibid.*

uncommitted or vacant space is entitled to exemption. In those cases the vacancy was temporary and there was an intended use of the property. The court stated that in the cases cited by the dissent, and in which the majority agreed the exemption was properly applied, "the unused space, when used, was intended to be used for tax-exempt purposes. By contrast . . . it is unknown how the unused space will be used, but it appears that at least for near-term purposes it will either be leased to others or used for other programs of [the Indian Corporation]."[46]

In the instant case, the property is reverting back to the federal government and will be inarguably exempt from taxation at that time. In the meanwhile, as the court in *United Way of the Midlands* held, "Oftentimes a qualified organization acquires or maintains building space in reasonable anticipation of full occupancy for an exempt purpose but cannot do so because of economic conditions or other legitimate reasons."[47] Similarly, in the *Our Savior Lutheran Church* case cited by the *Ketchikan Gateway* court, the court explained, "We do not think that mere temporary vacancy or lack of use of a portion of an otherwise exempt parcel of property renders that portion taxable. To hold that when a portion of a building otherwise used for an exempt purpose becomes temporarily vacant or unused it loses its exempt status is nonsensical and impractical of application."[48]

The federal and tribal interests in the instant case still remain for the period in 2022 when the property is temporarily unused by NSHC. Provision of Indian health care services is comprehensively and pervasively regulated and the covenants of use that run with the deed of this property from HHS to NSHC manifest the federal control of the property. And, the federal government's reversionary interest in the property commenced in November 2021, so the federal interest in the property is superior. Accordingly, the city's tax is preempted.[49]

In *Ketchikan Gateway Borough*, the Alaska Supreme Court noted that while the rule of strict construction requires that "[t]axpayer exemptions are strictly construed against the taxpayer and in favor of the taxing authority . . . . where the question is whether federal law requires the exemption of tribal interests from taxation, ambiguities in federal law should be resolved *in favor of the tribe*."[50]

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[46] *Id.* at 1048 n.27 (citing *Dist. of Columbia v. Catholic Univ. of Am.*, 397 A.2d 915, 921–22 (D.C.1979); *Our Savior Lutheran Church v. Dep't of Revenue*, 204 Ill. App. 3d 1055, 150 Ill. Dec. 395, 562 N.E. 2d 1198, 1201 (1990); and *United Way of the Midlands v. Douglas County Bd. of Equalization*, 215 Neb. 1, 337 N.W. 2d 103, 107 (1983)).
[47] 337 N.W. 2d at 107.
[48] 562 N.E. 2d at 1201.
[49] *Ketchikan Gateway Borough*, 75 P.3d at 1048.
[50] *Id.* at 1045 (citing *Cotton Petroleum Corp. v. New Mexico*, 490 U.S. 163, 177 (1989)).

U.S. General Services Administration
Public Buildings Service

VIA EMAIL agorn@nshcorp.org

November 1, 2021

Ms. Angie Gorn
President
Norton Sound Health Corporation
100 Greg Kruschek Ave.
P.O. Box 966
Nome, Alaska 99762

Subject: 200 West 1st Avenue, Nome, AK 99762
GSA Control No. 9-F-AK-1298-AA

Dear Ms. Gorn:

Thank you for your email of October 4th informing us of Norton Sound Health Corporation's (NSHC) Board of Director's final decision to proceed with the reversion of the 200 West 1st Avenue property (Property). GSA is working with the Department of Health and Human Services (HHS) on the reversion and reconveyance of the Property to another entity since there is not a federal need for the building. Our intent is to identify a potential new owner through a competitive sale and that the Property would be transferred from NSHC to that entity as part of the sale closing process.

GSA will prepare for the Spring 2022 public sale on our auction website, RealEstateSales.gov. To prepare for conveyance, GSA will draft in coordination with NSHC a quitclaim deed for your signature as the Grantor. We will also draft and execute a Release of Restrictions to enable the new purchaser to own the property without restrictions. Both legal documents will be deposited contemporaneously in escrow at sale closing and recorded when the balance of the sale proceeds is received. Proceeds would be remitted to the U.S. Treasury.

As the fee owner, NSHC remains responsible for the Property's protection and maintenance until title is conveyed to a new owner. Please provide GSA with a preliminary title report or limited liability report and any available building reports and environmental reports.

Thank you for your cooperation and assistance as we prepare the property for public sale. Andrew Schwartz, Realty Specialist will continue to serve as your primary point of contact and can be reached at (253) 293-4557 or andrew.schwartz@gsa.gov.

Sincerely,

David Haase

David Haase
Director
Real Property Utilization and Disposal Division (9PZ)

cc: Clayon Solomon Clayon.Solomon@psc.hhs.gov

Pacific Rim Region 9
50 United Nations Plaza
San Francisco, CA 94102-3434
www.gsa.gov

2006-000676-0
Recording Dist: 201 - Nome
5/19/2006 12:48 PM Pages: 1 of 11

A L A S K A

Title: Recording Norton Sound Health Corporation's Quitclaim Deed for property and building located in Nome Alaska.

Legal Description: Bock 30, Lots 66 and 67 (except West 48 feet of South 74 feet), Commonly known as 200 West 1st Avenue. Nome Tax lot #001-241-54

Recording District: Cape Nome

Return to: Norton Sound Health Corporation
Attn: Darlene Hebel
PO Box 966
Nome, AK 99762

Address for Parties involved:

Norton Sound Health Corporation
PO Box 966
Nome, AK 99762

Program Support Center
Parklawn Building 5600 Fishers Lane Room 5B-41
Rockville, MD 20857

Contract No. 09-AK-2280

QUITCLAIM DEED

THIS INDENTURE, made this 18th day of January, 2006, between the United States of America, acting through the Secretary of Health and Human Services, by the Chief, Space Management Branch, Division of Property Management, Program Support Center, U.S. Department of Health and Human Services (HHS) (hereinafter referred to as "Grantor"), under and pursuant to the power and authority delegated by the Federal Property and Administrative Services Act of 1949 (40 U.S.C. § 550), as amended (hereinafter referred to as "the Act"), and regulations promulgated pursuant thereto at 45 C.F.R. Part 12, and Norton Sound Health Corporation (hereinafter referred to as "Grantee").

WITNESSETH

WHEREAS, by letter dated November 22, 2005 and amended December 9, 2005, from the U.S. General Services Administration Region IX, certain surplus property consisting of 0.16 acres, more or less, improved with one three-story office building, hereinafter described (hereinafter referred to as "the Property"), was assigned to HHS for disposal upon the recommendation of the Grantor that the Property is needed for public health purposes in accordance with the provisions of the Act; and

WHEREAS, said Grantee has made a firm offer to purchase the Property under the provisions of the Act, has made application for a public benefit allowance, and proposes to use the Property in accordance with the approved program of utilization dated August 26, 2005 and amended on October 7 and November 14, 2005; and

WHEREAS, Grantor has accepted the offer of the Grantee,

NOW, THEREFORE, Grantor, for and in consideration of the foregoing and of the observance and performance by Grantee of the covenants, considerations and restrictions hereinafter contained and other good and valuable consideration, the receipt of which is hereby acknowledged, has remised, released and quitclaimed and by these presents does remise, release and quitclaim to Grantee, its successors and assigns, all right, title, interest, claim and demand, excepting and reserving such rights as may arise from the operation of the conditions subsequent hereinafter expressed, which the United States of America has in and to the Property, situate, lying, and being in the Town of Nome, State of Alaska, and more particularly described as follows:

Block 30, Lots 66 and 67 (except West 48 feet of South 74 feet) in the City of Nome, Alaska. Commonly known as 200 West 1st Avenue Nome Tax Lot # 001-241-54.

SUBJECT to any and all other existing easements, encumbrances, covenants, restrictions, reservations or conditions affecting the above described property whether or not the same appear on record.

Grantee shall comply with all applicable Federal, State, municipal, and local laws, rules, orders, ordinances, and regulations in the occupation, use, and operation of the Property.

TO HAVE AND TO HOLD the Property subject, however, to each of the following conditions subsequent, which shall be binding upon and enforceable against Grantee, its successors and assigns, as follows:

1. That for a period of thirty (30) years from the date hereof the Property herein conveyed will be used continuously for health purposes in accordance with Grantee's approved program of utilization as set forth in its application dated August 26, 2005 and amended on October 7 and November 14, 2005, and for no other purpose;

2. That during the aforesaid period of thirty (30) years Grantee will not resell, lease, mortgage, or encumber or otherwise dispose of any part of the Property or interest therein except as Grantor or its successor in function may authorize in writing;

3. Where construction or major renovation is not required or proposed, the Property must be placed into use within twelve (12) months from the date of this Deed. Where construction or major renovation is contemplated at the time of transfer, the Property must be placed into use within thirty-six (36) months from the date of this Deed;

4. That one year from the date hereof and annually thereafter for the aforesaid period of thirty (30) years, unless Grantor or its successor in function directs otherwise, Grantee will file with Grantor or its successor in function reports on the operation and maintenance of the Property and will furnish, as requested, such other pertinent data evidencing continuous use of the Property for the purposes specified in the above-identified application;

5. That during the aforesaid period of thirty (30) years Grantee will at all times be and remain a tax-supported organization or a nonprofit institution, organization, or association exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986, as amended; and

6. That, for the period during which the Property is used for the purpose for which the Federal assistance is hereby extended by Grantor or for another purpose involving the provision of similar services or benefits, Grantee hereby agrees that it will comply with the requirements of section 606 of the Act (40 U.S.C. § 476); the Fair Housing Act (42 U.S.C. § 3601-19) and implementing regulations; and, as applicable, Executive Order 11063 (Equal Opportunity in Housing) and implementing regulations; Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d to d-4) (Nondiscrimination in Federally Assisted Programs) and implementing regulations; Title IX of the Education Amendments of 1972 (20

U.S.C. § 1681) and implementing regulations; the prohibitions against discrimination on the basis of age under the Age Discrimination Act of 1975 (42 U.S.C. § 6101-07) and implementing regulations; the prohibitions against otherwise qualified individuals with handicaps under Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and implementing regulations, and all requirements imposed by or pursuant to the regulations of Grantor (45 CFR Parts 12, 80, 84, 86 and 91) issued pursuant to said Acts and now in effect, to the end that, in accordance with said Acts and regulations, no person in the United States shall, on the ground of race, color, national origin, sex, age, or handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under the program and plan referred to in condition numbered 1 above or under any other program or activity of Grantee, its successors or assigns, to which said Acts and regulations apply by reason of this conveyance.

In the event of a breach of any of the conditions subsequent set forth above, whether caused by the legal or other inability of Grantee, its successors and assigns, to perform any of the obligations herein set forth, Grantor or its successor in function will, at its option, have an immediate right of reentry thereon, and to cause all right, title, and interest in and to the Property to revert to the United States of America, and Grantee, its successors and assigns, shall forfeit all right, title, and interest in and to the Property and to any and all of the tenements, hereditaments, and appurtenances thereunto belonging;

PROVIDED, HOWEVER, that the failure of Grantor or its successor in function to insist in any one or more instance upon complete performance of any of the said conditions subsequent shall not be construed as a waiver of or a relinquishment of the future performance of any of said conditions subsequent, but the obligations of Grantee with respect to such future performance shall continue in full force and effect;

PROVIDED FURTHER, that, in the event Grantor or its successor in function fails to exercise its option to reenter the premises and to revert title thereto for any such breach of conditions numbered 1, 2, 3, 4, or 5 herein within thirty-one (31) years from the date of this conveyance, conditions numbered 1, 2, 3, 4, and 5 herein, together with all rights to reenter and revert title for breach of condition, will, as of that date, terminate and be extinguished; and

PROVIDED FURTHER, that the expiration of conditions numbered 1, 2, 3, 4, and 5 and the right to reenter and revert title for breach thereof, will not affect the obligation of Grantee, its successors and assigns, with respect to condition numbered 6 herein or the right reserved to Grantor, or its successor in function, to reenter and revert title for breach of condition numbered 6.

Grantee may secure abrogation of the conditions subsequent numbered 1, 2, 3, 4, and 5 herein by:

a. Obtaining the consent of Grantor, or its successor in function, therefor; and

b. Payment to the United States of America of 1/360th of the percentage public benefit allowance granted of the fair market value as of the date of such requested abrogation, exclusive of the value of improvements made by Grantee to the extent that they add to the value of that portion of the Property to be released, for each month of the period to be abrogated.

Grantee, by acceptance of this Deed, covenants and agrees for itself, its successors and assigns, with respect to the Property or any part thereof--which covenant shall attach to and run with the land for so long as the Property is used for a purpose for which Federal assistance is hereby extended by Grantor or for another purpose involving the provision of similar services or benefits, and which covenant shall in any event, and without regard to technical classification or designation, legal or otherwise, be binding to the fullest extent permitted by law and equity, for the benefit of and in favor of and enforceable by Grantor or its successor in function against Grantee, its successors and assigns for the Property, or any part thereof--that it will comply with the requirements of section 606 of the Act (40 U.S.C. § 476); the Fair Housing Act (42 U.S.C. § 3601-19) and implementing regulations; Executive Order 11063 (Equal Opportunity in Housing) and implementing regulations; Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d to d-4) (Nondiscrimination in Federally Assisted Programs) and implementing regulations; the prohibitions against discrimination on the basis of age under the Age Discrimination Act of 1975 (42 U.S.C. § 6101-07) and implementing regulations; and the prohibitions against otherwise qualified individuals with handicaps under Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and implementing regulations; and all requirements imposed by or pursuant to the regulations of Grantor (45 CFR Parts 12, 80, 84 and 91) issued pursuant to said acts and now in effect, to the end that, in accordance with said acts and regulations, no person in the United States shall, on the ground of race, color, national origin, sex, age, or handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under the program and plan referred to in condition numbered 1 above or under any other program or activity of Grantee, its successors or assigns, to which such Acts and regulations apply by reason of this conveyance.

Grantee covenants and agrees that the Property will be used for secular purposes, with no more than a de minimis level of other activity.

Grantee, by acceptance of this Deed, covenants and agrees for itself, its successors and assigns, that in the event Grantor exercises its option to revert all right, title, and interest in and to the Property to Grantor, or Grantee voluntarily returns title to the Property in lieu of a reverter, then Grantee shall provide protection to and maintenance of the Property at all times until such time as the title is actually reverted or returned to and accepted by Grantor. Such protection and maintenance shall, at a minimum, conform to the standards prescribed by the General Services Administration and codified in the Federal Property Management Regulations at 41 C.F.R. Subpart 101-47.4913 now in effect, a copy of which is attached to Grantee's aforementioned application.

In the event title to the Property or any part thereof is reverted to the United States of America for noncompliance or is voluntarily reconveyed in lieu of reverter, Grantee, its

successors or assigns, at the option of Grantor, or its successor in function, shall be responsible for and shall be required to reimburse the United States of America for the decreased value thereof that is not the result of reasonable wear and tear, an act of God, or alterations and conversions made by Grantee, its successors or assigns, to adapt the property to the health use for which the property was transferred. The United States of America shall, in addition thereto, be reimbursed for such damage, including such costs as may be incurred in recovering title to or possession of the above-described property, as it may sustain as a result of such noncompliance.

Grantee, by acceptance of this deed, further covenants and agrees for itself, its successors and assigns, that in the event the Property or any part thereof is, at any time within the period of thirty (30) years from the date of this conveyance, sold, leased, disposed of, or used for purposes other than those designated in condition numbered 1 above without the consent of Grantor, or its successor in function, all revenues therefrom or the reasonable value, as determined by Grantor, or its successor in function, of benefits to Grantee, deriving directly or indirectly from such sale, lease, disposal, or use, shall be considered to have been received and held in trust by Grantee for the United States of America and shall be subject to the direction and control of Grantor, or its successor in function; but the provisions of this paragraph shall not impair or affect the rights reserved to Grantor under any other provision of this deed.

Grantee, by acceptance of this Deed, covenants and agrees for itself, its successors and assigns, that the Property is transferred on an "as is, where is," basis, without warranty of any kind, either expressed or implied, including as to the condition of the Property. Grantee also covenants and agrees for itself, its successors and assigns, that Grantor has no obligation to provide any additions, improvements, or alterations to the Property.

Grantor, in its capacity as a public benefit conveyance authority for the United States of America, does not assume liability, custody, or accountability for the property in the event title to the Property reverts, revests or is reconveyed to the United States of America for noncompliance with this Deed, or in connection with any hazardous substance activity or condition on the Property.

The following covenants and restrictions are provided pursuant to the aforementioned letters of assignment from the General Services Administration, Region IX.

NOTICE Regarding Hazardous Substance Activity. Pursuant to 40 C.F.R. 373.2 and Section 120(h)(3)(A)(i) of the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended (CERCLA)(42 U.S.C.§9620(h)(3)(A)(i), and based upon a complete search of agency files, the United States gives notice that no hazardous substances have been released or disposed of or stored for one year or more on the Property.

CERCLA Covenant. The United States of America warrants that it shall take any additional response action found to be necessary after the date of this conveyance regarding hazardous substances located on the Property on the date of this conveyance.

(1) This covenant shall not apply:

(a) in any case in which Grantee, its successor(s) or assign(s), or any successor in interest to the Property or part thereof is a Potentially Responsible Party (PRP) with respect to the Property immediately prior to the date of this conveyance: OR

(b) to the extent that such additional response action or part thereof found to be necessary is the result of an act or failure to act of the Grantee, its successor(s) or assign(s), or any party in possession after the date of this conveyance that either:

(i) results in a release or threatened release of a hazardous substance that was not located on the Property on the date of this conveyance; OR

(ii) causes or exacerbates the release or threatened release of a hazardous substance the existence and location of which was known and identified to the applicable regulatory authority as of the date of this conveyance.

(2) In the event Grantee, its successor(s) or assign(s), seeks to have the United States of America conduct any additional response action, and, as a condition precedent to the United States of America incurring any additional cleanup obligation or related expenses, the Grantee, its successor(s) or assign(s), shall provide the United States of America at least 45 days written notice of such a claim. In order for the 45-day period to commence, such notice must include credible evidence that:

(a) the associated contamination existed prior to the date of this conveyance; and

(b) the need to conduct any additional response action or part thereof was not the result of any act or failure to act by the Grantee, its successor(s) or assign(s), or any party in possession.

ACCESS. The United States of America reserves the right of access to all portions of the Property for environmental investigation, remediation or other corrective action. This reservation includes the right of access to and use of available utilities at reasonable cost to the United States of America. These rights shall be exercisable in any case in which remedial action, response action or corrective action is found to be necessary after the date of this conveyance, or in which access is necessary to carry out a remedial action, response action or corrective action on adjoining property. Pursuant to this reservation, the United States of America, and its respective officers, agents, employees, contractors and subcontractors shall have the right (upon reasonable advance written notice to the record title owner) to enter upon the Property and conduct investigations and surveys, to include drilling, test-pitting, borings, data and records complication and other activities related to environmental investigation, and to carry out remedial or removal actions as required or necessary, including but not limited to the installation and operation of monitoring wells, and treatment facilities.. Any such entry, including such activities, responses or remedial actions, shall be coordinated with the record title owner and shall

be performed in a manner that minimizes interruption with activities of authorized occupants.

NOTICE OF THE PRESENCE OF ASBESTOS

The Grantee is warned that the property contains asbestos-containing materials. Unprotected or unregulated exposures to asbestos in product manufacturing, shipyard, and building construction workplaces have been associated with asbestos-related diseases. Both the Occupational Safety and Health Administration (OSHA) and the Environmental Protection Agency (EPA) regulate asbestos because of the potential hazards associated with exposure to airborne asbestos fibers. Both OSHA and EPA have determined that such exposure increases the risk of asbestos-related diseases, which include certain cancers and which can result in disability or death.

Grantee is invited, urged and cautioned to inspect the property as to its asbestos content and condition and any hazardous or environmental conditions relating thereto. The disposal agency will assist Grantee in obtaining any authorization(s) which may be required in order to carry out any such inspection(s). Grantee shall be deemed to have relied solely on their own judgment in assessing the overall condition of all or any portion of the property including, without limitation, any asbestos hazards or concerns.

No warranties either express or implied are given with regard to the condition of the property including, without limitation, whether the property does or does not contain asbestos or is or is not safe for a particular purpose.

The description of the property set forth in the Quitclaim Deed and any other information provided therein with respect to said property is based on the best information available to the disposal agency and is believed to be correct, but any error or omission, including but not limited to the omission of any information available to the agency having custody over the property and/or any other Federal agency, shall not constitute grounds for any claim by the Grantee against the Government.

The Government assumes no liability for damages for personal injury, illness, disability or death, to the Grantee, or to the Grantee's successors, assigns, employees, invitees, or any other person subject to Grantee's control or direction, or to any other person, including members of the general public, arising from or incident to the purchase, transportation, removal, handling, use, disposition, or other activity causing or leading to contact of any kind whatsoever with asbestos on the property which is subject of this conveyance, whether the Grantee, its successors or assigns has or have properly warned or failed properly to warn the individuals(s) injured.

The Grantee further agrees that in its use and occupancy of the property it will comply with all Federal, state, and local laws relating to asbestos.

NOTICE OF THE PRESENCE OF LEAD-BASED PAINT

Grantee hereby acknowledges the required disclosure in accordance with the Residential Lead-Based Paint Hazard Reduction Act of 1992, 42 U.S.C. 4852d (Title X), of the presence of any known lead-based paint and/or lead-based paint hazards in target housing constructed prior to 1978 on the Property. This disclosure includes the receipt of available records and reports, namely the Report of Findings for Bureau of Indian Affairs Asbestos/Lead-Based Paint Survey dated August 1997; receipt of the lead hazard information pamphlet; and inclusion of the 24 C.F.R. 35 and 40 C.F.R. 745 disclosure and lead warning language in its contract of conveyance. Grantee further acknowledges that Grantee was given the opportunity to inspect, and thereby assess, the Property for lead-based paint hazards.

Grantee covenants and agrees that, with respect to any improvements on the Property constructed prior to 1978, lead-based paint hazards will be disclosed to potential occupants in accordance with Title X before any use of such improvements as a residential dwelling.

Grantee further covenants that, before any use of the Property as a residential dwelling, GRANTEE will abate, at Grantee's own cost, all lead hazards in accordance with 40 C.F.R. 745.227(e) and other applicable laws and regulations, prior to the occupancy of any residential structures on the Property. Following the abatement, Grantee shall obtain a clearance examination, in accordance with 40 C.F.R. 745.227(e) and 24 C.F.R. 35.1340(c) through (f), and conducted by a person certified to perform risk assessments or lead-based paint inspections. The examination must show that the clearance samples meet the standards set forth in 24 C.F.R. 35.1320(b)(2). Grantee must obtain a clearance report, prepared by a person certified to perform risk assessments or lead-based paint inspections and in accordance with 40 C.F.R. 745.227(e)(10). Prior to occupancy of the Property, Grantee shall provide Grantor with a fully executed CERTIFICATION OF COMPLETION OF LEAD ABATEMENT.

Grantee covenants and agrees that in its use and occupancy of the Property it will comply with 24 C.F.R. 35 and 40 C.F.R. 745 and all applicable Federal, State and local laws relating to lead-based paint; and that Grantor assumes no liability for damages for property damage, personal injury, illness, disability, or death, to Grantee, its successors or assigns, or to any other person, including members of the general public, arising from or incident to the purchase, transportation, removal, handling, use disposition, or other activity causing or leading to contact of any kind whatsoever with lead-based paint on the Property described in this Deed, whether Grantee, and its successors or assigns, have properly warned or failed properly to warn the individual(s) injured. Grantee further agrees to indemnify, defend and hold harmless Grantor, to the extent permitted by state law, from any and all loss, judgment, claims, demands, expenses or damages, of whatever nature which might arise or be made against the United States of America, due to, or relating to the presence of lead-based paint hazard on the Property, any related abatement activities, or the disposal of any material from the abatement process.

Grantee covenants and agrees that it will comply with all Federal, State, local, and any other applicable law regarding the lead-based paint hazards with respect to the Property.

NOTICE AFFECTING NAVIGABLE AIRSPACE

OBJECTS AFFECTING NAVIGABLE AIRSPACE. The property is located within six nautical miles of the Nome Airport. By acceptance of this deed, the Grantee herein named and its successors, and assigns and every successor in interest to the property herein described, or any part thereof, covenant that any construction or alternation is prohibited unless a determination of no hazard to air navigation is issued by the Federal Aviation Administration in accordance with Title 14 code of Federal Regulations, Part 77, entitled "Objects Affecting Navigable Airspace," or under the authority of the Federal Aviation Act of 1958, as amended.

IN WITNESS WHEREOF, Grantor has caused this instrument to be executed as of the day and year first above written.

UNITED STATES OF AMERICA
Acting through the Secretary of Health and Human Services

By: _____
John G. Hicks, Chief, Space Management Branch
Division of Property Management
Program Support Center

ACKNOWLEDGMENT

STATE OF MARYLAND)
COUNTY OF MONTGOMERY) SS

On this 18th day of January 2006, before me the undersigned officer, personally appeared John G. Hicks, known to me to be the Chief, Space Management Branch, Division of Property Management, Department of Health and Human Services, and known to me to be the person who executed the foregoing instrument on behalf of the Secretary of Health and Human Services, for the United States of America, and acknowledged to me that he subscribed to the said instrument in the name of the Secretary of Health and Human Services and on behalf of the United States of America.

Witness my hand and official seal.

(SEAL) _____
Notary Public

My commission expires March 1, 2007

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2006-000676-0

ACCEPTANCE

Norton Sound Health Corporation hereby accepts this deed and thereby agrees to all the terms, covenants, conditions and restrictions contained therein.

By Helen Pootoogooluk
Helen Pootoogooluk
Acting President/CEO

ACKNOWLEDGMENT

STATE OF ALASKA)
COUNTY OF) SS

On this 9th day of February, 2006, before me, a Notary Public in and for the City of Nome, County of , State of Alaska, personally appeared Helen Pootoogooluk, known to me to be the Acting President/CEO, and known to me to be the person who executed the foregoing instrument on behalf of Norton Sound Health Corporation, and acknowledged to me that she executed the same as the free act and deed of Norton Sound Health Corporation.

Witness my hand and official seal.

(SEAL)

Donna Adams
Notary Public

My commission expires May 21, 2008

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2006-000676-0

Community Health Needs Assessment Survey Report

Norton Sound Health Corporation

January 2021

For additional information regarding the Norton Sound Health Corporation Community Health Needs Assessment, contact Quality Improvement at (907) 443-4501.

EXECUTIVE SUMMARY

Norton Sound Regional Hospital

Norton Sound Health Corporation (NSHC) is a tribally owned and operated, independent, not-for profit health care organization, founded in 1970 to meet the health care needs of the Inupiat, Siberian Yup'ik and Yup'ik people of the Being Strait region. NSHC is governed by a 22-member board of directors who represent all communities and areas of the Bering Strait region, a 44,000 square-mile section of northwestern Alaska.

Norton Sound Health Corporation puts the patient first. This principle applies equally at the new Norton Sound Regional Hospital and at the 15 village clinics managed by NSHC.

Every day, NSHC's approximately 750 employees – about 62% of them Alaska Native – demonstrate their commitment to our mission: providing quality health services and promoting wellness within our people and environment. NSHC strives to train local people to deliver and manage its services. NSHC offers a 2-year Registered Nurse Program through the University of Alaska Anchorage, a Certified Nursing Assistant Course, and other local trainings in partnership with the local Nome Northwest Campus and the region's partners.

In 2019, Norton Sound Health Corporation was recognized as one of the nation's top clinically performing community health centers. HRSA named NSHC as a "gold tier" Health Center Quality Leader awardee, meaning that the organization is among the top 10% of health centers to achieve best overall clinical performance nationwide. NSHC improved on measures such as tobacco intervention, colorectal cancer screening, and childhood immunization status.

The organization also increased the level of medical and mental health care provided to patients. Significant steps have been taken by NSHC to ensure that whole-person care is being delivered; behavioral health services have been prioritized, and resources have been increased. Full-time psychiatry services were implemented to better meet the needs of our patients. In FY19, NSHC opened a drug rehabilitation program, known as the "day shelter", which utilizes the skills of recovery coaches to facilitate lifestyle changes. The resource and recovery program has resulted in guests securing jobs, housing, reducing emergency department visits, and achieving GED status. The day shelter is just one of the critical steps necessary to enhance the behavioral health continuum of care model.

The goal to increase access to care for all communities is being realized; village visits have doubled and more mid-level providers have been hired to provide higher level care in the village clinics, to provide relief to health aides, and to facilitate additional on-call coverage. A Population Health Department was implemented to coordinate prevention care and to ensure clinical standards of care are being met for patients. An In-home support program was also initiated, in which NSHC will administer the Personal Care Attendant (P.C.A) Program for the region with the goal to offer end-of-life care for families who need the services.

In January 2019, NSHC started offering MRI services locally, with its new state-of-the-art MRI machine, the only one of its kind in Alaska and in the nation serving rural health needs. A staff neurologist was also hired. NSHC continued to offer tribal healing services and acupuncture services to compliment its pain management services.

NSHC continues to promote state-of-the-art facilities. Since 2017, NSHC has completed the construction of four new health clinics located in Savoonga, Gambell, Shaktoolik, and Little Diomede. The construction of two new health clinics are underway in St. Michael and Shishmaref, and a new clinic with staffing housing is under design for the village of Wales. NSHC has made village-based housing a priority to ensure the staff who work at the clinic have adequate housing available. New housing has been constructed in St. Michael, Savoonga, and Golovin to-date. The responsibility for the maintenance and oversight of the village-based facilities has also improved through NSHC's ability to establish 105(l) leases with the Indian Health Services.

Although significant improvements been made in health care delivery, five of the fifteen villages remain without water and sewer. One of NSHC's highest priorities is to continue to strengthen the region's best practice scores to remain eligible for water and sewer capital infrastructure funding. A sanitation engineer was hired in FY19 to manage and coordinate the region's water and sewer goals and objectives.

NSHC is excited to open its new Wellness and Training Center in June 2021; the new facility will include a sobering center with integrated wellness services to facilitate sobriety. The new training facility will provide expanded classroom space to train the organization's health aide workforce. It

Norton Sound Health Corporation is a model of how Indian Self-Determination is meant to work, with tribes taking responsibility for their own health and well-being.

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BACKGROUND INFORMATION

In 1969, the Alaska Federation of Natives (AFN) sought a demonstration project to give Alaska Natives greater power in health care decisions. Norton Sound was selected for development of a model for community-based health care services as an alternative to regional, hospital-based care. Norton Sound Health Corporation (NSHC) was incorporated November 27, 1970. The first board had just three directors: William Takak of Shaktoolik, president; Winfred James of Gambell, treasurer; and Dorothy Isabell of Teller, secretary.

That first NSHC Board of Directors faced a formidable task: Bring health care services to a remote area with limited resources. At the time, northwest Alaskans had little access to health care, and getting medical treatment often meant traveling long distances to regional hospitals. One of the first initiatives NSHC launched was the health aide program, established in 1971. While health aides continue to be the backbone of the NSHC organization today, more than 40 years later, NSHC's services have expanded to include clinic travel clerks, village-based counselors, patient benefit coordinators, dental health therapists and nurse practitioners in all the villages served.

At its first meeting in November 1970, the NSHC Board of Directors established its highest goal: provide a "comprehensive and quality inpatient facility in Nome." That year, NSHC opened its first office in the basement of Maynard-McDougall Memorial Hospital in Nome, with a budget of $143,000. Six years later, NSHC purchased the hospital, and in 1978 Norton Sound Regional Hospital opened in Nome. It was quickly followed by Unalakleet' s sub-regional health clinic, staffed by a physician assistant and community health aides serving four villages.

In 1975, NSHC became the first Native health corporation to become independent of AFN and contract directly with the Indian Health Service. The following year, the board assumed responsibility for regional environmental health services through assignment of a federal Public Health Service sanitarian.

Over the years, NSHC's board focused on expanding patient care in the Bering Strait region of Alaska, adding basic services in 15 villages throughout the Norton Sound area as well as specialty clinics in Nome. In 2008, the Board of Directors opened The Patient Hostel, a 38-bed facility, located on the east side of Nome and positioned close to where the new facility would be constructed someday.

Another milestone was reached in 2009, when Indian Health Services awarded NSHC full funding to complete a new hospital building in Nome. Construction began in October 2009 and was completed in 2012. The first patients were seen at the new Norton Sound Regional Hospital and Quyanna Care Center in March 2013.

In October 2014, NSHC went live with its new electronic medical record, "Cerner" and completed the renovation for the Wales clinic and replaced the Shishmaref clinic. In 2015, NSHC initiated a village clinic improvement program and assumed oversight and responsibility for nearly all village clinics and hired housekeepers and maintenance workers to keep the clinics maintained in all the villages. The Nome outpatient clinic received a HRSA new access point grant and was integrated with the village primary health care services for the first time.

In 2016, NSHC began an ambitious mission to replace and/or update aging clinic facilities throughout the region. In 2017, saw NSHC's Nome Primary Care Center receive recognition as a Patient Centered Medical Home by the National Committee on Quality Assurance. New clinics were completed in the villages of Gambell, Savoonga, and Shaktoolik. Village-based housing projects were also completed in Savoonga and Golovin.

In 2018 an MRI was added to the NSHC hospital to further advanced our diagnostic capabilities and a new health clinic for the village of Shakoolik was opened.

In 2020, NSHC achieved its vision to complete construction for a new health clinic for the remote village of Little Diomede.

In 2021, NSHC expects to open the long- awaited Wellness and Training Center which will create the first sobering center in the region as well as add intensive outpatient mental health services to our comprehensive service wrap around services.

The COVID-19 pandemic saw Norton Sound Health Corporation face the challenge of the generations while minimizing morbidity and mortality, supporting communities in mitigation and suppression methods while retaining high quality preventative, chronic and emergency care.

NORTON SOUND HEALTH CORPORATION: MISSION, VISION, AND VALUES

Our purpose, core values and vision for the future are built on our commitment to providing the Native people of the Norton Sound region with the highest quality health care possible.

Our mission:
Providing quality health services and promoting wellness within our people and environment.

Our core values:

- Integrity
- Cultural sensitivity and respect for traditional values
- Always learning and improving
- Compassion
- Teamwork
- Pride

Our vision for the future:

- We will ensure that all patients receive quality and respectful health care.
- We will educate our patients and communities to be proactive in caring for themselves and promoting wellness.
- We will listen to, honor, and respect our elders, preserve their right to speak, and ensure they receive the best care in gratitude for their leadership.
- We will increase wellness efforts to reduce addictive behaviors and to raise the quality of life among our people and communities.
- We will advocate that our environment (air, land and water) will be clean, and our water and waste disposal systems are safe and affordable, in order to ensure our subsistence way of life.

- We will assert and implement tribal self-governance to achieve our vision through effective leadership.
- We will hire and support our tribal members to deliver and manage our services.
- We will develop state of the art and efficient health care facilities throughout the region.
- We will be financially strong through aggressive, effective and efficient financial management.
- We will support and develop our youth to pursue higher education and health care careers to ensure there is future tribal leadership.

SCOPE OF THE STUDY

The purpose of the 2020 Norton Sound Health Corporation Community Health Needs Assessment is to collect data on specific information regarding community perception of the Use of Healthcare Services, Awareness of Services, Community Health, and Health Insurance. Additionally, data were collected regarding the demographics of survey responders. The data are presented in a format that can be useful to Norton Sound Health Corporation board of directors, administration, health care providers and community.

METHODOLOGY

A comprehensive survey was developed by the Quality Assurance/Performance Improvement Team "Aquutaq". The survey was loaded electronically into Microsoft Forms. It was distributed electronically via advertisement, QR code, email, public information, Facebook, community meetings and other avenues. Paper copies of the form were also mailed to all box holders in the region as well as made available at all clinics and within the Nome hospital site. The survey was also distributed at various Health Forums held within the region.

Data collection began in early 2019 and continued until early 2020 with a goal of at least 1000 responses. Processing of data and this report was delayed due to reallocation of staff during the pandemic and completed in 2021. The survey was closed for responses in January 2020, after 1004 responses had been received, (32.4% of households in the region). The data was entered into a Microsoft Forms/ Microsoft Excel database and are presented in the Survey Results section of this report. At the time of survey closure, data was first prepared and shared with the NSHC Board of Directors, final report was completed on January 26, 2021.

Population Data

PEOPLE		
Population		
Population estimates, July 1, 2019, (V2019)	**10,004**	**731,545**
Population estimates base, April 1, 2010, (V2019)	9,492	710,249
Population, percent change - April 1, 2010 (estimates base) to July 1, 2019, (V2019)	5.4%	3.0%
Population, Census, April 1, 2010	9,492	710,231
Age and Sex		
Persons under 5 years, percent	10.0%	7.0%
Persons under 18 years, percent	34.6%	24.6%
Persons 65 years and over, percent	8.0%	12.5%
Female persons, percent	47.4%	47.9%
Race and Hispanic Origin		
White alone, percent	15.7%	65.3%
Black or African American alone, percent(a)	0.9%	3.7%
American Indian and Alaska Native alone, percent(a)	75.3%	15.6%
Asian alone, percent(a)	1.5%	6.5%
Native Hawaiian and Other Pacific Islander alone, percent(a)	0.2%	1.4%
Two or More Races, percent	6.5%	7.5%
Hispanic or Latino, percent(b)	2.9%	7.3%
White alone, not Hispanic or Latino, percent	14.9%	60.2%
Population Characteristics		
Veterans, 2015-2019	394	65,186
Foreign born persons, percent, 2015-2019	2.5%	7.8%
Housing		
Housing units, July 1, 2019, (V2019)	4,100	319,854
Owner-occupied housing unit rate, 2015-2019	60.5%	64.3%
Median value of owner-occupied housing units, 2015-2019	$154,600	$270,400
Median selected monthly owner costs -with a mortgage, 2015-2019	$1,470	$1,933
Median selected monthly owner costs -without a mortgage, 2015-2019	$469	$582
Median gross rent, 2015-2019	$1,287	$1,244
Building permits, 2019	6	1,680
Families & Living Arrangements		
Households, 2015-2019	2,844	253,346
Persons per household, 2015-2019	3.30	2.80
Living in same house 1 year ago, percent of persons age 1 year+, 2015-2019	84.1%	82.1%

Language other than English spoken at home, percent of persons age 5 years+, 2015-2019	31.0%	16.1%
Computer and Internet Use		
Households with a computer, percent, 2015-2019	90.7%	94.1%
Households with a broadband Internet subscription, percent, 2015-2019	74.1%	85.5%
Education		
High school graduate or higher, percent of persons age 25 years+, 2015-2019	84.6%	92.8%
Bachelor's degree or higher, percent of persons age 25 years+, 2015-2019	16.1%	29.6%
Health		
With a disability, under age 65 years, percent, 2015-2019	6.8%	8.9%
Persons without health insurance, under age 65 years, percent	18.4%	13.9%
Economy		
In civilian labor force, total, percent of population age 16 years+, 2015-2019	64.8%	65.5%
In civilian labor force, female, percent of population age 16 years+, 2015-2019	66.8%	63.1%
Total accommodation and food services sales, 2012 ($1,000)(c)	14,821	2,221,335
Total health care and social assistance receipts/revenue, 2012 ($1,000)(c)	D	6,375,483
Total manufacturers shipments, 2012 ($1,000)(c)	D	D
Total merchant wholesaler sales, 2012 ($1,000)(c)	D	5,216,303
Total retail sales, 2012 ($1,000)(c)	78,672	10,474,275
Total retail sales per capita, 2012(c)	$7,935	$14,320
Transportation		
Mean travel time to work (minutes), workers age 16 years+, 2015-2019	6.7	19.1
Income & Poverty		
Median household income (in 2019 dollars), 2015-2019	$61,048	$77,640
Per capita income in past 12 months (in 2019 dollars), 2015-2019	$23,581	$36,787
Persons in poverty, percent	20.7%	10.1%
BUSINESSES		
Businesses		
Total employer establishments, 2018	168	21,293
Total employment, 2018	2,119	261,053
Total annual payroll, 2018 ($1,000)	121,975	15,732,010
Total employment, percent change, 2017-2018	-2.9%	-0.4%
Total nonemployer establishments, 2018	551	57,391

All firms, 2012	676	68,032
Men-owned firms, 2012	380	35,402
Women-owned firms, 2012	212	22,141
Minority-owned firms, 2012	381	13,688
Nonminority-owned firms, 2012	264	51,147
Veteran-owned firms, 2012	61	7,953
Nonveteran-owned firms, 2012	578	56,091

GEOGRAPHY

Geography		
Population per square mile, 2010	0.4	1.2
Land area in square miles, 2010	22,961.76	570,640.95
FIPS Code	02180	02

About datasets used in this table

Value Notes

Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable.

The vintage year (e.g., V2019) refers to the final year of the series (2010 thru 2019). *Different vintage years of estimates are not comparable.*

Fact Notes

- (a)Includes persons reporting only one race
- (b)Hispanics may be of any race, so also are included in applicable race categories
- (c)Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

Value Flags

- -Either no or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest or upper interval of an open ended distribution.
- D- Suppressed to avoid disclosure of confidential information

QuickFacts data are derived from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area Health Insurance Estimates, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits.

Source: US Department of Commerce. US Census Bureau

http://quickfacts.census.gov/qfd/index.html

BEHAVIORAL RISK FACTOR DATA

Alaska Behavioral Risk Factor Surveillance System

2018 Nome Region

Risk Fact	Nome (%)	Alaska (%)
Health Status: General Health Excellent/Very Good	41.7	51.3
Health Status: Poor physical health	18.0	16.4
Health Status: Frequent mental distress	18.8	11.3
Thoughts of Suicide in past 12 months (2013)	5.0	4.2
Ever told had depressive disorder	15.4	21.2
HTN: Ever told HTN (2017)	25.7	29.9
CVD: Ever told heart attack	3.7	4.4
CVD: Diagnosis of Angina or Coronary Heart Disease	1	2.8
COPD	4.6	5.3
Cancer: Any type	4.2	7.8
Weight Status: Severely Obese (BM>40)	10.3	7.8
Weight Status: Obese (BMI 30-39.9)	26.5	31.2
Weight Status: Overweight	28.1	35.1
Weight Status: Underweight	0.6	1.8
Seen a provider in the last 12 months	56.0	69.3
Access: No Health Care Coverage	6.1	9.1
Follow Subsistence Lifestyle (2017)	79.7	30.2
Rent Home	20.3	27.2
Believe currently get enough physical activity (2015)	59.7	46.9
Activity Time: Adequate Aerobic Physical Activity (at least 150 minutes per week) (2017)	86.9	56.7
Activity Time: Adequate Aerobic Physical Activity (at least 300 minutes per week) (2017)	69.9	36.2
Received Food Assistance from Community Program(s) (2013)	14.7	7
Received Food Assistance from Government Program(s) (2013)	34.9	15.6
Less than 3 vegetables and 2 fruits per day	81.5	93.8
Sweetened carbonated beverages 1+ per day (2017)	27.5	13.2
Sweetened non-carbonated beverages 1+ per day (2017)	45.4	12.1
Cigarette Smoking: Current Smoker Everyday (2018)	30.3	17.1
Cigarette Smoking: Former Smoking (2018)	27.7	28.3
Cigarette Smoking: Never Smoked (2018)	42.1	54.6
Tobacco Use (not including e-cig) (2018)	63.4	25.2
Current Marijuana Use (2018)	44.6	17.3
Current Alcohol Use (2018)	34.9	58.6
Binge Drinking (2018)	13.4	16.4
Before age 18, lived with problem drinker/alcoholic/drugs/rx med (2015)	47.4	32.3
Seat Belt Use: always use a seatbelt (2018)	73.1	83.0
Hurt by intimate partner last 5 years (2017)	15.2	6.6

NOME CA MAPP: BRFSS DATA: 2015-2018: MIXED

COMMUNITY HEALTH NEEDS SURVEY RESULTS (as of 1/26/2021) (1004 households reporting)

Norton Sound Health Corporation

*NOTE SOME TOTALS MAY NOT EQUAL TO 100% DUE TO ROUNDING AND ALLOWANCE FOR MULTIPLE RESPONSES PER ITEM. ALSO NUMBER OF RESPONSES DIFFERS TO EACH ITEM ALLOWING FOR NON-RESPONDERS AND MULTIPLE RESPONSES TO SOME ITEMS.

Section A: Please tell us about yourself

1. What is your zip code?

Village	Zip Code	Number	Percentage
Nome, Golovin, Diomede	99762	481	47.91%
Brevig	99785	28	2.79%
Elim	99739	73	7.27%
Gambell	99742	55	5.48%
Koyuk	99753	25	2.49%
St. Michael	99659	15	1.49%
Savoonga	99769	31	3.09%
Shaktoolik	99771	17	1.69%
Shishmaref	99772	56	5.58%
Stebbins	99671	49	4.88%
Teller	99778	16	1.59%
Unalakleet	99684	96	9.56%
Wales	99783	9	0.90%
White Mountain	99784	29	2.89%
OTHER		11	1.10%
NO RESPONSE		13	1.29%
Total		**1004**	**100%**

2. What is your gender?

Gender	Number	Percentage
Male	295	29.38%
Female	679	67.63%
Transgender	2	0.20%
Other	1	0.10%
Prefer not to answer	27	2.69%
Total	**1004**	**100.0%**

3. What is your age range?

Age	Number	Percentage
18-25	100	9.96%
26-35	260	25.90%
36-45	163	16.24%
46-55	164	16.33%
56-65	197	19.62%
66-75	79	7.87%
76-85	21	2.09%
86+	1	0.10%
Unanswered/Prefer not to say	19	1.89%
Total	**1004**	**100.0%**

4. Are you an IHS beneficiary?

Response	Count	Percentages
Yes	660	65.74%
No	286	28.49%
Unanswered/Prefer not to say	58	5.78%
Total	**800**	**100%**

5. How many people, including yourself, live in your household?

Number	Count	Percentage
1	141	14.04%
2	196	19.52%
3	167	16.63%
4	150	14.94%
5	118	11.75%
6	75	7.47%
7	61	6.08%
8	38	3.78%
9	16	1.59%
10+	30	3%
Unanswered/ Prefer not to say	12	1.2%
Total	**1004**	**100%**

6. How many children under the age of 18 live in your household?

Number	Count	Percentage
0	425	42.37%
1	164	16.35%
2	160	15.95%
3	110	10.97%
4	61	6.08%
5	37	3.69%
6	18	1.79%
7	7	0.70%
8	1	0.10%
9+	2	0.20%
Unanswered/ Prefer not to say	19	1.89%
Total	**1004**	**100%**

7. What is your employment status?

Response	Count	Percentage
Work full-time	529	52.69%
Work part-time	129	12.85%
Retired	116	11.55%
Unemployed and looking for employment	103	10.26%
Not currently seeking employment	69	6.87%
Disabled	25	2.49%
Student	21	2.09%
Unanswered/Prefer not to say	12	1.20%
Total	**1004**	**100%**

8. Do you access the internet in your home?

Response	Count	Percentages
Yes	646	64.34%
No	343	34.16%
Unanswered/Prefer not to say	15	1.49%
Grand Total	**1004**	**100.00%**

9. Do you have plumbed drinking water in your home?

Response	Count	Percentages
No	180	17.93%
Yes	813	80.98%
Unanswered/Prefer not to say	11	1.10%

Grand Total	1004	100.00%

10. Do you have plumbed septic/sewer in your home?

Response	Count	Percentages
No	203	20.22%
Yes	789	78.59%
Unanswered/Prefer not to say	12	1.20%
Grand Total	**1004**	**100.00%**

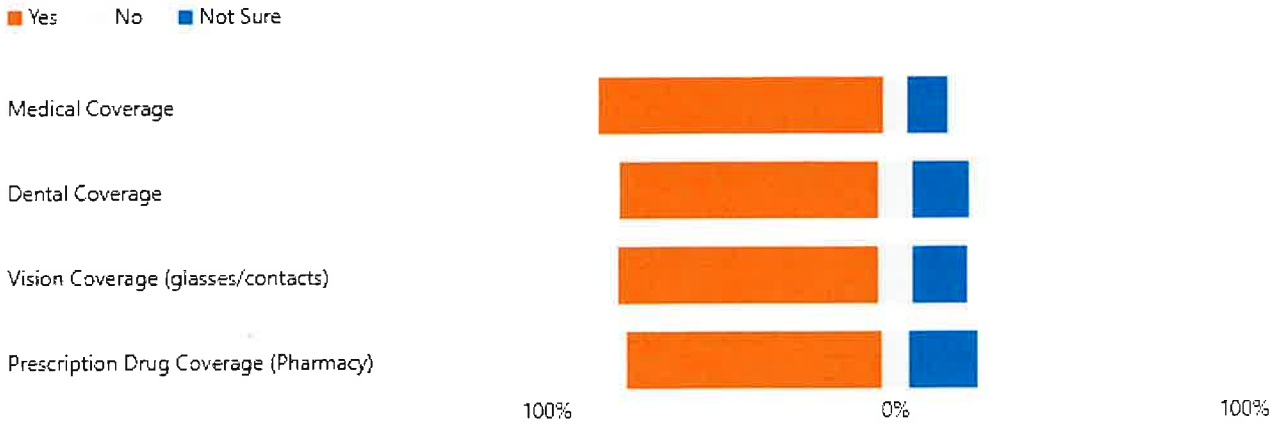
11. What is the best way for NSHC to communicate with you? (Preferential choice ranking, only first preference listed below)

Response	Count	Percentage
Email	112	11.16%
Mail	90	8.96%
Phone	156	25%
Text Message	366	36.45%
Other Media	11	1.1%
Unanswered/Prefer not to say	296	29.48%
Total	**1004**	**100%**

12. What type(s) of health care coverage do you have? (Multiple responses allowed).

Response	Count	Percentage
Indian Health Services (IHS)	507	33.82%
Employer Sponsored	494	32.96%
Medicaid	259	17.28%
Medicare	111	7.40%
No coverage	38	3.78%
VA/Military	20	1.33%
Health Savings Account	9	0.60%
Other	38	3.78%
Unanswered/Prefer not to say	11	1.01%
Total	1004	100%

13. What types of coverage do you have?



Section B: Tell us about your healthcare experience

1. Have you used any Norton Sound Health Corporation facilities?

Response	Count	Percentages
Yes	943	93.92%
No	38	3.78%
Unanswered/Prefer not to say	23	2.29
Total	**1004**	**100%**

2. Why do you choose to use NSHC facilities?
(multiple responses allowed)

Response	Count
Only clinic available	759
Has services I need	264
Needed medication refefilled	187
Emergency, no other choices	185
Provider listens to me	126
Provider knows me by name	119
Referred	92
Great experiences prior	89
Short waiting time	87
Hospital/Clinic reputation for quality	70
Required by my insurance	46
Recommended by family/friends	42
Cost of Care	35
n/a, I NEVER use NSHC facilities	18
Other, free text responses	17
VA/Military requirement	6

3. If you ever choose not to use NSHC facilities, why not?
(multiple responses allowed)

Response	Count	Percentage
n/a, I ONLY use NSHC	336	27.77%
Service I needed was unavailable	213	17.60%
Lack of privacy/confidentiality	83	6.86%
Costs too much money	77	6.36%
No appointment available in a timely manner	77	6.36%
Did not trust the provider	63	5.21%
Unsure if service I need is available	62	5.12%
Not treated with respect	52	4.30%
Do not like provider	50	4.13%
Appointments do not fit my schedule	46	3.80%
My insurance would not cover my care	30	2.48%
Provider is my co-worker/relative	26	2.15%
Other – free text response	66	5.45%
Unanswered/Prefer not to say	191	19.02%

4. In the past 12 months, was there a time when you or someone living in your home needed medical care from NSHC but were not seen?

Response	Count	Percentages
Yes	202	20%
No	731	73%
Other	39	4%
Unanswered/Prefer not to say	32	3%
Total	**788**	**100%**

5. If you answered "yes" above, what service were you not able to use:

Response	Count
Nome Hospital	20
Nome Clinic	45
Village Clinic	80
BHS Nome	11
BHS Village	4
Other	41

6. Check any of the reasons below that help explain why you were not seen. (multiple responses allowed)

Reason	Count
Clinic is too far away	3
Costs too much money	19
Did not trust the provider	21
Do not like provider (MD, DO, PA, NP, Health Aide)	14
Had no one to watch kids	6
Lack of privacy/confidentiality	21
Language barrier	0
My insurance would not cover	8
No appointment available in a timely manner	73
No appointments that fit my schedule	26
No transportation	14
Not treated with respect	25
Other	47
Provider is my co-worker/relative	7
Too afraid or nervous	7
Unsure if service I need is available	11
Service I needed was unavailable	40

7. In the past 12 months, check all of the health care providers you or anyone living your home has seen: (multiple responses allowed)

Provider	Count
General practice provider (MD, DO, PA, NP)	646
Dentist/DHAT	488
Optometrist (Eye doctor)	420
Health Aide	394
Audiologist (hearing)	276
Pediatrician	212
Physical Therapist	179
Behavioral Health Clinician/Therapist	164
ENT Specialist (ear, nose, throat specialist)	156
Obstetrician/Gynecologist (female reproductive specialist)	134
Tribal Healer	128
Orthopedist (bone/joint specialist)	93
Cardiologist (heart specialist)	89
Dietitian	73
Neurologist (brain/nerve specialist)	72
Urologist (kidney/bladder/male reproductive specialist)	69
Surgeon	68
Diabetes Specialist	66
Psychiatrist	61
Rheumatologist (arthritis specialist)	42
Dermatologist (skin specialist)	35
Oncologist (cancer specialist)	34
Chiropractor	33
Social Worker	31
Tobacco Counselor	31
Pulmonologist (lung specialist)	30
Infant Learning Program	30
Podiatrist (foot/ankle specialist)	23
Allergy Specialist	23
Substance Abuse Counselor	15
Other (Free text)	44

8. How long did you have to wait to see the specialist from the time you were referred or requested an appointment?

Column1	Count	Percentage
1 month	240	23.90%
2 months	102	10.16%
3 months	60	5.98%
4 months	24	2.39%
5 months	13	1.29%
6 moths or more	50	4.98%
Unanswered/choose not to respond	515	51.29%
Total	**1004**	**100%**

9. Please rate the following services Norton Sound Health Corporation offers and tell where you used that service most:

	Excellent	Good	Fair	Poor
Emergency Room	44.20%	43.30%	7.59%	4.91%
Inpatient (Acute Care)	16.57%	40.51%	35.54%	7.38%
QCC (Quyanna Care Center, Nursing Home)	31.76%	44.12%	20.00%	4.12%
Nome Primary Care	25.48%	52.71%	18.59%	3.22%
Village Clinic	32.13%	44.68%	20.91%	2.28%
Laboratory	33.28%	47.68%	17.50%	1.54%
Physical Therapy	33.04%	46.67%	17.39%	2.90%
Eye Care Clinic (Optometry)	42.48%	42.48%	12.07%	2.98%
Audiology	38.39%	47.16%	12.32%	2.13%
Dental	39.55%	42.93%	13.67%	3.86%
Behavioral Health	27.09%	44.15%	21.40%	7.36%
Case Management	22.87%	40.96%	23.55%	12.63%
CAMP Program	36.33%	39.45%	19.92%	4.30%
Tribal Healing	50.76%	36.64%	9.54%	3.05%
Infant Learning Program	34.68%	42.74%	18.55%	4.03%
Radiology/Diagnostic Imaging	39.64%	44.42%	13.44%	2.51%
EMS-Medevac Team	57.38%	32.07%	10.13%	0.42%
WIC Program	42.93%	41.46%	13.66%	1.95%
Environmental Health (OEH)	27.93%	45.95%	22.52%	3.60%
Respiratory Therapy	33.74%	51.53%	12.88%	1.84%
Medical Records/HIM	27.73%	45.48%	21.81%	4.98%
Billing Department	27.38%	38.39%	22.32%	11.90%
Human Resources Department	24.91%	37.37%	24.57%	13.15%
Patient Driver	39.21%	40.84%	14.15%	5.80%
Patient Advocate	33.69%	36.56%	19.71%	10.04%
Administration	29.52%	38.10%	21.59%	10.79%

10. Have you or anyone in your household been affected by these community issues:

	% Yes
Elder abuse	5.87%
Child Abuse	7.39%
Domestic Violence	17.54%
Drug Abuse	17.87%
Alcohol Abuse	29.63%
Tobacco Use	44.82%
Chronic Disease	22.83%
Obesity	28.12%
Heart Disease	19.98%
Diabetes	22.05%
Stroke	13.74%
Cancer	26.08%
Teen Pregnancy	10.23%
Sexually Transmitted Infections	17.16%
Suicide	23.58%
Lack of Access to Healthcare	19.41%
Lack of Access to Medications	15.47%
Lack of Quality childcare	19.41%
Lack of Quality Schooling	14.67%
Lack of Quality Housing	31.62%
Lack of Strong Family Support	14.51%
Lack of Safety	11.89%
Lack of Good Jobs	34.26%
Lack of Food due to expense	28.37%
Lack of healthy food available	36.08%
Lack of Native/Traditional foods	24.80%
Lack of Indoor Exercise Facilities	37.66%
Lack of Outdoor Recreational Spaces (parks, walking paths, etc)	24.85%
Lack of Running Water/Sewer	22.20%
Lack of Sobering Center	20.82%
Lack of Homeless Shelter	19.11%
Lack of Law Enforcement	30.87%

11. What would improve your access to care? (multiple responses allowed)

	Count
More providers/health aides	352
More specialty clinics	309
End of Life Care Program	126
Prescription deliver	127
Home visits by providers/health aides	164
Longer hours at the clinics	145
Telemedicine availability	67
Personal Care Attendants	152
Transportation to clinic or hospital	152
Assisted Living Center	171
Availability of Long Term Care	109
Financial Support for Out of Region	91
Other (free text)	

Nurse Call Line

12. Have you ever used the NSHC Nurse Call Line, and based on your experience, how would you rate it? (1 – Excellent, 5 - poor)

Row Labels	Count of ID	Sum of ID
No - but I've head of it	**103**	**18.35%**
1	28	6.47%
2	16	3.21%
3	38	5.12%
4	7	1.28%
5	14	2.28%
No - but I've heard of it	**3**	**1.08%**
1	3	1.08%
No - Never heard of it	**8**	**1.26%**
1	1	0.22%
2	2	0.53%
3	3	0.37%
5	2	0.13%
Yes, I have used the Nurse Call Line	**392**	**79.31%**
1	108	22.31%
2	75	14.64%
3	101	19.89%
4	46	9.87%
5	62	12.60%
Grand Total	**506**	**100.00%**

Performance Improvement Goals Summary

Over the next three years, NSHC will strive to:

1) Improve Communication with Patients by asking the patient what their preferred method of communication is and utilizing it to provide meaningful feedback to patients.

2) Improve Access to Care for Patient by ensuring the NSHC Primary Care System has both appointments available for patients to accommodate same-day access to care when needed.

3) Improve Notification and Reminders to Patients about scheduled appointments.

4) Improve customer service by training staff on phone etiquette and by improving the switchboard operator experience.

5) Improve the quality of patient care by performing audits of patients who present to NSHC's outpatient clinics for care on a frequent basis; reports will be made to the HRSA quality committee to ensure there is accountability.

6) Continue the initiatives of the Population Health Department to ensure patients are receiving coordinated care and referrals for prevention tests and receiving care that meets clinical standards for disease states.

7) Continue to strengthen the nurse call line by listening to consumer feedback; share success stories when possible.

8) Ensure patient privacy and confidentiality is preserved at all times by providing training to all staff at regular intervals.

9) Continue to focus on Tobacco cessation counseling and prevention activities, substance abuse treatment programs, and suicide prevention activities.

10) Improve access to healthy foods region-wide by collaborating with village leadership.

11) Increase access to indoor workout space region-wide by working with local leaders to develop partnerships for solutions.

12) Continue to develop and expand NSHC's in-home support program to provide personal care attendant services (PCA Program) and to offer end-of-life care for family's in the region at all locations.

13) Continue to provide patient transport services in all locations and to deliver prescription medications.

FUNDING AGREEMENT
BETWEEN CERTAIN ALASKA NATIVE TRIBES
SERVED BY THE
NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
OF THE
UNITED STATES OF AMERICA
FISCAL YEARS 2018-2020

This Funding Agreement is entered into by and between certain Alaska Native Tribes in the Bering Straits region of the Norton Sound Service Unit, as identified on the signature page herein, and the Secretary of the Department of Health and Human Services. These Tribes have authorized the Norton Sound Health Corporation to sign this Funding Agreement for them and to be responsible for and carry out the terms of this Funding Agreement.

Section 1 – Obligations of the IHS.

1.1 Generally. Under the authority of Section 325 of P.L. 105-83, and P.L. 93-638 as amended, non-residual programs, services, functions and activities (PSFAs) of the Alaska Area Office and the Alaska Native Medical Center (ANMC) have been transferred to tribal management.

Delivery of PSFAs shall be consistent with each Co-Signer's Funding Agreement (FA). The Indian Health Service (IHS) shall remain responsible for performing all federal residual PSFAs. The IHS shall remain responsible for negotiating assurances with the Alaska Native Tribal Health Consortium (ANTHC) and Southcentral Foundation (SCF) on behalf of Alaska Natives and American Indians to the effect that Co-Signers continue to receive non-residual PSFAs from the ANMC and Area Office and provided by ANTHC and SCF at a minimum at the level that such PSFAs were provided by the IHS as of October 1, 1997, to the extent permitted by Section 325 of P.L. 105-83. To the extent authorized by federal law, the IHS will respond to written Co-Signer concerns about the extent with which such assurances have not been complied and take appropriate action. IHS shall further be responsible for performing its special trust responsibilities and legal obligations as provided in the Indian Health Care Improvement Act, the Indian Self-Determination and Education Assistance Act, and other applicable provisions of federal law.

This FA obligates the IHS to provide funding and services identified herein and as provided in the Alaska Tribal Health Compact (ATHC) between the Norton Sound Health Corporation (NSHC) and certain other Co-Signers thereof and the United States in Fiscal Years 2018-2020.

The "Memorandum of Agreement Describing the Continuing Services of the IHS, Alaska Area Native Health Service" among the Co-Signers and the Alaska Area Native Health Service

(AANHS) reflects the understanding of the parties regarding services to be provided by the AANHS to Co-Signers. This document, attached as Appendix C, is hereby incorporated by reference.[1]

In addition, although funds are provided from Headquarters and Area Office in support of this ATHC, the IHS will agree to continue to make available to NSHC PSFAs from both Area Office and Headquarters unless 100 percent of the tribal shares for these PSFAs have been specifically included in this FA. In cases where a portion of tribal shares has been transferred, there may be some diminishment in the level of PSFAs provided by IHS. Furthermore, the IHS will reorganize both Headquarters and the Area Office to continue to provide the remaining PSFAs which have not been included in this FA, in the most effective and efficient manner possible, provided that the decisions about the array and level of PSFAs to be offered by the IHS shall be made in consultation with Alaska Tribes. The IHS PSFAs not negotiated into or listed in Appendix A are the responsibility of the IHS.

Unless funds are specifically provided from Headquarters, Headquarters retains all PSFAs and NSHC will not be denied access to, or services from, Headquarters. Specifically, NSHC will receive the following services from IHS Headquarters:

1.1.1 Information Services. IHS will provide the full range of Office of Information Technology (OIT) national support to ANTHC and ANMC OIT will provide specified services directly to NSHC. In addition, OIT will provide support to ANTHC to assist it to carry out its responsibility to provide day-to-day technical support, user support, distribution of software and files and other typical information technology support to Co-Signers as defined in the Assurances Appendix to the ANTHC FA. Upon request of ANTHC, after good faith efforts to resolve NSHC's technical issue, OIT's support of NSHC will include technical support needed on-site by NSHC. A list of the services due under this paragraph, with identification of the method of delivery, is shown below.

Office of Information Technology Provides:	Directly to ANTHC	Directly to Co-Signer	Indirectly to Cosigner through ANTHC
National Database Services			
100% Data Center Services	X		
Process Data exports into National Database		X	
Evaluate, correct, convert site data for National Database		X	
Telecommunications Management Services			
100% Telecommunications Management Services	X		
Maintain IHS to Alaska connection		X	
Email transfer and global address listing		X	
SMTP Gateway		X	
Intranet and Internet Access (to available bandwidth)		X	
Antivirus Software			X

[1] All references to Appendix A and Appendix C in this FA are to the Appendix for the applicable fiscal year.

Office of Information Technology Provides:	Directly to ANTHC	Directly to Co-Signer	Indirectly to Cosigner through ANTHC
Software Development and Maintenance			
100% Software Development and Maintenance	X		
Use of IHS contract vehicles		X	
RPMS Integrated Commercial-Off-The-Shelf packages (Average Wholesale Prices, CPT, ICD-9, Immunization Algorithm) licenses (This does not include licenses for stand-alone or interfaced commercial software.)			X
RPMS Package Support/Installation			X
System Support and Training			
100% System Support and Training	X		
Nationally Available OIT Training instruction (as available)		X	
Alaska On-site training instruction (four annual classes)			X
Hardware and Operating System Support			X
Cache Upgrade (initial installations)			X
National Patient File (2000) conversion			X
Envoy (WebMD) installation			X
Additional Services - Fee for Service	X	X	X

1.1.2 Access to Training and Technical Assistance. To the extent funds are identified by the IHS, NSHC shall have access to training, continuing education, and technical assistance in the manner and to the same extent NSHC would have received such services if it were not a Self-Governance Co-Signer.

1.1.3 Intellectual Property. In the course of administering federal contracts, grants, subgrants, and other agreements, IHS acquired various copyrights and licenses, including licenses pursuant to 45 CFR § 74.36 and 45 CFR § 92.34, in works which the IHS possessed, reproduced, published and otherwise used and allowed others to possess, reproduce, publish, and otherwise use. To carry out the PSFAs assumed by NSHC under this and previous FAs and contracts NSHC has the delegated authority and permission from IHS to use and allow others to reproduce, publish, and otherwise make use of these works to the same extent as IHS, consistent with the copyrights or licenses acquired by IHS in such works.

1.1.4 HIPAA Compliance. IHS retains the responsibility for complying with the Health Insurance Portability and Accountability Act of 1996 for retained IHS health care component activities.

1.2 Historical PSFAs. NSHC has historically received certain PSFAs from ANMC and AANHS. Responsibility for these PSFAs has been transferred to ANTHC by ANMC and AANHS prior to the transfer of management to ANTHC and SCF, NSHC attached to its FY 2002 FA Addendum I entitled "Memorialization of Historical Level of PSFAs provided by ANMC and AANHS." The PSFAs listed in this addendum are taken from NSHC's FY 1999 Annual FA. The addendum was attached to the FY 2002 FA only for the purpose of identifying historical levels of PSFAs received by the NSHC from ANMC and AANHS, and is specifically not made part of this

FA.

1.3 Community Health Aide Program Certification. The IHS retains the responsibility, pursuant to Section 119 of the Indian Health Care Improvement Act, as amended, to maintain the IHS Community Health Aide Program Certification Board (CHAPCB), which was established by and is under the direct control and supervision of IHS, to accredit training for and to certify community health aides, which includes community health aides/practitioners, dental health aides, and behavioral health aides/practitioners.

Section 2 – Obligations of the Co-Signer.

2.1 Generally. This FA obligates NSHC to be responsible for and to provide health PSFAs identified in Section 3 [Tribal Programs and Budget], utilizing the resources transferred under this FA and other funds as they may become available to NSHC. This FA further authorizes NSHC to consolidate and redesign PSFAs as provided in the Act and the ATHC. Whether providing, purchasing, or authorizing health care services described in the Compact and this Funding Agreement, in accordance with Section 2901(b) of Pub. L. 111-148, the Affordable Care Act, and as otherwise provided in law, NSHC shall be the payer of last resort. NSHC is committed to and will strive to provide quality health services and will strive to meet standards NSHC believes to be appropriate and applicable to the delivery of those health services.

2.2 Tribal Facilities and Locations. NSHC operates the programs described in this FA out of more than one facility or location. These include, but are not limited to the facilities and locations listed in Appendix B, which will be submitted prior to the effective date of this FA, and will be incorporated by reference herein. The Area Division of Planning Evaluation and Health Statistics shall compile from this Appendix a list of all health facilities identified in the Appendix and forward that list annually to the Headquarters' Office of Program Statistics, which shall include each of these facilities and locations in the annual list it must provide to the Centers for Medicare and Medicaid Services (CMS) (formerly Health Care Financing Administration) pursuant to the Memorandum of Agreement between the Health Care Financing Administration and the IHS (December 19, 1996).

Section 3 – Tribal Programs and Budget.

The NSHC agrees to be responsible for the health PSFAs identified below in accordance with the ATHC and this FA, including administration of the Norton Sound Service Unit of the IHS, a tribally operated Service Unit of the IHS. NSHC provides and facilitates a range of services directly, and in cooperation with ANMC, ANTHC, SCF and other Co-signers, through field clinics, referrals to ANMC, and other arrangements with tribal health organizations. Any PSFA described in this section 3 [Tribal Programs and Budget] may be performed by any organizational unit of NSHC at NSHC's discretion. For the purposes of this FA, the NSHC's General Budget Categories consolidate related health PSFAs as listed below.

3.1 Executive Leadership. NSHC through its Board of Directors and administration provides policy and administrative/executive/legal direction and oversight for all PSFAs in this FA. Board members, officers, General Counsel, and staff represent NSHC on the local, regional,

state and national committees and boards to provide for advocacy, negotiations, coordination, consultation, development of new programs and information activities.

3.2 Hospital and Clinic Services. NSHC is committed to providing quality patient care achieved through maintaining qualified staff, physical plant, and adequate supply of medical provisions. Under a comprehensive health care delivery plan NSHC provides the following direct patient care services:

3.2.1 Acute patient care swing-bed;

3.2.2 Twenty-four hour emergency services, including those associated with being a Level IV trauma center;

3.2.3 Ambulatory care services, including after-hour nursing phone triage service;

3.2.4 Medevac/air ambulance services;

3.2.5 Referral/transport system from the villages and/or Nome to and from the next higher level of care (e.g. travel coordination and authorization, patient transport vehicle, medivac transport and patient transportation, including adult escort, health professional and other escort as NSHC deems appropriate and emergency or non-emergency air transportation where ground transportation is not feasible and transportation by private vehicle where no other means is available, including specially-equipped vehicle and ambulance) subject to available funding. NSHC may provide the above described patient transportation services in accordance with Section 213 of the Indian Health Care Improvement Act as amended at 25 U.S.C. § 1621*l*;

3.2.6 Specialty clinic support;

3.2.7 Sexual Assault Response Team (SART), including forensic exams and counseling of victims;

3.2.8 Comprehensive health care nursing services for the elderly, disabled and others needing long term health care services as defined by Section 205(a)(4) of the Indian Health Care Improvement Act, as amended, and in accordance with Section 205(c) of such Act. Such services will include but not be limited to the nursing facility services of Quyanna Care Center;

3.2.9 Emergency and minor surgery within the expected capability of Medical Practitioners;

3.2.10 Services associated with training medical students, residents, physician assistant students, nursing students, and allied health provider students from accredited institutions, under supervision of appropriate staff;

3.2.10.1 Physician coverage for services provided in the hospital and villages in person and through daily contact by telephone and/or video telemedicine equipment as needed with the physician assistants and/or Community Health Aides/Practitioners in the villages, and for teleradiology services;

3.2.11 Comprehensive, well person, emergency, acute and chronic care and preventive services at the subregional/community health centers and surrounding village clinics. These services include, but are not limited to, Early Periodic Screening, Diagnosis and Treatment (EPSDT), immunizations, maternal and child health services including family planning, prenatal care and case management of care provided to children and other high-risk individuals; urgent care services 24 hours a day; and specialty clinics, dental services, optometry services, diagnostic imaging services, laboratory services, and telemedicine, telehealth, telepharmacy, teleradiology, telepsychiatry services, dialysis, and mammography, colonoscopy and other cancer screenings, and cancer

treatment;

3.2.12 Diabetes prevention program, including community exercise and activity programs, such as "Summercise" programs, community health fairs, and water aerobics. As authorized under Section 204(d) of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621c, NSHC provides dialysis services and is committed to and shall provide quality dialysis services that will at all times meet standards applicable to such services;

3.2.13 Ancillary services will be maintained at levels sufficient to support medical diagnosis, including but not limited to physical therapy, smoking cessation, respiratory therapy, diagnostic imaging, laboratory, pharmacy, social services, nutrition services, and point of care testing;

3.2.14 Provide lodging for patients, family members of patients, and/or their escorts, including but not limited to housing at the patient hostel, and elder housing;

3.2.15 Coordination with, support of, and assistance to tribal and non-profit entities with their provision of health and social services; and

3.2.16 Provides training and continuing education for NSHC employees and NSHC beneficiaries, and, subject to availability of funding, provides limited financial support for NSHC beneficiaries to assist them to be prepared to pursue health related careers. NSHC also provides a nursing educational program.

3.3 Behavioral Health Services. Provides behavioral health services including, but not limited to:

3.3.1 Substance Abuse Services. Provide services to reduce and prevent substance abuse and associated problems through in/outpatient services, prevention/education, referral services, transitional/residential care services, outreach services, and community involvement, diagnostic and primary alcoholism and drug abuse treatment services, including individual assessment and referrals, individual and group counseling, detoxification services, case management, and substance abuse education classes and Alcoholics Anonymous and/or Narcotics Anonymous meeting sponsorship.

3.3.2 Mental Health Service. Provides professional and paraprofessional staff that travel within the Norton Sound Service Unit, and provides family, child, adolescent and community mental health programs. As needed, a psychiatrist provides mental health services in the hospital. Services include but are not limited to assessment and diagnostic services, individual and group therapy, crisis intervention services, suicide prevention and psychological testing, and telebehavioral health.

3.3.3 Village Based Counseling Program. Provides supportive counseling to identified clients, including abused children, children with behavioral health problems, families in crisis, adults and adolescents with substance abuse and/or mental health issues, and the chronically mentally ill. This program works in conjunction with the substance abuse and mental health program and includes the services of behavioral health aides.

3.3.4 Rainbow Services. Provides services to clients with developmental disabilities. The program assists clients to remain in their homes and communities by developing skills to increase self-control and participation in the community. When this is not possible, the

program assists families to find appropriate treatment and services outside the home for the client.

3.3.5 Transitional Living Services. Provides transitional living services, including residential programs, to assist clients in maintaining sobriety while attending outpatient substance abuse treatment, and after completion of treatment until the client is ready to return to his/her home community.

3.3.6 Fetal Alcohol Spectrum Disorder Prevention Services. Provides education and assistance regarding Fetal Alcohol Spectrum Disorder, targeting pregnant women with substance abuse issues to educate them about the effects of substance abuse on children and families.

3.3.7 Children's Services. Provides intensive outpatient behavioral health services to high risk clients with severe emotional problems ages 9-20 and their families. The program aims to help youth succeed at school, home and in the community while eliminating the need to send them elsewhere. Children's services also may include a full array of behavioral health prevention, early intervention, and treatment programs, including recreational and activity programs and residential and day camps. Providing culturally relevant services involving the community in the treatment process.

3.4 Other Health Services. Provides other health services, including but not limited to:

3.4.1 Dental Services. Provides services at the hospital and in field clinics to raise dental health and lower the incidence of dental disease. The field dental program offers visits to all the villages. Dental services may include dental health aide and dental health aide therapist, training, supervision, and services under the Standards and Procedures approved by the IHS Community Health Aide Program Certification Board.

3.4.2 Audiology. Audiology Services will be delivered, both at the hospital and through field clinics throughout the Norton Sound Service Unit.

3.4.3 Optometry Services. Optometry Services will be provided consistent with the needs of the patients, both in Nome and through field clinics throughout the region.

3.4.4 Village Health Services. Provides training, supervision and services of Community Health Aides/Practitioners (CHA/Ps) and the Clinic Travel Clerks who act as support staff to the village clinics. The Community Health Aide Program will be carried out under the Standards and Procedures approved by the IHS Community Health Aide Program Certification Board.

3.4.5 Health Aide Training. Provides Community Health Aide Program training to trainees from throughout Alaska.

3.4.6 Traditional and Alternative Medicine. Provides traditional healing-services in coordination with existing western medicine services; and alternative healing practices only upon a referral from a provider credentialed in accord with the standards cited in Section 8 of this FA.

These services will be provided in accordance with Section 831 of the Indian Health Care Improvement Act, amended at 25 U.S.C. § 1680u.

3.4.7 Emergency Medical Services. NSHC will maintain Emergency Medical Services (EMS) to lower the incidence of death and disability by providing air ambulance services. The NSHC departments also provide various levels of EMS and injury prevention training for staff and community members throughout the region. NSHC participates in EMS delivery in cooperative with community fire departments, other emergency response, and rescue services throughout the region.

3.4.8 Maternal and Child Health Program. Provides:

3.4.8.1 Prematernal home care for village women awaiting delivery in Norton Sound Regional Hospital;
3.4.8.2 Prenatal, family planning and newborn patient education; and
3.4.8.3 Assistance in risk screening and coordination of prenatal care.

3.4.9 Office of Environmental Health. Provides inspections of the hospital and clinics; technical assistance, training and research to help protect the public from illness and injury related to problems with water, waste, food, air, pests, safety, hazardous waste sites and bioterrorism. Technical assistance is provided to local, state and federal officials as necessary to assist with funding processes and the development of local environmental programs. Training is provided to regional water/wastewater operators and utility managers as needed to ensure safe operation and management of environmental systems.

3.4.10 Public Health Nursing. Provides public health nursing services, including but not limited to consultation to CHA/Ps in the villages, child health and developmental screening, prenatal care, EPSDT, school screenings, immunizations, and tuberculosis and other infectious disease screening and monitoring.

3.4.11 Research and Prevention. Participate in research activities to determine whether genetic factors predispose Alaska Natives to disease.

3.4.12 Home Care and Other Community Based Services. Through a combination of western methods and traditional modalities, provides home care and other community based services, which includes but is not limited to assistance with activities of daily living such as bathing, dressing, laundry, light housekeeping, cooking, vital signs, and medication reminders. These services are provided to all individuals throughout the Bering Straits region who are unable to perform their activities of daily living on their own, or when the families are unable to meet their needs. Home and Community Based Services also provides palliative care and other end-of-life services, such as hospice care, respite, chore, nutrition, transportation, and other supportive services including various senior programs and activities. Such services may also include Assisted Living Services. NSHC will provide home and community based services, hospice and assisted living in accordance with the requirements at § 205 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621d.

3.4.13 Nutrition Services for Women, Young Children, and Infants. Provides supplemental foods, and nutritional education, counseling and other services to women, infants and young children who are at nutritional risk.

3.4.14 Infant and Young Child Developmental Program. Provides services that promote growth and development of infants and young children. Children who qualify for services may have been born prematurely, have delays in their development, or have a diagnosed disability such as Down's syndrome or cerebral palsy. Other child development and family services include, but are not limited to, health-oriented education; socialization; health screening; growth and nutritional assessment; individualized culturally-appropriate child development services; family services; and family involvement.

3.4.15 Injury Prevention Services. Provides services to lower the incidence of death and disability, including but not limited to, the provision of safety information, equipment, and training.

3.4.16 HIV Services. Provides testing, referrals, data collection, and training end education.

3.4.17 Purchased/Referred Care Services. Purchases services, which are not otherwise available or accessible to eligible beneficiaries, on a contractual or open-market basis within funds available. NSHC agrees to be bound by 42 C.F.R. Part 136, subpart I, in the administration and provision of Purchased/Referred Care (PRC) services carried out under this Agreement. Accordingly, NSHC has opted to pay at Medicare Like Rates for PRC in accordance with that subpart of the regulations.

3.4.18 Morgue. Provides morgue services in each village.

3.5 Support Services. Support services required to support the provision of health services, including, but not limited, to plant operations, biomedical services, housekeeping and linen/laundry services, security (for patients and staff), human resources, information systems, administration and board support, corporate planner, grant management, compliance officer and performance improvement, material management (procurement, receiving, processing and distribution), central sterile supply, infection control/employee health, and financial, including business office functions, coding and medical records, planning and implementation of an electronic health records system, patient benefits coordinator, and the provision of staff housing.

3.6 Capital Projects. Provides technical assistance, planning, design, engineering, management and general contracting for construction, maintenance and operation of all facilities used by NSHC, including both federal facilities and those leased or owned by NSHC. This program also provides technical assistance and construction related services to other tribes and tribal organizations inside and outside NSHC's service area.

3.7 Village Built Clinic (VBC) Lease Program. Provides funds to eligible entities to

support the rental of CHA/P clinic space. NSHC will operate this program directly with all VBC lessees, who so elect, including the provision of support services and technical assistance. NSHC will ensure that each lessee is in compliance with the standards referenced in the VBC lease.

3.8 Public Health and Epidemiology. Directly and/or through ANTHC, including its Epidemiology Center,[2] NSHC carries out public health, epidemiology and health research functions. These activities include, but are not limited to: collecting and receiving personally identifiable health information for the purpose of

3.8.1 preventing or controlling disease, injury, or disability;

3.8.2 reporting disease, injury, and vital events such as birth and death; and

3.8.3 the conduct of public health and epidemiological investigations, surveillance, and interventions, including the maintenance of disease and injury registries.

3.9 Other Programs/Services Funded.

3.9.1 Generally. This FA includes programs, functions, services and activities resulting from tribal redesign, or consolidation, reallocation or redirection of funds, including its own funds or funds from other sources, provided that such consolidation, redesign, or reallocation or redirection of funds results in carrying out programs, functions, services and activities that may be included in the FA pursuant to section 505 of Title V and Article III, Section 6 [Consolidation with Other Programs] of the ATHC. This includes any other new health care programs, including, but not limited to, those identified in the Indian Health Care Improvement Act funded during the fiscal years.

3.9.2 Non-IHS Funding. NSHC will complement and supplement the PSFAs described throughout Section 3 [Tribal Programs and Budget] with funding from sources other than the IHS through this Funding Agreement, subject to the availability of such other funding sources. Consistent with Article III, Section 5 [Reallocation], 6 [Merging with Other Programs], and 7 [Program Income] of the ATHC, non-IHS funds will be added to or merged with funds provided by the IHS through this FA.

3.10 FTCA. The Federal Tort Claims Act applies to NSHC's PSFAs under this FA as provided in Section 516(a) of Title V (which incorporates Section 102(d) of Title I of the Act and Section 314 of P.L. 101-512). The extent of Federal Tort Claims Act coverage is described more particularly in 25 C.F.R. Sections §§ 900-180-900.210.

Section 4 – Amounts Available During the Term of the FA

4.1 The following amounts shall be available to NSHC pursuant to the ATHC and Title V of the Act and are subject to reductions only in accordance with Section 508(d) of Title V and Section 106 of Title I of the Act.[3]

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[2] The ANTHC Epidemiology Center was previously operated by the Alaska Native Health Board.

[3] A breakout of these funds is shown in Appendix A, which cites the source document used to determine the amount. These amounts are subject to change under the Act and as provided in this FA. For other fiscal

Recurring Base: Inclusive of all recurring funding, including recurring contract support funds and Village Built Clinic Funds of $425,417.[4]	$48,467,747
Non-recurring funds: inclusive of all non-recurring contract support funds and such other funding which may be added to the contract.[5]	$13,954,404
Subtotal: (This amount is subject to amendments in accordance with Section 14 [Amendment or Modification of this FA])[6]	$62,422,151
Area "Tribal" share to include funding identified from the Area Office and identified in Appendix A to this Agreement.[7]	$1,031,630
Headquarters-tribal share: "Tribal Size Adjustment Pool," including all funds identified in Appendix A. The amount identified is exclusive of funds for which distribution amount has not been determined. The final amount due shall be determined as set forth in this FA or Appendix A.[8]	$731,037
Headquarters-Tribal share: "Program Formula Pool" – to include all funds identified in Appendix A, and such additional funds which the IHS may make available on a program formula basis during the year based on the programs accepted for this allocation in Appendix A.	$0

years to which this FA may be applicable, the replacement Appendix A will be negotiated between IHS and NSHC for the respective year and amended to this FA and incorporated by reference, accordingly.

4 A breakout of these recurring costs is found in Appendix A, fully incorporated herein and citing the actual documents used to determine the amount. *See* Footnote 3.

5 These non-recurring funds include contract support costs and routine Maintenance and Improvement funds available at the beginning of the fiscal year. *See* Footnote 3.

6 The Radiologist Consultation funds in the amount of $195,131 and Biomed funds in the amount of $67,102 are not included in this amount (neither of these amounts include any adjustments for mandatory increases). These recurring funds and any mandatories associated with them are in the ANTHC FA and will be negotiated annually as a flow-thru from the ANTHC, in accordance with the interpretation of Section 325 of P.L. 105-83 by the IHS.

7 Funds from the Alaska Area were distributed according to methods agreed upon in a caucus open to all Alaska Tribes and tribal organizations. The specific methodology is identified in Appendix A.

8 Headquarters tribal shares were allocated according to the following process, which was adopted in a caucus open to all Alaska tribal organizations: The Alaska Area Tribal shares of Headquarters was first defined using the national IHS recommended methodology. The total Alaska Area Tribal shares was then reallocated to each Co-Signer according to the agreed upon Alaska Area methodology, which is identified specifically for each line in Appendix A.

Subtotal – Tribal Shares[9]	$1,762,667
TOTAL ATHC FUNDING	**$64,184,818**

These amounts are subject to additions for other reimbursements, and for new funds received during the term of this Agreement including amounts that have historically been distributed as non-recurring funds under the Act. Any amounts remaining unspent under the prior FA, after adjustments and services, as of the previous fiscal year, shall be included and spent under this FA.

Of the amount shown above for non-recurring program funds, $1,211,108 are for Routine Maintenance and Improvement (M&I); the Routine M&I amount paid as a part of the lump sum due NSHC was determined by multiplying the FY 2017 Routine M&I amount paid to the Co-Signer by 90%. The final Routine M&I amounts paid in FYs 2018-2020 will be based on the final 2018-2020 Routine M&I allocations. If the final Routine M&I amounts, as determined by the final FYs 2018-2020 Routine M&I allocations, is less than the 90% calculation, NSHC will return the difference to the IHS. See also Appendix A, footnote to line 19 on page 6.

Of the amount shown above for Headquarters Tribal Share "Program Formula," $141,878 are for Equipment Replacement, the Equipment Replacement amount paid as part of the lump sum due NSHC was determined by multiplying the FY 2017 Equipment Replacement amount paid to NSHC by 90%. The final Equipment Replacement amounts paid in FYs 2018-2020 will be based on the final FYs 2018-2020 Equipment Replacement allocations. If the final Equipment Replacement amounts, as determined by the final FYs 2018-2020 Equipment Replacement allocations, is less than the 90% calculation, NSHC will return the difference to the IHS. See also Appendix A, footnote to line 22 on page 6.

The Recurring Base amount shown above includes $291,158 that NSHC received, recurring in FY 2006 for Congressionally earmarked alcohol funds. Such funds are subject to "Adjustments Due to Congressional Actions" as described herein in Section 6 as well as any conditions on those funds that may be described in the FYs 2018-2020 Interior Appropriations Acts (Act) or Congressional Reports. After each Act is passed into law, such conditions, including Congressionally-directed reporting requirements, will be added by amendment not requiring NSHC's signature as described in Section 14 [Amendment or Modification of this FA].

The parties agree Section 505(b)(2) of Title V provides, among other things, that grants administered by the Department of Health and Human Services through the IHS may be added to NSHC's FA after award of such grants. In accordance with this provision of Title V and its implementing regulations, the Secretary will add NSHC's diabetes grants and any other statutorily mandated grant(s) administered by the Department through the IHS to this FA after such grant(s) have been awarded. Grant funds will be paid to NSHC as a lump sum advance payment through the PMS grants payment system as soon as practicable after award of the grant. NSHC will use interest

[9] The subtotal of Tribal shares does not include certain Headquarters for which the amount or availability has not been determined. This amount will be adjusted to make available all Tribal shares for which NSHC is eligible. IHS will pay mandatory increases on some Headquarters Tribal shares, subject to appropriations.

earned on such funds to enhance the purposes of the grant including allowable administrative costs. NSHC will comply with all terms and conditions of the grant award, including reporting requirements, and will not reallocate grant funds nor redesign the grant program, except as provided in the implementing regulations or the terms of the grant.

4.2 Contract Support Costs. Contract support costs (CSC) will be paid in accordance with 25 U.S.C. § 5325 and § 5388(c). The parties agree that, according to the best data available as of the date of execution of this agreement, the amount to be paid under FY 2018, which represents the parties' estimate of the Tribe's full CSC requirement pursuant to 25 U.S.C. § 5325, is $16,798,500, including $4,197,082 for direct CSC and $12,601,418 for indirect or indirect-like CSC.[10] This estimate shall be recalculated as necessary as additional data becomes available including information regarding the direct cost base, pass throughs and exclusions, and the indirect cost rates to reflect the full CSC required under 25 U.S.C. § 5325. The parties will cooperate in updating the relevant data to make any agreed upon adjustments. In the event the parties disagree on the CSC amounts estimated and paid pursuant to this paragraph and the Tribe's full CSC requirement under the ISDEAA, the parties may pursue any remedies available to them under the ISDEAA, the Compact, and the Contract Disputes Act, 41 U.S.C. §7101 et seq.

4.3 Base Budgets.

4.3.1 Categories and Base Year. At the end of the first period of the base budget option, the IHS and Co-Signers agreed to extend the three year (FY1998-FY2000) base budgets implemented for the ATHC for an additional two years (FY2001-FY2002). IHS and NSHC have subsequently agreed to additional extensions through FY 2009. The IHS and Co-Signers have agreed to further extend the base budget period at the Co-Signer's option. The following categories are subject to base budgeting for the base year period and the period, as noted below.

Category of Funding	Base Period for Base Funding	Extended through:
Headquarters TSA amounts[11]	FY 97	FY 2020
Equipment Replacement Funding	Not Included	N/A
Area Tribal Share	Not Included	N/A

4.3.2 Adjustments. Adjustments to base funding shall be permitted in direct proportion to changes in appropriated amounts (by sub-activity), as provided under Section 6.1 of this FA titled "Adjustments, Due to Congressional Actions." Adjustments shall also be permitted for the addition of new Co-Signers to the ATHC and when current Co-Signers add or retrocede PSFAs,

10 For other fiscal years to which this FA is applicable, the CSC estimates will be negotiated between the IHS and NSHC for the respective year and amended to this FA in Appendix A.

11 ATHC base budgets for TSA amounts shall be considered as a whole (entire ATHC amount) and shall be subject to adjustment of the internal allocation subject to ATHC agreements.

as provided in Section 14.4 [Due to Addition of New Programs].[12] Adjustments also shall be permitted when Co-Signer chooses to restrict or un-restrict previously "restricted" or "un-restricted" categories, provided that restrictions shall be changed only during annual negotiations. NSHC shall also be eligible for funding for new service increases, mandatories, specific Congressional appropriation for population growth, health services priority system, contract support costs and other increases in resources on the same basis as all other Tribes. Adjustments for changes required when a Tribe joins or withdraws from a Tribal consortium shall also be permitted, as provided under Section 10.3 [Withdrawal Procedures] of this FA. Co-Signers shall also remain eligible for the distribution of additional Tribal shares for Assessments, Workers Compensation, Emergency Reserve, Management Initiatives, and other PSFAs from Headquarters.

Section 5 – Methods of Payment.

5.1 Payment Schedule. Except as provided in subsection 5.2 [Availability of Tribal Shares], 5.3 [Buyback/Withholding], and 5.4 [Periodic Payments] of this Section, all funds identified in Section 4 [Amounts Available During the Term of the FA] of this FA shall be paid to NSHC, in accordance with Article II, Section 4(a) [Payment Schedule] of the ATHC; payment to NSHC to be made as follows: One annual lump sum payment to be made in advance.

5.2 Availability of Tribal Shares. NSHC will be paid 100 percent of Headquarters and Area Tribal Shares in its initial lump sum payment, as negotiated in this FA, for each year under the term of this FA.

5.3 Buyback/Withholding. NSHC may carry out its responsibility to provide certain PSFAs included in this FA by using services or other resources of the Federal government under Article V, Section 22 [Purchases from the IHS] of the ATHC, as permitted by law. Except as provided herein, the cost of such services and the terms under which they may be available to NSHC are set forth in the Buyback/Withhold Agreement between the IHS and NSHC, which is attached as Appendix D to this FA and incorporated by reference herein. The administrative surcharge provided for in Section 2.2.4 of the Buyback/Withhold Agreement for FY 2018 shall be .285 percent. During the term of this FA, the Administrative surcharge rates will be negotiated annually. Notwithstanding Section 5 of the Buyback/Withhold Agreement, upon the request of the IHS or any Co-Signer, such FA will be negotiated for future fiscal years annually during negotiation of this FA.

5.4 Periodic Payments. Payment of funds otherwise due to NSHC under this FA, which are added or identified after the initial payment is made, shall be made promptly upon request of NSHC by check or wire transfer.

Section 6 – Adjustments.

[12] This includes addition of new facilities when the addition of these facilities includes an increase in equipment funds identified for the new facilities.

6.1 Due to Congressional Actions. The parties to this FA recognize that the total amount of the funding in this FA is subject to adjustment due to Congressional action in appropriations Acts or other law affecting availability of funds to the IHS and the Department of Health and Human Services. Upon enactment of any such Act or law, the amount of funding provided to NSHC in this FA shall be adjusted as necessary, after NSHC has been notified of such pending action and subject to any rights which NSHC may have under this FA, the ATHC, or the law.

6.2 Proposals by Authorizing Tribes. Should any authorizing Tribe assume responsibility for PSFAs (or portions thereof) under a contract or annual FA pursuant to the Act, adjustment to funding amounts under this FA will be negotiated.

Section 7 – Records.

7.1 Incorporation of the Privacy Act. Pursuant to Section 506(d)(1) of Title V, records acquired, generated or maintained by NSHC shall not be treated as Federal records under chapter 5 of title 5 of the United States Code, except that:

7.1.1 Patient medical, financial records and personnel records may be disclosed only in accordance with 5 U.S.C § 552a(b); and

7.1.2 Medical records generated by NSHC shall be eligible for storage in Federal Records Centers at NSHC's option in accordance with Section 105(o) of Title I.

7.2 Confidentiality Standards. NSHC will seek to comply with the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including, but not limited to, privacy, security, transactions, and code set regulations, codified at 45 CFR Parts 160, 162, and 164. If a record is not subject to HIPAA, NSHC will maintain the confidentiality of its records in accordance with policies and procedures adopted by its Governing Body, which will be consistent with the purposes and guidelines of HIPAA and the Federal Privacy Act of 1974.

7.3 Quality Assurance Records. NSHC operates a medical quality assurance program and treats the records of such program as confidential and privileged in accordance with section 805 of the Indian Health Care Improvement Act as amended at 25 U.S.C. § 1674.

Section 8 – Program Rules.

NSHC in carrying out the PSFAs in this FA agrees to comply only with those guidelines, manuals, and policy directives that are listed below: Joint Commission (formerly known as JCAHO) standards, as applicable, and Community Health Aide/Practitioner certification standards.

Except as specifically set forth in this Section, pursuant to Section 517(e) of Title V, NSHC does not agree to be subject to any agency circular, policy, manual, guidance or rule adopted by the IHS, except for the eligibility provisions of Section 105(g) and the regulations promulgated under Section 517 of Title V, unless otherwise waived.

Section 9 - Real Property Reporting Requirements

9.1 Leases. The IHS must report on its federally leased facilities. NSHC agrees to notify the AANHS of changes of occupancy, size, use, and general condition of Village Built Clinic (VBC) leased facilities in locations where NSHC has bought back services from the IHS. IHS will annually, or upon renegotiation, provide to NSHC a copy of each VBC lease. No increase in the amount due to the lessor pursuant to a lease will be negotiated by IHS without advance notice to NSHC. In administering these leases, the IHS will work with NSHC to ensure that each lease is in compliance with the standards referenced in the VBC lease.

9.2 Maintenance and Improvement Funds. NSHC agrees to use maintenance and improvement funds received through this FA in accordance with the appropriation language for Indian Health Facilities in the Department of Interior and Related Agencies Appropriation Act for FYs 2018-2020 or any comparable Act of Congress that contains the subject appropriation and in accordance with 41 U.S.C. § 12 to the extent applicable.

Section 10 – Services to Non-Beneficiaries.

Section 813 of the Indian Health Care Improvement Act, as amended, 25 U.S.C. 1680c, (Section 813), authorizes the governing body of a Tribal Organization carrying out health services of the IHS under the Indian Self-Determination and Education Assistance Act to determine whether health services should be provided under the Tribal Organization's FA with the IHS "to individuals who are not eligible for such health services under any other subsection of this section or under any other provision of law", 25 U.S.C. 1680c(c). The NSHC Board of Directors has made such determination consistent with Section 813, and provides for its findings in Resolution No. 2010-16. Resolution No. 2010-16 is attached as Appendix E and incorporated by reference herein. NSHC may provide services under this FA to "non-beneficiaries" as described in Resolution No. 2010-16. In addition services may be provided to U.S. Public Health Service Commissioned Corps Officers and their dependents.

Section 11 – Retrocession and Discontinuance.

11.1 Retrocession. The retrocession provisions of Section 506(f) of the Act are herein adopted, except that the effective date from a retrocession request of the ATHC and FA, in whole or in part, shall be one year from the date of the request by an authorizing Tribe or Village, except as provided below. Retrocession may be effective with less then one years notice, providing the Tribe or Village requesting retrocession, NSHC and the IHS agree to an effective date of less than one year from the date of retrocession request.

11.2 Discontinuance. NSHC may discontinue its participation in the ATHC after written notice to each authorizing Tribe or Village and the IHS. Notice must be provided one year in advance of the effective date of the request except that the effective date of a request may be less than one year upon approval of all authorizing Tribes and Villages and the IHS.

11.3 Withdrawal Procedures.

11.3.1 Process. Unless prohibited by law and in accordance with § 506(g) of Title V, an Indian tribe may fully or partially withdraw from a participating inter-tribal consortium or tribal organization its share of any program, function, service or activity (or portions thereof) included in the ATHC or FA, and any such withdrawal will become effective within the time frame specified in the resolution which authorized transfer to the participating inter-tribal consortium or tribal organization, provided that in the absence of a specific time frame being set forth in the resolution, such withdrawal shall become effective on -

11.3.1.1 The earlier of

11.3.1.1.1 One year after the date of submission of such request; or

11.3.1.1.2 The date on which the FA expires, or

11.3.1.2 Such date as may be mutually agreed upon by the Secretary, the withdrawing Indian tribe, and the participating tribal organization or inter-tribal consortium that has signed the ATHC or FA on behalf of the withdrawing Indian tribe, inter-tribal consortium, or tribal organization.

11.3.2 Distribution of Funds. In accordance with Sections 503(b) and 506(g) of the Act, when a tribe proposing to enter into a contract under Title I or a compact and FA under Title V fully or partially withdraws from a participating tribal organization, the withdrawing Tribe shall, upon written request, be entitled to be paid its tribal share of funds supporting those PSFAs (or portions thereof) which it will be carrying out under its own contract or compact and FA, and such funds shall be removed from the FA of the tribal organization and awarded to the Tribe upon approval of a Title I contract or compact and FA. The IHS shall retain any funds removed, but not awarded in a Title I contract or compact and FA.

Section 12 – Memorandum of Agreement with Member Village.

Funds provided under this FA may be allocated to and expended by an Alaska Native Village ("Village") which is party to this FA in accordance with the terms of the ATHC, this FA and a Memorandum of Agreement (MOA) approved by NSHC and the Village. The Federal Tort Claims Act shall apply to PSFAs carried out by the Village under such MOA and to the Village and its employees to the same extent as if they had been carried out directly by NSHC. Such an MOA may include provisions for the assignment of federal employees under IPA assignment or Commissioned Corps detail. Such assignment shall be subject to the approval of the AANHS Director. NSHC shall be responsible for assuring compliance by the Village with the ATHC, this FA and the MOA.

Section 13 – Consolidation of Contract and Previous Annual FAs.

The contracts listed below and all previous Annual FAs shall be amended or terminated, as appropriate to transfer applicable contract funds into this FA for services, materials and activities, programs, functions and facilities provided to the Tribes represented by NSHC: Title I, P.L. 93-638 Contract #243-89-0011, as modified.

Section 14 – Amendment or Modification of this FA.

14.1 Form of Amendments. Except as otherwise provided by this FA, the ATHC, or by law, any modifications of this FA shall be in the form of a written amendment and shall require written consent of each of the signatory Tribes, acting directly or through NSHC as authorized by resolution, the NSHC, and the United States. Participation or written consent of Tribes and Co-Signers not subject to the terms of this FA shall not be required.

14.2 Funding Increases.

14.2.1 Written consent of NSHC shall only be required for issuing amendments for those funds which:

14.2.1.1 require a change to Section 3 [Tribal Programs and Budget];

14.2.1.2 require a specific commitment by NSHC (*e.g.*, Maintenance & Improvement projects and prior fiscal year Sanitation Facility Construction projects); or

14.2.1.3 reduce funding other than changes in Congressional appropriations pursuant to Section 6.1 [Adjustments Due to Congressional Actions].

14.2.2 Amendments not requiring written consent may include, but are not limited to:

14.2.2.1 Program/Area/HQ Mandatories;

14.2.2.2 Program/Area/HQ End-of-Year Distributions;

14.2.2.3 CHEF, subject to the condition that if a case initially qualifying for reimbursement is paid (in whole or in part) by an alternate resource or cancels for any reason, NSHC will return the unused amount to the IHS CHEF account;

14.2.2.4 PRC Deferred Services;

14.2.2.5 Routine Maintenance & Improvement; or

14.2.2.6 Collections and reimbursements.

14.2.3 Amendments reflecting payment of these funds shall be provided to NSHC after any such funds are added to the FA. NSHC retains the right to reject the addition of such funds to the FA and return the funds to the IHS.

14.3 Services from IHS. Should NSHC determine that it wishes the IHS to provide PSFAs included in this FA for which funding has been identified but not provided, the parties shall negotiate an amendment to the FA to reflect the transfer of responsibilities from NSHC back to the IHS and the pro-rata share of funding for that program, services, function or activity shall be retained by the IHS. Unless otherwise negotiated, IHS will not transfer centrally paid expenses including but not limited to Workers Compensation to any ATHC Co-Signer.

14.4 Due to the Addition of New Programs. Should NSHC determine that it wishes to provide a program, service, function or activity of the IHS not included in this FA, NSHC shall submit a proposal to the IHS to provide such program, service, function or activity. The parties agree to negotiate such a proposal and, should the parties fail to reach agreement, NSHC may submit a final offer in accordance with the Title V procedures set forth in Sections 507(b)-(d) of Title V. A

proposal submitted pursuant to this section shall be treated as a request for amendment to the FA and, once approved by the IHS, the Alaska Area Office shall prepare within 30 days an amendment to this FA and the amendment shall be executed through the Area Office and added to the FA.

14.5 Due to Availability of Additional Funding. NSHC shall be eligible for any increases in funding or funding for Medicaid, Medicare, maintenance and improvement, other reimbursements and new programs for which it would have been eligible had it been administering programs under a self-determination contract, rather than under the ATHC and this FA, and for any other funds that are not restricted by appropriations language for which any Alaska Tribe or tribal organizations may be eligible, including any new funds appropriated for IHS Headquarters and funds passed to Alaska Area as recurring or non recurring funds, and this FA shall be amended to provide for timely payment of such new funds to NSHC. Such amendment shall be originated and prepared within 30 days by the Alaska Area Office and executed through the Area Office in consultation with the Co-Signer.

14.6 Other Adjustments. Upon written authorization by NSHC and agreed to by the IHS, the IHS may reallocate funds retained by the IHS, which are obligated to NSHC, for the purpose of reimbursing the IHS for services or equipment provided to NSHC to assist NSHC in carrying out the terms of the ATHC and this FA.

14.7 General Procedures for Amending or Modifying this FA. Amendments or modifications proposed by NSHC shall be submitted in writing to the IHS Alaska Area Director with a copy to the Office of Tribal Self Governance at IHS. Except as provided with respect to the incorporation of a provision of Title I under Article V, Section 21 [Applicability of Title I Provisions] of the ATHC, or as provided above in paragraphs .1, .2, .3 and .4 of this Section 14 [Amendment or Modification of this FA], a request to amend or modify this FA submitted by NSHC shall be processed in accordance with Sections 507(b)-(d) of Title V and all provisions of those identified sub-sections are incorporated herein for this purpose.

Section 15 – Third Party Recoveries.

Any funds recovered by NSHC through the filing, litigating, or settling a claim against a third party to require that third party to pay for services previously provided to IHS-eligible beneficiaries by NSHC, or for such services previously provided by the IHS in a PSFA now operated by NSHC, shall be the property of the Co-Signer and shall be considered program income to be utilized by NSHC as provided in Article III, Section 7 [Program Income] of the ATHC. Any prospective recovery of funds for such services shall likewise be considered program income to be utilized pursuant to Article III, Section 7 [Program Income] of the ATHC.

Section 16 – Severability.

This FA shall not be considered invalid, void or voidable if any section or provision of this FA is found to be invalid, unlawful or unenforceable by a court of competent jurisdiction. Should such a court make such a finding, the parties will seek agreement to amend, revise or delete any such

invalid, unlawful or unenforceable section or provision, in accordance with the provisions of the ATHC.

Section 17 – Memorializing Disputes.

The parties to this FA may have failed to reach agreement on certain matters which remain unresolved and in dispute. Such matters may be addressed through the process set forth in Sections 507(b)-(d) of Title V, or, at the option of NSHC, may be set forth in Addendum II to this FA, which shall be identified as "Memorialization of Matters Remaining in Dispute." This attachment shall not be considered a part of this FA but is attached for the purpose of recording matters in dispute for future reference, discussion and resolution as appropriate. The NSHC does not waive any remedy it may have under the law with regard to these issues and any others not listed herein.

Section 18 – Title I Provisions Applicable to This FA. As authorized in 25 U.S.C. § 5396(b), NSHC exercises its option to include the following provisions of Title I of the Act as part of this FA, and these provisions shall have the force and effect as if they were set out in full in Title V of the Act.

18.1. 25 U.S.C. § 5304(e) (definition of "Indian Tribe");
18.2. 25 U.S.C. § 5322(b) (related to grants for health facility construction and planning, training and evaluation);
18.3. 25 U.S.C. § 5322(d)(1) (related to duty of IHS to provide technical assistance);
18.4. 25 U.S.C. § 5324(a)(1) (exemption from Federal procurement and other contracting laws and regulations);
18.5. 25 U.S.C. § 5328(b), (conflicting provisions of law);
18.6. 25 U.S.C. § 5329(c), section 1(b)(8)(F) (screener identification);
18.7. 25 U.S.C. § 5329(c), section 1(b)(9) (availability of funds);
18.8. 25 U.S.C. § 5329(c), section 1(d)(1)(B) (construction of contract);
18.9. 25 U.S.C. § 5329(c), section 1(d)(2) (good faith).

Section 19 – Exemption from Licensing Fees.

In accordance with Section 124 of the IHCIA, as amended at 25 U.S.C. 1616q, employees of the NSHC health programs shall be exempt from payment of licensing, registration, and any other fees imposed by a federal agency to the same extent that officers of the Public Health Service commissioned corps and other employees of the Indian Health Service are exempt from such fees.

Section 20 – Licensure.

Licensed NSHC health professionals will be licensed in accordance with section 221 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621t.

Section 21 – Purchase of Health Coverage.

NSHC may use federal funds for purchase of health care coverage in accordance with section

402 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1642.

Section 22 – Medicare & Medicaid Reimbursements.

22.1 Medicare & Medicaid. NSHC has elected to directly collect Medicare and Medicaid payments as provided in 25 U.S.C. § 1641, as amended. NSHC is obligated and entitled to directly collect and retain reimbursement for Medicare and Medicaid and any other third party payers for services provided under this Agreement in accordance with section 401 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1641 and section 206 of such Act, 25 U.S.C. § 1621e, as amended.

22.2 Recovery Right. NSHC has the right to recover reimbursement from certain third parties of the reasonable charges for health services in accordance with section 206 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621e.

Section 23 – Federal Insurance. IHS will assist NSHC to obtain information about the coverage, rights and benefits available for its employees under chapters 87 and 89 of title 5, United States Code, the cost of such coverage, rights and benefits (including any options in coverage, rights and benefits that may be available), and the procedures by which NSHC may exercise its rights under Section 409 of the IHCIA, as amended, to have access to such Federal insurance for its employees.

Section 24 – Environmental and Cultural Resources. The National Environmental Policy Act (NEPA), National Historic Preservation Act (NHPA), and related provisions of law require the IHS to review and approve actions resulting in the use or commitment of IHS funds or that affect IHS property, and which may significantly impact the environment or cultural resources. Unless NSHC has assumed these responsibilities under a construction project agreement in accordance with Section 509 of Title V and 42 C.F.R. § 137.285-312, the IHS must carry out these responsibilities and has elected to utilize Appendix H. Where NSHC plans to undertake an action, as described in Appendix H, on IHS owned real property or utilizing IHS funds received through this Funding Agreement, and NSHC has not assumed these responsibilities, NSHC will provide the IHS with a Project Summary Document (see Appendix F) and a completed Environmental Information and Documentation Form (see Appendix G) so that the IHS can accomplish these requirements, and issue a Determination Document (Categorical Exclusion (CATEX) or Finding of No Significant Impact (FONSI)), as soon as possible. All documentation shall be submitted to the IHS as early as possible in the planning phase of the project to prevent delays in the action. No irreversible action can be taken by NSHC until the IHS completes its compliance responsibilities and so advises NSHC with a Determination Document. Pending resource availability, the IHS is available for education and consultation on NEPA, NHPA, and related provisions of law on an as needed basis.

Section 25 – Effective Date and Duration.

This Funding Agreement becomes effective on October 1, 2017, and will remain in effect through the 2020 Federal Fiscal Year or until a subsequent agreement is negotiated and becomes effective pursuant to Article II, Section 12 [Subsequent Funding Agreements] of the ATHC.

United States of America
Secretary of Department of Health and Human Services

By: _____
Director, Indian Health Service

Date: 6-14-2019

Norton Sound Health Corporation On Behalf of Itself and Certain Alaska Native Tribes, Identified in Exhibit A of the Compact.

By: _____
Angie Gorn
President/CEO

JUN 14 2019

Date: _____

FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

Amendment Effective October 1, 2018

In accordance with Section 14.1 of the Norton Sound Health Corporation (NSHC) FYs 2018-2020 Multi-Year Funding Agreement (MFA), NSHC's MFA is hereby amended as follows:

1. Section 3.2.9 is amended as follows: "Emergency surgery, and-minor and other outpatient day surgery, within the scope of qualified ~~expected capability of~~ Medical Practitioners;"

2. Section 3.3.4 is amended to change the title from "Rainbow Services" to "Developmental Disability Program."

3. Appendix B, the list of facilities in which Norton Sound is carrying out health services, is amended as follows:

   In the portion pertaining to "Nome and all Villages," change the Facility Name to add the underlined language: "staff housing owned/rented including "Lawyer's apts," St. Michael Triplex, Golovin 2-bedroom home, and Savoogna duplexes".

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

By: Angie Gorn
Angie Gorn, President/CEO

6/4/2019
Date

United States of America
Secretary of
Department of Health and Human Services

By:
Director, Indian Health Service

8/2/2019
Date

FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

In accordance with Section 14.1 of the FYs 2018-2020 Funding Agreement made and entered into by Norton Sound Health Corporation (NSHC) and the Secretary of the Department of Health and Human Services of the United States of America, effective October 1, 2017, the Funding Agreement, as amended, is hereby further amended as follows:

1. **Appendices.** The following appendices are incorporated by reference and attached:

   - Appendix A (Financial Summary Agreement) FY 2021
   - Appendix B (Facility List) FY 2021

2. **Effective Date**. This amendment is effective October 1, 2020.

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

Angie Gorn 4/30/2021

By: _____ _____
Angie Gorn, President/CEO Date

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S Digitally signed by Evangelyn L. Dotomain -S Date: 2022.03.11 16:22:11 -09'00' _____
Alaska Area Director, Indian Health Service Date

Norton Sound Health Corporation

Appendix A - Financial Summary Tribal Shares Funding Agreement - FY 2021

Tribal Share Summary Norton Sound Health Corporation	FY 2021 Negotiated Amount	NSHC Restricted	Total Due NSHC	Initial Lump Sum Payment
Area TS Amount	$1,094,886	$45,473	$1,049,412	$1,049,412
	0		0	0
Subtotal Area TS Amount	$1,094,886	$45,473	$1,049,412	$1,049,412
Headquarters TSA Amount	$828,953	$93,107	$735,846	$735,846
Headquarters Other Program Formula (OEHE)	$48,412	$48,412	$0	$0
Subtotal Headquarters TS amounts	$877,365	$141,519	$735,846	$735,846
Total Tribal Shares	$1,972,250	$186,992	$1,785,258	$1,785,258

Driving Variables Norton Sound Health Corporation	FY 2021
Population (2010 Census AN/AI population)	7749
Tribes (Federally Recognized Tribes)	20
Recurring Base - FY 2013 (less VBC)	$34,794,479
Percentage of Total Area TS (of all Alaska Tribes)	8.12295%
Percentage of ATHC (of all Title V Alaska Tribes)	8.22359%
Number of MOA employees	3
Number of IPA employees	0

Individually Restricted Items Norton Sound Health Corporation	FY 2021
Area Office (Individual Restricted Only)	
Supply Service Center	YES
Emergency Medical Services	NO
Village Clinic Leasing Management	YES
Headquarters (ATHC Restricted Only)	
ACOG	YES
OIT - Negotiated Alaska Plan	YES
Clinical Sup. Ctr. (Inc. CME Cert.)	YES

Appendix A - Financial Summary for Funding Agreement-Area Tribal Shares
Norton Sound Health Corporation

Line #	FY 2021 Budget Activity/Service	Total Area Budget	Residual Amount	ATHC restricted		Total AO Tribal Shares	NSHC AK Dist.	NSHC Retained	NSHC Total TS Due
		(Column 1)	(Column 2)	Trans. Fed. (Column 3)	ANTHC (Column 4)	(Column 5)	(Column 6)	(Column 7)	(Column 8)
1	TRIBAL SHARE FUNDS	$11,900,108	$0		$0	$11,900,108	$966,640		$966,640
2									
3	AREA OFFICE PFSAs (excluding OEHE)								
4	Area Office PFSA's	$4,193,809	$2,442,960	$681,500	$1,069,349	$0	$0		$0
5	Lease Costs-	$1,657,267	$185,820	$193,220	$1,278,227	$0	$0		$0
5a	Space Costs- negotiations	$19,000	$0	$19,000					
6	Area Director's Reserve	$100,000	$0	$100,000	$0	$0	$0		$0
7	Headquarters Assessments	$488,590	$54,720	$230,202	$203,668	$0	$0		$0
8	Human Resources	$849,441	$210,962	$356,311	$282,168	$0	$0		$0
9	Human Resources (ANMC) funds	$0	$0	$0	$0	$0	$0		$0
10	Area PFSA transferred to ANTHC	$3,028,546	$0	$0	$3,028,546	$0	$0		$0
11	CHC Reserve	$1,555,064	$0	$0	$1,555,064	$0	$0		$0
12	Area Managed Care	$723,423	$0	$0	$723,423	$0	$0		$0
13	ANHB (inc. tobacco funds)	$389,983	$0	$0	$389,983	$0	$0		$0
14	Supply Service Center	$853,749	$0	$0	$335,598	$518,151	$42,089	$42,089	$0
15	Epidemiologists	$196,885	$0	$0	$0	$196,885	$15,993		$15,993
16	EMS program at ANMC	$195,140	$0		$0	$195,140	$15,851	$0	$15,851
17	Centers for Disease Control	$282,902	$0	$0	$282,902	$0	$0		$0
18	Subtotal Area PFSAs (ex. OEHE)	$14,533,798	$2,894,462	$1,580,233	$9,148,927	$910,176	$73,933	$42,089	$31,844
19									
20	OFFICE OF ENVIRONMENTAL HEALTH AND DESIGN								
21	Office of Envir. Hlth and Eng.-.(EH	$5,961,749	$244,466		$5,127,476	$589,807	$47,910		$47,910
22	Real Property/Realty (FSA)	$148,888	$92,682		$14,547	$41,659	$3,384	$3,384	$0
23	Health Facilities/Main./ Spec. Pro	$1,368,036	$114,204		$1,216,669	$37,163	$3,019		$3,019
24	Subtotal OEHE	$7,478,673	$451,352	$0	$6,358,692	$668,629	$54,312	$3,384	$50,928
25	**TOTAL AREA OFFICE**	$33,912,579	$3,345,814	$1,580,233	$15,507,619	$13,478,914	$1,094,886	$45,473	$1,049,412

595

General Notes on Alaska Area Office Tribal Shares

Column 1 - Includes all FY17 changes allocated to TS, Residual, & Transitional as of FY17. In FY 2019 TS changes will be added as received.
Column 2 - Residual includes no changes in residual functions. Based on FY2018 Area approved residual budgets.
Remaining funds at 9/30 distributed (Non-Recurring) to all Alaska Area health programs based on recurring base.
Column 3 - Transitional funds agreed by co-signers to remain at Area Office. Based on FY2018 approved transitional budget.
Column 4 - Restricted by all co-signers & transferred to the ANTHC to provide "Area PSFAs" .
Column 5 - Includes Area TS for all Alaska Tribes, including Title I & Title V. FY19 mandatories to be added if received.
Column 6 - Available Tribal shares for Co-Signer (amounts for ANTHC include pass-through to awardees with shares captured by Sec. 325).
Distributed by the approved ATHC methodology of - 30% # of Tribes / 35% 2010 Census Pop. / 35% 2013 Rec. Base (less VBC).
All Area TS for Services line items will be recurring, Area TS for Facilities will be non recurring.
Column 7 - Items restricted by individual co-signer to pay for continued services from ANTHC. (Restricted amounts are added to ANTHC FA.)
Column 8 - The agreed upon amount due (col. 6 - col. 7) to the co-signer after all retained shares are withheld.
Line 1 - All TS funds for non-OEHE Area Office PSFAs except where co-signers have individually decided to retain certain PSFAs at the ANTHC or AANHS.
Line 5 - Lease on Inuit Building.
Line 5a - $20,000 (less sequester) from transitional funding held by IHS to rent space for annual negotiations. Funds transferred to ANTHC upon confirmation of space availa
Line 7 - Centrally paid expenses, including personnel & finance support for Area positions, costs & funds for departmental assessments.
Line 8 - Area Human Resources functions (previously Office of Personnel & Training).
Line 9 - Funding originally from ANMC - have all been returned to SCF/ANTHC as IPA/MOAs were reduced.
Line 10 - Includes funding for Area PSFAs transferred to ANTHC under Section 325.
Line 11 - Funds to ANTHC to support the statewide Contract Health Services reserve program.
Line 12 - Funds to ANTHC to support specialized services in Barrow, NSHC, & BBAHC & certain statewide laboratory contracts.
Line 13 - ANHB funds from Loc 77 including previous tobacco prevention funding.
Line 14 - Supply Service Center individually withheld amounts retained for ANTHC for all co-signers except YKHC, Seldovia, & Eklutna.
Line 15 - Funds distributed to support the Epidemiology Center distributed to co-signers for individual payment to ANTHC.
Line 16 - Funds for EMS training. Retained by IHS for transfer to ANTHC for Maniilaq, BBAHC, & Chugachmiut for EMS training at ANMC.
Line 18 - Does not include funds from surcharge, assessments, or other services purchased through Area Office.
Line 22 - Funds retained for ANTHC for all co-signers except YKHC, SCF, & KIC.
Line 24 - Does not include NR SFC funds for Health Facilities design and construction oversight.

Appendix A - Financial Summary for Annual Funding Agreement - Headquarters Tribal Shares
Norton Sound Health Corporation

Sub Act.	Line Item	Account	TSA	PF	BB	National FY 2021 TSA Pool	Chickaloon inc in All AK	Knik in All AK	All Alaska	ATHC Eligible Shares Total ATHC TS	NSHC Eligible shares	Co - Signer 0% Retained	0 Due	
						Column 1				*Column 2*	*Column 3*	*Column 4*	*Column 5*	
Hospitals and Clinics														
	101	Emergency Fund		x		$3,956,016			$462,063	462,063	End of year funds to be dist. on AK TSA formula.			
	104	Inter-Agency Agreements				$0			$138,380	138,380	$11,380	$0	$11,380	
	105	Management Initiatives		x		$2,049,512			$239,383	239,383	End of year funds to be dist. on AK. TSA formula.			
	106	A.C.O.G. Contract	x			$98,592			11,209	11,209	$922	$922	$0	
	107	H.P./D.P. Initiatives	x			$3,484,867			200,844	200,844	$16,517	$0	$16,517	
	110	N.E.C.I.	x			$1,107,951			124,173	124,173	$10,211	$0	$10,211	
	111	Nurse Initiatives	x			$1,287,656			140,892	140,892	$11,586	$0	$11,586	
	112	Nursing Co-steps	x			$648,528			72,677	72,677	$5,977	$0	$5,977	
	113	Chief Clinical Consultant	x			$277,340			31,086	31,086	$2,556	$0	$2,556	
	115	Emer. Medical Svcs	x			$465,222			41,980	41,980	$3,452	$0	$3,452	
	117	Traditional Advocacy Prog.	x			$100,578			11,272	11,272	$927	$0	$927	
	118	Research Projects	x			$1,283,252			143,088	143,088	$11,767	$0	$11,767	
	119	A.A.I.P. Contract	x			$26,731			2,994	2,994	$246	$0	$246	
	120	Clinical Support Center-Phoenix	x			$1,744,883			204,917	204,917	$16,852	$2,549	$14,302	
	121	Co-steps Non-physicians	x			$81,839			9,159	9,159	$753	$0	$753	
	123	Physician Residency	x			$277,416			31,093	31,093	$2,557	$0	$2,557	
	124	Recruitment/Retention	x			$2,057,393			230,592	230,592	$18,963	$0	$18,963	
	125	U.S.U.H.S., etc.	x			$3,071,317			344,246	344,246	$28,309	$0	$28,309	
	126	DIR Support Fund	x			$24,915,898			2,762,946	2,762,946	$227,213	$63,165	$164,048	
	127	Evaluation	x			$1,063,992			119,272	119,272	$9,808	$0	$9,808	
	128	National Indian Health Board	x			$459,114			51,111	51,111	$4,203	$0	$4,203	
	129	Albq./HQ Administration	x			$892,404			112,813	112,813	$9,277	$0	$9,277	
	130	Nutrition Training Center	x			$345,053			41,806	41,806	$3,438	$0	$3,438	
	131	Diabetes Program- Albq./HQ	x			$1,295,589			151,342	151,342	$12,446	$0	$12,446	
	132	Cancer Prevention- Albq./HQ	x			$716,968			84,278	84,278	$6,931	$0	$6,931	
	133	Health Records	x			$136,277			12,043	12,043	$990	$0	$990	
	134	AIDS Program	x			$422,971			78,823	78,823	$6,482	$0	$6,482	
	135	Handicapped Children	x			$346,083			40,775	40,775	$3,353	$0	$3,353	
	137	National OIT Sup.- Albq./HQ	x			$8,292,508			925,939	925,939	$76,145	$21,168	$54,977	
	154	Prescription Drug Monitoring	x			$1,002,361			$115,171	115,171	$9,471	$0	$9,471	
Dental Health														
	201	IHS Dental Program	x			$2,505,120			$300,609	300,609	$24,721	$0	$24,721	
	202	IHS Dental Program- Program formula		x		$5,269,192					$0	$0	$0	
Mental Health														
	301	MH/SS Tech. Asst.	x			$1,542,507			$174,272	174,272	$14,331	$0	$14,331	
	302	C.M.I. Grants	x			$628,310			$70,130	70,130	$5,767	$0	$5,767	
	303	National Conference	x			$107,552			$11,990	11,990	$986	$0	$986	
Alcohol/Sub. Abuse														
	401	Clinical Advocacy	x			$3,148,617			$516,623	516,623	$42,485	$0	$42,485	
	402	Collaborative Initiatives	x			$848,033			$48,451	48,451	$3,984	$0	$3,984	

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Appendix A - Financial Summary for Annual Funding Agreement - Headquarters Tribal Shares
Norton Sound Health Corporation

Sub Act.	Line Item	Account	TSA	PF	BB	National FY 2021 TSA Pool	Chickaloon inc in All AK	Knik in All AK	All Alaska	ATHC Eligible Shares Total ATHC TS	NSHC Eligible shares	Co - Signer 0% Retained	0 Due
						Column 1				*Column 2*	*Column 3*	*Column 4*	*Column 5*
Contract Health Care													
	501	Fiscal Immediary		x						$0	$0	$0	$0
	504	C.H.S. Reserve & Undistrib.	x			$3,377,832			$361,250	361,250	$29,708	$0	$29,708
Public Health Nursing													
	601	Preventive Health Initiatives	x			$951,210			$103,180	103,180	$8,485	$0	$8,485
	602	Preventive H. Init. - Prog. Formula		x							$0	$0	$0
Health Education													
	701	IHS Health Education Program	x			$1,133,793			$127,796	127,796	$10,509	$0	$10,509
CHR													
	801	IHS CHR Program	x			$2,412,266			$267,854	267,854	$22,027	$0	$22,027
Direct Operations													
	1301	Direct Operations	x			$13,847,784			$1,557,559	1,557,559	$128,087	$0	$128,087
	1301a	Direct Operations- OIT	x			$2,716,551			$305,550	305,550	$25,127	$5,302	$19,825
	1302	Direct Ops Dental	x			$0			$0	-	$0	$0	$0
Facilities and Environmental Health Services													
	2401	Sanitation Fac. Construction Sup.		x		$6,761,916				$325,101	$0	$0	$0
	2402	Environmental Health Ser. Support		x		$5,114,837				$197,905	$25,264	$25,264	$0
	2403	Facilities & Property Support		x		$24,019,205				$221,409	$17,947	$17,947	$0
	2404	Facilities Engineering Support		x						$0	$0	$0	$0
	2405	Engineering Services Support		x						$51,699	$5,201	$5,201	$0
TOTAL TSA AMOUNT						$89,122,358	$0	$0	$10,080,185	10,080,185	$828,953	$93,107	$735,846
TOTAL PROGRAM FORMULA AMOUNT						$47,170,678				$1,497,560	48,412	$48,412	$0
TOTAL HEADQUARTERS TRIBAL SHARE						$136,293,036				$11,577,745	$877,365	$141,519	$735,846

Column 1 - All numbers are based on HQ PFSAs for FY20 Table #4 dated 1/13/20 & FY21 Table 4F dated 7/16/20 (facilities)
Column 2 - All numbers are based on HQ PFSAs for FY20 Table #4 dated 1/13/20 & FY21 Table 4F dated 7/16/20 (facilities)

Column 3 - Individual Co-Signer share of column 2.
Column 4 - Co-Signer amounts left with (retained by) IHS to provide service- If service is not available IHS shall pay to each Co-Signer amount provided.
Column 5 - This column (col. 3 - col. 4) is the HQ. TS funds due to Co-Signer, calculated by Alaska TSA formula.
All Headquarters Tribal Shares shall be recurring except for Facilities (lines 2401 -2405) and funds in lines 101 and 105.
Line 101 - Any funds remaining will be distributed non recurring on 9/30 (from HQ by TSA formula) and to each Co-Signer on ATHC distribution method.
Line 105 - Any funds remaining will be distributed non recurring on 9/30 (from HQ by TSA formula) and to each Co-Signer on ATHC distribution method.
Line 106 - All Alaska Co-Signers restricted all funds to continued advanced OB training opportunities for all Alaska Area physicians.
Line 120 -Alaska Co-Signers restricted a total of $31,000 dollars for the clinical support center for CME certification and "IHS Provider" magazine.
Line 124 - BBAHC, EAT, Chugachmiut, Eyak, and Maniilaq retrocede 50% of line 124 to IHS in exchange for use of recruitment website ihs.gov/jobs.
Line 126, 137 -DIR withheld were computed at 27.8% of each Co-Signer on ATHC proposal. See Section 1 of the Funding Agreement.
Line 0154 New line for Prescription Drug monitoring. Full share included in co-signers TS.
Line 201 - Dental Program - approximately $800,000 transferred to line 1302 in Direct Ops Dental. No impact on TS.
Line 1301a - DIR Withheld was computed at 21.1% of each Co-Signer share based on continuing agreements with Dir. DIR.
Linr 1302 - Direct Ops Dental is now in line 201
Lines 2401-2405 - Funds available for OEHE support functions (from table 4f) provided based on national formula at tribal option.

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Name of Tribe/Tribal Org. **Norton Sound Health Corporation** **58G950016**

Contract/Compact Period **October 1, 2020 through September 30, 2021**

	Initial Negotiated Annual Funding Agreement						
	Budget Activity	Program/Service Unit Base		Area Tribal Share	Headquarter Tribal Share	Contract (Reductions)	Net Annual Payment Obligation
		Recurring	Non-Recurring	0.081229506		IPA/MOA	
		(1)	(2)	(3)	(4)	(5)	1+2+3+4+5=(6)
1	Hospitals & Clinics	$23,213,352		$275,437	$424,929	($224,613)	$23,689,105
2	Dental	$2,533,887		$17,016	$24,721	$0	$2,575,624
3	Mental Health	$765,746		$104,878	$21,085		$891,708
4	Alcohol & Substance Abuse	$1,174,320		$69,541	$46,469		$1,290,330
5	Public Health Nursing	$1,063,687		$9,956	$8,485		$1,082,128
6	Health Education	$117,928		$20,402	$10,509		$148,840
7	Community Health Representativ	$329,970		$7,517	$22,027		$359,515
8	Immunization (AK only)	$10,316		$28,276	$0	$0	$38,592
9	Direct Operations	$40,186		$347,386	$147,913		$535,484
10							
11							
12	Self-Governance				$0		$0
13	Other, Services (Annual)						
14	TOTAL, Services (Annual)	$29,249,392	$0	$880,409	$706,138	($224,613)	$30,611,327
15	Purchased/Referred Care	$13,412,656		$118,066	$29,708		$13,560,429
16	Operational Cost for Tribal Clinics					0	$0
17	Environmental Health Support	$661,707		$47,910			$709,617
18	Facilities Support	$1,828,331		$3,028			$1,831,359
19	OEHE Support				$0		$0
20	Maintenance & Improvement		$1,462,821		$0		$1,462,821
21	Sanitation Facilities - Housing				$0		$0
22	Sanitation Facilities - Regular				$0		$0
23	Equipment		$180,666				$180,666
24	TOTAL, Facilities	$2,490,038	$1,643,487	$50,937	$0	$0	$4,184,463
25	Current year CSC Direct	$4,630,788					$4,630,788
26	Current year CSC Indirect		$12,264,014				$12,264,014
27							
28	Other (*See* Remarks)						$0
29	TOTAL, CSC	$4,630,788	$12,264,014	$0	$0	$0	$16,894,802
30	Quarters						$0
31	Contract Health Services (Prior Year)						$0
32	Indian Health Facilities (Prior Year)						$0
33	Others						
34	TOTAL, Other	$0	$0	$0	$0	$0	$0
35					$0		$0
36	**GRAND TOTAL, AFA**	**$49,782,874**	**$13,907,501**	**$1,049,412**	**$735,846**	**($224,613)**	**$65,251,021**

Footnotes:

The FA program funding amount in column 1 and 2 are as of FA 12 dated 7/31/2020

The FA funding also includes all funds from Diomede ISDA TI agreement transferred in FY15.

Line 20 and 23 - Routine M&I and Equipment funding is estimated at 90% of prior FY amount for lump sum payment -subject to adjustn with Sec. 4 of the FA.

d Health Corporation

Norton Sound Health Corporation
Withhold Calculation

The Co-Signer will "withhold" 100% of all estimated costs for IPA/MOA, SSC, VBC, **No**

surcharge **0.285%** **(Yes or No)**

The Co-Signer will "withhold" the minimum initial amount for IPA, etc., and "buyback" services. **Yes**

0.285% **(Yes or No)**

Service	Annual Amount				Est. Monthly Payment	Initial Auth. Withhold
	(1)	(2)	(3)	Total Annual Estimated Costs		
	(1)	(2)	(3)	1+2+3=(4)	(4)/12=(5)	*see* Footnotes
H & C						
IPA/MOA Personnel Costs	$566,729	18,731	$1,615	$587,076	$48,923	$195,692
VBC	$0		$0	$0	$0	$0
Other	$86,516		$247	$86,763	$7,230	$28,921
SUBTOTAL H & C	$653,245	$18,731	$1,862	$673,838	$56,153	$224,613
DENTAL						
IPA/MOA personnel costs			$0	$0	$0	$0
Supply Service Center		$0	$0	$0	$0	$0
All other costs-			$0	$0	$0	$0
SUBTOTAL DENTAL	$0	$0	$0	$0	$0	$0
IMMUNIZATION						
IPA/MOA personnel costs			$0	$0	$0	$0
Supply Service Center		$0	$0	$0	$0	$0
Village Clinic Leases			$0	$0	$0	$0
All other costs-			$0	$0	$0	$0
SUBTOTAL IMMUNIZATION	$0	$0	$0	$0	$0	$0
T-CLINIC						
VBC Increases			$0	$0	$0	$0
		$0	$0	$0	$0	$0
			$0	$0	$0	$0
SUBTOTAL T-CLINIC	$0	$0	$0	$0	$0	$0
Withhold Total	$653,245	$18,731	$1,862	$673,838	$56,153	$224,613

Footnotes:

Column 2 - IPA/MOA Centrally Paid Expenses are estimated at $588 for each IPA and $6,243.81 for each MOA.

Column 2 - IPA/MOA Centrally Paid Expenses are estimated at $588 for each IPA and $5,293.74 for each MOA.

Employee Dispute Pool Costs are no longer charged in advance (*see* Section 2.3.2.3 of Buyback Agreement).

Column 3 - Surcharge for all Co-Signers using buyback is .285%

This sheet not to be included in Appendix A - Provided to assist in completing Section 4 of the FA then disca

Norton Sound Health Corporation	
Recurring base	$49,782,874
Non Recurring base	$13,907,501
Subtotal recurring and non recurrir	$63,690,375
Area tribal Share	$1,049,412
HDQ TSA Tribal Share	$735,846
HDQ program formula tribal share	**$0**
Subtotal tribal shares	$1,785,258
TOTAL Funding Agreement	$65,475,634

non recurring includes M & I $1,462,821

FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

Amendment Effective December 30, 2018

In accordance with Section 14.1 of the Norton Sound Health Corporation (NSHC) FYs 2018-2020 Multi-Year Funding Agreement (MFA), as amended, the NSHC and IHS agree to the following revision:

Appendix B (as previously amended) is hereby further amended and restated by the version of Appendix B attached.

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

Angie Gorn 12/9/20

By: _____ _____
Angie Gorn, President/CEO Date

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S Digitally signed by Evangelyn L. Dotomain -S Date: 2021.01.05 14:53:56 -09'00' _____
Director, Indian Health Service Date

Norton Sound Health Corporation Funding Agreement - Appendix B
Fiscal Years 2018-2020

This non-exhaustive list of Tribal Facilities and Locations identifies the sites where Norton Sound Health Corporation owns, leases, occupies, or otherwise used real property to carry out its responsibilities under the Alaska Tribal Health Compact and its Funding Agreement. Each description of facilities and locations is intended to include surrounding and adjacent grounds.

Additionally, the cross references to specific PSFAs are not intended to limit the scope of PSFAS that may be performed at a facility or for which a facility may be used; rather, cross references are intended as an example of the type of PSFA that may be performed at the facility or of the manner in which a facility may be utilized. Cross references are not exhaustive and may not be construed to be exclusory of other PSFAs that may be performed at a facility or of the uses of the facility.

LOCATION	FACILITY NAME	TRIBAL PROGRAMS (including but not limited to)
Nome	Norton Sound Regional Hospital-Main Campus (Replacement Facility)	Section 3.1; Sections 3.2.1-3.2.7; Sections 3.2.9-3.2.13; Section 3.2.15; Section 3.2.16; Section 3.3.6; Sections 3.4.1-3.4.4; Sections 3.4.6-3.4.8; Sections 3.4.11-3.4.14; Section 3.5; Section 3.6; Section 3.7; Section 3.8.
Nome	Quyanna Care Center	Section 3.2.8
Nome	Hostel	Section 3.2.14
Nome	BIA EMT Training Center/Drug and Alcohol Rehabilitation Center	Section 3.2.13; Sections 3.3.1-3.3.3, 3.3.5-3.3.7; Section 3.4.6, 3.4.12
Nome	Kusgi House	Section 3.3.5, 3.3.6
Nome 607 Division Street	NSHC Behavioral Health Clinic	Section 3.3.1-3.3.3, 3.3.5-3.3.7; Section 3.4.10; Section 3.8
Nome	Health Aide Training	Section 3.4.5
Brevig Mission	Brevig Mission Clinic	Section 3.2.5, 3.2.10, 3.2.11; Section 3.3.1-3.3.3; Section 3.4.1-3.4.4, 3.4.12; Section 3.7; Section 3.8
Diomede	Diomede Clinic	Section 3.2.5, 3.2.10, 3.2.11; Section 3.3.1-3.3.3; Section 3.4.1-3.4.4, 3.4.12; Section 3.7; Section 3.8

All Villages	Village-Based Counselor Office Space	Section 3.3
All Villages	Village Based Morgues	Section 3.4.17

AMENDMENT TO
FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

In accordance with Section 14.1 of the FY's 2018-2020 Funding Agreement made and entered into by Norton Sound Health Corporation and the Secretary of the Department of Health and Human Services of the United States of America, effective October 1, 2017, the funding agreement, as amended, is hereby further amended as follows:

1. **Appendices.** The following appendices are incorporated by reference and attached:

   - Appendix C – FY 2020 Continuing Services Agreement

2. **Effective Date**. This amendment is effective October 1, 2019.

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

By: Angie Gorn 3/29/21

Angie Gorn, President/CEO — Date

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S Digitally signed by Evangelyn L. Dotomain -S Date: 2021.04.27 16:07:52 -08'00'

Director, Indian Health Service — Date

MEMORANDUM OF AGREEMENT DESCRIBING THE CONTINUING SERVICES OF THE INDIAN HEALTH SERVICE, ALASKA AREA NATIVE HEALTH SERVICE TO NORTON SOUND HEALTH CORPORATION FOR FY 2020

I. INTRODUCTION

This agreement provides for the continuation by the Indian Health Service (IHS) of certain services from the Alaska Area Office for the benefit of Norton Sound Health Corporation under its Funding Agreement (FA) under the Alaska Tribal Health Compact (ATHC) Self-Governance Compact.

This agreement is limited to the programs, services, functions, and activities (PSFAs) performed by the residual and transitional federal staff of the Alaska Area Office.

This agreement should be interpreted in conjunction with Norton Sound Health Corporation's FA and Appendix A to that FA, which may provide for additional detail on "restrictions" of funds at the Area or Headquarters level to ensure that specific services are continued to the individual Co-Signer.

In FY 2020, funding for these continuing services and activities will be from the funds, which have been designated as residual and from funds, which have been designated in support of temporary transitional federal PSFAs. In addition funding to purchase specific services, i.e., use of IPA/MOA assignees and Village Built Clinic leases, may be provided through reimbursement by Norton Sound Health Corporation to the IHS.

II. DEFINITIONS

The following definitions are in common usage in the Alaska Area:

A. ATHC Tribal Restricted Share - Used in Alaska to refer to those retained Tribal shares all compacting Tribes jointly initially agreed to leave in the Area Office in support of Alaska Area state wide PSFAs. Pursuant to Section 325 of PL 105-83, these shares now are in the Alaska Native Tribal Health Consortium (ANTHC) FA or are used for transitional federal PSFAs.

B. Buyback - The process by which Co-Signers use cash to purchase Area services from the Area Office. Requires accurate description and pricing of service, and mechanism for Area to invoice and receive payment.

C. Co-Signer Restricted Shares - Used in Alaska to refer to "retained Tribal shares" that have been left at the Area Office or Headquarters on an individual basis by a Co-Signer to allow the Area, Headquarters or ANTHC to provide specific services to the Co-Signer. Pursuant to Section 325 of PL 105-83, these Area shares now are in the ANTHC FA or are used for transitional federal PSFAs.

D. Residual - The resources necessary to support the PSFAs required for the United

A. OFFICE OF THE DIRECTOR

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Director	Provides overall executive direction and support on behalf of the Secretary.	R	1
Deputy Director, Chief Medical Officer	Provides public health advocacy; clinical consultation (CMO); legally required certification of health aide credentials and oversight of CHAP certification process; consultation in CHAP/Rural Health program management.	R	1
Executive Officer	Serves as principal advisor to the Director on overall management policies and procedures.	R	1
Attorney	Provides Region X attorney support and consultation.	R	1
EEO	Provides EEO support. 1		
Support Staff	Secretarial, clerical and administrative support to inherent and transitional federal functions at all levels of the Area Office.	R T	3 1
Planning, Evaluation & Statistics	Prepare statistical reports and publications in support of planning, evaluation and resource allocation requirements.	R	2
	Total		10

The Office will provide the specific PSFAs defined below:

1. Executive direction on behalf of the Secretary to the remaining inherently federal functions.
2. Advocacy at national level on behalf of the Tribes of Alaska including: legislative, policy, resource allocation, and appropriation advocacy.
3. Policy formulation and interpretation; supervision of non-IPA/MOA federal employees; negotiate, execute and administer compacts and FAs; resource allocation.
4. Public health coordination with Tribal, state and federal governments.
5. Provide legal advice and consultation on behalf of the Secretary.
6. Provides representation on the Executive Committee and Planning Committee of the Alaska Federal Health Care Partnership (AFHCP). Through the government-to-government relationship with Tribes and Tribal organizations, provides the mechanism for Tribal membership on the AFHCP.
7. Eligibility determinations assistance.
8. Equal Employment Opportunity program management in support of federal employment rights.
9. Oversight of certification of Community Health Aides as outlined by law and the *IHS Community Health Aide Program Certification Board Standards and Procedures*.
10. Consultation and technical assistance to Tribes and Tribal organizations staff and programs including
    a. Program review or evaluation at the request of the Area Director or the invitation of Tribal programs;
    b. Submission of electronic health record data to IHS National Data Warehouse; and
    c. Maintain current Area statistics to provide statistical analysis in support of resource needs and allocations.

1 The EEO function is provided under an intra-agency agreement among the IHS Alaska, California and Portland Area Offices.

B. OFFICE OF ACQUISITION AND PROPERTY MANAGEMENT [2]

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Federal Contracting ,, Personal Property, and FOIA Coordinatio n	Responsible for federal acquisitions to support the Alaska Area Office, including the federal credit card program. Maintains the federal personal property inventory. Provides or coordinates various administrative services for the Alaska Area Office.	R	1
	Total		1

The Office will provide the specific PSFAs defined below:

1. Negotiate, award and administer federal acquisitions.
2. Maintain or develop Alaska Area Interagency and Cooperative Agreements in close partnership with appropriate IHS or other federal, state or Tribal entity(s).
3. Coordinate various administration functions including Freedom of Information Act requests and IHS delegations and directives.
4. Maintain the federal personal property management inventory, including excess and disposal.
5. Provide technical assistance to Tribally managed facilities on procurement issues as requested regarding procurement issues and acquired federal excess property.
6. Maintain the federal credit card program.

2 Residual (1) FTE moved to Office of Tribal Programs in support of Title 1 contracts and audit resolution.

a. Overall direction of resources and related environmental surveillance for statewide public health impacts.

b. Continue to carry out functions related to serving as one of the health and medical representatives to the Alaska Federal Emergency Response Group.

c. Provide management and verification of tribal input data in the IHS Environmental Health Services data system known as the Web-based Environmental Health Reporting System (WebEHRS).

d. Provide safety assurance, compliance and reporting relating to federal workers, and professional programmatic support for staff.

e. In the event of a national disaster situation as defined in the Federal Response Plan, IHS is the lead agency for emergency response related to water and sewer damage assessment and mitigation.

3. **Health Facilities:** PSFAs include:

a. Perform budget allocation;

b. Support and approve project or resource allocations derived through a priority system developed through the Maintenance & Improvement Resource Allocation Committee (MIRAC) and ANTHC process consistent with IHS national project eligibility criteria. Verify data submittals and manage IHS facilities databases in conformance with IHS national project and health facilities space eligibility criteria.

c. Respond to Congressional inquiries;

d. Review Project Justification Document/Program Of Requirements (PJD/POR) documents prepared by others;

e. Review and approve national priority systems applications, including Tribal Equipment Funds and Dental Facilities Funds;

f. Maintenance of Alaska portion of the IHS Healthcare Facilities Data System (HFDS) including the Facilities Maintenance and Improvement/Equipment database for federally and Tribally owned health facilities;

g. Support for new health facility construction project funds distribution and project development;

h. Stewardship responsibility for oversight of environmental cleanup of federally owned real property;

i. Approve workload statistics;

j. Advocate statewide and nationally for the DEHE program and facilitates its implementation.

4. **Realty:** PSFAs include:

a. Monitor and manage real property assets in accordance with Executive Order 13327, "Federal Real Property Asset Management" and existing authority under law or by executive order for real property, capital improvements, square footage, use or disposal.

b. Maintain the IHS Real Property Inventory by updating the asset book values with costs relating to acquisition of real property, capital improvements, square footage, use or disposal.

c. Verify construction project closeout documentation for capital improvements made to federal facilities prior to adjusting the real property subsidiary ledger.

d. Perform annual review of real property.

e. Warranted Lease Contracting Officer authorized to lease Village Built Clinics

Co-Signers and contractors to maintain accurate records of funding allocations, reconciliations and cash management issues.

8. Reconciliation, billing and amendment management related to contractor and compactor use of federal resources including but not limited to IPA/MOA employees and the Village Built Clinic lease program. Reconciliation includes transaction verification of buyback services with corrections and reports.

9. Support withhold and buyback management including payment for continuing government contracts for goods and services, permanent change of station moves, etc.

10. Monthly general ledger reconciliation including cash management related to Prompt Pay Act, Treasury, cash and others.

11. Process reimbursement requests including Beneficiary Medical Program (BMP), Interagency Payment and Collections (IPAC), quarters collections, CHEF and others. Make deposits and transfers of such reimbursements to Co-Signers no less often than monthly.

12. Assist Tribes during annual Budget Formulation for the second succeeding year's annual budget, including preparation for the National Budget Formulation meeting.

E. OFFICE OF HUMAN RESOURCES

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Civil Service Staffing, Classification & Employee/ Labor Relations	Advertise and recruit for federal, direct and IPA/MOA replacements; process personnel and pay actions; provide job information; maintain official records; rate applicants, appoint new employees, and provide HR consultation; Title 38 and Physician's Comparability Allowance, Market Pay & Locality Pay maintenance; process Reduction in Force and counseling; provides transportation services and relocation assistance for federal employees and consultation re: Tribal direct hires as requested; administers Workers' Compensation program; grievances, discipline/adverse actions; Merit Systems Protection Board, appeals and agency representation; performance management; retirements; payroll; benefits; outside activities; ethics program; suitability adjudication; manage Federal Employee Assistance program and Family Medical Leave and Family Friendly Acts consultation; conducts desk audits; applies Classification Standards and consultation. Initiate and assure completion of suitability investigations as needed on federal employees and personal services contractors.	R T	2 0
	Total		2

Under the direction of the IHS Western Region Human Resources Director, the Office of Human Resources will provide the specific PSFAs defined below for the current approximately 340 federal employees employed either directly or through Civil Service IPAs (58) or Commissioned Corps MOAs (254):

1. Advertise and recruit for direct federal employees. Replacement IPA positions may be filled with a current IPA already on board (such as by reassignment) or a new or replacement MOA. Process Reductions In Force (RIF). Provide counseling on RIF.

2. Maintain official personnel files (electronic and paper) and records for Civil Service employees.

F. COMMISSIONED CORPS PERSONNEL[4]

P/S/F/A	MAJOR FUNCTIONS	Buyback	Staffing (FTE)
Commissioned Corps Personnel	Orient and assist officers and their families to include: recruitment support, liaison between areas, TRICARE advice, wage verifications, grievances, leave programs, COERs and COSTEP. As necessary, Corps-specific personnel discipline advice to CEOs and HR staff of 638 awardees with MOA assignees and supervisors of MOAs.	B	2
	Total		2

Under the direction of the IHS Division of Commissioned Personnel Support, the Commissioned Corps Personnel component will provide the specific PSFAs defined below for the approximately 259 USPHS Commissioned Officers in the Alaska Area:

1. Provide general orientation to new Commissioned Officers.
2. Counsel Commissioned Officers; provide Corps-specific discipline advice to appropriate Co-Signer managers.
3. Maintain unofficial files and records for Commissioned Officers.
4. Process required federal personnel actions for Commissioned Officers including orders for deployment.
5. Assist and consult with officers and their supervisors.

G. OFFICE OF TRIBAL PROGRAMS

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Director	Management of Area Title V responsibilities for Self-Governance and Title I review, approval and technical assistance. Managing CHEF submissions, and fund distribution; clerical and secretarial support.	T	1
Health Care (Management) Consultation	Title V compacts/FAs (including amendments and database management of same), cooperative agreements, and grants; negotiate and administer CSC funds.	T	3
Health Care [5] (Management) Consultation	Negotiate, manage, and execute Title I contracts. Review audit findings and work with Tribal contractors to resolve as needed.	R	1
	Total		5

The Office will provide the specific PSFAs defined below:

1. Provide or facilitate technical assistance to Tribes which may or may not lead to the preparation of proposal(s) to assume PSFAs for Title I contracting, Title V compacting and Tribal Management grants for Tribes and Tribal organizations
2. Evaluate P.L. 93-638 proposal(s) to determine acceptance, declination or rejection; if

4 During FY 2005 this PSFA was centralized under the Division of Commissioned Personnel Support at IHS Headquarters. Effective FY 2006, it is funded by assessing the locations that use Commissioned Officers. See, also, Appendix A.

5 Formally P/S/F/A: Federal Contracting Title I awards, (1) Residual FTE moved from the Office of Acquisition and Property Management; to support Title I contracts and audit resolution.

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S
Digitally signed by Evangelyn L. Dotomain -S
Date: 2021.04.27 16:06:22 -08'00'

Director
Alaska Area Native Health Service, IHS

Date: _____

Norton Sound Health Corporation
on Behalf of Itself and Certain Alaska Tribes,
Identified in Exhibit A to the Compact.

By: Angie Gorn

Angie Gorn, President/CEO
Norton Sound Health Corporation

Date: 10/30/2020

Appendix D
Buyback/Withhold Agreement
between
the Indian Health Service
and
Norton Sound Health Corporation

Section 1. Generally. Pursuant to Section 5.3 of the Funding Agreement between Certain Alaska Native Tribes Served by Norton Sound Health Corporation (hereinafter "NSHC") and the Secretary of the Department of Health and Human Services of the United States of America (hereinafter "Secretary"), NSHC has determined that it wishes to carry out its responsibility to provide certain programs, activities, functions or services (e.g. salaries of IPA/MOA employees, and Village Built Clinics Program) included in its Funding Agreement utilizing services, personnel or other resources of the Federal Government, (hereinafter "services") under Article V, section 22 of the Compact, as permitted by law. These services may include some that are expected to be used throughout the year and some incidental services to be identified by NSHC on an as needed basis, and provided by the Indian Health Service (hereinafter "IHS") when IHS has the capacity to do so. The cost of providing the purchased services to NSHC shall be determined under section 2 below. NSHC's purchase of services is contingent upon the availability of IHS resources to provide those services. In addition, services must be paid for in advance, in order to avoid violation of the Anti-Deficiency Act and are subject to full cost recovery in accord with 25 USC 458aaa-7(f) and 31 USC 9701.

Section 2. Determination of Cost.

2.1 Generally. NSHC may acquire services from the IHS by either providing for full year withhold (with appropriate reconciliation) under terms agreed upon in this funding agreement, in which case the administrative surcharge provided for under section 2.2.4 shall not apply. In the alternative, NSHC may acquire services by authorizing partial year withhold amounts, as provided for in section 2.2, in which case the payment schedule and administrative surcharge provided for in section 2.2.4 shall apply. Whether full or partial year withhold is authorized, the full costs of IPA/MOAs including those detailed in section 2.3, Determination of IPA/MOA Costs, shall be paid by NSHC.

2.2 Conditions for Partial Year Withhold and Buyback.

2.2.1 IPA/MOA.

2.2.1.1 Advance withhold. The funds for IPA/MOA salary and other costs detailed in section 2.3, "Determination of IPA/MOA Costs," will be paid as a lump sum in accord with Section 5(a) of the Funding Agreement, except that an amount equal to three monthly payments based on the initial mutually agreed upon estimate of the annual IPA/MOA salary costs and related surcharges, as provided in section 2.2.4, will be withheld and retained by the Indian Health Service pending final disbursement for the last three months of the fiscal year as provided in section 3.2.2.2.

services to NSHC.

2.3 Determination of IPA/MOA Costs.

2.3.1 List of Costs. It is agreed by the parties that the entire cost of IPA/MOA assignments, including costs associated with the initiation, maintenance, and termination of the assignments are the responsibility of NSHC. The IHS must be reimbursed for all such costs which include but are not limited to the following:

2.3.1.1 Permanent change of station costs including the cost of moving replacement IPAs from the lower forty-eight to Alaska and the cost of moving IPA employees who separate back to the lower forty-eight.

2.3.1.2 Recruitment, relocation and retention bonuses if such funds are necessary to attract or retain employees.

2.3.1.3 Severance pay for employees who are released by NSHC and separated without cause.

2.3.1.4 Payment of turnaround leave travel expenses. All individuals who are eligible for these expenses shall be identified in the IPA negotiated between the parties. The IHS will retain liability for existing IPAs. NSHC assumes the liability for new IPAs and upon renewal of an existing IPA.

2.3.1.5 Lump sum leave payments for employees who leave federal service. All leave accrued prior to the employee becoming employed by NSHC shall be identified in the IPA/MOA negotiated between the parties. The liability for accrued leave on existing, renewing, and new IPA/MOAs shall be the responsibility of NSHC.

2.3.1.6 Costs associated with settling or resolving employment related disputes, subject to the terms specified in section 2.3.2 below.

2.3.1.7 Centrally paid expenses, subject to the terms specified in section 2.3.3 below.

2.3.1.8 The cost of paying unemployment benefits assessed to the Area in FY 2002 and thereafter on behalf of an employee who was employed by NSHC under an IPA immediately prior to voluntary or involuntary separation from IHS regardless of the year in which unemployment benefits were paid. The NSHC is not responsible for unemployment costs that were assessed to the Area in Fiscal Years 2000 and 2001.

2.3.2 Costs Related to Employment Related Disputes.

2.3.2.1 Responsibilities of the IHS. The Indian Health Service shall be responsible for the payment of all costs of the IHS Office of Human Resources and any other section of the Indian Health Service, the Office of General Counsel, and the Department of

2.3.3 Costs Related to IPA/MOA Centrally Paid Expenses. Certain costs associated with IPA and MOA employees are paid centrally by Headquarters from Area funds. These include costs detailed in columns 6, 7, and 8 of the spreadsheet entitled "Allocation of Centrally Paid Expenses (Excluding FTS)," Corrected May 11, 1998, that was prepared by David Mather. These are costs associated with Commissioned Corps, Personnel and Payroll, and Balance of Human Resources. The Alaska Area Native Health Service may pay for or recover assessments from Headquarters to cover these identified costs by including in the monthly charge for each IPA or MOA the monthly cost to the IHS of such Centrally Paid Expenses. The cost charged NSHC for each IPA/MOA may not exceed the average cost per federal employee actually paid by IHS. For purposes of calculating the initial withhold amount and estimated monthly payments, the estimated average cost per month for each IPA or MOA is shown in Appendix A of the Funding Agreement.

2.4 Limitation on Obligations and Notice.

2.4.1 Obligations. IHS shall within 30 days provide notice to NSHC of the best available estimate of the costs that may be incurred under this Agreement of leases, contracts, salaries and related expenses and permanent change of station.

2.4.2 Content of Notices of Best Available Estimates and Costs. Notice of best available estimates under section 2.4.1 and full accounting of all costs due under section 3.3.1 shall include the amount, vendor and reason for obligation or expenditure, including the name of the employee, if any.

Section 3. Method of Payment.

3.1 Full Year Withhold. Payment for services being purchased from the IHS may be made by NSHC authorizing a withhold of the full year's initial mutually agreed upon estimate of the annual cost of each category of services NSHC proposes to purchase from the IHS. In such case, no monthly payments are due from NSHC. Upon periodic reconciliation, provided for under section 3.3.1, excess withheld funds will be paid by the IHS to NSHC and adjustments in the amount of withhold or payments needed to pay for all services NSHC has purchased, or proposes to purchase, will be made to the IHS by NSHC. *See* "Summary of Withhold/Buyback" page of Appendix A for calculation of the amount NSHC hereby authorizes for full year withhold, if any.

3.2 Purchases through Buyback under section 2.2.

3.2.1 Calculations.

3.2.1.1 Of Initial Estimated Monthly Payment. The initial estimated monthly payment is determined by estimating the annual cost of services to be purchased from IHS, including the surcharge on all services under section 2.2.4, and dividing by 12. *See* "Summary of Withhold/Buyback" page of Appendix A for calculation of the amount of the initial estimated monthly payment.

reconciliation is due any under recovery must be paid by NSHC.

3.3.2 For Administrative Surcharge.

3.3.2.1 Use and Rebate. The administrative surcharge shall be used exclusively for administration of the buyback provisions under this Buyback/Withholding Agreement. All income from the administrative surcharge will be accounted for separately and compared on an annual basis to the cost of administering buyback at the Area Office. This accounting and reconciliation shall be complete within 60 days of the end of the last day of the fiscal year. Any surplus in administrative surcharges shall be returned to the Co-Signers who participated in the buyback option on a pro rata basis depending on the amount of administrative surcharge paid.

3.3.3 Adjustment in Estimated Monthly Payment. In addition to adjustments in estimated payments that may occur under sections 3.3.1 and 3.3.2.1, the parties may at any time mutually agree, based on a change in circumstances, to change the estimated monthly payment due from NSHC.

3.4 Use of Other Funds Due NSHC to Avoid Default or Satisfy Obligations to IHS and other Remedies.

3.4.1 Avoiding Default. Default may be avoided to the extent funds are held by the IHS from other funds due to NSHC, which may be withheld to satisfy the amount of the payment, which would otherwise be in default or to satisfy amounts due IHS after reconciliation of costs and payments when an amount is due to IHS.

3.4.2 Recoupment. Any amount due to the IHS by reason of NSHC's failure to pay in full all amounts owing under the buyback provisions of the Funding Agreement for the immediately preceding fiscal year shall be recouped by the IHS from any funds due to NSHC under this funding agreement.

3.4.3 Full Year Withhold as Penalty for Default. Notwithstanding any other provision of this Buyback/Withholding Agreement, the IHS may require "full year withhold" as permitted herein as a condition of permitting a Co-Signer who was in arrears at the end of the immediately preceding fiscal year to buyback services from the IHS under the terms of this Agreement.

Section 4. Dispute Resolution. The parties shall endeavor to resolve any disputes concerning amounts due by NSHC under this Agreement in a manner agreeable to NSHC and to the IHS. In the event of a failure to reach agreement on the resolution of any such dispute, NSHC may, after providing written notice to the IHS, choose not to include the disputed amount in any subsequent payment due. Payment in such a manner shall not be considered as a resolution of the dispute. The parties shall thereafter attempt to resolve the dispute through Alternative Dispute Resolution following, as appropriate, the principles and processes set forth in Executive Order 12988 signed by President Clinton on February 5, 1996, and made effective as of May 5, 1996. NSHC shall have the option of resolving the dispute in accordance with Article

Funding Agreement Appendix E

P.O. BOX 966
NOME, ALASKA 99762
(907) 443-3311

NORTON SOUND HEALTH CORPORATION

Norton Sound Health Corporation

RESOLUTION # 2010-16
Services for Non-Eligible Individuals

WHEREAS, the Norton Sound Health Corporation (NSHC) is a tribal organization that is a Co-Signer of the Alaska Tribal Health Compact (ATHC) and has negotiated a Funding Agreement (FA) with the Indian Health Service (IHS) under Title V of the Self-Determination Education and Assistance Act (ISDEAA); and

WHEREAS, the ATHC authorizes Co-Signers to provide services to non-eligible individuals provided Section 813 of the Indian Health Care Improvement Act (IHCIA) is complied with (*See* ATHC Article III, Section 4), and Section 813, as amended at 25 U.S.C. § 1680c(c)(2), provides that a tribe or tribal organization which operates a health facility under an ISDEAA agreement may make its own determination whether to provide health services to persons not otherwise eligible (i.e. non-beneficiaries) to receive IHS-funded health services; and

WHEREAS, NSHC is authorized to determine whether it will provide health services under its IHS-funded programs to persons who are not eligible beneficiaries under federal law, provided that NSHC gives consideration to whether the provision of such services will result in a denial or diminution of health services to eligible beneficiaries; and

WHEREAS, NSHC has determined that the provision of health services on a fee-for-service basis to non-beneficiaries, in an amount not less than the actual costs of providing such services, will not result in a denial or diminution of health services to beneficiaries; and

NOW THEREFORE, BE IT RESOLVED, that NSHC has decided to extend all available health services under the ATHC and its FAs to non-beneficiaries on a fee-for-service basis; and

BE IT FURTHER RESOLVED, that whenever significant evidence is presented to NSHC Board of Directors that services to non-eligible, non-beneficiaries have resulted in a denial or diminution of health services to beneficiaries, NSHC may suspend the delivery of such services to non-beneficiaries.

DATED this 25 day of June, 2010.

CERTIFICATION

The above Resolution was passed at a regular meeting of the Norton Sound Health Corporation Executive Board held on this 25 day of June, 2010 at Nome, Alaska at which a quorum was present. 8 FOR, 0 AGAINST, 0 ABSTAIN.

Attest: _____ Attest: Berda Willson
Emily Hughes, Board Chair — Berda Willson, Board Secretary

"Serving the communities of: Brevig Mission, Council, Diomede, Elim, Gambell, Golovin, King Island, Koyuk, Mary's Igloo, Nome, St. Michael, Savoonga, Shaktoolik, Shishmaref, Solomon, Stebbins, Teller, Unalakleet, Wales, White Mountain"

Norton Sound Health Corporation

APPENDIX F

PROJECT SUMMARY DOCUMENT

requirements. Cite specific, code or JCAHO references by standard clause, chapter, paragraph, etc.]

III. DEFICIENCIES

The following deficiencies will be corrected as part of this project:

[List and describe only those facility deficiencies this project will address. The types of deficiencies include BEMAR, JCAHO, NFPA, HFPM, Public Law compliance items, ADA, etc.]

IV. COST ESTIMATE

Provide a budgetary cost estimate and the funding sources for the proposed project, including separate line items for design Architect/Engineer fees, project construction, construction contract administration fees, and project contingency.

V. PROJECT SCORE SHEET DOCUMENT (*only required for BEMAR competitive pool funds*)

Complete a project score sheet further detailing the scope, impact and benefits of this project. Provide the information required by the project score sheet.

VI. OTHER PROJECT ITEMS TO BE ADDRESSED

Supporting Documents: Drawings, Photos, Estimates, Etc.

Norton Sound Health Corporation

APPENDIX G

ENVIRONMENTAL INFORMATION AND DOCUMENTATION

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

6. Does the proposed action have significant adverse direct or indirect effects on park land, other public lands, or areas of recognized scenic or recreational value?	Yes or No. Explanation.
7. Does the proposed action include construction of a new municipal solid waste landfill at a new solid waste disposal site?	Yes or No. Explanation.
8. Will the proposed action create a need for additional capacity at solid waste disposal facilities?	Yes or No. Explanation.
9. Does the proposed action include construction of a new wastewater treatment facility that will discharge treated sewage effluent to the waters of the U.S.	Yes or No. Explanation.
10. Will the proposed action create a need for additional capacity at wastewater treatment facilities?	Yes or No. Explanation.
11. Will the proposed action create a need for additional capacity in the drinking water supply?	Yes or No. Explanation.
12. Are there other considerations about the proposed action that could adversely affect the environment and/or public health and safety?	Yes or No. Explanation.

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

19. Will the proposed action require major sedimentation and erosion control measures?	Yes or No. Explanation.
20. Will the proposed action violate a storm water permit or a wastewater discharge permit either for construction or on-going operations?	Yes or No. Explanation.
21. Safe Drinking Water Act: Will the proposed action impact an EPA designated sole source aquifer?	Yes or No. Explanation.
22. Wetlands and Water Resources (lakes, rivers, ponds, streams, etc.): Will the proposed action violate a Section 404 (Clean Water Act) permit for actions in a wetland and/or Section 10 (Rivers and Harbors Act) permit for actions in a stream or river?	Yes or No. Explanation.
23. Floodplains: a. Is the proposed action located in either a 100-year or, for critical actions, a 500-year floodplain? (If Flood Insurance Rate Maps do not exist for the project site, a floodplain survey or consultation may be required. Also may need to consider if the facility will require flood insurance).	Yes or No. Explanation.
b. Will the proposed action adversely impact flood flows in a floodplain or support development in a floodplain?	Yes or No. Explanation.

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

27. Does the proposed action involve the sale or transfer of real property, on which any hazardous substance was stored for one year or more, known to have been released, or disposed of? (Provide relevant documentation for any hazardous substance releases. See 40 CFR 373.2(b), 302.4, and 261.30 for reportable quantities.)	Yes or No. Explanation.
28. Does the proposed action involve the sale or transfer of real property, on which underground or above ground storage tanks are located?	Yes or No. Explanation.
29. Will the proposed action violate Tribal, local, state, or federal law on the use and storage of hazardous substances or the transportation, storage, and disposal of hazardous wastes or medical wastes? (Activities that may generate reportable quantities include air conditioning repair and service, pesticide application, motor pools, automobile repair, welding, landscaping, agricultural activities, print shops, hospitals, clinics, & medical centers. Repair, renovation, or demolition activities can generate waste that has asbestos-containing materials, asbestos, lead-based paint, PCBs, CFCs, etc.)	Yes or No. Explanation.

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

36. Wild and Scenic Rivers Act: Will the proposed action affect a wild, scenic, or recreational river area or create conditions inconsistent with the character of the river? (A consideration for activities that are in or near any wild and scenic waterway including construction of stream/river crossings, intake structures, outfalls, etc.)	Yes or No. Explanation.

I certify that to the best of my knowledge and ability the information presented above is true and correct. The record was examined to identify potential extraordinary or exceptional circumstances which would require further environmental review.

Review by:

Title Date Environmental Coordinator Date

Norton Sound Health Corporation

APPENDIX H

ACTIONS REQUIRING IHS ENVIRONMENTAL REVIEW AND DETERMINATION

[]	Pg 571 (K)(4): Those involving the use of technology where the possible effects are highly uncertain or involve unique or unknown risks and where such technology has not been assessed previously for environmental impact;
[]	Pg 571 (K)(5): Those which have adverse effects on unique geographic characteristics (e.g. historic, archeological, or cultural resources, park recreation or refuge lands, wilderness, areas, wild or scenic rivers, sole or principal drinking water aquifers, prime farmlands, wetlands, floodplains, coastal management zones, or ecological or critical areas including those listed on the Department of Interior National Register of National landmarks);
[]	Pg 571 (K)(6): Those which establish a precedent for future action or represent a decision in principle about future actions with potentially significant environmental effects;
[]	Pg 571 (K)(7): Those which have adverse effects on properties listed or eligible for listing on the National Register of Historic Places;
[]	Pg 571 (K)(8): Those which have adverse effects on species listed by the Federal Government as Endangered or Threatened Species, or which have adverse effects on any designated critical habitat for these species;
[]	Pg 571 (K)(9): Those which require assessment in accordance with Executive Order 11988 (Floodplain Management), or Executive Order 11990 (Protection of Wetlands), or the Fish and Wildlife Coordination Act; and
[]	Pg 572 (K)(10): Those which involve the use, transfer, or lease of real property which has been determined, after investigation in accordance with the provisions of CERCLA 120 (h), to have been used as a storage facility for hazardous waste for more than 1 year; and
[]	Pg 572 (K)(11): Construction projects which are significantly greater in scope or size than normally experienced for a particular category of action.

Any action NOT categorically excluded per Federal Register Vol. 58, No. 3, pg 569-572, dated January 6, 1993 attached hereto.	**The Environmental Review and Determination Process for this group of actions ranges from 60 to 180 days from the receipt by the IHS of the proposal package.**

* The time needed to complete Environmental Reviews is highly dependent on required consultations with other Federal and State Agencies. As an example, the NHPA Section 106 Process requires the State Historic Preservation Officer (SHPO) be allotted 30 days to review and comment on a proposed action (36 CFR Part 800.3(c)(4)). Furthermore, additional time beyond the 30 days may be required for consultation with SHPO to adequately review and determine the effects of the proposed action on existing historical resources. Coordination early in the planning phase of the project can help identify these potential issues and allow NSHC and IHS to resolve them early.

employed varies from Area to Area. Population, health indices, and facilities and services available from sources other than the IHS are evaluated to determine the methods IHS uses to provide services.

The IHS program consists of two major systems: (1) A Federal health care delivery system, administered by Federal employees, and (2) a tribal health delivery system, administered by tribes and tribal groups under grants, contracts or cooperative agreements. The categorical exclusions apply to IHS program actions whether carried out directly by the IHS, or funded or otherwise sponsored by the IHS. The IHS contracts, grants, and cooperative agreements are actions defined in NEPA and are subject to the IHS review procedures established to ensure NEPA compliance, including provisions covering extraordinary and exceptional circumstances. The NEPA compliance for the tribal health care delivery system is ensured through IHS administrative procedures for contracts, grants, and cooperative agreements.

The selection of IHS program actions to list as categorical exclusions has been determined, in part, by agency experience in complying with NEPA, during the past 10 years. Actions required to provide health care services will not have significant impact on the environment except when exceptional or extraordinary circumstances exist. The IHS has categorically excluded these actions, since enactment of NEPA; however, actions involving construction normally have required completion of an environmental review/assessment.

The IHS administers programs for the construction of domestic sanitation facilities (water, wastewater, and solid waste) for Indian homes and communities, construction of new or replacement health care facilities and staff quarters, and renovations to existing health care facilities and quarters units.

Environmental reviews/assessments of construction projects undertaken during the past 10 years have concluded that an EIS was not required for any of them. Approximately 2,300 sanitation facilities construction projects and fewer than 60 health care facilities/staff quarters construction projects have been approved during this time.

The type of program and procedures employed to administer the construction of sanitation facilities for Indian homes and communities, and the consistent determinations that these projects do not have a significant impact on the environment, are the basis for the decision to list most sanitation facilities projects as categorically excluded.

Factors considered in making this determination include:

1. Projects are undertaken to improve health and/or environment.

2. Projects are untaken at the request and with approval of the tribal governing body, which provides for discussion and evaluation of the project and its impacts.

3. Projects are normally constructed on tribally owned or individually owned tribal land within reservation boundaries.

4. Projects are constructed to comply with all current applicable environmental regulations and plans and specifications are submitted to State and Federal agencies as necessary for review and comment.

5. Projects are constructed to provide utilities (water, sewer, solid waste) either for existing American Indian or Alaska Native homes or for new homes constructed with Federal, tribal, State or other resources. New homes are constructed at sites and locations approved by the Tribal Governing Board. Utilities are not provided for future development or undeveloped parcels, and capacity provided is limited to that routinely provided by standard engineering practice for the current design population.

6. The IHS projects fall into the category of minor construction projects based on cost. During the last 10 years, 85 of the 2,300 projects exceeded $1 million, and the average estimated cost was $250,000.

7. Standard IHS procedures require documentation of an environmental review of each construction project to identify any exceptional or extraordinary circumstances and to ensure compliance with all environmental laws, regulations, and executive orders; e.g., those concerning floodplains, wetlands, endangered species, etc. This review is required early in the project planning process.

The categorical exclusion for construction of health care facilities and staff quarters has been limited to renovation or new construction at existing health care delivery sites, and construction or development of relatively small facilities at new locations. The procedures noted in item 7 above for sanitation facilities construction projects also apply to all health care facility and staff quarters construction projects. Most health care facility and staff quarters renovation projects can be classified as minor construction projects based on cost. Fewer than 200 major renovation projects have been undertaken and only a few were funded at a level exceeding $1 million.

Categorical Exclusions

A. Health Services

Direct delivery of medical, dental, nursing, and other related health services; e.g., patient care/counseling administered from hospitals, health centers, health stations, satellite clinics, and in private homes by IHS staff or contract providers to authorized recipients.

B. Research

Research activities that are consistent with the mission of IHS including: (a) Biological and behavioral studies conducted in laboratories, clinics, and the field; (b) studies on the development and delivery of prevention and treatment services and their administration and financing; and (c) evaluations of prevention and treatment.

C. Pesticides

Application of pesticides which are not classified for restricted use under provisions of the Federal Insecticide, Fungicide and Rodenticide Act when used for routine pest control purposes.

D. Contracts, Grants, and Cooperative Agreements

Contracts, grants, and cooperative agreements and continuations, supplements, extensions, and amendments of these documents for IHS programs or actions that are categorically excluded. (Includes Self-Determination Act contracts, Contract Health Care contracts, etc.)

E. Technical Assistance

Action involving the provision of technical assistance to American Indian and Alaska Native tribes and groups. other Federal agencies, State and local governments, and non-profit organizations are excluded. These actions include but are not limited to:

1. The provision of technical assistance to American Indian and Alaska Native tribes and groups for the purpose of developing management capabilities needed to enable eventual tribal assumption of health program operation;

2. The provision of technical assistance to American Indian and Alaska Native tribes and groups for the purpose of developing capabilities in the areas of epidemiology, disease reduction, injury prevention, environmental improvement, and the operation and maintenance of sanitation facilities; and

3. The assignment of IHS personnel to agencies/organizations for the purpose of providing technical expertise (e.g.,

Order 11990 (Protection of Wetlands), or the Fish and Wildlife Coordination Act; and

10. Those which involve the use, transfer, or lease of real property which has been determined, after investigation in accordance with the provisions of CERCLA 120 (h), to have been used as a storage facility for hazardous waste for more than 1 year; and

11. Construction projects which are significantly greater in scope or size than normally experienced for a particular category of action.

Dated: December 29, 1992.

Michel E. Lincoln,

Deputy Director.

[FR Doc. 93-173 Filed 1-5-93; 8:45 am]

BILLING CODE 4160-16-M

ADDENDUM I

MEMORIALIZATION OF HISTORICAL LEVEL OF PFSA'S PROVIDED BY ANMC AND AANHS TO THE NORTON SOUND HEALTH CORPORATION

The ANMC and the Alaska Area Native Health Services, Area Office, subject to available appropriations, has historically provided the following PFSAs to Norton Sound Health Corporation as of October 1, 1997 and continued to provide such services through December 31, 1998:

- Coordination and support for the NSHC dental clinic, including dental specialty referral services, and the annual Alaska dental chiefs meeting. Commissioned Corp recruitment assistance including transportation costs of the recruiter to and from Nome, any applicable documentation, award information for Commissioned Officer promotions, and career counseling for officers desiring long term affiliation with IHS.

- Specialty care field clinics, consultation to Norton Sound Health Corporation physicians, arrange contracts for reference laboratory services, routine reading of x-rays, medivacs support for neonatal emergencies patient travel support for NSHC patients returning home from treatment at the ANMC.

- Accepting all referrals of Alaskan Natives from the Norton Sound Regional Hospital.

- The ANMC EMS program provided specialized training such as ACLS, ATLS, PALS, including hypothermia, cold water drowning and frostbite.

- The NSHC Laboratory received the following services from ANMC: (a) pathologist consultation and visitation twice a year; (b) Anatomical tissue analysis and reporting; and (c) Access to TDY Services as needed and available.

- The ANMC provided consultation and informational support for the NSHC Social Services program, including JCAHO standards and other licensure issues.

- The ANMC provided support including screening, diagnosis, consultations, referrals, personnel training, information, network and recruitment assistance for the FAS program at NSHC and for its Maternal Child Health Program.

- The ANMC provided recruitment assistance to the Mental Health program as needed.

- STD/HIV testing, counseling, partner notification, education and consultation as requested by NSHC.

- Nutrition education and counseling services from the statewide Diabetes program based at ANMC.

- Environmental Health /Sanitation services including, but not limited to, appropriate village visits for environmental services, injury prevention, institutional services.

- Diabetes patients tracking and registration.

- Engineering services inclusive of maintenance and improvement for federal facilities and projects;

- Purchasing activities under GSA contracts;

- Office of Environmental Health Services and activities, health facilities support, real property support especially for village built clinics; projects for health facilities management, special projects and sanitations facilities.

- Administration and management of IPA/MOAs;

- Certain contract health services, not otherwise contracted under Title I;

- Region X legal consultation.

ADDENDUM II
NORTON SOUND HEALTH CORPORATION
MEMORIALIZATION OF MATTERS REMAINING IN DISPUTE

(1) Norton Sound Health Corporation (NSHC) does not agree with the IHS' position that Area Office tribal shares that were restricted by individual Co-Signer decision or by a consensus decision of all Co-Signers from FY 1995 through FY 2000 are not available for inclusion in FY 2002 because of Section 325, P.L. 105-83. NSHC believes it has the right to include such tribal shares in its FY 2002 funding agreements notwithstanding Section 325. NSHC reserves any remedies it may have under law.

ALASKA TRIBAL HEALTH COMPACT

BETWEEN

CERTAIN ALASKA NATIVE TRIBES

AND THE

UNITED STATES OF AMERICA

OCTOBER 1, 1994

—

AMENDED AND RESTATED

OCTOBER 1, 2017

ALASKA TRIBAL HEALTH COMPACT

OCTOBER 1, 1994

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AMENDED AND RESTATED
OCTOBER 1, 2010

This Compact of Self-Governance, which under Title III of Public Law No. 93-638, as amended, became effective October 1, 1994, was amended and restated effective October 1, 1995, October 1, 1996, October 1, 1997, October 1, 1998, October 1, 2000, and was further amended and restated in FY 2001, effective October 1, 2000, to conform with Public Law 106-260, Title V of the Indian Self-Determination and Education Assistance Act, as amended (hereinafter Title V), October 1, 2003, October 1, 2006, October 1, 2008, and October 1, 2010 is made and entered into by and between the Secretary of Health and Human Services of the United States of America, represented by the Director of the Indian Health Service, and certain Alaska Native Tribes recognized by the United States acting collectively, and the Alaska Native Tribal Health Consortium, as set forth in Exhibit A. This Compact is entered into under the Title V, which authorizes the Secretary to enter into Compacts and Funding Agreements with the governing bodies of participating Tribal governments. The Secretary has delegated the authority to enter into this Compact and funding agreements to the Director, Indian Health Service (hereinafter IHS). This Compact reflects the United States' special trust responsibility and legal obligations to Indians and Alaska Natives, as stated in 25 U.S.C. section 1602, and the unique tribal cooperation that has developed in Alaska to assure that all Alaska Natives have access to a comprehensive, integrated, and tribally-controlled health care delivery system. The parties are committed to ensuring that the essential statewide functions of the Alaska Native Medical Center in Anchorage remain intact, whether operated by the Indian Health Service, the Alaska Native Tribal Health Consortium or by Alaska Native Tribes recognized by the United States.

WITNESSETH:

WHEREAS, the Alaska Native people have governed themselves and lived in the area known as Alaska since time immemorial;

WHEREAS, federally recognized tribal governments in the State of Alaska

> . . . have the same governmental status as other federally acknowledged Indian tribes by virtue of their status as Indian tribes with a government-to-government relationship with the United States; are entitled to the same protection, immunities, privileges as other acknowledged tribes; have the right, subject to general principles of Federal Indian law, to exercise the same inherent and delegated authorities available to other tribes; and are subject to the same limitations imposed by law on other tribes;

(*Indian Entities Recognized and Eligible to Receive Services from the United States Bureau of Indian Affairs*, 58 Fed. Reg. 54364 (October 21, 1993));

WHEREAS, for the purposes of ensuring that all Alaska Natives and America Indians in Alaska can receive the services provided by the Federal Government through an Alaska Native provider, the Congress has defined the term, "Indian Tribe," to mean:

> . . . any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(Indian Self-Determination and Education Assistance Act, as amended, 25 U.S.C. § 450b(e));

WHEREAS, to prioritize between the entities eligible to authorize contracting under the Indian Self-Determination and Education Assistance Act, as amended, the Indian Health Service has established in the Alaska Area the following order of preference:

> If there is an Indian Reorganization Act (IRA) Council, and it provides governmental functions for the village, it will be recognized.
>
> If there is no IRA Council, or it does not provide governmental functions, then the traditional village council will be recognized.
>
> If there is no IRA Council and no traditional village council, then the village profit corporation will be recognized.
>
> If there is no IRA Council, no traditional village council, and no village profit corporation, then the regional profit corporation will be recognized for that particular village.

(*Alaska Area Guidelines for Tribal Clearances for Indian Self-Determination Contracts*, 46 Fed.

Reg. 27178);

WHEREAS, the United States of America has recognized certain entities in Alaska as American Indian Tribes for purposes of the Indian Self-Determination and Education Assistance Act (*See* 25 U.S.C. § 450b(e); *Indian Entities Recognized and Eligible To Receive Services from the United States Bureau of Indian Affairs*, 58 Fed. Reg. 54364 (October 21, 1993); and *Alaska Area Guidelines for Tribal Clearances for Indian Self-Determination Contracts*, 46 Fed. Reg. 27178, (hereinafter "the Tribes");

WHEREAS, certain Tribes of Alaska have formed and authorized certain Tribal Organizations and Inter-Tribal Consortia as defined in 25 U.S.C. § 450b(*l*) and section 501(a)(5) of Title V, for the purpose of providing health care to Alaska Natives and to contract with the Indian Health Service and other federal and non-tribal agencies for such purpose as well as to provide health care to the other residents of their respective service areas, as permitted by section 813 of the Indian Health Care Improvement Act, as amended, or other applicable law;

WHEREAS, the Congress has declared its commitment to the maintenance of the Federal Government's unique and continuing relationship with, and responsibility to, Alaska Native and American Indian Tribes and to the Alaska Native and American Indian people as a whole through the permanent establishment of a meaningful Indian self-governance policy, which will permit an orderly transition from the federal domination of programs for, and services to, Alaska Natives and American Indians to effective and meaningful participation by the Alaska Native and American Indian people in the planning, conduct, and administration of those programs and services; 25 U.S.C. § 458aaa(note);

WHEREAS, the Congress has declared its commitment to strengthening the government-to-government relationship and to supporting and assisting Alaska Native and American Indian Tribes in the orderly transition from the federal domination of programs and services to provide Alaska Native and American Indian Tribes with meaningful authority, control, funding and discretion to plan, conduct, redesign and administer programs, services, functions and activities (or portions thereof) that meet the needs of the individual tribal communities, 25 U.S.C. § 458aaa(note);

WHEREAS, Federal health services to maintain and improve the health of the Indians and Alaska Natives are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian and Alaska Native people, 25 U.S.C.§§ 1601(1), (2);

WHEREAS, in accordance with 25 U.S.C. § 1601(2) a major national goal of the United States is to provide resources, processes and structures that will enable Indians and Alaska Natives to obtain the quality and quantity of health care services and opportunities that will eradicate health disparities between Indians and Alaska Natives and the general population of the United States;

WHEREAS, the Congress has declared that it is the policy of the United States as stated in 25 U.S.C. § 1602, in fulfillment of its special trust responsibilities and legal obligations to the American Indian and Alaska Native people, to ensure the highest possible health status for Indians

and Alaska Natives and to provide all resources necessary to effect that policy; to raise the health status of Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives; and also the ensure maximum Indian and Alaska Native participation in the direction of health care services so as to render the person administering such services and the services themselves more responsive to the needs and desires of Indian and Alaska Native communities;

WHEREAS, for the purposes of this Compact,

"ANTHC" shall mean only the Alaska Native Tribal Health Consortium;

"Co-Signer" shall mean all Tribes and tribal organizations or Inter-Tribal Consortia, including the ANTHC, participating in the Compact;

"Signatory Tribe(s)" shall mean all Tribes participating in the Compact either directly or through a tribal organization or Inter-Tribal Consortium that has been authorized to participate by resolution;

"Tribal Co-Signer" shall mean only those Tribes, tribal organizations and Inter-Tribal Consortia authorized by resolution of a Tribe, as defined in 25 U.S.C. § 450b(*l*) and sections 501(a)(5) and (b) of Title V, to participate in the Compact and shall not include the ANTHC; and

WHEREAS, under authority from the Tribes, certain Tribal Organizations and Inter-Tribal Consortia in Alaska have provided health services for many years under self-determination contracts with the Indian Health Service and have been recognized by the Indian Health Service as tribally-operated service units;

WHEREAS, pursuant to section 325 of P.L. 105-83, the Alaska Native Tribal Health Consortium (herein "ANTHC"), a tribal organization and Inter-tribal Consortium, as defined in section 501(a)(5) of Title V, was organized and is controlled by the Alaska Native tribes and tribal organizations which are represented on its Board of Directors;

WHEREAS, Tribes, Tribal Organizations and Inter-Tribal Consortia throughout Alaska are reliant on the services to be provided by the ANTHC;

WHEREAS, participation by the ANTHC in the Alaska Tribal Health Compact promotes the commitment of Alaska Native Tribes, Tribal Organizations and Inter-Tribal Consortia to maintain the unique tribal cooperation that has developed in Alaska to assure that all Alaska Natives have access to a comprehensive, integrated, organized, tribally controlled health care delivery system in which Alaska tribal health providers participate in numerous joint activities including utilization review and provide their health services in a clinically integrated care setting in which individuals typically receive health care from more than one of these Alaska tribal providers;

WHEREAS, in furtherance of the federal policy of Alaska Native and American Indian tribal self-determination and self-governance, Congress has directed the Secretary of Health and Human Services (herein the "Secretary") to carry out the Tribal Self-Governance Program under Title V.;

WHEREAS, Congress, in Title V, has authorized the Secretary to negotiate and implement a Compact of Self-Governance and Funding Agreements with the governing bodies of participating Tribal governments of qualified Alaska Native and American Indian Tribes that have completed a planning activity;

WHEREAS, Congress has directed that the Funding Agreements, which the Secretary negotiates with Alaska Native and American Indian tribes, shall authorize the Co-Signers to plan, conduct, consolidate, administer, receive full tribal shares of funding, redesign programs, and reallocate funds for programs, services, functions and activities as provided in sections 505(b)(1) and, (b)(2) and 506 (e) of Title V;

WHEREAS, each Funding Agreement shall specify the programs, services, functions or activities to be performed or administered, the funds to be provided, and the responsibilities of the Co-Signer and the Secretary in accordance with section 505 of Title V;

WHEREAS, the Funding Agreement shall specify the authority of the Co-Signer to redesign or consolidate programs, functions, services and activities (or portions thereof) and to reallocate or redirect funds or modify budget allocations pursuant to section 506(e) of Title V;

WHEREAS, to the extent to which, funding is provided to a Co-Signer, as authorized by Alaska Native Tribes, pursuant to a Funding Agreement, such Co-Signer shall be responsible for administration of programs, services, functions and activities pursuant to the Agreement, consistent with section 505 of Title V;

WHEREAS, nothing in this Compact or associated Funding Agreements shall be construed to limit or reduce in any way the funding for any program, project or activity serving an Indian Tribe under Title V or any other applicable Federal law, pursuant to section 515(a) of Title V;

WHEREAS, in Title V, Congress has directed that the Funding Agreements, which the Secretary negotiates with Co-Signers shall contain certain provisions and, at the option of the Co-Signers, apply to certain programs, activities, functions and services of the Indian Health Service (including construction) as specified in sections 505, 507(a)(2)(A), and 509 of Title V;

WHEREAS, Congress has directed that, at the request of the governing body of qualifying Tribes and the ANTHC and under the terms of a Funding Agreement, the Secretary shall provide funding to the Tribes and the ANTHC to implement the Funding Agreement in accordance with section 508 of Title V;

WHEREAS, Congress has directed that the Secretary shall interpret federal laws and regulations in a manner that will facilitate the implementation of a Compact of Self-Governance and Funding Agreement authorized by section 512(a) of Title V;

WHEREAS, Congress has directed that the Secretary shall interpret federal laws and regulations in a manner that will facilitate the inclusion of activities, programs, services, and functions (or portions thereof) in Compacts of Self-Governance and Funding Agreements authorized by section 512(a) of Title V;

WHEREAS, it is the intent of certain Alaska Native Tribes to collectively enter into a single Compact with the Secretary. To carry out that intent, such Tribes (hereafter referred to as signatory Tribes) enter into this Compact either by individual signature or by means of a delegation of signature authority as authorized by resolution of the Tribal government. Such resolutions are attached as Exhibit "A".

WHEREAS, it is the intent of the signatory Tribes that this Compact will be carried out either by the Tribe itself, by tribal organizations or Inter-Tribal Consortia, as authorized by resolution of Tribe(s) as defined by 25 USC § 450b(e), section 501(b), and by the ANTHC under section 325 of P.L. 105-83. These Tribes, tribal organizations and Inter-Tribal Consortia, including the ANTHC, are bound by the terms of this Compact and are signing separately as Co-Signers.

WHEREAS, it is the intent of the parties that each Tribal Co-Signer Funding Agreement entered into under this Compact shall be executed by the Tribes, either by individual signature or by means of a delegation of signature authority as authorized by resolution of the Tribal government. Each such Funding Agreement also will be signed by a Tribal Co-Signer, designated by the Tribal governing body. The Tribal Co-Signer will carry out the terms of the Funding Agreement for the signatory Tribe(s) from which it has obtained a resolution of authority and be bound by its terms;

WHEREAS, the ANTHC may enter into this Compact and into Funding Agreements under this Compact as authorized by the Board of Directors of the Alaska Native Tribal Health Consortium; and

WHEREAS, for purposes of clarification, and to recognize the government to government relationship between the signatory Tribes and the Secretary, the parties agree that the signatory Tribes, by entering into this Compact, do not relinquish any aspects of Tribal sovereignty to the Co-Signers. The Tribal Co-Signers act only for and on behalf of the signatory Tribe(s) within the scope of the authority granted to them by tribal resolution or by law and the ANTHC has only the authority granted to it under section 325 of P.L. 105-83. Tribal Co-Signers and the ANTHC by carrying out the terms of this Compact and the associated Funding Agreements do not gain the status of a sovereign tribal government;

WHEREAS, the parties have determined that all of the provisions of this Compact are authorized by Title V or other provisions of federal law and the parties have executed this Compact in reliance on this representation;

NOW, THEREFORE, the Secretary, signatory Tribes and the Co-Signers do hereby agree to enter into, undertake, and be bound by this Compact in accordance with the foregoing principles.

ARTICLE I — AUTHORITY AND PURPOSE

Section 1 – Authority. This Compact of Self-Governance, which became effective October 1, 1994, was amended and restated effective October 1, 1995, October 1, 1996, October 1, 1997, October 1, 1998, and October 1, 2000, and was further amended and restated in FY 2001 effective October 1, 2000, to conform with Title V, October 1, 2003, October 1, 2006, October 1,

2008, and October 1, 2010 (hereinafter the "Compact"), is authorized by Title V of the Indian Self-Determination and Education Assistance Act, as amended, and is hereby entered into by the Secretary of the Department of Health and Human Services of the United States of America (hereinafter the "Secretary"), represented by the Director of the Indian Health Service, certain Alaska Native Tribes, as identified in Exhibit A, recognized by the United States, acting individually or collectively, and the Alaska Native Tribal Health Consortium (hereinafter the "ANTHC"). The Director of the Indian Health Service by signing this Compact commits the Secretary to the extent and within the scope of the Secretary's delegation of authority to enter into Compacts and Funding Agreements pursuant to Title V or as otherwise authorized.

Section 2 – Purpose. This Compact shall be liberally construed to achieve its purposes:

(a) This Compact is to carry out a Self-Governance Program authorized by Title V, and is intended to transfer to tribal governments, at a tribe's request, the power to decide how federal programs, services, functions and activities (or portions thereof) shall be funded and carried out. Title V is meant to strengthen the government-to-government relationship and to uphold the United States trust responsibility for each Indian Tribe. This Compact promotes the autonomy of the Tribes in Alaska in the realm of health care.

(b) This Compact is to enable the signatory Tribes and the Co-Signers to re-design health programs, activities, functions, and services of the Indian Health Service; to reallocate funds for programs, activities, functions, or services according to the priorities of the signatory Tribes and Co-Signers; to enhance the effectiveness and long-term financial stability of the Tribes and the Co-Signers; and to streamline the federal Indian Health Service bureaucracy.

(c) This Compact is to enable the United States to maintain and improve its unique and continuing relationship with, and special trust responsibilities and legal obligations, pursuant to 25 U.S.C. 1602 of the IHCIA, to the Tribes through tribal self-governance and to permit an orderly transition from federal domination of programs and services.

(d) This Compact and Funding Agreement shall transfer to signatory Tribes, acting individually or collectively, and the ANTHC the responsibility for the programs, activities, functions and services of the Indian Health Service included in the Funding Agreement. This Compact allows signatory Tribes, acting individually or collectively, and the ANTHC to exercise meaningful authority to plan, conduct, and administer those programs and services to meet the health care needs of the Alaska Native Tribes. In fulfilling its responsibilities under the Compact and consistent with 25 U.S.C. §§ 1602(5), (6), and the November 5, 2009 Memorandum for the Heads of Executive Departments and Agencies, the April 29, 1994, Memorandum from the President of the United States of America for the Heads of Executive Departments and Agencies, attached hereto as Exhibit B, Executive Order 13175 on Consultation and Coordination with Indian Tribal Governments, the September 23, 2004, Memorandum from the President of the United States of America for the Heads of Executive Departments and Agencies, and the Department of Health and Human Services Tribal Consultation Policy, the Secretary hereby pledges that the Indian Health Service will conduct all relations with the Tribes on a government-to-government basis.

ARTICLE II — TERMS, PROVISIONS AND CONDITIONS

Section 1 – Term and Resolutions.

(a) Term. The term of this Compact begins as to each Co-Signer on the effective date of the Co-Signer's first Funding Agreement and shall extend thereafter as to each Co-Signer throughout the period authorized by Title V of the Indian Self-Determination and Education Assistance Act, and any subsequent amendment thereto, provided the Co-Signer has a Funding Agreement in effect, and shall remain in effect for so long as is permitted by Federal law or until terminated by mutual written agreement, retrocession, or reassumption pursuant to section 504(d) of Title V.

(b) Resolutions from Signatory Tribes. Those Tribes which intend to participate in this Compact and the applicable Funding Agreement through delegation of signature authority as provided in this Compact must have issued a written resolution authorizing the Tribal Co-Signer, on their behalf, to enter into this Compact and Funding Agreement on or before the date the Compact and the applicable Funding Agreement is signed by the Tribal Co-Signer for that Tribe, provided that if a Tribal Co-Signer negotiates a Funding Agreement prior to obtaining an authorizing resolution from a Tribe, nothing herein shall be construed to limit or impair in any way a tribal government's sovereign right to decide whether or not to sign such a resolution.

(c) Resolution from the Board of the ANTHC. The ANTHC may participate in this Compact and the applicable Funding Agreement upon receipt of an authorizing resolution of the Board of Directors of the ANTHC, attached hereto as a part of Exhibit A.

Section 2 – Effective Date.

(a) Once this Compact and the Funding Agreements, attached hereto as Exhibit C, are approved and signed by the Co-Signers and the Secretary, they shall be effective as of October 1, 2008. Subsequent Funding Agreements will be effective on the date signed by the Secretary and Co-Signer or another date mutually agreed upon.

(b) During the term of this Compact any Co-Signer which has not previously negotiated a Funding Agreement may do so. All Funding Agreements shall be subject to, and all the activities thereunder shall be governed by, the terms of this Compact to the same extent as the initial Funding Agreements. New Funding Agreements will be effective on the date signed by the Secretary and Co-Signer or another date mutually agreed upon.

(c) Each Funding Agreement and subsequent Funding Agreement of a Co-Signer is deemed to be incorporated, as negotiated, by reference into this Compact, for the purposes only of that Co-Signer and the United States. In the event of inconsistency between the Compact and any subsequent Funding Agreement, the provisions of the Compact shall prevail.

Section 3 – Funding Amount. Subject only to the appropriation of funds by the Congress of the United States and in accordance with section 508 of Title V, the Secretary shall provide the total amounts specified in the Funding Agreements.

Section 4 – Payment.

(a) Payment Schedule. Payment shall be made expeditiously and shall include financial arrangements to cover funding during periods under continuing resolutions to the extent permitted by such resolutions. For each fiscal year covered by the Compact, the Secretary shall make available the funds specified for that fiscal year under the Funding Agreements by paying the respective total amount as provided for in each Funding Agreement in advance lump sum, as permitted by law, or such other payments as provided in the schedule set forth in each Funding Agreement. The first payment shall be made on or before ten calendar days after the date on which the Office of Management and Budget (hereinafter "OMB") apportions the appropriations for that fiscal year for the programs, activities, functions and services subject to the Compact. The Prompt Payment Act, Chapter 39 of Title 31, United States Code, shall apply to the payment of funds due under this Compact and to each Funding Agreement negotiated thereunder.

(b) Interest on Advances. Co-Signers receiving funds under applicable Funding Agreements pursuant to this Compact shall be permitted to retain interest earned on funds advanced pending disbursement as authorized by law. Interest earned on advances shall not diminish the amount of funds the Co-Signer is authorized to receive under its Funding Agreement in the year earned or in any subsequent fiscal year. All funds transferred under Funding Agreements pursuant to this Compact shall be managed using the prudent investment standard pursuant to section 508(h) of Title V.

Section 5 – Reports to Congress. In accordance with section 514 of Title V, the Secretary shall submit to the Senate Committee on Indian Affairs and the House Resources Committee a written report not later than January 1 of each year on the administration of Title V. Each report shall include a detailed analysis on the level of need being presently funded or unfunded for each signatory Tribe and Co-Signer. The contents of each report shall comply with section 514(b). In compiling the reports, the Secretary may not impose any reporting requirements on Co-Signers not otherwise provided in Title V. The Secretary shall provide each Co-Signer with a draft of each report required to be submitted to Congress under this provision for a thirty (30) day comment period prior to the submission of the report to Congress so that the Co-Signers may comment on the report. The Secretary shall include each Co-Signer's comments in the final report to Congress.

Section 6 – Audits

(a) Single Audit. Each Co-Signer that has executed a Funding Agreement pursuant to this Compact shall provide to the National External Audit Review Center (or its successor), which is the designee of the Secretary for the purposes of this section, an annual single organization-wide audit as prescribed by the Single Audit Act of 1984, as amended, 31 U.S.C. § 7501, *et seq*. A copy of this audit will be sent simultaneously to the Indian Health Service Area Office, the cognizant agency, and the Federal Audit Clearinghouse.

(b) Cost Principles. Each Co-Signer shall apply cost principles under the applicable OMB Circular, except as modified by section 106(k) of the Indian Self-Determination and Education Assistance Act, as amended, which section is hereby incorporated into this Compact, or by any exemptions subsequently granted by OMB. To the extent that OMB Circular A-87 or its successor, or other applicable circulars, permit agency pre-approval of allowable costs,

the agency hereby grants that pre-approval. The Secretary will assist the Co-Signers in obtaining such additional waivers from OMB as are requested by the Co-Signers. No other audit or accounting standards shall be required by the Secretary. Any claim by the Federal Government against any Co-Signer receiving funds under a Funding Agreement based on any audit under this section shall be subject to the provisions of section 106(f) of the Indian Self-Determination and Education Assistance Act, as amended.

Section 7 – Records. Each Co-Signer's practices relating to document disclosure and record-keeping associated with this Compact shall, in accordance with applicable law, be set forth in the respective Funding Agreement.

Section 8 – Property.

(a) In General. The provisions of section 512(c) and section 1(b)(8) of the Model Agreement set forth in section 108(c) of the Indian Self-Determination and Education Assistance Act, as amended, are hereby incorporated into this Compact.

(b) Property Management. Management of property under this Compact shall be in accordance with additional provisions included in each Co-Signer's Funding Agreement.

(c) Access to Property Subject to Destruction. Prior to the destruction of federal property which would otherwise be declared surplus or excess and which is located within the service area of a Co-Signer, the Secretary, if previously requested by the Co-Signer, shall provide notice of such proposed destruction to the Co-Signer. Such notice shall inform the Co-Signer of the name and address of the official responsible for determining whether such property will be destroyed or declared surplus or excess. If the Secretary is the responsible official, the Secretary will consider information provided by the Co-Signer regarding transfer of the property, rather than destruction, and, if not the responsible official, the Secretary will assist the Co-Signer in communicating information to the responsible official.

(d) Leases. Upon the request of a Co-Signer, the Secretary shall enter into a lease with the Co-Signer in accordance with section 105(*l*) of the Indian Self-Determination and Education Assistance Act, as amended.

Section 9 – Regulatory Authority. The Secretary and the Co-Signers agree to utilize the following procedures governing the establishment and application of program rules and regulations under this Compact:

(a) Program Rules. No Co-Signer is required to comply with any agency circular, policy, manual, guidance or rule adopted by the Indian Health Service other than those identified in this section or expressly incorporated by reference in the individual Co-Signer's Funding Agreement in carrying out the programs, services, activities and functions under the Compact, except for the eligibility provisions of section 105(g) of the Indian Self-Determination and Education Assistance Act, as amended, and regulations promulgated under section 517 of Title V.

(b) Federal Regulations.

(1) Applicable Federal Regulations. The Co-Signers, in carrying out the provisions of this Compact and applicable Funding Agreements, will be required to comply only with applicable federal regulations, which include regulations promulgated under section 517 of Title V unless waived as provided in section 512(b) of Title V.

(2) Waiver of Federal Regulations.

(A) The Secretary and the Co-Signer will seek to identify federal regulations promulgated pursuant to section 517 or under the authorities specified in section 512(b) of Title V which may require waiver in order to effectively carry out this Compact or any Funding Agreement.

(B) Waivers of regulations shall be submitted and addressed in accordance with the procedures set forth in section 512(b).

(c) Title I Section Incorporated by Reference. Section 105(a)(1) of the Indian Self-Determination and Education Assistance Act, as amended, 25 U.S.C. § 450j(a)(1), is hereby incorporated in this Compact and shall have the same force and effect as if it were set forth in full in Title V of the Act.

Section 10 – Disputes.

(a) All disputes between the Indian Health Service and any Co-Signer or between the Indian Health Service and all Co-Signers under this Compact shall be subject to Title V and the provisions of section 110 of the Indian Self-Determination and Education Assistance Act, as amended, and all remedies provided for therein shall be available to each Co-Signer of this Compact. Actions and proceedings to enforce the Co-Signer's rights and the Secretary's obligations under this Compact shall be subject to the Equal Access to Justice Act, Public Law 96-481, as amended, to the same extent as are actions and proceedings involving Public Law 93-638 contracts.

(b) In the alternative, the Indian Health Service and the Co-Signers may use the processes authorized and encouraged in the Administrative Dispute Resolution Act, 5 U.S.C. § 581 note, for more informal resolution of disputes arising under this Compact and associated Funding Agreements.

Section 11 – Retrocession and Withdrawal

(a) Retrocession. Section 506(f) of the Act is herein adopted. A Co-signer may retrocede, fully or partially, to the Secretary programs, services, functions, or activities (or portions thereof) included in the compact or funding agreement. Unless the Co-signer rescinds the request for retrocession, such retrocession will become effective within the timeframe specified by the parties in the compact or funding agreement. In the absence of such a specification, such retrocession shall become effective on

(1) the earlier of

(A) one year after the date of submission of such request; or

(B) the date on which the funding agreement expires; or

(2) such date as may be mutually agreed upon by the Secretary and the Co-signer.

(b) Withdrawal. Section 506(g) of the Act is herein adopted. Unless prohibited by law and in accordance with Section 506(g) of the Act, a Tribe may fully or partially withdraw from a participating inter-tribal consortium or tribal organization its share of any program, function, service, or activity (or portions thereof) included in a compact or funding agreement. The withdrawal shall become effective within the timeframe specified in the resolution which authorizes transfer to the participating tribal organization or inter-tribal consortium. In the absence of a specific timeframe set forth in the resolution, such withdrawal shall become effective on

(1) the earlier of

(A) one year after the date of submission of such request; or

(B) the date on which the funding agreement expires; or

(2) such date as may be mutually agreed upon by the Secretary, the withdrawing Indian tribe, and the participating tribal organization or inter-tribal consortium that has signed the compact or funding agreement on behalf of the withdrawing Indian tribe, inter-tribal consortium, or tribal organization.

Section 12 – Discontinuance. Co-signer may discontinue its participation in the Alaska Tribal Health Compact after written notice to each authorizing Tribe or Village and the IHS. Notice must be provided one year in advance of the effective date of the request except that the effective date of a request may be less than one year upon approval of all authorizing Tribes and Villages and the IHS.

Section 13 – Subsequent Funding Agreements.

(a) Negotiations for subsequent Funding Agreements, as provided for in Article VI, section 2, shall begin no later than 120 days in advance of the conclusion of the preceding Funding Agreement. Each Co-Signer is hereby assured that future funding of the Co-Signer's subsequent Funding Agreements shall only be reduced pursuant to the provisions of section 508(d) of Title V provided, however, that future funding for each Co-Signer's non-recurring funds and tribal shares shall be subject to adjustments in accordance with a yearly reallocation decision by the Co-Signers. The Secretary agrees to prepare and supply relevant information, and promptly to comply with the Co-Signers' requests for information reasonably needed to determine the funds that may be available for a subsequent Funding Agreement as provided for in Article VI, Section 2 of this Compact.

(b) If the parties are unable to conclude negotiation of a subsequent Funding Agreement, the terms of this Compact and the existing Funding Agreement shall, at the option of the Co-Signer, continue on in 30-day, 90-day or longer increments until a subsequent Funding Agreement is agreed to. As provided in section 505(e) of Title V, the terms of the subsequent Funding Agreement will become retroactive to the end of the term of the preceding Funding Agreement. Any increases in funding to which Tribes are entitled by law or which have been made available by Congress, or increases which Co-Signers subsequently negotiate, shall be included in each Co-Signer's subsequent Funding Agreement.

Section 14 – Health Status Reports. In accordance with section 507(a)(1), Co-Signers shall provide the Secretary a health status and service delivery report to the extent that relevant data is not otherwise available to the Secretary and specific funds for this purpose are provided to the Co-Signer in its Funding Agreement. Such reporting may impose only minimal burdens on the Co-Signer and shall be consistent with regulations promulgated under section 517 of Title V.

Section 15 – Secretarial Approval. For the term of the Compact, the provisions of 25 U.S.C. § 81 and 25 U.S.C. § 476 shall not apply to attorney and other professional contracts of signatory tribal governments of Alaska Native Tribes operating under the Compact pursuant to section 511(b) of Title V.

Section 16 – Transportation and Other Supply Sources.

(a) Use of Motor Vehicles. Subject to agreement of the General Services Administration, the Secretary hereby authorizes each Co-Signer to obtain Interagency Motor Pool vehicles and related services for performance of any programs, activities, functions and services under this Compact.

(b) Other Supply Sources. Federal supply sources (including lodging, airline transportation, and other means of transportation) shall be available to each Co-Signer in accordance with sections 508(e) and 516(a) of Title V.

Section 17 – Limitation of Costs. Each Co-Signer shall not be obligated to continue performance that requires an expenditure of funds in excess of funds awarded under the Funding Agreement. In accordance with section 508(k), if, at any time the Co-Signer has reason to believe that the total amount required for performance of a Funding Agreement, or a specific activity conducted under the Funding Agreement, would be greater than the amount of funds awarded under the Funding Agreement, the Co-Signer shall provide reasonable notice to the Indian Health Service and affected Tribes and tribal organizations. If the Indian Health Service does not take such action as may be necessary to increase the amount of funds awarded under the Funding Agreement, the Co-Signer may suspend performance of the Funding Agreement until such time as additional funds are transferred.

ARTICLE III — OBLIGATIONS OF EACH CO-SIGNER

Section 1 – Consolidation. Each Co-Signer will be responsible for performing the health programs, activities, functions and services as specified in Section 3 of this Article III and in their respective Funding Agreements, as provided for in Article VI, Section 2 of this Compact. To the extent a program, activity, function, or service included within a contract or grant entered into pursuant to sections 102 or 103 of the Indian Self-Determination and Education Assistance Act, as amended, is included within a Funding Agreement, that contract or grant shall be modified or terminated as appropriate. The parties' obligations shall be governed by this Compact and all funds previously obligated under contracts or grants (including carry-over funds) will be re-obligated to the Co-Signer under the applicable Funding Agreement. Such terminated contracts shall be identified by contract number in each Funding Agreement.

Section 2 – Amount of Funds. The total amount of funds covered by the consolidation and redesign provided for in Section 1 of this Article that the Secretary shall make available to the Co-Signers shall be determined in accordance with section 508(c) of Title V and shall be set forth in the respective Funding Agreements between the Secretary and each Co-Signer.

Section 3 – Compact Programs. The health programs, activities, functions and services will be the responsibility of each Co-Signer under this Compact and shall be identified in each Co-Signer's Funding Agreement.

Section 4 – Eligibility for Services. In determining eligibility for services, the Co-Signers shall comply with applicable eligibility provisions set forth in the Indian Health Care Improvement Act, as amended, applicable regulations, and other statutory law.

Section 5 – Reallocation, Redesign and Consolidation. In accordance with section 506(e) of Title V, a Co-Signer may redesign or consolidate programs, services, functions, and activities (or portions thereof) included in a Funding Agreement and reallocate or redirect funds for such programs, services, functions, and activities (or portions thereof) in any manner in which the Co-Signer deems to be in the best interest of the health and welfare of the Indian community being served, only if the redesign or consolidation does not have the effect of denying eligibility for services to population groups otherwise eligible to be served under applicable federal law.

Section 6 – Consolidation with Other Programs. Each Co-Signer may consolidate programs, services, functions, and activities and associated funds identified in its funding agreement with other programs, services, functions, and activities provided with its own funds or funds from other sources, provided that the programs, services, functions, and activities are allowable for inclusion in a funding agreement under Section 505 of Title V. When programs, services, functions, and activities are consolidated in a funding agreement by a Co-Signer in accordance with the terms of the Funding Agreement and Title V, the Co-signer and its employees carrying out those programs, services, functions, and activities may receive Federal Tort Claims Act coverage in accordance with the statutory provisions and regulations cited in the Compact. Whether the Federal Tort Claims Act applies in any particular case is decided on an individual case-by-case basis by the United States Department of Justice and subsequently by the Federal courts. In cases in which a Co-Signer consolidates programs, services, functions, and activities under this section, the Co-Signer shall not be required to separate dollars or programs, services, functions, and activities so long as the Co-Signer can provide sufficient data to permit an acceptable program and financial audit to be conducted.

Section 7 – Program Income, including Medicare/Medicaid. All Medicare, Medicaid or other program income earned by a Co-Signer shall be treated as additional supplemental funding to that negotiated in the Funding Agreement and the Co-Signer may retain all such income, including Medicare/Medicaid, and expend such funds in the current year or in future years, nor shall such funds result in any off-set or reduction in the negotiated amount of the Funding Agreement. Medicare/Medicaid collections of a Co-Signer under Title IV of Public Law 94-437, as amended, shall be used by the Co-Signer in accordance with any applicable statutory restrictions on the use of such funds.

Section 8 – Carry-over. Congressionally appropriated funds allocated in accordance with

a Funding Agreement under this Compact are "no year" funds and may be expended by the Co-Signer in accordance with its budget for the year for which the funds are appropriated or carried over and expended in any subsequent fiscal year, and such carry-over shall not diminish the amount of funds the Co-Signer is authorized to receive under its Funding Agreement for any such subsequent fiscal year.

Section 9 – Matching Funds. Funds may be used to meet matching and other cost participation requirements under any other federal or non-federal programs pursuant to section 512(d) of Title V.

ARTICLE IV — OBLIGATIONS OF THE UNITED STATES

Section 1 – Trust Responsibility. In accordance with sections 507(g) and 515(b) of Title V, nothing in this Compact waives, modifies, or diminishes in any way the trust responsibility of the United States with respect to the Alaska Native Tribes or individual Alaska Natives and American Indians which exists under treaty, executive orders, and acts of Congress.

Section 2 – Programs Retained.

(a) The Secretary hereby retains the responsibility for the programs, activities, functions and services with respect to the signatory Tribes that are not specifically assumed by the signatory Tribes, acting individually or collectively, or by the ANTHC through their applicable Funding Agreements and they shall continue to be entitled to the full benefit of those programs, activities, functions, and services retained by the Indian Health Service. In accordance with section 506(h), each Co-Signer shall be eligible for new programs, activities, functions and services of the Secretary and the Indian Health Service on the same basis as other Tribes and Tribal Organizations. The Indian Health Service, in consultation with the Tribes, may reorganize to sustain its ability to provide, in the most effective and efficient manner, all programs, activities, functions, and services that have not been included in the Funding Agreement.

(b) No later than 120 days prior to the end of each fiscal year, the Indian Health Service shall provide each signatory Tribe and Co-Signer with a written list of the retained programs, activities, functions, and services relevant to Native health care in Alaska for the upcoming fiscal year. To the fullest extent permitted by law, the Secretary shall provide any requesting signatory Tribe and Co-Signer access to, and copies of, all documents and other information relevant to any ongoing retained programs, activities, functions, or services, and shall cooperate with any evaluation which the Co-Signer or signatory Tribe may wish to conduct. The Secretary will cooperate with each Tribe and Co-Signer to facilitate the inclusion of programs, activities, functions and services in future Funding Agreements of those Tribes and Co-Signer.

Section 3 – Financial and Other Information.

(a) To assist the Tribes and Co-Signers in monitoring compliance with section 508(c) of the Indian Self-Determination and Education Assistance Act, as amended, the Secretary shall provide to Co-Signers:

(1) all monthly reports of obligations and allowances, including all reports from Central Office, Headquarters, the Office of Tribal Self-Governance and the Alaska Area Office, concerning funds provided to support programs, activities, functions and services provided by Tribes or Tribal Organizations under this Compact and funds retained by the Indian Health Service to support programs, activities, functions and services retained by the Indian Health Service; and

(2) prompt notice of any new programs, activities, functions and services for which the Tribes or Co-Signers are eligible, including the funding available for such programs, activities, functions and services.

(b) The Secretary shall prepare and promptly supply relevant financial information and comply with each Co-Signer's request for information needed to determine funds that may be available for a successor Funding Agreement.

Section 4 - Savings. If the programs, services, functions and activities carried out under Title V Funding Agreements and this Compact result in a reduction to the administrative or other responsibilities of the Secretary, with respect to the operation of Indian programs, and thereby result in saving that have not otherwise been included in the amount of tribal shares and other funds determined under section 508(c) of Title V, the Secretary shall make such savings available to the Co-Signers for the provision of additional services in accordance with section 507(f) of Title V.

ARTICLE V — OTHER PROVISIONS

Section 1 – Designated Officials/Agent.

(a) Parties. On or before the effective date of this Compact, both the Secretary and each Co-Signer shall provide a written designation of an individual as their representative/liaison. The Secretary shall direct all communications about the Compact, and relevant Funding Agreement to the Co-Signer's designee, except in the case where the Compact or Funding Agreement requires notice to the signatory Tribes, in which case notice shall also be sent to the Tribes. Reference herein to Co-Signers or the Secretary shall include the respective Designated Official thereof.

(b) Agent for Notice. If Co-Signers assign an agent to accept and distribute notices, those Co-Signers shall provide the name and address of the agent and a description of the limited powers and duties of the agent.

Section 2 – Indian Preference in Employment, Contracting and Sub-Contracting. The Co-Signers will comply with the Indian and Alaska Native preference provisions of sections 7(b) and 7(c) of the Indian Self-Determination and Education Assistance Act, as amended. The parties agree that any Co-Signer may comply with any Indian or Alaska Native preference established by their respective Tribes, including preference based on tribal affiliation.

Section 3 – Federal Tort Claims Act Coverage; Insurance.

(a) The Tribes and Co-Signers are deemed by statute to be part of the Public Health

Service (PHS), and the employees of the Tribes and Co-Signers are deemed by statute to be part of or employed by the Public Health Service, for purposes of coverage under the Federal Tort Claims Act, while performing programs, activities, functions or services under this Compact and described in the Co-Signer's Funding Agreement (including new and existing programs, services, functions and activities as provided under Article III, Section 5 or 6, or supported with income received in accordance with Article III, Section 7), including coverage for claims of medical malpractice, as is more fully described in 25 C.F.R. Part 900 Subpart M, attached hereto as Exhibit E, and incorporated by reference herein, and section 102(d) of the Indian Self-Determination and Education Assistance Act, as amended, as required by section 516(a).

(b) The above status of a Tribe or Co-Signer, or an employee's status as an employee of a Tribe or employee of a Co-Signer, is not affected by the source of the funds used by the Tribe or Co-Signer to carry out the programs, services, functions or activities or to pay the employee's salary and benefits as long as the employee does not receive any additional compensation for the performance of covered services from anyone other than the Tribe or Co-Signer.

(c) The Tribe's employee or the Co-Signer's employee may, while performing under this Compact and any applicable Co-Signer's Funding Agreement and as a condition of employment, be required by the Tribe or Co-Signer to provide services to non-Indian Health Service beneficiaries in order to meet the obligations under this Compact either in facilities of the Tribe or Co-Signer or in facilities other than those of the Tribe or Co-Signer.

(d) Funds provided under a Funding Agreement may be used to purchase such additional liability and other insurance as is prudent in the judgment of a Co-Signer performing under this Compact and Funding Agreement for its protection and the protection of its employees.

(e) Personal services contracts shall be covered under this provision to the extent provided under section 102(d) of the Indian Self-Determination and Education Assistance Act, as amended.

(f) Coverage shall also apply in accordance with Section 813(e) of the IHCIA, as amended.

Section 4 – Compact Modifications or Amendments.

(a) Any request for a modification of this Compact must be communicated in writing to all signatory Tribes and Co-Signers and to the Indian Health Service. To be effective any modifications of this Compact shall be in the form of a written amendment to the Compact, and shall require written consent of each of the signatory Tribes, acting directly or through an agent authorized by resolution, and the Secretary.

(b) This provision shall not apply to amendment of the Compact to include additional Tribes and/or Co-Signers. Such amendment shall only require the concurrence of the additional Tribe and/or Co-Signer, and the Secretary.

Section 5 – Construction. This Compact shall apply to funds included in the facilities category of Indian Health Service appropriations. A Co-signer may assume construction projects or programs in accordance with Titles I or V or P.L. 86-121. In doing so, the Co-Signer elects to comply with the regulations of the elected statutory provision.

Section 6 – Officials Not To Benefit. No member of or delegate to Congress shall be admitted to any share or part of any Compact executed pursuant to this Compact, or to any benefit that may arise there from; but this provision shall not be construed to extend to any contract under this Compact if made with a corporation for its general benefit.

Section 7 – Covenant Against Contingent Fees. The parties warrant that no person or selling agency has been employed or retained to solicit or secure any contract executed pursuant to this Compact upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial or selling agencies maintained by the contractor for the purpose of securing business.

Section 8 – Penalties. The parties agree that the criminal penalties set forth in 25 U.S.C. § 450d apply to all activities conducted pursuant to this Compact.

Section 9 – Use of Federal Employees. Section 104 of the Indian Self-Determination and Education Assistance Act, as amended, shall apply to this Compact and to any individuals assigned or detailed to any Co-Signer performing functions under this Compact or leaving federal employment to perform services under this Compact, including assignments either on detail or on leave without pay and with or without reimbursement by the Co-Signer for the travel and transportation expenses to or from the place of assignment and for the pay, or supplemental pay, or a part thereof, of the employee during assignment.

Section 10 – Extraordinary or Unforeseen Events. This Compact is intended to obligate each Co-Signer to carry out all usual and ordinary functions respecting the programs, activities, functions and services that it is undertaking to assume responsibility for under its Funding Agreement. In the event major unforeseen or extraordinary events occur, as jointly identified by each Co-Signer and the Secretary, with consequences beyond the control of the Co-Signer, that the Co-Signer shall have access to additional services and funding amounts for its Funding Agreement as described in its Funding Agreement. The parties will seek to ensure that funds available to the Co-Signer to deal with the unforeseen circumstance will not be less than would have been available to non-Compact Tribes or the Indian Health Service had they encountered a similar circumstance. Each Co-Signer's participation in the Indian Health Service Catastrophic Health Emergency Funds will be identified in the Co-Signer's Funding Agreement.

Section 11 – Mature Contractor Status upon Compact Termination. In accordance with section 506(g)(3) of Title V, should any signatory Tribe, tribal organization at the direction of a signatory Tribe or Tribes, or the ANTHC, elect to convert all or some of the programs operated under the Compact back to contract status under Public Law 93-638, as amended, such conversion shall not affect the Co-Signer's or the Tribe's status as having operated a mature contract within the meaning of section 4(h) of the Indian Self-Determination and Education Assistance Act, as amended. Such conversion would occur only at the end of the Compact term, on another date mutually acceptable to the Tribe, the Co-Signer and the Secretary, or as otherwise provided in this Compact, and will be implemented in a manner which avoids any interruption of services to

individual tribal members. If the Compact is terminated or a Tribe determines that it will retrocede any program, activity, function or service operated under the Compact, neither the Tribe nor the Co-Signer shall lose its mature contractor status under section 4(h) as provided above.

Section 12 – Startup Costs. In accordance with section 508(c) of Title V, startup costs may be separately negotiated by each Co-Signer and shall be included in each Co-Signer's Funding Agreement, if available. Startup costs are designed to compensate the Tribe for costs associated with implementing this Compact which the Co-Signer would not normally incur. Upon agreement to such costs on an annual basis, funds for such costs shall be included in the Funding Agreement, if available.

Section 13 – Limitation of Liability. Any liability to the United States or to any third party incurred by a Co-Signer arising out of its performance of or expenditure of funds under this Compact and each Co-Signer's Funding Agreement shall be the obligation only of that Co-Signer and shall not be the obligation of any Co-Signer of this Compact which did not participate in such performance or expenditure.

Section 14 – Contracting Rights. Nothing in this Compact or in any Funding Agreement shall be construed to preclude a Co-Signer from contracting with the Secretary to perform a program, activity, function, or service under Title I of P.L. 93-638, as amended, subject, however, to constraints against duplication pursuant to section 506(h) of Title V.

Section 15 – Sovereign Immunity. Nothing in this Compact or in any Funding Agreement shall be construed to affect the sovereign immunity, to the extent that it may exist, of any Tribe or Co-Signer.

Section 16 – Interpretation of Federal Law. In the implementation of this Compact, the Secretary, to the extent feasible, shall interpret all federal laws, executive orders, and regulations and this Compact in a manner that effectuates and facilitates the purposes of this Compact and achievement of the Co-Signers' health goals and objectives in accordance with section 512(a) of Title V.

Section 17 – Inadequacy of Program Funding. The parties to this Compact understand that the Indian Health Service budget is inadequate to fully meet the special responsibilities and legal obligations of the United States to assure the highest possible health status for American Indians and Alaska Natives and that, accordingly, the funds provided to the Co-Signers are inadequate to permit the Co-Signers to achieve this goal. The Secretary commits to advocate for increases in the Indian Health Service budget to further the ability of the Co-Signers to provide the full range of services that are the responsibility and obligation of the United States to make available to American Indian and Alaska Native people and to meet the goals of the Indian Health Care Improvement Act.

Section 18 – Effect on Non-Signatory Tribes.

(a) Nothing in this Compact or associated Funding Agreements shall be construed to limit or reduce in any way the service, contracts or funds that any Indian tribe, inter-tribal

consortium or tribal organization is eligible to receive. It is the intent of the parties to this Compact that the Compact will not have an adverse impact on any tribe choosing not to participate in this Compact directly or through a tribal organization.

(b) The Compact shall not be construed to limit or curtail the right of any Tribe to pursue a contract under Title I of the Indian Self-Determination and Education Assistance Act, as amended, individual participation in this Compact under Title V, or an independent compact under Title V.

Section 19 – Gaining Mature Contractor Status. Subject to Secretarial approval, a tribe that participates in this Compact by authorizing a tribal organization or inter-tribal consortium to be a Co-signer and receive funds on its behalf, which enters into a Memorandum of Agreement with the Co-Signer, for three years manages a program, activity, function or service identified in the Co-Signer's Funding Agreement and obtains three audits with no material unresolved audit exceptions, shall be deemed a mature contractor for all purposes, including entering into a Compact under section 503(c) of Title V. Nothing in this section precludes the right of a tribe to become a mature contractor under other provisions of law.

Section 20 – Severability. This Compact shall not be considered invalid, void or voidable if any section or provision of this Compact is found to be invalid, unlawful or unenforceable by a court of competent jurisdiction. Should such a court make such a finding, the parties will seek agreement to amend, revise or delete any such invalid, unlawful or unenforceable section or provision, in accordance with the provisions of this Compact.

Section 21 – Applicability of Title I Provisions. At the request of a Co-Signer, any provision of Title I, not already specified in section 516(a) of Title V, to the extent such provision does not conflict with a provision in Title V, shall be made a part of a Funding Agreement. The Secretary is obligated to include such provision at the option of the Co-Signer. If such provision is incorporated it shall have the same force and effect as if it were set out in full in Title V and in the Funding Agreement. Should the Co-Signer request such an incorporation sometime other than during the negotiation stage of the Funding Agreement, the Co-Signer will present the proposed incorporated Section to the Indian Health Service, OTSG, with a copy to the Alaska Area IHS Director. The Director of the Indian Health Service shall approve a written addendum to the Funding Agreement within 30 days after verifying that the provision is in Title I. In the case of any such provision, it shall be deemed incorporated in the Funding Agreement at the end of the 30 day period unless the Co-Signer receives a written notice from the Indian Health Service stating that the provision is not in Title I. In the event a Co-Signer requests such incorporation at the negotiation stage of this Compact or a Funding Agreement, such incorporation shall be deemed effective immediately and shall control the negotiation and resulting Compact and Funding Agreement.

Section 22 — Purchases from the Indian Health Service. With respect to functions transferred by the Indian Health Service to a Co-Signer under this Compact or an applicable Funding Agreement, the Indian Health Service shall provide goods and services to the Co-Signer, on a reimbursable basis, including payment in advance with subsequent adjustment. The reimbursements received from those goods and services, along with the funds received from the Co-Signer pursuant to this section, may be credited to the same or subsequent appropriation account which provided the funding, such amounts to remain available until expended.

ARTICLE VI — ATTACHMENTS

Section 1 – Approval of Compact. The resolutions of the Tribes approving this Compact for each Co-Signer are attached as part of Exhibit A. Additional resolutions for each Co-Signer may be filed with the Indian Health Service and included in Exhibit A up to the effective date of each Co-Signer's Funding Agreement. The resolution of the Board of Directors of the ANTHC is attached as part of Exhibit A.

Section 2 – Funding Agreements. Each Co-Signer's Funding Agreement shall be attached hereto as Exhibit C.

ARTICLE VII — COUNTERPART SIGNATURES

This Compact may be signed in counterparts.

CITY OF NOME
ADMINSTRATIVE REVIEW AND APPEAL FORM

Appeal #: 28

This form is for you to appeal the assessed valuation on your property. Complete Sections 1, 2 and 3. Retain a copy for your records, and return or mail the original copy to the City Clerk's Office. Appeals must be returned or postmarked no later than the date indicated on the Assessment Notice. The Assessor will contact you regarding your appeal.

****

RECEIVED
APR 21 2022
CITY OF NOME
CLERKS DEPARTMENT

1) I appeal the value of tax parcel #: 0 0 1 . 2 1 1 . 0 3 A

Property legal description: Block 110, Lot 1-2, Mineral Survey _____, Other _____

Print Owner's Name: Norton Sound Health Corporation

Owner's Mailing Address: PO Box 966, Day Phone: ( ) 443-3337

Nome, AK 99762, Evening Phone: ( ) ____-____

Address to which all correspondence should be mailed (if different than above): _____

Please also email all information to: dpardee@nshcorp.org

****

2)

Assessor's Value	Land:	Bldg:	Total:	Purchase Date:
	$77,000	$1,827,100	$1,904,100	
Owner's Estimate of Value	$0.00	$0.00	exempt	

Owner's reason for estimate of value (including inventory corrections, sales of comparable properties, and property income statements, if appropriate). The Appellant bears the burden of proof. Grounds for adjustment of assessment are proof of unequal, excessive, improper, or under-valuation based on facts that are stated in a valid written appeal or proven at the appeal hearing.

Appeal based on AS 29.45.030 (a)(3) Hospital, Charitable Activities and Federal Law. Assessment is improper.

See attached

(PLEASE ATTACH STATEMENT IF YOU NEED MORE SPACE)

****

3) I hereby affirm that the foregoing information is true and correct, that I have read and understand the guidelines above, and that I am the owner or owner's authorized agent of the property described above.

Angie Gom — **Signature of owner or authorized agent**

4/20/22 — Date signed

Angie Gom — Print Name (if different form item # 1)

SUBSCRIBED and SWORN to before me this 20 day of apr. 1, 20 22

NOTARY PUBLIC in and for the STATE of ALASKA: Meredith Ahmasuk

Commission Expires: 2026, Jan. 5.

Seal:

STATE OF ALASKA
NOTARY PUBLIC
Meredith Ahmasuk
My Commission Expires Jan 5, 2026

Appeal#: 28

4)

Assessor's Decision	From:	Land:	Building:	Total:
	To:			

Assessor's Reason for Decision: _____

(PLEASE ATTACH STATEMENT IF YOU NEED MORE SPACE)

Date Rec'd	Decision made by	Date	Approved by	Date	Date mailed

5) **Appellant's Response**:

☐ **I ACCEPT** the assessor's decision in Block 4 above and hereby withdraw my appeal.

☒ **I DO NOT ACCEPT** the assessor's decision and desire to have my appeal presented to the Board of Equalization.

Signature of owner or authorized agent	Date	Printed Name
	4/19/2022	Geoffrey D. Strommer

6)

BOARD OF EQUALIZATION DECISION	LAND:	BUILDING:	TOTAL:

Date Received	Date Heard	Certified (Chairman or Clerk of Board)	Date	Date Mailed

2022 BOARD OF EQUALIZATION DATE: MAY 4, 5, & 6 2022

THE FINAL DAY TO APPEAL (April 25, 2022) IS 30 DAYS AFTER THE POSTMARK OF YOUR ASSESSMENT NOTICE (*March 25, 2022*)

Attachment to Administrative Review and Appeal Form
Block 30, Lots 66 and 67, 200 W. 1st Avenue ("BIA")

I. Property Use Description

1. General Scope of Activities on Hospital-Owned Properties.

The Norton Sound Health Corporation (NSHC) is a tribally owned and operated, independent, not-for-profit healthcare organization founded in 1970 to meet the healthcare needs of the Inupiat, Siberian Yup'ik, and Yup'ik people of the Bering Strait region. NSHC is governed by a 22-member board of directors who represent all communities and areas of the Bering Strait region, a 44,000 square-mile section of Northwestern Alaska. The NSHC service area encompasses these 44,000 square miles. NSHC is the only regional health system serving Northwestern Alaska.

The NSHC healthcare system includes a tribally owned regional hospital which is operated pursuant to an Indian Self-Determination and Education Assistance Act (ISDEAA) agreement. NSHC operates health facilities and provides health care services to Alaska Natives and other beneficiaries pursuant to the Alaska Tribal Health Compact (ATHC), a multi-tribe self-governance compact with the Indian Health Service (IHS) under Title V of the ISDEAA, 25 U.S.C. § 5381, et seq., and funding agreements (FAs), which include program funding amounts that are negotiated for each fiscal year between the IHS and NSHC to fund the programs, functions, services, and activities (PFSAs) that NSHC performs on behalf of IHS. IHS funds the administration of the PFSAs, including the operation of the hospital facilities in Nome, that NSHC has contracted to perform on behalf of IHS.[1]

NSHC is an "instrumentality" of the United States in providing healthcare services under Title V of the ISDEAA. Healthcare services are federal PFSAs provided under the ISDEAA pursuant to the federal trust responsibility to Indians for health care.[2]

The ISDEAA deems tribes and tribal organizations carrying out ISDEAA agreements to be federal executive agencies for purposes of coverage under the Federal Tort Claims Act (FTCA) and access to federal sources of supply.[3] NSHC employees, like employees of other tribal entities operating agreements with IHS under the ISDEAA, are similarly equally covered by the FTCA and are "federal employees" for these purposes.[4] The ISDEAA also authorizes tribal contractors and compactors to perform personal services otherwise performed by federal employees in determining eligibility for IHS services and benefits, the amounts of such services and benefits, and how such services and benefits should be provided.[5] In addition, tribal

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[1] 25 U.S.C. § 5325; 25 U.S.C. § 5396(a) (mandatory application of § 5325 to Title V agreements).

[2] 25 U.S.C. § 1602.

[3] 25 U.S.C. §§ 450f(d) and 450j(k).

[4] *See* 25 U.S.C. §§ 5321(d) and 5396(a); *M.J. ex rel. Beebe v. United States*, 721 F.3d 1079, 1084 (9th Cir. 2013).

[5] 25 USC § 450j(g).

facilities operated under the ISDEAA are interpreted by the Centers for Medicare and Medicaid Services as IHS facilities for purposes of the 100 percent Federal Medical Assistance Percentage under Section 1905 of the Social Security Act.[6]

The ATHC expressly provides that ATHC co-signers, such as NSHC, "are deemed by statute to be part of the Public Health Service (PHS), and the employees of the Tribes and Co-Signers are deemed by statute to be part of or employed by the Public Health Service, for purposes of coverage under the [FTCA]," while performing PFSAs under the ATHC's compact and as described in its Funding Agreement.[7] The current NSHC Funding Agreement expressly provides that "support services required to support the provision of health services," including human resources activities, administration and board support, performance management, financial functions, and the provision of staff housing, are part of the scope of work,[8] as is the training of community health aides;[9] emergency medical services training for staff and community members throughout the region;[10] and the provision of lodging for patients, family members of patients, and their escorts.[11]

2. Specific Use of BIA Building.

This building is currently vacant. This property was deeded to NSHC by the HHS, a federal agency, in 2006. Covenants of use are placed on this property by the federal government which require it to be "used continuously for health purposes." This property has been used for health purposes through 2020 for behavioral services, including a day shelter and sobering center. Those functions have been moved to another hospital-owned building at Block 116, Lot 1A. The NSHC Board voted in November 2021 to deed the property back to HHS, which is expected to be complete by May of 2022. (See attached reversion letter).

II. NSHC Enjoys the Sovereign Immunity of its Member Tribes and is Immune from Suits to Collect Taxes

Tribal healthcare entities like NSHC performing self-determination contracts under the ISDEAA for health services enjoy sovereign immunity,[12] including those operating off-reservation.[13] "Indian tribes have long been recognized as possessing the common-law immunity from suit traditionally enjoyed by sovereign powers."[14] "As a matter of federal law,

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[6] 42 U.S.C. § 1396(d).

[7] *See* ATHC Article V Sec. 3(a).

[8] Funding Agreement Between Certain Alaska Native Tribes Served By The Norton Sound Health Corporation And The Secretary Of Human Health And Human Services Of The United States of America Fiscal Years 2018-2020 § 3.5.

[9] *Id.* §§ 3.4.4, 3.4.5.

[10] *Id.* § 3.4.7.

[11] *Id.* at § 3.2.14.

[12] *Manzano v. S. Indian Health Council, Inc.*, No. 20-cv-02130-BAS-BGS, 2021 WL 2826072, at *1 (S.D. Cal. July 7, 2021) (non-profit healthcare corporation formed by membership of seven tribes entitled to sovereign immunity).

[13] *See Pink v. Modoc Indian Health Proj., Inc.*, 157 F.3d 1185, 1189 (9th Cir. 1998) (nonprofit corporation created and controlled by two tribes entitled to sovereign immunity).

[14] *Santa Clara Pueblo v. Martinez*, 436 U.S. 49, 58 (1978).

an Indian tribe is subject to suit only where Congress has authorized the suit or the tribe has waived its immunity."[15] "[T]ribal immunity is a matter of federal law and is not subject to diminution by the States."[16] Tribal immunity extends to tribal governing bodies and to tribal agencies or entities that act as an "arm of the tribe."[17] Lastly, "[i]t is settled that a waiver of [tribal] sovereign immunity cannot be implied but must be unequivocally expressed."[18]

In *Barron v. Alaska Native Tribal Health Consortium*, the U.S. District Court for the District of Alaska held a tribal health consortium organization enjoyed sovereign immunity where the organization was formed by Alaska Native tribes; its creation was authorized pursuant to the ISDEAA; it received federal funding to conduct activities that benefitted tribal members; the structure of its board placed control over its ownership and management in representatives of the Alaska Native tribes; its purpose of entering into self-determination and self-governance agreements was "core to the notion of sovereignty"; and it received federal funding "to carry out governmental functions critical to Alaska Native tribes," i.e., healthcare services.[19] Like the entity in *Barron*, and as more fully discussed below, NSHC shares these same attributes.

Tribal immunity extends to suits to collect unpaid taxes. This is because, as the U.S. Supreme Court noted in *Oklahoma Tax Commission v. Citizen Band Potawatomi Indian Tribe of Oklahoma*, "[a]lthough Congress has occasionally authorized limited classes of suits against Indian tribes, *it has never authorized suits to enforce tax assessments*."[20]

In *Matter of 1981–85 Delinquent Property Taxes Owed to the City of Nome, Alaska*, the Supreme Court of Alaska held that the Indian Reorganization Act (IRA) barred a city from foreclosing on lands held by groups of Alaska Natives organized under Section 16 of the IRA on the basis of non-payment of local property taxes.[21] In that case, the city sought to foreclose on two tracts owed by the Alaska Native group which were "purchased in part with funds from a federal grant under the [ISDEAA]."[22] In that case, the Court found the IRA was "intended to promote tribal self-government and conserve Indian lands and resources," and that had any doubt remained, the Court "would rest on the settled principle that, in Indian law, all ambiguities must be resolved in favor of the Indians."[23]

In the U.S. Circuit Court of Appeals for the Ninth Circuit, where NSHC is located, courts look to the following factors to determine whether a tribal entity functions as an "arm of the tribe" and is therefore entitled to share in the tribe's sovereign immunity: "(1) the method of creation of the economic entities; (2) their purpose; (3) their structure, ownership, and management, including the amount of control the tribe has over the entities; (4) the tribe's intent with respect to the sharing of its sovereign immunity; and (5) the financial relationship between

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[15] *Kiowa Tribe of Okla.* v. *Mfg. Techs., Inc.*, 523 U.S. 751, 754 (1998) (citations omitted).
[16] *Id.* at 756 (citations omitted).
[17] *Cook v. AVI Casino Enters., Inc.*, 548 F.3d 718, 725 (9th Cir. 2008).
[18] *Santa Clara Pueblo*, 436 U.S. at 58 (citation omitted) (internal quotation omitted).
[19] 373 F.Supp.3d 1232, 1239–40 (D. Alaska 2019).
[20] 498 U.S. 505, 510 (1991) (emphasis added).
[21] 780 P.2d 363 (Alaska 1989).
[22] *Id.* at 364.
[23] *Id.* at 367 (citation omitted).

the tribe and the entities."[24] In *White v. University of California*, the Ninth Circuit upheld the district court's application of this test to hold that a tribal repatriation committee formed by twelve tribes was entitled to sovereign immunity because it was created by resolution of each of the tribes; comprised solely of tribal members appointed by each tribe; funded exclusively by the tribes; and its purpose, "to recover remains and educate the public, [was] 'core to the notion of sovereignty.'"[25] And in *Pink v. Modoc Indian Health Project, Inc.*, the court held that a subsidiary tribal entity established and controlled by several tribes to provide health care services was protected by sovereign immunity.[26]

1. NSHC's method of creation supports immunity.

NSHC was incorporated on November 27, 1970 under the Alaska Non-Profit Corporation Act. Article VII of the NSHC Articles of Incorporation names three individuals representing the Alaska Native villages of Shaktoolik, Gambell, and Teller to the initial Board of Directors, and Article VIII shows the same three Village representatives as the initial incorporators. The formation and governance of NSHC was thereby tied directly to the member Villages. Article I and Article III of the Articles of Incorporation also provide that NSHC shall be "non-profit in nature," weighing in favor of treating it as an arm of the tribes. It is clear that NSHC's member tribes have delegated their governmental, rather than commercial, responsibility to provide health care to NSHC, which is not a for-profit venture but a vehicle for providing government health services.

2. NSHC's purpose to provide governmental health care supports immunity.

NSHC's Bylaws, adopted in 1977 and revised in 1978–79, expressly establish the Corporations purposes as follows:

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[24] *White v. Univ. of Cal.*, 765 F.3d at 1025 (2014) (citation omitted). Although not included in the Ninth Circuit's "arm of the tribe" test, an additional factor is examined by the Tenth Circuit: "the policies underlying tribal sovereign immunity and its connection to tribal economic development, and whether those policies are served by granting immunity to the economic entities." *Breakthrough Mgmt. Grp., Inc. v. Chukchansi Gold Casino and Resort*, 629 F.3d 1173, 1187 (2010).
Here, a grant of immunity to NSHC furthers the policies underlying tribal sovereign immunity. The doctrine of tribal sovereign immunity exists in order to avoid "interference with tribal autonomy and self-government," *Santa Clara Pueblo*, 436 U.S. at 59, and "infringe[ment] on the right of the Indians to govern themselves." *Williams v. Lee*, 358 U.S. 217, 223 (1959). Like the doctrine of tribal sovereign immunity, the fundamental policy underlying the ISDEAA is to enhance tribal autonomy and control in the provision of services to tribal communities. *See, e.g.*, 25 U.S.C. § 5302(a) (declaring that policy of ISDEAA is to assure "maximum Indian participation in the direction of educational as well as other Federal services to Indian communities so as to render such services more responsive to the needs and desires of those communities"). NSHC has taken on the entire federal responsibility for health care services for its member tribes. The essential federal-tribal nature of the ISDEAA program and the fact ISDEAA programs are funded by the federal resources that would have been spent on programs serving those tribes shows that NSHC is completely financially dependent on the tribes' right to ISDEAA funding, and has stepped into the tribes' shoes and operates as the "health arm" of its member tribes. Because NSHC has stepped into the shoes of its member tribes as the "health arm" of those tribes in order to enter a government-to-government relationship with the United States, NSHC's immunity from suit protects the tribal autonomy of NSHC's member governments.
[25] *White*, 765 F.3d at 1025.
[26] 157 F.3d at 1188–89.

1. To establish and maintain facilities, including but not limited to hospital and clinics, for the care of people suffering from injury, illness or disability requiring medical and hospital services and utilizing both inpatient and outpatient facilities and services, such care to be given regardless of the person's race, color, creed, age, sex, nationality or ability to pay.
2. To participate, so far as the circumstances may warrant, in any activity to promote the general health of the principal area.
3. To carry on educational programs, including the training of healing arts personnel, relating to rendering care to the sick and the promotion of health and the maintenance of high health care standards.
4. To advance general community understanding of, confidence in and proper use of the total program of health services.
5. To carry out the foregoing purposes [through the receipt and disbursement of funds and assets].

Each of these purposes reflects the delegation from the member tribes of their respective governmental health care responsibilities to NSHC. Indeed, the purpose of NSHC is to "step into the shoes" of the federal government to carry out, through the ISDEAA, the United States' responsibility to provide health care for Alaska Native and American Indian people.[27]

3. The tribal governments' close ownership, and management and control of NSHC support immunity.

NSHC is structured such that NSHC's member tribes directly control the governance of NSHC. Article IV of the Bylaws established a Board of Directors of 22 elected directors. Each of the 16 member villages elects one representative to the Board of Directors, and the Nome Eskimo Community elects two directors. The Nome City Council may elect one director, and the Board of Directors, among themselves, elects three additional directors representing Nome. Article V provides that the NSHC officers, including the Chairman, are elected from among the Board of Directors.

To this point, in 1980, the United States Department of the Interior unequivocally determined, based on the member tribal organizations' direct control of NSHC, that NSHC is an arm of the member tribes.[28]

In his Memorandum, Alaska Regional Solicitor Dennis J. Hopewell informed the BIA Area Director, Juneau Area Office that "[NSHC] is not only considered the 'health arm' of the Bering Straits Native Corporation . . . which is a recognized Indian tribe . . . but the Norton Sound Health Corporation is controlled, sanctioned and chartered by other tribal governing bodies." Hopewell considered the NSHC Bylaws to be conclusive evidence of NSHC's direct control by its member tribal entities, stating "[s]ince the Bylaws for the [NSHC] also spell out that '[t]he management of the property, funds, affairs and business of this Corporation shall be vested in a Board of Directors consisting of ...' the members listed above, there can be no doubt that the corporation is controlled by tribal governing bodies." Hopewell found that NSHC "in

[27] *See* 25 U.S.C. § 5302.
[28] Status of Norton Sound Health Corporation As A Tribal Organization Pursuant to P.L. 93-638.

addition to being controlled by, is also sanctioned and chartered by such tribal governing bodies," and "[t]his representation also shows that the operation and management of [NSHC] includes the maximum participation of Indians in all phases of its activities."

4. The tribal governments intended that NSHC share in their tribal sovereign immunity.

In 1975, Congress signed the ISDEAA (Pub. L. No. 93-638) into law. In 1978 and 1979, NSHC's member Alaska Native Villages each executed resolutions authorizing NSHC to enter contracts and grants with the United States on their behalf.[29] In 1994, the member Villages executed additional resolutions, which provide the current authority for NSHC to enter into the compact and funding agreements.[30]

Each resolution acknowledged that Congress enacted the ISDEAA as a "far reaching Indian Self-Determination Policy" that "grants Alaska Native villages the *sovereign right to designate tribal organizations which shall have the authority to provide services through contracts or grants with the Federal Government* under Public Law 93-638 for the provision of Government services to Native peoples."[31] The resolutions further note that NSHC "has village representation and traditionally provided information both to and from the village on health related matters" and that NSHC "is controlled and operated by a Board of Directors appointed by the tribal governments" of its member communities.[32]

In recognition of the foregoing, the resolutions authorize NSHC "to apply for, negotiate, appeal from adverse decisions, and secure contracts and grants with the Indian Health Service of the Department of Health, Education and Welfare for health care and related programs serving Native people" in the region.[33] The resolutions further authorize NSHC and its Board of Directors "to act on behalf of this village on health and related services" and "to accept funding for health and related service projects for this village from all funding agencies private and public."[34] The United States Supreme Court has noted that "[t]he common law sovereign immunity possessed by the Tribe is a necessary corollary to Indian sovereignty and self-governance."[35] The resolutions' provisions that NSHC would "act on behalf" of the villages as their health arm and delegation of governmental duties to NSHC reflects their intent that NSHC would share in the "corollary" privilege of immunity from suit in carrying out those functions.

5. NSHC is wholly financially dependent on the member tribes' assignment of their right to contract with IHS to provide health services to their members.

Under the ATHC, all Alaska tribes participate in the delivery of health care services to their members and other beneficiaries in accordance with the principles of tribal self-governance.

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[29] A representative resolution from the Native Village of Elim is attached [hereafter Elim Resolution].
[30] A representative resolution from the Native Village of Diomede is attached.
[31] *See, e.g.,* Elim Resolution at 1 (emphasis added).
[32] *Ibid.*
[33] *Ibid.*
[34] *Ibid.*
[35] *Three Affiliated Tribes of Fort Berthold Reservation v. Wold Eng'g*, 476 U.S. 877, 890 (1986) (emphasis added).

The Compact allowed NSHC, on behalf of its member tribes, to enter into a government-to-government relationship with the United States. Since 1994, NSHC has participated each year with other co-signers and the IHS in the negotiation of annual funding agreements and amendments to the ATHC.

The funding agreement (FA) NSHC negotiates annually with IHS on behalf of the member tribes includes a broad scope of work covering a wide variety of health care services, from hospital and clinic services to long-term care, from dental services to lodging for patients.[36] In fact, while NSHC is the *signatory* to the funding agreement, the *parties* to the FA are the HHS Secretary and NSHC's member villages themselves. The 2018 Funding Agreement, titled, "Funding Agreement Between Certain Alaska Native Tribes Served by the Norton Sound Health Corporation and the Secretary Of Health And Human Services Of The United States Of America," states:

> This Funding Agreement is entered into by and between certain Alaska Native Tribes in the Bering Straits region of the Norton Sound Service Unit, as identified on the signature page herein, and the Secretary of the Department of Health and Human Services. These Tribes have authorized the Norton Sound Health Corporation to sign this Funding Agreement for them and to be responsible for and carry out the terms of this Funding Agreement.[37]

Section 2.1 of the 2018 FA "obligates NSHC to be responsible for and to provide health PSFAs identified in Section 3 [Tribal Programs and Budget], utilizing the resources transferred under this FA and other funds as they may become available to NSHC." Section 5.2 provides these resources represent the entirety of the member Tribes' entitlement to these funds: "NSHC will be paid 100 percent of Headquarters and Area Tribal Shares in its initial lump sum payment, as negotiated in this FA." Section 4 of the 2018 FA describes the total FY 2018 funding made available to NSHC from funds that would otherwise be allocated to NSHC's member tribes. Without the Compact and Funding Agreements, through which NSHC performs governmental functions for their member villages, NSHC would be unable to function. Accordingly, the financial relationship between NSHC and the tribal entities supports NSHC's immunity.[38]

In substance and in form, NSHC serves as an arm of its member tribes. NSHC is dependent on the authorization and support of its member tribal governments to operate, and it fills a critically under-resourced governmental function–far different from a private, for-profit economic venture or other state-incorporated non-profits that may operate in the public sector but are not fulfilling government functions. NSHC shares in the sovereign immunity of its member tribes, and this immunity from suit extends to suits to collect unpaid taxes. This sovereign immunity operates unless specifically and unequivocally waived, and NSHC has not waived its immunity.

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[36] Funding Agreement Between Certain Alaska Native Tribes Served By The Norton Sound Health Corporation And The Secretary Of Health And Human Services Of The United States Of America Fiscal Years 2018-2020 §§ 3.2, 3.4.1, and 3.2.14.

[37] *Id.* at 1.

[38] *See White*, 765 F.3d at 1025 (fact that entity was funded solely by the tribe supported determination that entity was an "arm of the tribe" entitled to immunity).

III. The City's Taxation is Preempted by Federal Law

Alaska Statute 29.45.030(a)(8) exempts from tax, "property of a political subdivision, agency, corporation, or other entity of the United States to the extent required by federal law…" The city of Nome's tax on all real property owned by NSHC is preempted by federal law.

In *United States v. New Mexico*, the U.S. Supreme Court announced a rule to apply generally to determine immunity from state and local taxation under the supremacy doctrine:

> [T]ax immunity is appropriate in only one circumstance; when the levy falls on the United States itself, or on an agency or *instrumentality* so closely connected to the Government that the two cannot realistically be viewed as separate entities, *at least insofar as the activity being taxed is concerned.*[39]

Under the implied federal preemption doctrine, space that is used to carry out federal programs and that is subject to comprehensive and pervasive federal oversight is exempt from state or local taxation.[40]

In *Ketchikan Gateway Borough v. Ketchikan Indian Corporation*, the Alaska Supreme Court upheld application of the implied federal preemption doctrine to exempt from borough taxes "*all space in a building that contains a tribally operated clinic.*"[41] In that case, the tribally operated clinic was funded by the IHS and operated on land conveyed by the United States.[42] The only space held not to be exempt from taxation was "space not committed to use by the clinic," because it was "uncertain how the uncommitted space would be used" and it "appear[ed] that at least for near-term purposes it [would] either be leased to others or used for other [i.e., non-clinic-related] programs of [the Indian corporation]."[43]

This property is integral to the provision of healthcare under NSHC's ISDEAA agreement. As programs and services that support the healthcare operations are included under the scope of work as defined in NSHC's Funding Agreement, all areas used for human resources, administration and board support, performance management, training, medical personnel housing, patient housing, and financial function are integral to NSHC's healthcare operations under the ISDEAA.

The Alaska Supreme Court, in *Ketchikan Gateway Borough,* acknowledged that federal law preempts state taxation where the activity is subject to comprehensive and pervasive federal oversight.[44] However, the court was considering only whether preemption still applies to uncommitted, vacant property which will ultimately be put to non-exempt uses.[45] In *Ketchikan Gateway Borough*, the court distinguished the facts of that case with others where it is held that

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[39] 455 U.S. 720, 735 (1982) (emphasis added).
[40] *Ketchikan Gateway Borough v. Ketchikan Indian Corp.*, 75 P.3d 1042, 1048 (Alaska 2003).
[41] *Id.* at 1044 (emphasis added).
[42] *Ibid.*
[43] *Id.* at 1049; 1048 n.27.
[44] *Id.* at 1048.
[45] *Ibid.*

uncommitted or vacant space is entitled to exemption. In those cases the vacancy was temporary and there was an intended use of the property. The court stated that in the cases cited by the dissent, and in which the majority agreed the exemption was properly applied, "the unused space, when used, was intended to be used for tax-exempt purposes. By contrast . . . it is unknown how the unused space will be used, but it appears that at least for near-term purposes it will either be leased to others or used for other programs of [the Indian Corporation]."[46]

In the instant case, the property is reverting back to the federal government and will be inarguably exempt from taxation at that time. In the meanwhile, as the court in *United Way of the Midlands* held, "Oftentimes a qualified organization acquires or maintains building space in reasonable anticipation of full occupancy for an exempt purpose but cannot do so because of economic conditions or other legitimate reasons."[47] Similarly, in the *Our Savior Lutheran Church* case cited by the *Ketchikan Gateway* court, the court explained, "We do not think that mere temporary vacancy or lack of use of a portion of an otherwise exempt parcel of property renders that portion taxable. To hold that when a portion of a building otherwise used for an exempt purpose becomes temporarily vacant or unused it loses its exempt status is nonsensical and impractical of application."[48]

The federal and tribal interests in the instant case still remain for the period in 2022 when the property is temporarily unused by NSHC. Provision of Indian health care services is comprehensively and pervasively regulated and the covenants of use that run with the deed of this property from HHS to NSHC manifest the federal control of the property. And, the federal government's reversionary interest in the property commenced in November 2021, so the federal interest in the property is superior. Accordingly, the city's tax is preempted.[49]

In *Ketchikan Gateway Borough*, the Alaska Supreme Court noted that while the rule of strict construction requires that "[t]axpayer exemptions are strictly construed against the taxpayer and in favor of the taxing authority . . . . where the question is whether federal law requires the exemption of tribal interests from taxation, ambiguities in federal law should be resolved *in favor of the tribe*."[50]

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[46] *Id.* at 1048 n.27 (citing *Dist. of Columbia v. Catholic Univ. of Am.*, 397 A.2d 915, 921–22 (D.C.1979); *Our Savior Lutheran Church v. Dep't of Revenue*, 204 Ill. App. 3d 1055, 150 Ill. Dec. 395, 562 N.E. 2d 1198, 1201 (1990); and *United Way of the Midlands v. Douglas County Bd. of Equalization*, 215 Neb. 1, 337 N.W. 2d 103, 107 (1983)).
[47] 337 N.W. 2d at 107.
[48] 562 N.E. 2d at 1201.
[49] *Ketchikan Gateway Borough*, 75 P.3d at 1048.
[50] *Id.* at 1045 (citing *Cotton Petroleum Corp. v. New Mexico*, 490 U.S. 163, 177 (1989)).

Community Health Needs Assessment Survey Report

Norton Sound Health Corporation

January 2021

For additional information regarding the Norton Sound Health Corporation Community Health Needs Assessment, contact Quality Improvement at (907) 443-4501.

EXECUTIVE SUMMARY

Norton Sound Regional Hospital

Norton Sound Health Corporation (NSHC) is a tribally owned and operated, independent, not-for profit health care organization, founded in 1970 to meet the health care needs of the Inupiat, Siberian Yup'ik and Yup'ik people of the Being Strait region. NSHC is governed by a 22-member board of directors who represent all communities and areas of the Bering Strait region, a 44,000 square-mile section of northwestern Alaska.

Norton Sound Health Corporation puts the patient first. This principle applies equally at the new Norton Sound Regional Hospital and at the 15 village clinics managed by NSHC.

Every day, NSHC's approximately 750 employees – about 62% of them Alaska Native – demonstrate their commitment to our mission: providing quality health services and promoting wellness within our people and environment. NSHC strives to train local people to deliver and manage its services. NSHC offers a 2-year Registered Nurse Program through the University of Alaska Anchorage, a Certified Nursing Assistant Course, and other local trainings in partnership with the local Nome Northwest Campus and the region's partners.

In 2019, Norton Sound Health Corporation was recognized as one of the nation's top clinically performing community health centers. HRSA named NSHC as a "gold tier" Health Center Quality Leader awardee, meaning that the organization is among the top 10% of health centers to achieve best overall clinical performance nationwide. NSHC improved on measures such as tobacco intervention, colorectal cancer screening, and childhood immunization status.

The organization also increased the level of medical and mental health care provided to patients. Significant steps have been taken by NSHC to ensure that whole-person care is being delivered; behavioral health services have been prioritized, and resources have been increased. Full-time psychiatry services were implemented to better meet the needs of our patients. In FY19, NSHC opened a drug rehabilitation program, known as the "day shelter", which utilizes the skills of recovery coaches to facilitate lifestyle changes. The resource and recovery program has resulted in guests securing jobs, housing, reducing emergency department visits, and achieving GED status. The day shelter is just one of the critical steps necessary to enhance the behavioral health continuum of care model.

The goal to increase access to care for all communities is being realized; village visits have doubled and more mid-level providers have been hired to provide higher level care in the village clinics, to provide relief to health aides, and to facilitate additional on-call coverage. A Population Health Department was implemented to coordinate prevention care and to ensure clinical standards of care are being met for patients. An In-home support program was also initiated, in which NSHC will administer the Personal Care Attendant (P.C.A) Program for the region with the goal to offer end-of-life care for families who need the services.

In January 2019, NSHC started offering MRI services locally, with its new state-of-the-art MRI machine, the only one of its kind in Alaska and in the nation serving rural health needs. A staff neurologist was also hired. NSHC continued to offer tribal healing services and acupuncture services to compliment its pain management services.

NSHC continues to promote state-of-the-art facilities. Since 2017, NSHC has completed the construction of four new health clinics located in Savoonga, Gambell, Shaktoolik, and Little Diomede. The construction of two new health clinics are underway in St. Michael and Shishmaref, and a new clinic with staffing housing is under design for the village of Wales. NSHC has made village-based housing a priority to ensure the staff who work at the clinic have adequate housing available. New housing has been constructed in St. Michael, Savoonga, and Golovin to-date. The responsibility for the maintenance and oversight of the village-based facilities has also improved through NSHC's ability to establish 105(l) leases with the Indian Health Services.

Although significant improvements been made in health care delivery, five of the fifteen villages remain without water and sewer. One of NSHC's highest priorities is to continue to strengthen the region's best practice scores to remain eligible for water and sewer capital infrastructure funding. A sanitation engineer was hired in FY19 to manage and coordinate the region's water and sewer goals and objectives.

NSHC is excited to open its new Wellness and Training Center in June 2021; the new facility will include a sobering center with integrated wellness services to facilitate sobriety. The new training facility will provide expanded classroom space to train the organization's health aide workforce. It

Norton Sound Health Corporation is a model of how Indian Self-Determination is meant to work, with tribes taking responsibility for their own health and well-being.

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BACKGROUND INFORMATION

In 1969, the Alaska Federation of Natives (AFN) sought a demonstration project to give Alaska Natives greater power in health care decisions. Norton Sound was selected for development of a model for community-based health care services as an alternative to regional, hospital-based care. Norton Sound Health Corporation (NSHC) was incorporated November 27, 1970. The first board had just three directors: William Takak of Shaktoolik, president; Winfred James of Gambell, treasurer; and Dorothy Isabell of Teller, secretary.

That first NSHC Board of Directors faced a formidable task: Bring health care services to a remote area with limited resources. At the time, northwest Alaskans had little access to health care, and getting medical treatment often meant traveling long distances to regional hospitals. One of the first initiatives NSHC launched was the health aide program, established in 1971. While health aides continue to be the backbone of the NSHC organization today, more than 40 years later, NSHC's services have expanded to include clinic travel clerks, village-based counselors, patient benefit coordinators, dental health therapists and nurse practitioners in all the villages served.

At its first meeting in November 1970, the NSHC Board of Directors established its highest goal: provide a "comprehensive and quality inpatient facility in Nome." That year, NSHC opened its first office in the basement of Maynard-McDougall Memorial Hospital in Nome, with a budget of $143,000. Six years later, NSHC purchased the hospital, and in 1978 Norton Sound Regional Hospital opened in Nome. It was quickly followed by Unalakleet' s sub-regional health clinic, staffed by a physician assistant and community health aides serving four villages.

In 1975, NSHC became the first Native health corporation to become independent of AFN and contract directly with the Indian Health Service. The following year, the board assumed responsibility for regional environmental health services through assignment of a federal Public Health Service sanitarian.

Over the years, NSHC's board focused on expanding patient care in the Bering Strait region of Alaska, adding basic services in 15 villages throughout the Norton Sound area as well as specialty clinics in Nome. In 2008, the Board of Directors opened The Patient Hostel, a 38-bed facility, located on the east side of Nome and positioned close to where the new facility would be constructed someday.

Another milestone was reached in 2009, when Indian Health Services awarded NSHC full funding to complete a new hospital building in Nome. Construction began in October 2009 and was completed in 2012. The first patients were seen at the new Norton Sound Regional Hospital and Quyanna Care Center in March 2013.

In October 2014, NSHC went live with its new electronic medical record, "Cerner" and completed the renovation for the Wales clinic and replaced the Shishmaref clinic. In 2015, NSHC initiated a village clinic improvement program and assumed oversight and responsibility for nearly all village clinics and hired housekeepers and maintenance workers to keep the clinics maintained in all the villages. The Nome outpatient clinic received a HRSA new access point grant and was integrated with the village primary health care services for the first time.

In 2016, NSHC began an ambitious mission to replace and/or update aging clinic facilities throughout the region. In 2017, saw NSHC's Nome Primary Care Center receive recognition as a Patient Centered Medical Home by the National Committee on Quality Assurance. New clinics were completed in the villages of Gambell, Savoonga, and Shaktoolik. Village-based housing projects were also completed in Savoonga and Golovin.

In 2018 an MRI was added to the NSHC hospital to further advanced our diagnostic capabilities and a new health clinic for the village of Shakoolik was opened.

In 2020, NSHC achieved its vision to complete construction for a new health clinic for the remote village of Little Diomede.

In 2021, NSHC expects to open the long- awaited Wellness and Training Center which will create the first sobering center in the region as well as add intensive outpatient mental health services to our comprehensive service wrap around services.

The COVID-19 pandemic saw Norton Sound Health Corporation face the challenge of the generations while minimizing morbidity and mortality, supporting communities in mitigation and suppression methods while retaining high quality preventative, chronic and emergency care.

NORTON SOUND HEALTH CORPORATION: MISSION, VISION, AND VALUES

Our purpose, core values and vision for the future are built on our commitment to providing the Native people of the Norton Sound region with the highest quality health care possible.

Our mission:
Providing quality health services and promoting wellness within our people and environment.

Our core values:

- Integrity
- Cultural sensitivity and respect for traditional values
- Always learning and improving
- Compassion
- Teamwork
- Pride

Our vision for the future:

- We will ensure that all patients receive quality and respectful health care.
- We will educate our patients and communities to be proactive in caring for themselves and promoting wellness.
- We will listen to, honor, and respect our elders, preserve their right to speak, and ensure they receive the best care in gratitude for their leadership.
- We will increase wellness efforts to reduce addictive behaviors and to raise the quality of life among our people and communities.
- We will advocate that our environment (air, land and water) will be clean, and our water and waste disposal systems are safe and affordable, in order to ensure our subsistence way of life.

- We will assert and implement tribal self-governance to achieve our vision through effective leadership.
- We will hire and support our tribal members to deliver and manage our services.
- We will develop state of the art and efficient health care facilities throughout the region.
- We will be financially strong through aggressive, effective and efficient financial management.
- We will support and develop our youth to pursue higher education and health care careers to ensure there is future tribal leadership.

SCOPE OF THE STUDY

The purpose of the 2020 Norton Sound Health Corporation Community Health Needs Assessment is to collect data on specific information regarding community perception of the Use of Healthcare Services, Awareness of Services, Community Health, and Health Insurance. Additionally, data were collected regarding the demographics of survey responders. The data are presented in a format that can be useful to Norton Sound Health Corporation board of directors, administration, health care providers and community.

METHODOLOGY

A comprehensive survey was developed by the Quality Assurance/Performance Improvement Team "Aquutaq". The survey was loaded electronically into Microsoft Forms. It was distributed electronically via advertisement, QR code, email, public information, Facebook, community meetings and other avenues. Paper copies of the form were also mailed to all box holders in the region as well as made available at all clinics and within the Nome hospital site. The survey was also distributed at various Health Forums held within the region.

Data collection began in early 2019 and continued until early 2020 with a goal of at least 1000 responses. Processing of data and this report was delayed due to reallocation of staff during the pandemic and completed in 2021. The survey was closed for responses in January 2020, after 1004 responses had been received, (32.4% of households in the region). The data was entered into a Microsoft Forms/ Microsoft Excel database and are presented in the Survey Results section of this report. At the time of survey closure, data was first prepared and shared with the NSHC Board of Directors, final report was completed on January 26, 2021.

Population Data

PEOPLE		
Population		
Population estimates, July 1, 2019, (V2019)	**10,004**	**731,545**
Population estimates base, April 1, 2010, (V2019)	9,492	710,249
Population, percent change - April 1, 2010 (estimates base) to July 1, 2019, (V2019)	5.4%	3.0%
Population, Census, April 1, 2010	9,492	710,231
Age and Sex		
Persons under 5 years, percent	10.0%	7.0%
Persons under 18 years, percent	34.6%	24.6%
Persons 65 years and over, percent	8.0%	12.5%
Female persons, percent	47.4%	47.9%
Race and Hispanic Origin		
White alone, percent	15.7%	65.3%
Black or African American alone, percent(a)	0.9%	3.7%
American Indian and Alaska Native alone, percent(a)	75.3%	15.6%
Asian alone, percent(a)	1.5%	6.5%
Native Hawaiian and Other Pacific Islander alone, percent(a)	0.2%	1.4%
Two or More Races, percent	6.5%	7.5%
Hispanic or Latino, percent(b)	2.9%	7.3%
White alone, not Hispanic or Latino, percent	14.9%	60.2%
Population Characteristics		
Veterans, 2015-2019	394	65,186
Foreign born persons, percent, 2015-2019	2.5%	7.8%
Housing		
Housing units, July 1, 2019, (V2019)	4,100	319,854
Owner-occupied housing unit rate, 2015-2019	60.5%	64.3%
Median value of owner-occupied housing units, 2015-2019	$154,600	$270,400
Median selected monthly owner costs -with a mortgage, 2015-2019	$1,470	$1,933
Median selected monthly owner costs -without a mortgage, 2015-2019	$469	$582
Median gross rent, 2015-2019	$1,287	$1,244
Building permits, 2019	6	1,680
Families & Living Arrangements		
Households, 2015-2019	2,844	253,346
Persons per household, 2015-2019	3.30	2.80
Living in same house 1 year ago, percent of persons age 1 year+, 2015-2019	84.1%	82.1%

Language other than English spoken at home, percent of persons age 5 years+, 2015-2019	31.0%	16.1%
Computer and Internet Use		
Households with a computer, percent, 2015-2019	90.7%	94.1%
Households with a broadband Internet subscription, percent, 2015-2019	74.1%	85.5%
Education		
High school graduate or higher, percent of persons age 25 years+, 2015-2019	84.6%	92.8%
Bachelor's degree or higher, percent of persons age 25 years+, 2015-2019	16.1%	29.6%
Health		
With a disability, under age 65 years, percent, 2015-2019	6.8%	8.9%
Persons without health insurance, under age 65 years, percent	18.4%	13.9%
Economy		
In civilian labor force, total, percent of population age 16 years+, 2015-2019	64.8%	65.5%
In civilian labor force, female, percent of population age 16 years+, 2015-2019	66.8%	63.1%
Total accommodation and food services sales, 2012 ($1,000)(c)	14,821	2,221,335
Total health care and social assistance receipts/revenue, 2012 ($1,000)(c)	D	6,375,483
Total manufacturers shipments, 2012 ($1,000)(c)	D	D
Total merchant wholesaler sales, 2012 ($1,000)(c)	D	5,216,303
Total retail sales, 2012 ($1,000)(c)	78,672	10,474,275
Total retail sales per capita, 2012(c)	$7,935	$14,320
Transportation		
Mean travel time to work (minutes), workers age 16 years+, 2015-2019	6.7	19.1
Income & Poverty		
Median household income (in 2019 dollars), 2015-2019	$61,048	$77,640
Per capita income in past 12 months (in 2019 dollars), 2015-2019	$23,581	$36,787
Persons in poverty, percent	20.7%	10.1%
BUSINESSES		
Businesses		
Total employer establishments, 2018	168	21,293
Total employment, 2018	2,119	261,053
Total annual payroll, 2018 ($1,000)	121,975	15,732,010
Total employment, percent change, 2017-2018	-2.9%	-0.4%
Total nonemployer establishments, 2018	551	57,391

All firms, 2012	676	68,032
Men-owned firms, 2012	380	35,402
Women-owned firms, 2012	212	22,141
Minority-owned firms, 2012	381	13,688
Nonminority-owned firms, 2012	264	51,147
Veteran-owned firms, 2012	61	7,953
Nonveteran-owned firms, 2012	578	56,091

GEOGRAPHY		
Geography		
Population per square mile, 2010	0.4	1.2
Land area in square miles, 2010	22,961.76	570,640.95
FIPS Code	02180	02

About datasets used in this table

Value Notes

Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable.

The vintage year (e.g., V2019) refers to the final year of the series (2010 thru 2019). *Different vintage years of estimates are not comparable.*

Fact Notes

- (a)Includes persons reporting only one race
- (b)Hispanics may be of any race, so also are included in applicable race categories
- (c)Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

Value Flags

- -Either no or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest or upper interval of an open ended distribution.
- D- Suppressed to avoid disclosure of confidential information

QuickFacts data are derived from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area Health Insurance Estimates, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits.

Source: US Department of Commerce. US Census Bureau

http://quickfacts.census.gov/qfd/index.html

BEHAVIORAL RISK FACTOR DATA

Alaska Behavioral Risk Factor Surveillance System

2018 Nome Region

Risk Fact	Nome (%)	Alaska (%)
Health Status: General Health Excellent/Very Good	41.7	51.3
Health Status: Poor physical health	18.0	16.4
Health Status: Frequent mental distress	18.8	11.3
Thoughts of Suicide in past 12 months (2013)	5.0	4.2
Ever told had depressive disorder	15.4	21.2
HTN: Ever told HTN (2017)	25.7	29.9
CVD: Ever told heart attack	3.7	4.4
CVD: Diagnosis of Angina or Coronary Heart Disease	1	2.8
COPD	4.6	5.3
Cancer: Any type	4.2	7.8
Weight Status: Severely Obese (BM>40)	10.3	7.8
Weight Status: Obese (BMI 30-39.9)	26.5	31.2
Weight Status: Overweight	28.1	35.1
Weight Status: Underweight	0.6	1.8
Seen a provider in the last 12 months	56.0	69.3
Access: No Health Care Coverage	6.1	9.1
Follow Subsistence Lifestyle (2017)	79.7	30.2
Rent Home	20.3	27.2
Believe currently get enough physical activity (2015)	59.7	46.9
Activity Time: Adequate Aerobic Physical Activity (at least 150 minutes per week) (2017)	86.9	56.7
Activity Time: Adequate Aerobic Physical Activity (at least 300 minutes per week) (2017)	69.9	36.2
Received Food Assistance from Community Program(s) (2013)	14.7	7
Received Food Assistance from Government Program(s) (2013)	34.9	15.6
Less than 3 vegetables and 2 fruits per day	81.5	93.8
Sweetened carbonated beverages 1+ per day (2017)	27.5	13.2
Sweetened non-carbonated beverages 1+ per day (2017)	45.4	12.1
Cigarette Smoking: Current Smoker Everyday (2018)	30.3	17.1
Cigarette Smoking: Former Smoking (2018)	27.7	28.3
Cigarette Smoking: Never Smoked (2018)	42.1	54.6
Tobacco Use (not including e-cig) (2018)	63.4	25.2
Current Marijuana Use (2018)	44.6	17.3
Current Alcohol Use (2018)	34.9	58.6
Binge Drinking (2018)	13.4	16.4
Before age 18, lived with problem drinker/alcoholic/drugs/rx med (2015)	47.4	32.3
Seat Belt Use: always use a seatbelt (2018)	73.1	83.0
Hurt by intimate partner last 5 years (2017)	15.2	6.6

NOME CA MAPP: BRFSS DATA: 2015-2018: MIXED

COMMUNITY HEALTH NEEDS SURVEY RESULTS (as of 1/26/2021) (1004 households reporting)

Norton Sound Health Corporation

*NOTE SOME TOTALS MAY NOT EQUAL TO 100% DUE TO ROUNDING AND ALLOWANCE FOR MULTIPLE RESPONSES PER ITEM. ALSO NUMBER OF RESPONSES DIFFERS TO EACH ITEM ALLOWING FOR NON-RESPONDERS AND MULTIPLE RESPONSES TO SOME ITEMS.

Section A: Please tell us about yourself

1. What is your zip code?

Village	Zip Code	Number	Percentage
Nome, Golovin, Diomede	99762	481	47.91%
Brevig	99785	28	2.79%
Elim	99739	73	7.27%
Gambell	99742	55	5.48%
Koyuk	99753	25	2.49%
St. Michael	99659	15	1.49%
Savoonga	99769	31	3.09%
Shaktoolik	99771	17	1.69%
Shishmaref	99772	56	5.58%
Stebbins	99671	49	4.88%
Teller	99778	16	1.59%
Unalakleet	99684	96	9.56%
Wales	99783	9	0.90%
White Mountain	99784	29	2.89%
OTHER		11	1.10%
NO RESPONSE		13	1.29%
Total		**1004**	**100%**

2. What is your gender?

Gender	Number	Percentage
Male	295	29.38%
Female	679	67.63%
Transgender	2	0.20%
Other	1	0.10%
Prefer not to answer	27	2.69%
Total	**1004**	**100.0%**

3. What is your age range?

Age	Number	Percentage
18-25	100	9.96%
26-35	260	25.90%
36-45	163	16.24%
46-55	164	16.33%
56-65	197	19.62%
66-75	79	7.87%
76-85	21	2.09%
86+	1	0.10%
Unanswered/Prefer not to say	19	1.89%
Total	**1004**	**100.0%**

4. Are you an IHS beneficiary?

Response	Count	Percentages
Yes	660	65.74%
No	286	28.49%
Unanswered/Prefer not to say	58	5.78%
Total	**800**	**100%**

5. How many people, including yourself, live in your household?

Number	Count	Percentage
1	141	14.04%
2	196	19.52%
3	167	16.63%
4	150	14.94%
5	118	11.75%
6	75	7.47%
7	61	6.08%
8	38	3.78%
9	16	1.59%
10+	30	3%
Unanswered/ Prefer not to say	12	1.2%
Total	**1004**	**100%**

6. How many children under the age of 18 live in your household?

Number	Count	Percentage
0	425	42.37%
1	164	16.35%
2	160	15.95%
3	110	10.97%
4	61	6.08%
5	37	3.69%
6	18	1.79%
7	7	0.70%
8	1	0.10%
9+	2	0.20%
Unanswered/ Prefer not to say	19	1.89%
Total	**1004**	**100%**

7. What is your employment status?

Response	Count	Percentage
Work full-time	529	52.69%
Work part-time	129	12.85%
Retired	116	11.55%
Unemployed and looking for employment	103	10.26%
Not currently seeking employment	69	6.87%
Disabled	25	2.49%
Student	21	2.09%
Unanswered/Prefer not to say	12	1.20%
Total	**1004**	**100%**

8. Do you access the internet in your home?

Response	Count	Percentages
Yes	646	64.34%
No	343	34.16%
Unanswered/Prefer not to say	15	1.49%
Grand Total	**1004**	**100.00%**

9. Do you have plumbed drinking water in your home?

Response	Count	Percentages
No	180	17.93%
Yes	813	80.98%
Unanswered/Prefer not to say	11	1.10%

Grand Total	1004	100.00%

10. Do you have plumbed septic/sewer in your home?

Response	Count	Percentages
No	203	20.22%
Yes	789	78.59%
Unanswered/Prefer not to say	12	1.20%
Grand Total	**1004**	**100.00%**

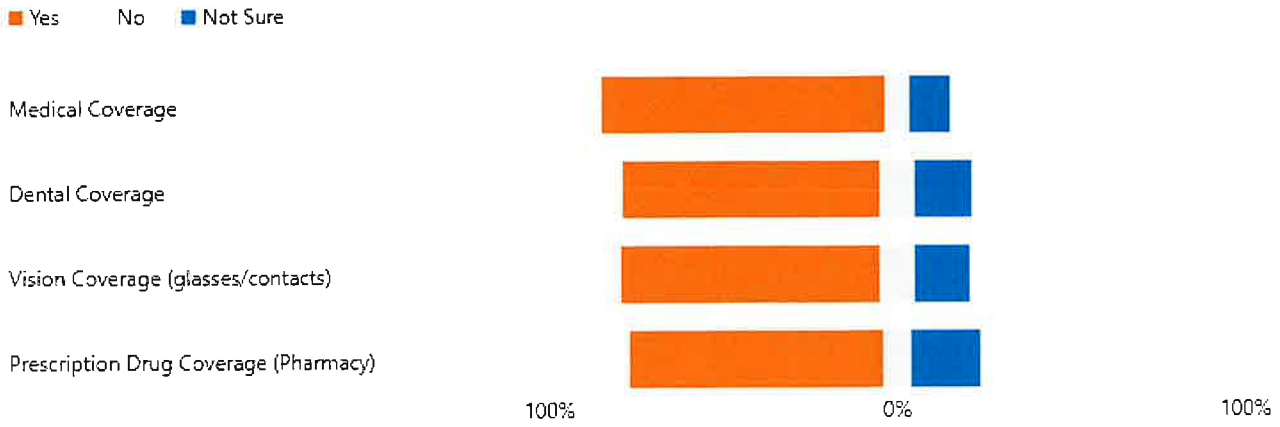
11. What is the best way for NSHC to communicate with you? (Preferential choice ranking, only first preference listed below)

Response	Count	Percentage
Email	112	11.16%
Mail	90	8.96%
Phone	156	25%
Text Message	366	36.45%
Other Media	11	1.1%
Unanswered/Prefer not to say	296	29.48%
Total	**1004**	**100%**

12. What type(s) of health care coverage do you have? (Multiple responses allowed).

Response	Count	Percentage
Indian Health Services (IHS)	507	33.82%
Employer Sponsored	494	32.96%
Medicaid	259	17.28%
Medicare	111	7.40%
No coverage	38	3.78%
VA/Military	20	1.33%
Health Savings Account	9	0.60%
Other	38	3.78%
Unanswered/Prefer not to say	11	1.01%
Total	1004	100%

13. What types of coverage do you have?



Section B: Tell us about your healthcare experience

1. Have you used any Norton Sound Health Corporation facilities?

Response	Count	Percentages
Yes	943	93.92%
No	38	3.78%
Unanswered/Prefer not to say	23	2.29
Total	**1004**	**100%**

2. Why do you choose to use NSHC facilities?
(multiple responses allowed)

Response	Count
Only clinic available	759
Has services I need	264
Needed medication refefilled	187
Emergency, no other choices	185
Provider listens to me	126
Provider knows me by name	119
Referred	92
Great experiences prior	89
Short waiting time	87
Hospital/Clinic reputation for quality	70
Required by my insurance	46
Recommended by family/friends	42
Cost of Care	35
n/a, I NEVER use NSHC facilities	18
Other, free text responses	17
VA/Military requirement	6

3. If you ever choose not to use NSHC facilities, why not?
(multiple responses allowed)

Response	Count	Percentage
n/a, I ONLY use NSHC	336	27.77%
Service I needed was unavailable	213	17.60%
Lack of privacy/confidentiality	83	6.86%
Costs too much money	77	6.36%
No appointment available in a timely manner	77	6.36%
Did not trust the provider	63	5.21%
Unsure if service I need is available	62	5.12%
Not treated with respect	52	4.30%
Do not like provider	50	4.13%
Appointments do not fit my schedule	46	3.80%
My insurance would not cover my care	30	2.48%
Provider is my co-worker/relative	26	2.15%
Other – free text response	66	5.45%
Unanswered/Prefer not to say	191	19.02%

4. In the past 12 months, was there a time when you or someone living in your home needed medical care from NSHC but were not seen?

Response	Count	Percentages
Yes	202	20%
No	731	73%
Other	39	4%
Unanswered/Prefer not to say	32	3%
Total	**788**	**100%**

5. If you answered "yes" above, what service were you not able to use:

Response	Count
Nome Hospital	20
Nome Clinic	45
Village Clinic	80
BHS Nome	11
BHS Village	4
Other	41

6. Check any of the reasons below that help explain why you were not seen. (multiple responses allowed)

Reason	Count
Clinic is too far away	3
Costs too much money	19
Did not trust the provider	21
Do not like provider (MD, DO, PA, NP, Health Aide)	14
Had no one to watch kids	6
Lack of privacy/confidentiality	21
Language barrier	0
My insurance would not cover	8
No appointment available in a timely manner	73
No appointments that fit my schedule	26
No transportation	14
Not treated with respect	25
Other	47
Provider is my co-worker/relative	7
Too afraid or nervous	7
Unsure if service I need is available	11
Service I needed was unavailable	40

7. In the past 12 months, check all of the health care providers you or anyone living your home has seen: (multiple responses allowed)

Provider	Count
General practice provider (MD, DO, PA, NP)	646
Dentist/DHAT	488
Optometrist (Eye doctor)	420
Health Aide	394
Audiologist (hearing)	276
Pediatrician	212
Physical Therapist	179
Behavioral Health Clinician/Therapist	164
ENT Specialist (ear, nose, throat specialist)	156
Obstetrician/Gynecologist (female reproductive specialist)	134
Tribal Healer	128
Orthopedist (bone/joint specialist)	93
Cardiologist (heart specialist)	89
Dietitian	73
Neurologist (brain/nerve specialist)	72
Urologist (kidney/bladder/male reproductive specialist)	69
Surgeon	68
Diabetes Specialist	66
Psychiatrist	61
Rheumatologist (arthritis specialist)	42
Dermatologist (skin specialist)	35
Oncologist (cancer specialist)	34
Chiropractor	33
Social Worker	31
Tobacco Counselor	31
Pulmonologist (lung specialist)	30
Infant Learning Program	30
Podiatrist (foot/ankle specialist)	23
Allergy Specialist	23
Substance Abuse Counselor	15
Other (Free text)	44

8. How long did you have to wait to see the specialist from the time you were referred or requested an appointment?

Column1	Count	Percentage
1 month	240	23.90%
2 months	102	10.16%
3 months	60	5.98%
4 months	24	2.39%
5 months	13	1.29%
6 moths or more	50	4.98%
Unanswered/choose not to respond	515	51.29%
Total	**1004**	**100%**

9. Please rate the following services Norton Sound Health Corporation offers and tell where you used that service most:

	Excellent	Good	Fair	Poor
Emergency Room	44.20%	43.30%	7.59%	4.91%
Inpatient (Acute Care)	16.57%	40.51%	35.54%	7.38%
QCC (Quyanna Care Center, Nursing Home)	31.76%	44.12%	20.00%	4.12%
Nome Primary Care	25.48%	52.71%	18.59%	3.22%
Village Clinic	32.13%	44.68%	20.91%	2.28%
Laboratory	33.28%	47.68%	17.50%	1.54%
Physical Therapy	33.04%	46.67%	17.39%	2.90%
Eye Care Clinic (Optometry)	42.48%	42.48%	12.07%	2.98%
Audiology	38.39%	47.16%	12.32%	2.13%
Dental	39.55%	42.93%	13.67%	3.86%
Behavioral Health	27.09%	44.15%	21.40%	7.36%
Case Management	22.87%	40.96%	23.55%	12.63%
CAMP Program	36.33%	39.45%	19.92%	4.30%
Tribal Healing	50.76%	36.64%	9.54%	3.05%
Infant Learning Program	34.68%	42.74%	18.55%	4.03%
Radiology/Diagnostic Imaging	39.64%	44.42%	13.44%	2.51%
EMS-Medevac Team	57.38%	32.07%	10.13%	0.42%
WIC Program	42.93%	41.46%	13.66%	1.95%
Environmental Health (OEH)	27.93%	45.95%	22.52%	3.60%
Respiratory Therapy	33.74%	51.53%	12.88%	1.84%
Medical Records/HIM	27.73%	45.48%	21.81%	4.98%
Billing Department	27.38%	38.39%	22.32%	11.90%
Human Resources Department	24.91%	37.37%	24.57%	13.15%
Patient Driver	39.21%	40.84%	14.15%	5.80%
Patient Advocate	33.69%	36.56%	19.71%	10.04%
Administration	29.52%	38.10%	21.59%	10.79%

10. Have you or anyone in your household been affected by these community issues:

	% Yes
Elder abuse	5.87%
Child Abuse	7.39%
Domestic Violence	17.54%
Drug Abuse	17.87%
Alcohol Abuse	29.63%
Tobacco Use	44.82%
Chronic Disease	22.83%
Obesity	28.12%
Heart Disease	19.98%
Diabetes	22.05%
Stroke	13.74%
Cancer	26.08%
Teen Pregnancy	10.23%
Sexually Transmitted Infections	17.16%
Suicide	23.58%
Lack of Access to Healthcare	19.41%
Lack of Access to Medications	15.47%
Lack of Quality childcare	19.41%
Lack of Quality Schooling	14.67%
Lack of Quality Housing	31.62%
Lack of Strong Family Support	14.51%
Lack of Safety	11.89%
Lack of Good Jobs	34.26%
Lack of Food due to expense	28.37%
Lack of healthy food available	36.08%
Lack of Native/Traditional foods	24.80%
Lack of Indoor Exercise Facilities	37.66%
Lack of Outdoor Recreational Spaces (parks, walking paths, etc)	24.85%
Lack of Running Water/Sewer	22.20%
Lack of Sobering Center	20.82%
Lack of Homeless Shelter	19.11%
Lack of Law Enforcement	30.87%

11. What would improve your access to care? (multiple responses allowed)

	Count
More providers/health aides	352
More specialty clinics	309
End of Life Care Program	126
Prescription deliver	127
Home visits by providers/health aides	164
Longer hours at the clinics	145
Telemedicine availability	67
Personal Care Attendants	152
Transportation to clinic or hospital	152
Assisted Living Center	171
Availability of Long Term Care	109
Financial Support for Out of Region	91
Other (free text)	

Nurse Call Line

12. Have you ever used the NSHC Nurse Call Line, and based on your experience, how would you rate it? (1 – Excellent, 5 - poor)

Row Labels	Count of ID	Sum of ID
No - but I've head of it	**103**	**18.35%**
1	28	6.47%
2	16	3.21%
3	38	5.12%
4	7	1.28%
5	14	2.28%
No - but I've heard of it	**3**	**1.08%**
1	3	1.08%
No - Never heard of it	**8**	**1.26%**
1	1	0.22%
2	2	0.53%
3	3	0.37%
5	2	0.13%
Yes, I have used the Nurse Call Line	**392**	**79.31%**
1	108	22.31%
2	75	14.64%
3	101	19.89%
4	46	9.87%
5	62	12.60%
Grand Total	688 **506**	**100.00%**

Performance Improvement Goals Summary

Over the next three years, NSHC will strive to:

1) Improve Communication with Patients by asking the patient what their preferred method of communication is and utilizing it to provide meaningful feedback to patients.

2) Improve Access to Care for Patient by ensuring the NSHC Primary Care System has both appointments available for patients to accommodate same-day access to care when needed.

3) Improve Notification and Reminders to Patients about scheduled appointments.

4) Improve customer service by training staff on phone etiquette and by improving the switchboard operator experience.

5) Improve the quality of patient care by performing audits of patients who present to NSHC's outpatient clinics for care on a frequent basis; reports will be made to the HRSA quality committee to ensure there is accountability.

6) Continue the initiatives of the Population Health Department to ensure patients are receiving coordinated care and referrals for prevention tests and receiving care that meets clinical standards for disease states.

7) Continue to strengthen the nurse call line by listening to consumer feedback; share success stories when possible.

8) Ensure patient privacy and confidentiality is preserved at all times by providing training to all staff at regular intervals.

9) Continue to focus on Tobacco cessation counseling and prevention activities, substance abuse treatment programs, and suicide prevention activities.

10) Improve access to healthy foods region-wide by collaborating with village leadership.

11) Increase access to indoor workout space region-wide by working with local leaders to develop partnerships for solutions.

12) Continue to develop and expand NSHC's in-home support program to provide personal care attendant services (PCA Program) and to offer end-of-life care for family's in the region at all locations.

13) Continue to provide patient transport services in all locations and to deliver prescription medications.

FUNDING AGREEMENT
BETWEEN CERTAIN ALASKA NATIVE TRIBES
SERVED BY THE
NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
OF THE
UNITED STATES OF AMERICA
FISCAL YEARS 2018-2020

This Funding Agreement is entered into by and between certain Alaska Native Tribes in the Bering Straits region of the Norton Sound Service Unit, as identified on the signature page herein, and the Secretary of the Department of Health and Human Services. These Tribes have authorized the Norton Sound Health Corporation to sign this Funding Agreement for them and to be responsible for and carry out the terms of this Funding Agreement.

Section 1 – Obligations of the IHS.

1.1 Generally. Under the authority of Section 325 of P.L. 105-83, and P.L. 93-638 as amended, non-residual programs, services, functions and activities (PSFAs) of the Alaska Area Office and the Alaska Native Medical Center (ANMC) have been transferred to tribal management.

Delivery of PSFAs shall be consistent with each Co-Signer's Funding Agreement (FA). The Indian Health Service (IHS) shall remain responsible for performing all federal residual PSFAs. The IHS shall remain responsible for negotiating assurances with the Alaska Native Tribal Health Consortium (ANTHC) and Southcentral Foundation (SCF) on behalf of Alaska Natives and American Indians to the effect that Co-Signers continue to receive non-residual PSFAs from the ANMC and Area Office and provided by ANTHC and SCF at a minimum at the level that such PSFAs were provided by the IHS as of October 1, 1997, to the extent permitted by Section 325 of P.L. 105-83. To the extent authorized by federal law, the IHS will respond to written Co-Signer concerns about the extent with which such assurances have not been complied and take appropriate action. IHS shall further be responsible for performing its special trust responsibilities and legal obligations as provided in the Indian Health Care Improvement Act, the Indian Self-Determination and Education Assistance Act, and other applicable provisions of federal law.

This FA obligates the IHS to provide funding and services identified herein and as provided in the Alaska Tribal Health Compact (ATHC) between the Norton Sound Health Corporation (NSHC) and certain other Co-Signers thereof and the United States in Fiscal Years 2018-2020.

The "Memorandum of Agreement Describing the Continuing Services of the IHS, Alaska Area Native Health Service" among the Co-Signers and the Alaska Area Native Health Service

(AANHS) reflects the understanding of the parties regarding services to be provided by the AANHS to Co-Signers. This document, attached as Appendix C, is hereby incorporated by reference.[1]

In addition, although funds are provided from Headquarters and Area Office in support of this ATHC, the IHS will agree to continue to make available to NSHC PSFAs from both Area Office and Headquarters unless 100 percent of the tribal shares for these PSFAs have been specifically included in this FA. In cases where a portion of tribal shares has been transferred, there may be some diminishment in the level of PSFAs provided by IHS. Furthermore, the IHS will reorganize both Headquarters and the Area Office to continue to provide the remaining PSFAs which have not been included in this FA, in the most effective and efficient manner possible, provided that the decisions about the array and level of PSFAs to be offered by the IHS shall be made in consultation with Alaska Tribes. The IHS PSFAs not negotiated into or listed in Appendix A are the responsibility of the IHS.

Unless funds are specifically provided from Headquarters, Headquarters retains all PSFAs and NSHC will not be denied access to, or services from, Headquarters. Specifically, NSHC will receive the following services from IHS Headquarters:

1.1.1 Information Services. IHS will provide the full range of Office of Information Technology (OIT) national support to ANTHC and ANMC OIT will provide specified services directly to NSHC. In addition, OIT will provide support to ANTHC to assist it to carry out its responsibility to provide day-to-day technical support, user support, distribution of software and files and other typical information technology support to Co-Signers as defined in the Assurances Appendix to the ANTHC FA. Upon request of ANTHC, after good faith efforts to resolve NSHC's technical issue, OIT's support of NSHC will include technical support needed on-site by NSHC. A list of the services due under this paragraph, with identification of the method of delivery, is shown below.

Office of Information Technology Provides:	Directly to ANTHC	Directly to Co-Signer	Indirectly to Cosigner through ANTHC
National Database Services			
100% Data Center Services	X		
Process Data exports into National Database		X	
Evaluate, correct, convert site data for National Database		X	
Telecommunications Management Services			
100% Telecommunications Management Services	X		
Maintain IHS to Alaska connection		X	
Email transfer and global address listing		X	
SMTP Gateway		X	
Intranet and Internet Access (to available bandwidth)		X	
Antivirus Software			X

[1] All references to Appendix A and Appendix C in this FA are to the Appendix for the applicable fiscal year.

Office of Information Technology Provides:	Directly to ANTHC	Directly to Co-Signer	Indirectly to Cosigner through ANTHC
Software Development and Maintenance			
100% Software Development and Maintenance	X		
Use of IHS contract vehicles		X	
RPMS Integrated Commercial-Off-The-Shelf packages (Average Wholesale Prices, CPT, ICD-9, Immunization Algorithm) licenses (This does not include licenses for stand-alone or interfaced commercial software.)			X
RPMS Package Support/Installation			X
System Support and Training			
100% System Support and Training	X		
Nationally Available OIT Training instruction (as available)		X	
Alaska On-site training instruction (four annual classes)			X
Hardware and Operating System Support			X
Cache Upgrade (initial installations)			X
National Patient File (2000) conversion			X
Envoy (WebMD) installation			X
Additional Services - Fee for Service	X	X	X

1.1.2 Access to Training and Technical Assistance. To the extent funds are identified by the IHS, NSHC shall have access to training, continuing education, and technical assistance in the manner and to the same extent NSHC would have received such services if it were not a Self-Governance Co-Signer.

1.1.3 Intellectual Property. In the course of administering federal contracts, grants, subgrants, and other agreements, IHS acquired various copyrights and licenses, including licenses pursuant to 45 CFR § 74.36 and 45 CFR § 92.34, in works which the IHS possessed, reproduced, published and otherwise used and allowed others to possess, reproduce, publish, and otherwise use. To carry out the PSFAs assumed by NSHC under this and previous FAs and contracts NSHC has the delegated authority and permission from IHS to use and allow others to reproduce, publish, and otherwise make use of these works to the same extent as IHS, consistent with the copyrights or licenses acquired by IHS in such works.

1.1.4 HIPAA Compliance. IHS retains the responsibility for complying with the Health Insurance Portability and Accountability Act of 1996 for retained IHS health care component activities.

1.2 Historical PSFAs. NSHC has historically received certain PSFAs from ANMC and AANHS. Responsibility for these PSFAs has been transferred to ANTHC by ANMC and AANHS prior to the transfer of management to ANTHC and SCF, NSHC attached to its FY 2002 FA Addendum I entitled "Memorialization of Historical Level of PSFAs provided by ANMC and AANHS." The PSFAs listed in this addendum are taken from NSHC's FY 1999 Annual FA. The addendum was attached to the FY 2002 FA only for the purpose of identifying historical levels of PSFAs received by the NSHC from ANMC and AANHS, and is specifically not made part of this

FA.

1.3 Community Health Aide Program Certification. The IHS retains the responsibility, pursuant to Section 119 of the Indian Health Care Improvement Act, as amended, to maintain the IHS Community Health Aide Program Certification Board (CHAPCB), which was established by and is under the direct control and supervision of IHS, to accredit training for and to certify community health aides, which includes community health aides/practitioners, dental health aides, and behavioral health aides/practitioners.

Section 2 – Obligations of the Co-Signer.

2.1 Generally. This FA obligates NSHC to be responsible for and to provide health PSFAs identified in Section 3 [Tribal Programs and Budget], utilizing the resources transferred under this FA and other funds as they may become available to NSHC. This FA further authorizes NSHC to consolidate and redesign PSFAs as provided in the Act and the ATHC. Whether providing, purchasing, or authorizing health care services described in the Compact and this Funding Agreement, in accordance with Section 2901(b) of Pub. L. 111-148, the Affordable Care Act, and as otherwise provided in law, NSHC shall be the payer of last resort. NSHC is committed to and will strive to provide quality health services and will strive to meet standards NSHC believes to be appropriate and applicable to the delivery of those health services.

2.2 Tribal Facilities and Locations. NSHC operates the programs described in this FA out of more than one facility or location. These include, but are not limited to the facilities and locations listed in Appendix B, which will be submitted prior to the effective date of this FA, and will be incorporated by reference herein. The Area Division of Planning Evaluation and Health Statistics shall compile from this Appendix a list of all health facilities identified in the Appendix and forward that list annually to the Headquarters' Office of Program Statistics, which shall include each of these facilities and locations in the annual list it must provide to the Centers for Medicare and Medicaid Services (CMS) (formerly Health Care Financing Administration) pursuant to the Memorandum of Agreement between the Health Care Financing Administration and the IHS (December 19, 1996).

Section 3 – Tribal Programs and Budget.

The NSHC agrees to be responsible for the health PSFAs identified below in accordance with the ATHC and this FA, including administration of the Norton Sound Service Unit of the IHS, a tribally operated Service Unit of the IHS. NSHC provides and facilitates a range of services directly, and in cooperation with ANMC, ANTHC, SCF and other Co-signers, through field clinics, referrals to ANMC, and other arrangements with tribal health organizations. Any PSFA described in this section 3 [Tribal Programs and Budget] may be performed by any organizational unit of NSHC at NSHC's discretion. For the purposes of this FA, the NSHC's General Budget Categories consolidate related health PSFAs as listed below.

3.1 Executive Leadership. NSHC through its Board of Directors and administration provides policy and administrative/executive/legal direction and oversight for all PSFAs in this FA. Board members, officers, General Counsel, and staff represent NSHC on the local, regional,

state and national committees and boards to provide for advocacy, negotiations, coordination, consultation, development of new programs and information activities.

3.2 Hospital and Clinic Services. NSHC is committed to providing quality patient care achieved through maintaining qualified staff, physical plant, and adequate supply of medical provisions. Under a comprehensive health care delivery plan NSHC provides the following direct patient care services:

3.2.1 Acute patient care swing-bed;

3.2.2 Twenty-four hour emergency services, including those associated with being a Level IV trauma center;

3.2.3 Ambulatory care services, including after-hour nursing phone triage service;

3.2.4 Medevac/air ambulance services;

3.2.5 Referral/transport system from the villages and/or Nome to and from the next higher level of care (e.g. travel coordination and authorization, patient transport vehicle, medivac transport and patient transportation, including adult escort, health professional and other escort as NSHC deems appropriate and emergency or non-emergency air transportation where ground transportation is not feasible and transportation by private vehicle where no other means is available, including specially-equipped vehicle and ambulance) subject to available funding. NSHC may provide the above described patient transportation services in accordance with Section 213 of the Indian Health Care Improvement Act as amended at 25 U.S.C. § 1621*l*;

3.2.6 Specialty clinic support;

3.2.7 Sexual Assault Response Team (SART), including forensic exams and counseling of victims;

3.2.8 Comprehensive health care nursing services for the elderly, disabled and others needing long term health care services as defined by Section 205(a)(4) of the Indian Health Care Improvement Act, as amended, and in accordance with Section 205(c) of such Act. Such services will include but not be limited to the nursing facility services of Quyanna Care Center;

3.2.9 Emergency and minor surgery within the expected capability of Medical Practitioners;

3.2.10 Services associated with training medical students, residents, physician assistant students, nursing students, and allied health provider students from accredited institutions, under supervision of appropriate staff;

3.2.10.1 Physician coverage for services provided in the hospital and villages in person and through daily contact by telephone and/or video telemedicine equipment as needed with the physician assistants and/or Community Health Aides/Practitioners in the villages, and for teleradiology services;

3.2.11 Comprehensive, well person, emergency, acute and chronic care and preventive services at the subregional/community health centers and surrounding village clinics. These services include, but are not limited to, Early Periodic Screening, Diagnosis and Treatment (EPSDT), immunizations, maternal and child health services including family planning, prenatal care and case management of care provided to children and other high-risk individuals; urgent care services 24 hours a day; and specialty clinics, dental services, optometry services, diagnostic imaging services, laboratory services, and telemedicine, telehealth, telepharmacy, teleradiology, telepsychiatry services, dialysis, and mammography, colonoscopy and other cancer screenings, and cancer

treatment;

3.2.12 Diabetes prevention program, including community exercise and activity programs, such as "Summercise" programs, community health fairs, and water aerobics. As authorized under Section 204(d) of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621c, NSHC provides dialysis services and is committed to and shall provide quality dialysis services that will at all times meet standards applicable to such services;

3.2.13 Ancillary services will be maintained at levels sufficient to support medical diagnosis, including but not limited to physical therapy, smoking cessation, respiratory therapy, diagnostic imaging, laboratory, pharmacy, social services, nutrition services, and point of care testing;

3.2.14 Provide lodging for patients, family members of patients, and/or their escorts, including but not limited to housing at the patient hostel, and elder housing;

3.2.15 Coordination with, support of, and assistance to tribal and non-profit entities with their provision of health and social services; and

3.2.16 Provides training and continuing education for NSHC employees and NSHC beneficiaries, and, subject to availability of funding, provides limited financial support for NSHC beneficiaries to assist them to be prepared to pursue health related careers. NSHC also provides a nursing educational program.

3.3 Behavioral Health Services. Provides behavioral health services including, but not limited to:

3.3.1 Substance Abuse Services. Provide services to reduce and prevent substance abuse and associated problems through in/outpatient services, prevention/education, referral services, transitional/residential care services, outreach services, and community involvement, diagnostic and primary alcoholism and drug abuse treatment services, including individual assessment and referrals, individual and group counseling, detoxification services, case management, and substance abuse education classes and Alcoholics Anonymous and/or Narcotics Anonymous meeting sponsorship.

3.3.2 Mental Health Service. Provides professional and paraprofessional staff that travel within the Norton Sound Service Unit, and provides family, child, adolescent and community mental health programs. As needed, a psychiatrist provides mental health services in the hospital. Services include but are not limited to assessment and diagnostic services, individual and group therapy, crisis intervention services, suicide prevention and psychological testing, and telebehavioral health.

3.3.3 Village Based Counseling Program. Provides supportive counseling to identified clients, including abused children, children with behavioral health problems, families in crisis, adults and adolescents with substance abuse and/or mental health issues, and the chronically mentally ill. This program works in conjunction with the substance abuse and mental health program and includes the services of behavioral health aides.

3.3.4 Rainbow Services. Provides services to clients with developmental disabilities. The program assists clients to remain in their homes and communities by developing skills to increase self-control and participation in the community. When this is not possible, the

program assists families to find appropriate treatment and services outside the home for the client.

3.3.5 Transitional Living Services. Provides transitional living services, including residential programs, to assist clients in maintaining sobriety while attending outpatient substance abuse treatment, and after completion of treatment until the client is ready to return to his/her home community.

3.3.6 Fetal Alcohol Spectrum Disorder Prevention Services. Provides education and assistance regarding Fetal Alcohol Spectrum Disorder, targeting pregnant women with substance abuse issues to educate them about the effects of substance abuse on children and families.

3.3.7 Children's Services. Provides intensive outpatient behavioral health services to high risk clients with severe emotional problems ages 9-20 and their families. The program aims to help youth succeed at school, home and in the community while eliminating the need to send them elsewhere. Children's services also may include a full array of behavioral health prevention, early intervention, and treatment programs, including recreational and activity programs and residential and day camps. Providing culturally relevant services involving the community in the treatment process.

3.4 Other Health Services. Provides other health services, including but not limited to:

3.4.1 Dental Services. Provides services at the hospital and in field clinics to raise dental health and lower the incidence of dental disease. The field dental program offers visits to all the villages. Dental services may include dental health aide and dental health aide therapist, training, supervision, and services under the Standards and Procedures approved by the IHS Community Health Aide Program Certification Board.

3.4.2 Audiology. Audiology Services will be delivered, both at the hospital and through field clinics throughout the Norton Sound Service Unit.

3.4.3 Optometry Services. Optometry Services will be provided consistent with the needs of the patients, both in Nome and through field clinics throughout the region.

3.4.4 Village Health Services. Provides training, supervision and services of Community Health Aides/Practitioners (CHA/Ps) and the Clinic Travel Clerks who act as support staff to the village clinics. The Community Health Aide Program will be carried out under the Standards and Procedures approved by the IHS Community Health Aide Program Certification Board.

3.4.5 Health Aide Training. Provides Community Health Aide Program training to trainees from throughout Alaska.

3.4.6 Traditional and Alternative Medicine. Provides traditional healing services in coordination with existing western medicine services; and alternative healing practices only upon a referral from a provider credentialed in accord with the standards cited in Section 8 of this FA.

These services will be provided in accordance with Section 831 of the Indian Health Care Improvement Act, amended at 25 U.S.C. § 1680u.

3.4.7 Emergency Medical Services. NSHC will maintain Emergency Medical Services (EMS) to lower the incidence of death and disability by providing air ambulance services. The NSHC departments also provide various levels of EMS and injury prevention training for staff and community members throughout the region. NSHC participates in EMS delivery in cooperative with community fire departments, other emergency response, and rescue services throughout the region.

3.4.8 Maternal and Child Health Program. Provides:

3.4.8.1 Prematernal home care for village women awaiting delivery in Norton Sound Regional Hospital;
3.4.8.2 Prenatal, family planning and newborn patient education; and
3.4.8.3 Assistance in risk screening and coordination of prenatal care.

3.4.9 Office of Environmental Health. Provides inspections of the hospital and clinics; technical assistance, training and research to help protect the public from illness and injury related to problems with water, waste, food, air, pests, safety, hazardous waste sites and bioterrorism. Technical assistance is provided to local, state and federal officials as necessary to assist with funding processes and the development of local environmental programs. Training is provided to regional water/wastewater operators and utility managers as needed to ensure safe operation and management of environmental systems.

3.4.10 Public Health Nursing. Provides public health nursing services, including but not limited to consultation to CHA/Ps in the villages, child health and developmental screening, prenatal care, EPSDT, school screenings, immunizations, and tuberculosis and other infectious disease screening and monitoring.

3.4.11 Research and Prevention. Participate in research activities to determine whether genetic factors predispose Alaska Natives to disease.

3.4.12 Home Care and Other Community Based Services. Through a combination of western methods and traditional modalities, provides home care and other community based services, which includes but is not limited to assistance with activities of daily living such as bathing, dressing, laundry, light housekeeping, cooking, vital signs, and medication reminders. These services are provided to all individuals throughout the Bering Straits region who are unable to perform their activities of daily living on their own, or when the families are unable to meet their needs. Home and Community Based Services also provides palliative care and other end-of-life services, such as hospice care, respite, chore, nutrition, transportation, and other supportive services including various senior programs and activities. Such services may also include Assisted Living Services. NSHC will provide home and community based services, hospice and assisted living in accordance with the requirements at § 205 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621d.

3.4.13 Nutrition Services for Women, Young Children, and Infants. Provides supplemental foods, and nutritional education, counseling and other services to women, infants and young children who are at nutritional risk.

3.4.14 Infant and Young Child Developmental Program. Provides services that promote growth and development of infants and young children. Children who qualify for services may have been born prematurely, have delays in their development, or have a diagnosed disability such as Down's syndrome or cerebral palsy. Other child development and family services include, but are not limited to, health-oriented education; socialization; health screening; growth and nutritional assessment; individualized culturally-appropriate child development services; family services; and family involvement.

3.4.15 Injury Prevention Services. Provides services to lower the incidence of death and disability, including but not limited to, the provision of safety information, equipment, and training.

3.4.16 HIV Services. Provides testing, referrals, data collection, and training end education.

3.4.17 Purchased/Referred Care Services. Purchases services, which are not otherwise available or accessible to eligible beneficiaries, on a contractual or open-market basis within funds available. NSHC agrees to be bound by 42 C.F.R. Part 136, subpart I, in the administration and provision of Purchased/Referred Care (PRC) services carried out under this Agreement. Accordingly, NSHC has opted to pay at Medicare Like Rates for PRC in accordance with that subpart of the regulations.

3.4.18 Morgue. Provides morgue services in each village.

3.5 Support Services. Support services required to support the provision of health services, including, but not limited, to plant operations, biomedical services, housekeeping and linen/laundry services, security (for patients and staff), human resources, information systems, administration and board support, corporate planner, grant management, compliance officer and performance improvement, material management (procurement, receiving, processing and distribution), central sterile supply, infection control/employee health, and financial, including business office functions, coding and medical records, planning and implementation of an electronic health records system, patient benefits coordinator, and the provision of staff housing.

3.6 Capital Projects. Provides technical assistance, planning, design, engineering, management and general contracting for construction, maintenance and operation of all facilities used by NSHC, including both federal facilities and those leased or owned by NSHC. This program also provides technical assistance and construction related services to other tribes and tribal organizations inside and outside NSHC's service area.

3.7 Village Built Clinic (VBC) Lease Program. Provides funds to eligible entities to

support the rental of CHA/P clinic space. NSHC will operate this program directly with all VBC lessees, who so elect, including the provision of support services and technical assistance. NSHC will ensure that each lessee is in compliance with the standards referenced in the VBC lease.

3.8 Public Health and Epidemiology. Directly and/or through ANTHC, including its Epidemiology Center,[2] NSHC carries out public health, epidemiology and health research functions. These activities include, but are not limited to: collecting and receiving personally identifiable health information for the purpose of

3.8.1 preventing or controlling disease, injury, or disability;

3.8.2 reporting disease, injury, and vital events such as birth and death; and

3.8.3 the conduct of public health and epidemiological investigations, surveillance, and interventions, including the maintenance of disease and injury registries.

3.9 Other Programs/Services Funded.

3.9.1 Generally. This FA includes programs, functions, services and activities resulting from tribal redesign, or consolidation, reallocation or redirection of funds, including its own funds or funds from other sources, provided that such consolidation, redesign, or reallocation or redirection of funds results in carrying out programs, functions, services and activities that may be included in the FA pursuant to section 505 of Title V and Article III, Section 6 [Consolidation with Other Programs] of the ATHC. This includes any other new health care programs, including, but not limited to, those identified in the Indian Health Care Improvement Act funded during the fiscal years.

3.9.2 Non-IHS Funding. NSHC will complement and supplement the PSFAs described throughout Section 3 [Tribal Programs and Budget] with funding from sources other than the IHS through this Funding Agreement, subject to the availability of such other funding sources. Consistent with Article III, Section 5 [Reallocation], 6 [Merging with Other Programs], and 7 [Program Income] of the ATHC, non-IHS funds will be added to or merged with funds provided by the IHS through this FA.

3.10 FTCA. The Federal Tort Claims Act applies to NSHC's PSFAs under this FA as provided in Section 516(a) of Title V (which incorporates Section 102(d) of Title I of the Act and Section 314 of P.L. 101-512). The extent of Federal Tort Claims Act coverage is described more particularly in 25 C.F.R. Sections §§ 900-180-900.210.

Section 4 – Amounts Available During the Term of the FA

4.1 The following amounts shall be available to NSHC pursuant to the ATHC and Title V of the Act and are subject to reductions only in accordance with Section 508(d) of Title V and Section 106 of Title I of the Act.[3]

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[2] The ANTHC Epidemiology Center was previously operated by the Alaska Native Health Board.

[3] A breakout of these funds is shown in Appendix A, which cites the source document used to determine the amount. These amounts are subject to change under the Act and as provided in this FA. For other fiscal

Recurring Base: Inclusive of all recurring funding, including recurring contract support funds and Village Built Clinic Funds of $425,417.[4]	$48,467,747
Non-recurring funds: inclusive of all non-recurring contract support funds and such other funding which may be added to the contract.[5]	$13,954,404
Subtotal: (This amount is subject to amendments in accordance with Section 14 [Amendment or Modification of this FA])[6]	$62,422,151
Area "Tribal" share to include funding identified from the Area Office and identified in Appendix A to this Agreement.[7]	$1,031,630
Headquarters-tribal share: "Tribal Size Adjustment Pool," including all funds identified in Appendix A. The amount identified is exclusive of funds for which distribution amount has not been determined. The final amount due shall be determined as set forth in this FA or Appendix A.[8]	$731,037
Headquarters-Tribal share: "Program Formula Pool" – to include all funds identified in Appendix A, and such additional funds which the IHS may make available on a program formula basis during the year based on the programs accepted for this allocation in Appendix A.	$0

years to which this FA may be applicable, the replacement Appendix A will be negotiated between IHS and NSHC for the respective year and amended to this FA and incorporated by reference, accordingly.

4 A breakout of these recurring costs is found in Appendix A, fully incorporated herein and citing the actual documents used to determine the amount. *See* Footnote 3.

5 These non-recurring funds include contract support costs and routine Maintenance and Improvement funds available at the beginning of the fiscal year. *See* Footnote 3.

6 The Radiologist Consultation funds in the amount of $195,131 and Biomed funds in the amount of $67,102 are not included in this amount (neither of these amounts include any adjustments for mandatory increases). These recurring funds and any mandatories associated with them are in the ANTHC FA and will be negotiated annually as a flow-thru from the ANTHC, in accordance with the interpretation of Section 325 of P.L. 105-83 by the IHS.

7 Funds from the Alaska Area were distributed according to methods agreed upon in a caucus open to all Alaska Tribes and tribal organizations. The specific methodology is identified in Appendix A.

8 Headquarters tribal shares were allocated according to the following process, which was adopted in a caucus open to all Alaska tribal organizations: The Alaska Area Tribal shares of Headquarters was first defined using the national IHS recommended methodology. The total Alaska Area Tribal shares was then reallocated to each Co-Signer according to the agreed upon Alaska Area methodology, which is identified specifically for each line in Appendix A.

Subtotal – Tribal Shares[9]	$1,762,667
TOTAL ATHC FUNDING	**$64,184,818**

These amounts are subject to additions for other reimbursements, and for new funds received during the term of this Agreement including amounts that have historically been distributed as non-recurring funds under the Act. Any amounts remaining unspent under the prior FA, after adjustments and services, as of the previous fiscal year, shall be included and spent under this FA.

Of the amount shown above for non-recurring program funds, $1,211,108 are for Routine Maintenance and Improvement (M&I); the Routine M&I amount paid as a part of the lump sum due NSHC was determined by multiplying the FY 2017 Routine M&I amount paid to the Co-Signer by 90%. The final Routine M&I amounts paid in FYs 2018-2020 will be based on the final 2018-2020 Routine M&I allocations. If the final Routine M&I amounts, as determined by the final FYs 2018-2020 Routine M&I allocations, is less than the 90% calculation, NSHC will return the difference to the IHS. See also Appendix A, footnote to line 19 on page 6.

Of the amount shown above for Headquarters Tribal Share "Program Formula," $141,878 are for Equipment Replacement, the Equipment Replacement amount paid as part of the lump sum due NSHC was determined by multiplying the FY 2017 Equipment Replacement amount paid to NSHC by 90%. The final Equipment Replacement amounts paid in FYs 2018-2020 will be based on the final FYs 2018-2020 Equipment Replacement allocations. If the final Equipment Replacement amounts, as determined by the final FYs 2018-2020 Equipment Replacement allocations, is less than the 90% calculation, NSHC will return the difference to the IHS. See also Appendix A, footnote to line 22 on page 6.

The Recurring Base amount shown above includes $291,158 that NSHC received, recurring in FY 2006 for Congressionally earmarked alcohol funds. Such funds are subject to "Adjustments Due to Congressional Actions" as described herein in Section 6 as well as any conditions on those funds that may be described in the FYs 2018-2020 Interior Appropriations Acts (Act) or Congressional Reports. After each Act is passed into law, such conditions, including Congressionally-directed reporting requirements, will be added by amendment not requiring NSHC's signature as described in Section 14 [Amendment or Modification of this FA].

The parties agree Section 505(b)(2) of Title V provides, among other things, that grants administered by the Department of Health and Human Services through the IHS may be added to NSHC's FA after award of such grants. In accordance with this provision of Title V and its implementing regulations, the Secretary will add NSHC's diabetes grants and any other statutorily mandated grant(s) administered by the Department through the IHS to this FA after such grant(s) have been awarded. Grant funds will be paid to NSHC as a lump sum advance payment through the PMS grants payment system as soon as practicable after award of the grant. NSHC will use interest

[9] The subtotal of Tribal shares does not include certain Headquarters for which the amount or availability has not been determined. This amount will be adjusted to make available all Tribal shares for which NSHC is eligible. IHS will pay mandatory increases on some Headquarters Tribal shares, subject to appropriations.

earned on such funds to enhance the purposes of the grant including allowable administrative costs. NSHC will comply with all terms and conditions of the grant award, including reporting requirements, and will not reallocate grant funds nor redesign the grant program, except as provided in the implementing regulations or the terms of the grant.

4.2 Contract Support Costs. Contract support costs (CSC) will be paid in accordance with 25 U.S.C. § 5325 and § 5388(c). The parties agree that, according to the best data available as of the date of execution of this agreement, the amount to be paid under FY 2018, which represents the parties' estimate of the Tribe's full CSC requirement pursuant to 25 U.S.C. § 5325, is $16,798,500, including $4,197,082 for direct CSC and $12,601,418 for indirect or indirect-like CSC.[10] This estimate shall be recalculated as necessary as additional data becomes available including information regarding the direct cost base, pass throughs and exclusions, and the indirect cost rates to reflect the full CSC required under 25 U.S.C. § 5325. The parties will cooperate in updating the relevant data to make any agreed upon adjustments. In the event the parties disagree on the CSC amounts estimated and paid pursuant to this paragraph and the Tribe's full CSC requirement under the ISDEAA, the parties may pursue any remedies available to them under the ISDEAA, the Compact, and the Contract Disputes Act, 41 U.S.C. §7101 et seq.

4.3 Base Budgets.

4.3.1 Categories and Base Year. At the end of the first period of the base budget option, the IHS and Co-Signers agreed to extend the three year (FY1998-FY2000) base budgets implemented for the ATHC for an additional two years (FY2001-FY2002). IHS and NSHC have subsequently agreed to additional extensions through FY 2009. The IHS and Co-Signers have agreed to further extend the base budget period at the Co-Signer's option. The following categories are subject to base budgeting for the base year period and the period, as noted below.

Category of Funding	Base Period for Base Funding	Extended through:
Headquarters TSA amounts[11]	FY 97	FY 2020
Equipment Replacement Funding	Not Included	N/A
Area Tribal Share	Not Included	N/A

4.3.2 Adjustments. Adjustments to base funding shall be permitted in direct proportion to changes in appropriated amounts (by sub-activity), as provided under Section 6.1 of this FA titled "Adjustments, Due to Congressional Actions." Adjustments shall also be permitted for the addition of new Co-Signers to the ATHC and when current Co-Signers add or retrocede PSFAs,

10 For other fiscal years to which this FA is applicable, the CSC estimates will be negotiated between the IHS and NSHC for the respective year and amended to this FA in Appendix A.

11 ATHC base budgets for TSA amounts shall be considered as a whole (entire ATHC amount) and shall be subject to adjustment of the internal allocation subject to ATHC agreements.

as provided in Section 14.4 [Due to Addition of New Programs].[12] Adjustments also shall be permitted when Co-Signer chooses to restrict or un-restrict previously "restricted" or "un-restricted" categories, provided that restrictions shall be changed only during annual negotiations. NSHC shall also be eligible for funding for new service increases, mandatories, specific Congressional appropriation for population growth, health services priority system, contract support costs and other increases in resources on the same basis as all other Tribes. Adjustments for changes required when a Tribe joins or withdraws from a Tribal consortium shall also be permitted, as provided under Section 10.3 [Withdrawal Procedures] of this FA. Co-Signers shall also remain eligible for the distribution of additional Tribal shares for Assessments, Workers Compensation, Emergency Reserve, Management Initiatives, and other PSFAs from Headquarters.

Section 5 – Methods of Payment.

5.1 Payment Schedule. Except as provided in subsection 5.2 [Availability of Tribal Shares], 5.3 [Buyback/Withholding], and 5.4 [Periodic Payments] of this Section, all funds identified in Section 4 [Amounts Available During the Term of the FA] of this FA shall be paid to NSHC, in accordance with Article II, Section 4(a) [Payment Schedule] of the ATHC; payment to NSHC to be made as follows: One annual lump sum payment to be made in advance.

5.2 Availability of Tribal Shares. NSHC will be paid 100 percent of Headquarters and Area Tribal Shares in its initial lump sum payment, as negotiated in this FA, for each year under the term of this FA.

5.3 Buyback/Withholding. NSHC may carry out its responsibility to provide certain PSFAs included in this FA by using services or other resources of the Federal government under Article V, Section 22 [Purchases from the IHS] of the ATHC, as permitted by law. Except as provided herein, the cost of such services and the terms under which they may be available to NSHC are set forth in the Buyback/Withhold Agreement between the IHS and NSHC, which is attached as Appendix D to this FA and incorporated by reference herein. The administrative surcharge provided for in Section 2.2.4 of the Buyback/Withhold Agreement for FY 2018 shall be .285 percent. During the term of this FA, the Administrative surcharge rates will be negotiated annually. Notwithstanding Section 5 of the Buyback/Withhold Agreement, upon the request of the IHS or any Co-Signer, such FA will be negotiated for future fiscal years annually during negotiation of this FA.

5.4 Periodic Payments. Payment of funds otherwise due to NSHC under this FA, which are added or identified after the initial payment is made, shall be made promptly upon request of NSHC by check or wire transfer.

Section 6 – Adjustments.

[12] This includes addition of new facilities when the addition of these facilities includes an increase in equipment funds identified for the new facilities.

6.1 Due to Congressional Actions. The parties to this FA recognize that the total amount of the funding in this FA is subject to adjustment due to Congressional action in appropriations Acts or other law affecting availability of funds to the IHS and the Department of Health and Human Services. Upon enactment of any such Act or law, the amount of funding provided to NSHC in this FA shall be adjusted as necessary, after NSHC has been notified of such pending action and subject to any rights which NSHC may have under this FA, the ATHC, or the law.

6.2 Proposals by Authorizing Tribes. Should any authorizing Tribe assume responsibility for PSFAs (or portions thereof) under a contract or annual FA pursuant to the Act, adjustment to funding amounts under this FA will be negotiated.

Section 7 – Records.

7.1 Incorporation of the Privacy Act. Pursuant to Section 506(d)(1) of Title V, records acquired, generated or maintained by NSHC shall not be treated as Federal records under chapter 5 of title 5 of the United States Code, except that:

7.1.1 Patient medical, financial records and personnel records may be disclosed only in accordance with 5 U.S.C § 552a(b); and

7.1.2 Medical records generated by NSHC shall be eligible for storage in Federal Records Centers at NSHC's option in accordance with Section 105(o) of Title I.

7.2 Confidentiality Standards. NSHC will seek to comply with the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including, but not limited to, privacy, security, transactions, and code set regulations, codified at 45 CFR Parts 160, 162, and 164. If a record is not subject to HIPAA, NSHC will maintain the confidentiality of its records in accordance with policies and procedures adopted by its Governing Body, which will be consistent with the purposes and guidelines of HIPAA and the Federal Privacy Act of 1974.

7.3 Quality Assurance Records. NSHC operates a medical quality assurance program and treats the records of such program as confidential and privileged in accordance with section 805 of the Indian Health Care Improvement Act as amended at 25 U.S.C. § 1674.

Section 8 – Program Rules.

NSHC in carrying out the PSFAs in this FA agrees to comply only with those guidelines, manuals, and policy directives that are listed below: Joint Commission (formerly known as JCAHO) standards, as applicable, and Community Health Aide/Practitioner certification standards.

Except as specifically set forth in this Section, pursuant to Section 517(e) of Title V, NSHC does not agree to be subject to any agency circular, policy, manual, guidance or rule adopted by the IHS, except for the eligibility provisions of Section 105(g) and the regulations promulgated under Section 517 of Title V, unless otherwise waived.

Section 9 - Real Property Reporting Requirements

9.1 Leases. The IHS must report on its federally leased facilities. NSHC agrees to notify the AANHS of changes of occupancy, size, use, and general condition of Village Built Clinic (VBC) leased facilities in locations where NSHC has bought back services from the IHS. IHS will annually, or upon renegotiation, provide to NSHC a copy of each VBC lease. No increase in the amount due to the lessor pursuant to a lease will be negotiated by IHS without advance notice to NSHC. In administering these leases, the IHS will work with NSHC to ensure that each lease is in compliance with the standards referenced in the VBC lease.

9.2 Maintenance and Improvement Funds. NSHC agrees to use maintenance and improvement funds received through this FA in accordance with the appropriation language for Indian Health Facilities in the Department of Interior and Related Agencies Appropriation Act for FYs 2018-2020 or any comparable Act of Congress that contains the subject appropriation and in accordance with 41 U.S.C. § 12 to the extent applicable.

Section 10 – Services to Non-Beneficiaries.

Section 813 of the Indian Health Care Improvement Act, as amended, 25 U.S.C. 1680c, (Section 813), authorizes the governing body of a Tribal Organization carrying out health services of the IHS under the Indian Self-Determination and Education Assistance Act to determine whether health services should be provided under the Tribal Organization's FA with the IHS "to individuals who are not eligible for such health services under any other subsection of this section or under any other provision of law", 25 U.S.C. 1680c(c). The NSHC Board of Directors has made such determination consistent with Section 813, and provides for its findings in Resolution No. 2010-16. Resolution No. 2010-16 is attached as Appendix E and incorporated by reference herein. NSHC may provide services under this FA to "non-beneficiaries" as described in Resolution No. 2010-16. In addition services may be provided to U.S. Public Health Service Commissioned Corps Officers and their dependents.

Section 11 – Retrocession and Discontinuance.

11.1 Retrocession. The retrocession provisions of Section 506(f) of the Act are herein adopted, except that the effective date from a retrocession request of the ATHC and FA, in whole or in part, shall be one year from the date of the request by an authorizing Tribe or Village, except as provided below. Retrocession may be effective with less then one years notice, providing the Tribe or Village requesting retrocession, NSHC and the IHS agree to an effective date of less than one year from the date of retrocession request.

11.2 Discontinuance. NSHC may discontinue its participation in the ATHC after written notice to each authorizing Tribe or Village and the IHS. Notice must be provided one year in advance of the effective date of the request except that the effective date of a request may be less than one year upon approval of all authorizing Tribes and Villages and the IHS.

11.3 Withdrawal Procedures.

11.3.1 Process. Unless prohibited by law and in accordance with § 506(g) of Title V, an Indian tribe may fully or partially withdraw from a participating inter-tribal consortium or tribal organization its share of any program, function, service or activity (or portions thereof) included in the ATHC or FA, and any such withdrawal will become effective within the time frame specified in the resolution which authorized transfer to the participating inter-tribal consortium or tribal organization, provided that in the absence of a specific time frame being set forth in the resolution, such withdrawal shall become effective on -

11.3.1.1 The earlier of

11.3.1.1.1 One year after the date of submission of such request; or

11.3.1.1.2 The date on which the FA expires, or

11.3.1.2 Such date as may be mutually agreed upon by the Secretary, the withdrawing Indian tribe, and the participating tribal organization or inter-tribal consortium that has signed the ATHC or FA on behalf of the withdrawing Indian tribe, inter-tribal consortium, or tribal organization.

11.3.2 Distribution of Funds. In accordance with Sections 503(b) and 506(g) of the Act, when a tribe proposing to enter into a contract under Title I or a compact and FA under Title V fully or partially withdraws from a participating tribal organization, the withdrawing Tribe shall, upon written request, be entitled to be paid its tribal share of funds supporting those PSFAs (or portions thereof) which it will be carrying out under its own contract or compact and FA, and such funds shall be removed from the FA of the tribal organization and awarded to the Tribe upon approval of a Title I contract or compact and FA. The IHS shall retain any funds removed, but not awarded in a Title I contract or compact and FA.

Section 12 – Memorandum of Agreement with Member Village.

Funds provided under this FA may be allocated to and expended by an Alaska Native Village ("Village") which is party to this FA in accordance with the terms of the ATHC, this FA and a Memorandum of Agreement (MOA) approved by NSHC and the Village. The Federal Tort Claims Act shall apply to PSFAs carried out by the Village under such MOA and to the Village and its employees to the same extent as if they had been carried out directly by NSHC. Such an MOA may include provisions for the assignment of federal employees under IPA assignment or Commissioned Corps detail. Such assignment shall be subject to the approval of the AANHS Director. NSHC shall be responsible for assuring compliance by the Village with the ATHC, this FA and the MOA.

Section 13 – Consolidation of Contract and Previous Annual FAs.

The contracts listed below and all previous Annual FAs shall be amended or terminated, as appropriate to transfer applicable contract funds into this FA for services, materials and activities, programs, functions and facilities provided to the Tribes represented by NSHC: Title I, P.L. 93-638 Contract #243-89-0011, as modified.

Section 14 – Amendment or Modification of this FA.

14.1 Form of Amendments. Except as otherwise provided by this FA, the ATHC, or by law, any modifications of this FA shall be in the form of a written amendment and shall require written consent of each of the signatory Tribes, acting directly or through NSHC as authorized by resolution, the NSHC, and the United States. Participation or written consent of Tribes and Co-Signers not subject to the terms of this FA shall not be required.

14.2 Funding Increases.

14.2.1 Written consent of NSHC shall only be required for issuing amendments for those funds which:

14.2.1.1 require a change to Section 3 [Tribal Programs and Budget];

14.2.1.2 require a specific commitment by NSHC (*e.g.*, Maintenance & Improvement projects and prior fiscal year Sanitation Facility Construction projects); or

14.2.1.3 reduce funding other than changes in Congressional appropriations pursuant to Section 6.1 [Adjustments Due to Congressional Actions].

14.2.2 Amendments not requiring written consent may include, but are not limited to:

14.2.2.1 Program/Area/HQ Mandatories;

14.2.2.2 Program/Area/HQ End-of-Year Distributions;

14.2.2.3 CHEF, subject to the condition that if a case initially qualifying for reimbursement is paid (in whole or in part) by an alternate resource or cancels for any reason, NSHC will return the unused amount to the IHS CHEF account;

14.2.2.4 PRC Deferred Services;

14.2.2.5 Routine Maintenance & Improvement; or

14.2.2.6 Collections and reimbursements.

14.2.3 Amendments reflecting payment of these funds shall be provided to NSHC after any such funds are added to the FA. NSHC retains the right to reject the addition of such funds to the FA and return the funds to the IHS.

14.3 Services from IHS. Should NSHC determine that it wishes the IHS to provide PSFAs included in this FA for which funding has been identified but not provided, the parties shall negotiate an amendment to the FA to reflect the transfer of responsibilities from NSHC back to the IHS and the pro-rata share of funding for that program, services, function or activity shall be retained by the IHS. Unless otherwise negotiated, IHS will not transfer centrally paid expenses including but not limited to Workers Compensation to any ATHC Co-Signer.

14.4 Due to the Addition of New Programs. Should NSHC determine that it wishes to provide a program, service, function or activity of the IHS not included in this FA, NSHC shall submit a proposal to the IHS to provide such program, service, function or activity. The parties agree to negotiate such a proposal and, should the parties fail to reach agreement, NSHC may submit a final offer in accordance with the Title V procedures set forth in Sections 507(b)-(d) of Title V. A

proposal submitted pursuant to this section shall be treated as a request for amendment to the FA and, once approved by the IHS, the Alaska Area Office shall prepare within 30 days an amendment to this FA and the amendment shall be executed through the Area Office and added to the FA.

14.5 Due to Availability of Additional Funding. NSHC shall be eligible for any increases in funding or funding for Medicaid, Medicare, maintenance and improvement, other reimbursements and new programs for which it would have been eligible had it been administering programs under a self-determination contract, rather than under the ATHC and this FA, and for any other funds that are not restricted by appropriations language for which any Alaska Tribe or tribal organizations may be eligible, including any new funds appropriated for IHS Headquarters and funds passed to Alaska Area as recurring or non recurring funds, and this FA shall be amended to provide for timely payment of such new funds to NSHC. Such amendment shall be originated and prepared within 30 days by the Alaska Area Office and executed through the Area Office in consultation with the Co-Signer.

14.6 Other Adjustments. Upon written authorization by NSHC and agreed to by the IHS, the IHS may reallocate funds retained by the IHS, which are obligated to NSHC, for the purpose of reimbursing the IHS for services or equipment provided to NSHC to assist NSHC in carrying out the terms of the ATHC and this FA.

14.7 General Procedures for Amending or Modifying this FA. Amendments or modifications proposed by NSHC shall be submitted in writing to the IHS Alaska Area Director with a copy to the Office of Tribal Self Governance at IHS. Except as provided with respect to the incorporation of a provision of Title I under Article V, Section 21 [Applicability of Title I Provisions] of the ATHC, or as provided above in paragraphs .1, .2, .3 and .4 of this Section 14 [Amendment or Modification of this FA], a request to amend or modify this FA submitted by NSHC shall be processed in accordance with Sections 507(b)-(d) of Title V and all provisions of those identified sub-sections are incorporated herein for this purpose.

Section 15 – Third Party Recoveries.

Any funds recovered by NSHC through the filing, litigating, or settling a claim against a third party to require that third party to pay for services previously provided to IHS-eligible beneficiaries by NSHC, or for such services previously provided by the IHS in a PSFA now operated by NSHC, shall be the property of the Co-Signer and shall be considered program income to be utilized by NSHC as provided in Article III, Section 7 [Program Income] of the ATHC. Any prospective recovery of funds for such services shall likewise be considered program income to be utilized pursuant to Article III, Section 7 [Program Income] of the ATHC.

Section 16 – Severability.

This FA shall not be considered invalid, void or voidable if any section or provision of this FA is found to be invalid, unlawful or unenforceable by a court of competent jurisdiction. Should such a court make such a finding, the parties will seek agreement to amend, revise or delete any such

invalid, unlawful or unenforceable section or provision, in accordance with the provisions of the ATHC.

Section 17 – Memorializing Disputes.

The parties to this FA may have failed to reach agreement on certain matters which remain unresolved and in dispute. Such matters may be addressed through the process set forth in Sections 507(b)-(d) of Title V, or, at the option of NSHC, may be set forth in Addendum II to this FA, which shall be identified as "Memorialization of Matters Remaining in Dispute." This attachment shall not be considered a part of this FA but is attached for the purpose of recording matters in dispute for future reference, discussion and resolution as appropriate. The NSHC does not waive any remedy it may have under the law with regard to these issues and any others not listed herein.

Section 18 – Title I Provisions Applicable to This FA. As authorized in 25 U.S.C. § 5396(b), NSHC exercises its option to include the following provisions of Title I of the Act as part of this FA, and these provisions shall have the force and effect as if they were set out in full in Title V of the Act.

18.1. 25 U.S.C. § 5304(e) (definition of "Indian Tribe");
18.2. 25 U.S.C. § 5322(b) (related to grants for health facility construction and planning, training and evaluation);
18.3. 25 U.S.C. § 5322(d)(1) (related to duty of IHS to provide technical assistance);
18.4. 25 U.S.C. § 5324(a)(1) (exemption from Federal procurement and other contracting laws and regulations);
18.5. 25 U.S.C. § 5328(b), (conflicting provisions of law);
18.6. 25 U.S.C. § 5329(c), section 1(b)(8)(F) (screener identification);
18.7. 25 U.S.C. § 5329(c), section 1(b)(9) (availability of funds);
18.8. 25 U.S.C. § 5329(c), section 1(d)(1)(B) (construction of contract);
18.9. 25 U.S.C. § 5329(c), section 1(d)(2) (good faith).

Section 19 – Exemption from Licensing Fees.

In accordance with Section 124 of the IHCIA, as amended at 25 U.S.C. 1616q, employees of the NSHC health programs shall be exempt from payment of licensing, registration, and any other fees imposed by a federal agency to the same extent that officers of the Public Health Service commissioned corps and other employees of the Indian Health Service are exempt from such fees.

Section 20 – Licensure.

Licensed NSHC health professionals will be licensed in accordance with section 221 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621t.

Section 21 – Purchase of Health Coverage.

NSHC may use federal funds for purchase of health care coverage in accordance with section

402 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1642.

Section 22 – Medicare & Medicaid Reimbursements.

22.1 Medicare & Medicaid. NSHC has elected to directly collect Medicare and Medicaid payments as provided in 25 U.S.C. § 1641, as amended. NSHC is obligated and entitled to directly collect and retain reimbursement for Medicare and Medicaid and any other third party payers for services provided under this Agreement in accordance with section 401 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1641 and section 206 of such Act, 25 U.S.C. § 1621e, as amended.

22.2 Recovery Right. NSHC has the right to recover reimbursement from certain third parties of the reasonable charges for health services in accordance with section 206 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1621e.

Section 23 – Federal Insurance. IHS will assist NSHC to obtain information about the coverage, rights and benefits available for its employees under chapters 87 and 89 of title 5, United States Code, the cost of such coverage, rights and benefits (including any options in coverage, rights and benefits that may be available), and the procedures by which NSHC may exercise its rights under Section 409 of the IHCIA, as amended, to have access to such Federal insurance for its employees.

Section 24 – Environmental and Cultural Resources. The National Environmental Policy Act (NEPA), National Historic Preservation Act (NHPA), and related provisions of law require the IHS to review and approve actions resulting in the use or commitment of IHS funds or that affect IHS property, and which may significantly impact the environment or cultural resources. Unless NSHC has assumed these responsibilities under a construction project agreement in accordance with Section 509 of Title V and 42 C.F.R. § 137.285-312, the IHS must carry out these responsibilities and has elected to utilize Appendix H. Where NSHC plans to undertake an action, as described in Appendix H, on IHS owned real property or utilizing IHS funds received through this Funding Agreement, and NSHC has not assumed these responsibilities, NSHC will provide the IHS with a Project Summary Document (see Appendix F) and a completed Environmental Information and Documentation Form (see Appendix G) so that the IHS can accomplish these requirements, and issue a Determination Document (Categorical Exclusion (CATEX) or Finding of No Significant Impact (FONSI)), as soon as possible. All documentation shall be submitted to the IHS as early as possible in the planning phase of the project to prevent delays in the action. No irreversible action can be taken by NSHC until the IHS completes its compliance responsibilities and so advises NSHC with a Determination Document. Pending resource availability, the IHS is available for education and consultation on NEPA, NHPA, and related provisions of law on an as needed basis.

Section 25 – Effective Date and Duration.

This Funding Agreement becomes effective on October 1, 2017, and will remain in effect through the 2020 Federal Fiscal Year or until a subsequent agreement is negotiated and becomes effective pursuant to Article II, Section 12 [Subsequent Funding Agreements] of the ATHC.

United States of America
Secretary of Department of Health and Human Services

By: P. B. Sta
Director, Indian Health Service

Date: 6-14-2019

Norton Sound Health Corporation On Behalf of Itself and Certain Alaska Native Tribes, Identified in Exhibit A of the Compact.

By: Angie Gorn
Angie Gorn
President/CEO

JUN 14 2019

Date:

FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

Amendment Effective October 1, 2018

In accordance with Section 14.1 of the Norton Sound Health Corporation (NSHC) FYs 2018-2020 Multi-Year Funding Agreement (MFA), NSHC's MFA is hereby amended as follows:

1. Section 3.2.9 is amended as follows: "Emergency surgery, and-minor and other outpatient day surgery, within the scope of qualified ~~expected capability of~~ Medical Practitioners;"

2. Section 3.3.4 is amended to change the title from "Rainbow Services" to "Developmental Disability Program."

3. Appendix B, the list of facilities in which Norton Sound is carrying out health services, is amended as follows:

   In the portion pertaining to "Nome and all Villages," change the Facility Name to add the underlined language: "staff housing owned/rented including "Lawyer's apts," St. Michael Triplex, Golovin 2-bedroom home, and Savoogna duplexes".

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

By: Angie Gorn
Angie Gorn, President/CEO

6/4/2019
Date

United States of America
Secretary of
Department of Health and Human Services

By:
Director, Indian Health Service

8/2/2019
Date

FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

In accordance with Section 14.1 of the FYs 2018-2020 Funding Agreement made and entered into by Norton Sound Health Corporation (NSHC) and the Secretary of the Department of Health and Human Services of the United States of America, effective October 1, 2017, the Funding Agreement, as amended, is hereby further amended as follows:

1. **Appendices.** The following appendices are incorporated by reference and attached:

   - Appendix A (Financial Summary Agreement) FY 2021
   - Appendix B (Facility List) FY 2021

2. **Effective Date**. This amendment is effective October 1, 2020.

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

Angie Gorn 4/30/2021

By: _____ _____
Angie Gorn, President/CEO Date

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S Digitally signed by Evangelyn L. Dotomain -S Date: 2022.03.11 16:22:11 -09'00' _____
Alaska Area Director, Indian Health Service Date

Norton Sound Health Corporation

Appendix A - Financial Summary Tribal Shares Funding Agreement - **FY 2021**

Tribal Share Summary Norton Sound Health Corporation	FY 2021 Negotiated Amount	NSHC Restricted	Total Due NSHC	Initial Lump Sum Payment
Area TS Amount	$1,094,886	$45,473	$1,049,412	$1,049,412
	0		0	0
Subtotal Area TS Amount	$1,094,886	$45,473	$1,049,412	$1,049,412
Headquarters TSA Amount	$828,953	$93,107	$735,846	$735,846
Headquarters Other Program Formula (OEHE)	$48,412	$48,412	$0	$0
Subtotal Headquarters TS amounts	$877,365	$141,519	$735,846	$735,846
Total Tribal Shares	$1,972,250	$186,992	$1,785,258	$1,785,258

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Driving Variables Norton Sound Health Corporation	FY 2021
Population (2010 Census AN/AI population)	7749
Tribes (Federally Recognized Tribes)	20
Recurring Base - FY 2013 (less VBC)	$34,794,479
Percentage of Total Area TS (of all Alaska Tribes)	8.12295%
Percentage of ATHC (of all Title V Alaska Tribes)	8.22359%
Number of MOA employees	3
Number of IPA employees	0

Individually Restricted Items Norton Sound Health Corporation	FY 2021
Area Office (Individual Restricted Only)	
Supply Service Center	YES
Emergency Medical Services	NO
Village Clinic Leasing Management	YES
Headquarters (ATHC Restricted Only)	
ACOG	YES
OIT - Negotiated Alaska Plan	YES
Clinical Sup. Ctr. (Inc. CME Cert.)	YES

Appendix A - Financial Summary for Funding Agreement-Area Tribal Shares
Norton Sound Health Corporation

Line #	FY 2021 Budget Activity/Service	Total Area Budget	Residual Amount	ATHC restricted		Total AO Tribal Shares	NSHC AK Dist.	NSHC Retained	NSHC Total TS Due
		(Column 1)	*(Column 2)*	*(Column 3)*	*(Column 4)*	*(Column 5)*	*(Column 6)*	*(Column 7)*	*(Column 8)*
1	TRIBAL SHARE FUNDS	$11,900,108	$0		$0	$11,900,108	$966,640		$966,640
2									
3	AREA OFFICE PFSAs (excluding OEHE)								
4	Area Office PFSA's	$4,193,809	$2,442,960	$681,500	$1,069,349	$0	$0		$0
5	Lease Costs-	$1,657,267	$185,820	$193,220	$1,278,227	$0	$0		$0
5a	Space Costs- negotiations	$19,000	$0	$19,000					
6	Area Director's Reserve	$100,000	$0	$100,000	$0	$0	$0		$0
7	Headquarters Assessments	$488,590	$54,720	$230,202	$203,668	$0	$0		$0
8	Human Resources	$849,441	$210,962	$356,311	$282,168	$0	$0		$0
9	Human Resources (ANMC) funds	$0	$0	$0	$0	$0	$0		$0
10	Area PFSA transferred to ANTHC	$3,028,546	$0	$0	$3,028,546	$0	$0		$0
11	CHC Reserve	$1,555,064	$0	$0	$1,555,064	$0	$0		$0
12	Area Managed Care	$723,423	$0	$0	$723,423	$0	$0		$0
13	ANHB (inc. tobacco funds)	$389,983	$0	$0	$389,983	$0	$0		$0
14	Supply Service Center	$853,749	$0	$0	$335,598	$518,151	$42,089	$42,089	$0
15	Epidemiologists	$196,885	$0	$0	$0	$196,885	$15,993		$15,993
16	EMS program at ANMC	$195,140	$0		$0	$195,140	$15,851	*$0*	$15,851
17	Centers for Disease Control	$282,902	$0	$0	$282,902	$0	$0		$0
18	Subtotal Area PFSAs (ex. OEHE)	$14,533,798	$2,894,462	$1,580,233	$9,148,927	$910,176	$73,933	$42,089	$31,844
19									
20	OFFICE OF ENVIRONMENTAL HEALTH AND DESIGN								
21	Office of Envir. Hlth and Eng.-.(EH	$5,961,749	$244,466		$5,127,476	$589,807	$47,910		$47,910
22	Real Property/Realty (FSA)	$148,888	$92,682		$14,547	$41,659	$3,384	$3,384	$0
23	Health Facilities/Main./ Spec. Pro	$1,368,036	$114,204		$1,216,669	$37,163	$3,019		$3,019
24	Subtotal OEHE	$7,478,673	$451,352	$0	$6,358,692	$668,629	$54,312	$3,384	$50,928
25	**TOTAL AREA OFFICE**	$33,912,579	$3,345,814	$1,580,233	$15,507,619	$13,478,914	$1,094,886	$45,473	$1,049,412

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General Notes on Alaska Area Office Tribal Shares

Column 1 - Includes all FY17 changes allocated to TS, Residual, & Transitional as of FY17. In FY 2019 TS changes will be added as received.

Column 2 - Residual includes no changes in residual functions. Based on FY2018 Area approved residual budgets.
Remaining funds at 9/30 distributed (Non-Recurring) to all Alaska Area health programs based on recurring base.

Column 3 - Transitional funds agreed by co-signers to remain at Area Office. Based on FY2018 approved transitional budget.

Column 4 - Restricted by all co-signers & transferred to the ANTHC to provide "Area PSFAs" .

Column 5 - Includes Area TS for all Alaska Tribes, including Title I & Title V. FY19 mandatories to be added if received.

Column 6 - Available Tribal shares for Co-Signer (amounts for ANTHC include pass-through to awardees with shares captured by Sec. 325).
Distributed by the approved ATHC methodology of - 30% # of Tribes / 35% 2010 Census Pop. / 35% 2013 Rec. Base (less VBC).
All Area TS for Services line items will be recurring, Area TS for Facilities will be non recurring.

Column 7 - Items restricted by individual co-signer to pay for continued services from ANTHC. (Restricted amounts are added to ANTHC FA.)

Column 8 - The agreed upon amount due (col. 6 - col. 7) to the co-signer after all retained shares are withheld.

Line 1 - All TS funds for non-OEHE Area Office PSFAs except where co-signers have individually decided to retain certain PSFAs at the ANTHC or AANHS.

Line 5 - Lease on Inuit Building.

Line 5a - $20,000 (less sequester) from transitional funding held by IHS to rent space for annual negotiations. Funds transferred to ANTHC upon confirmation of space availa

Line 7 - Centrally paid expenses, including personnel & finance support for Area positions, costs & funds for departmental assessments.

Line 8 - Area Human Resources functions (previously Office of Personnel & Training).

Line 9 - Funding originally from ANMC - have all been returned to SCF/ANTHC as IPA/MOAs were reduced.

Line 10 - Includes funding for Area PSFAs transferred to ANTHC under Section 325.

Line 11 - Funds to ANTHC to support the statewide Contract Health Services reserve program.

Line 12 - Funds to ANTHC to support specialized services in Barrow, NSHC, & BBAHC & certain statewide laboratory contracts.

Line 13 - ANHB funds from Loc 77 including previous tobacco prevention funding.

Line 14 - Supply Service Center individually withheld amounts retained for ANTHC for all co-signers except YKHC, Seldovia, & Eklutna.

Line 15 - Funds distributed to support the Epidemiology Center distributed to co-signers for individual payment to ANTHC.

Line 16 - Funds for EMS training. Retained by IHS for transfer to ANTHC for Maniilaq, BBAHC, & Chugachmiut for EMS training at ANMC.

Line 18 - Does not include funds from surcharge, assessments, or other services purchased through Area Office.

Line 22 - Funds retained for ANTHC for all co-signers except YKHC, SCF, & KIC.

Line 24 - Does not include NR SFC funds for Health Facilities design and construction oversight.

Appendix A - Financial Summary for Annual Funding Agreement - Headquarters Tribal Shares
Norton Sound Health Corporation

Sub Act.	Line Item	Account	TSA	PF	BB	National FY 2021 TSA Pool	Chickaloon inc in All AK	Knik in All AK	All Alaska	ATHC Eligible Shares Total ATHC TS	NSHC Eligible shares	Co - Signer 0% Retained	0 Due	
						Column 1				*Column 2*	*Column 3*	*Column 4*	*Column 5*	
Hospitals and Clinics														
	101	Emergency Fund		x		$3,956,016			$462,063	462,063	End of year funds to be dist. on AK TSA formula.			
	104	Inter-Agency Agreements				$0			$138,380	138,380	$11,380	$0	$11,380	
	105	Management Initiatives		x		$2,049,512			$239,383	239,383	End of year funds to be dist. on AK. TSA formula.			
	106	A.C.O.G. Contract	x			$98,592			11,209	11,209	$922	$922	$0	
	107	H.P./D.P. Initiatives	x			$3,484,867			200,844	200,844	$16,517	$0	$16,517	
	110	N.E.C.I.	x			$1,107,951			124,173	124,173	$10,211	$0	$10,211	
	111	Nurse Initiatives	x			$1,287,656			140,892	140,892	$11,586	$0	$11,586	
	112	Nursing Co-steps	x			$648,528			72,677	72,677	$5,977	$0	$5,977	
	113	Chief Clinical Consultant	x			$277,340			31,086	31,086	$2,556	$0	$2,556	
	115	Emer. Medical Svcs	x			$465,222			41,980	41,980	$3,452	$0	$3,452	
	117	Traditional Advocacy Prog.	x			$100,578			11,272	11,272	$927	$0	$927	
	118	Research Projects	x			$1,283,252			143,088	143,088	$11,767	$0	$11,767	
	119	A.A.I.P. Contract	x			$26,731			2,994	2,994	$246	$0	$246	
	120	Clinical Support Center-Phoenix	x			$1,744,883			204,917	204,917	$16,852	$2,549	$14,302	
	121	Co-steps Non-physicians	x			$81,839			9,159	9,159	$753	$0	$753	
	123	Physician Residency	x			$277,416			31,093	31,093	$2,557	$0	$2,557	
	124	Recruitment/Retention	x			$2,057,393			230,592	230,592	$18,963	$0	$18,963	
	125	U.S.U.H.S., etc.	x			$3,071,317			344,246	344,246	$28,309	$0	$28,309	
	126	DIR Support Fund	x			$24,915,898			2,762,946	2,762,946	$227,213	$63,165	$164,048	
	127	Evaluation	x			$1,063,992			119,272	119,272	$9,808	$0	$9,808	
	128	National Indian Health Board	x			$459,114			51,111	51,111	$4,203	$0	$4,203	
	129	Albq./HQ Administration	x			$892,404			112,813	112,813	$9,277	$0	$9,277	
	130	Nutrition Training Center	x			$345,053			41,806	41,806	$3,438	$0	$3,438	
	131	Diabetes Program- Albq./HQ	x			$1,295,589			151,342	151,342	$12,446	$0	$12,446	
	132	Cancer Prevention- Albq./HQ	x			$716,968			84,278	84,278	$6,931	$0	$6,931	
	133	Health Records	x			$136,277			12,043	12,043	$990	$0	$990	
	134	AIDS Program	x			$422,971			78,823	78,823	$6,482	$0	$6,482	
	135	Handicapped Children	x			$346,083			40,775	40,775	$3,353	$0	$3,353	
	137	National OIT Sup.- Albq./HQ	x			$8,292,508			925,939	925,939	$76,145	$21,168	$54,977	
	154	Prescription Drug Monitoring	x			$1,002,361			$115,171	115,171	$9,471	$0	$9,471	
Dental Health														
	201	IHS Dental Program	x			$2,505,120			$300,609	300,609	$24,721	$0	$24,721	
	202	IHS Dental Program- Program formula		x		$5,269,192					$0	$0	$0	
Mental Health														
	301	MH/SS Tech. Asst.	x			$1,542,507			$174,272	174,272	$14,331	$0	$14,331	
	302	C.M.I. Grants	x			$628,310			$70,130	70,130	$5,767	$0	$5,767	
	303	National Conference	x			$107,552			$11,990	11,990	$986	$0	$986	
Alcohol/Sub. Abuse														
	401	Clinical Advocacy	x			$3,148,617			$516,623	516,623	$42,485	$0	$42,485	
	402	Collaborative Initiatives	x			$848,033			$48,451	48,451	$3,984	$0	$3,984	

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Appendix A - Financial Summary for Annual Funding Agreement - Headquarters Tribal Shares
Norton Sound Health Corporation

Sub Act.	Line Item	Account	TSA	PF	BB	National FY 2021 TSA Pool	Chickaloon inc in All AK	Knik in All AK	All Alaska	ATHC Eligible Shares Total ATHC TS	ATHC Eligible Shares NSHC Eligible shares	Co - Signer 0% Retained	Co - Signer 0 Due
						Column 1				*Column 2*	*Column 3*	*Column 4*	*Column 5*
Contract Health Care													
	501	Fiscal Immediary		x						$0	$0	$0	$0
	504	C.H.S. Reserve & Undistrib.	x			$3,377,832			$361,250	361,250	$29,708	$0	$29,708
Public Health Nursing													
	601	Preventive Health Initiatives	x			$951,210			$103,180	103,180	$8,485	$0	$8,485
	602	Preventive H. Init. - Prog. Formula		x							$0	$0	$0
Health Education													
	701	IHS Health Education Program	x			$1,133,793			$127,796	127,796	$10,509	$0	$10,509
CHR													
	801	IHS CHR Program	x			$2,412,266			$267,854	267,854	$22,027	$0	$22,027
Direct Operations													
	1301	Direct Operations	x			$13,847,784			$1,557,559	1,557,559	$128,087	$0	$128,087
	1301a	Direct Operations- OIT	x			$2,716,551			$305,550	305,550	$25,127	$5,302	$19,825
	1302	Direct Ops Dental	x			$0			$0	-	$0	$0	$0
Facilities and Environmental Health Services													
	2401	Sanitation Fac. Construction Sup.		x		$6,761,916				$325,101	$0	$0	$0
	2402	Environmental Health Ser. Support		x		$5,114,837				$197,905	$25,264	$25,264	$0
	2403	Facilities & Property Support		x		$24,019,205				$221,409	$17,947	$17,947	$0
	2404	Facilities Engineering Support		x						$0	$0	$0	$0
	2405	Engineering Services Support		x						$51,699	$5,201	$5,201	$0
TOTAL TSA AMOUNT						$89,122,358	$0	$0	$10,080,185	10,080,185	$828,953	$93,107	$735,846
TOTAL PROGRAM FORMULA AMOUNT						$47,170,678				$1,497,560	48,412	$48,412	$0
TOTAL HEADQUARTERS TRIBAL SHARE						$136,293,036				$11,577,745	$877,365	$141,519	$735,846

Column 1 - All numbers are based on HQ PFSAs for FY20 Table #4 dated 1/13/20 & FY21 Table 4F dated 7/16/20 (facilities)
Column 2 - All numbers are based on HQ PFSAs for FY20 Table #4 dated 1/13/20 & FY21 Table 4F dated 7/16/20 (facilities)

Column 3 - Individual Co-Signer share of column 2.
Column 4 - Co-Signer amounts left with (retained by) IHS to provide service- If service is not available IHS shall pay to each Co-Signer amount provided.
Column 5 - This column (col. 3 - col. 4) is the HQ. TS funds due to Co-Signer, calculated by Alaska TSA formula.
All Headquarters Tribal Shares shall be recurring except for Facilities (lines 2401 -2405) and funds in lines 101 and 105.
Line 101 - Any funds remaining will be distributed non recurring on 9/30 (from HQ by TSA formula) and to each Co-Signer on ATHC distribution method.
Line 105 - Any funds remaining will be distributed non recurring on 9/30 (from HQ by TSA formula) and to each Co-Signer on ATHC distribution method.
Line 106 - All Alaska Co-Signers restricted all funds to continued advanced OB training opportunities for all Alaska Area physicians.
Line 120 -Alaska Co-Signers restricted a total of $31,000 dollars for the clinical support center for CME certification and "IHS Provider" magazine.
Line 124 - BBAHC, EAT, Chugachmiut, Eyak, and Maniilaq retrocede 50% of line 124 to IHS in exchange for use of recruitment website ihs.gov/jobs.
Line 126, 137 -DIR withheld were computed at 27.8% of each Co-Signer on ATHC proposal. See Section 1 of the Funding Agreement.
Line 0154 New line for Prescription Drug monitoring. Full share included in co-signers TS.
Line 201 - Dental Program - approximately $800,000 transferred to line 1302 in Direct Ops Dental. No impact on TS.
Line 1301a - DIR Withheld was computed at 21.1% of each Co-Signer share based on continuing agreements with Dir. DIR.
Linr 1302 - Direct Ops Dental is now in line 201
Lines 2401-2405 - Funds available for OEHE support functions (from table 4f) provided based on national formula at tribal option.

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Name of Tribe/Tribal Org. **Norton Sound Health Corporation** **58G950016**

Contract/Compact Period **October 1, 2020 through September 30, 2021**

	Initial Negotiated Annual Funding Agreement						
	Budget Activity	Program/Service Unit Base		Area Tribal Share	Headquarter Tribal Share	Contract (Reductions)	Net Annual Payment Obligation
		Recurring	Non-Recurring	0.081229506		IPA/MOA	
		(1)	(2)	(3)	(4)	(5)	1+2+3+4+5=(6)
1	Hospitals & Clinics	$23,213,352		$275,437	$424,929	($224,613)	$23,689,105
2	Dental	$2,533,887		$17,016	$24,721	$0	$2,575,624
3	Mental Health	$765,746		$104,878	$21,085		$891,708
4	Alcohol & Substance Abuse	$1,174,320		$69,541	$46,469		$1,290,330
5	Public Health Nursing	$1,063,687		$9,956	$8,485		$1,082,128
6	Health Education	$117,928		$20,402	$10,509		$148,840
7	Community Health Representativ	$329,970		$7,517	$22,027		$359,515
8	Immunization (AK only)	$10,316		$28,276	$0	$0	$38,592
9	Direct Operations	$40,186		$347,386	$147,913		$535,484
10							
11							
12	Self-Governance				$0		$0
13	Other, Services (Annual)						
14	TOTAL, Services (Annual)	$29,249,392	$0	$880,409	$706,138	($224,613)	$30,611,327
15	Purchased/Referred Care	$13,412,656		$118,066	$29,708		$13,560,429
16	Operational Cost for Tribal Clinics					0	$0
17	Environmental Health Support	$661,707		$47,910			$709,617
18	Facilities Support	$1,828,331		$3,028			$1,831,359
19	OEHE Support				$0		$0
20	Maintenance & Improvement		$1,462,821		$0		$1,462,821
21	Sanitation Facilities - Housing				$0		$0
22	Sanitation Facilities - Regular				$0		$0
23	Equipment		$180,666				$180,666
24	TOTAL, Facilities	$2,490,038	$1,643,487	$50,937	$0	$0	$4,184,463
25	Current year CSC Direct	$4,630,788					$4,630,788
26	Current year CSC Indirect		$12,264,014				$12,264,014
27							
28	Other (*See* Remarks)						$0
29	TOTAL, CSC	$4,630,788	$12,264,014	$0	$0	$0	$16,894,802
30	Quarters						$0
31	Contract Health Services (Prior Year)						$0
32	Indian Health Facilities (Prior Year)						$0
33	Others						
34	TOTAL, Other	$0	$0	$0	$0	$0	$0
35					$0		$0
36	**GRAND TOTAL, AFA**	**$49,782,874**	**$13,907,501**	**$1,049,412**	**$735,846**	**($224,613)**	**$65,251,021**

Footnotes:

The FA program funding amount in column 1 and 2 are as of FA 12 dated 7/31/2020

The FA funding also includes all funds from Diomede ISDA TI agreement transferred in FY15.

Line 20 and 23 - Routine M&I and Equipment funding is estimated at 90% of prior FY amount for lump sum payment -subject to adjustn with Sec. 4 of the FA.

d Health Corporation

Norton Sound Health Corporation
Withhold Calculation

The Co-Signer will "withhold" 100% of all estimated costs for IPA/MOA, SSC, VBC, **No**

surcharge **0.285%** **(Yes or No)**

The Co-Signer will "withhold" the minimum initial amount for IPA, etc., and "buyback" services. **Yes**

0.285% **(Yes or No)**

Service	Annual Amount				Est. Monthly Payment	Initial Auth. Withhold
	(1)	(2)	(3)	Total Annual Estimated Costs		
	(1)	(2)	(3)	1+2+3=(4)	(4)/12=(5)	*see* Footnotes
H & C						
IPA/MOA Personnel Costs	$566,729	18,731	$1,615	$587,076	$48,923	$195,692
VBC	$0		$0	$0	$0	$0
Other	$86,516		$247	$86,763	$7,230	$28,921
SUBTOTAL H & C	$653,245	$18,731	$1,862	$673,838	$56,153	$224,613
DENTAL						
IPA/MOA personnel costs			$0	$0	$0	$0
Supply Service Center		$0	$0	$0	$0	$0
All other costs-			$0	$0	$0	$0
SUBTOTAL DENTAL	$0	$0	$0	$0	$0	$0
IMMUNIZATION						
IPA/MOA personnel costs			$0	$0	$0	$0
Supply Service Center		$0	$0	$0	$0	$0
Village Clinic Leases			$0	$0	$0	$0
All other costs-			$0	$0	$0	$0
SUBTOTAL IMMUNIZATION	$0	$0	$0	$0	$0	$0
T-CLINIC						
VBC Increases			$0	$0	$0	$0
		$0	$0	$0	$0	$0
			$0	$0	$0	$0
SUBTOTAL T-CLINIC	$0	$0	$0	$0	$0	$0
Withhold Total	$653,245	$18,731	$1,862	$673,838	$56,153	$224,613

Footnotes:

Column 2 - IPA/MOA Centrally Paid Expenses are estimated at $588 for each IPA and $6,243.81 for each MOA.

Column 2 - IPA/MOA Centrally Paid Expenses are estimated at $588 for each IPA and $5,293.74 for each MOA.
Employee Dispute Pool Costs are no longer charged in advance (*see* Section 2.3.2.3 of Buyback Agreement).

Column 3 - Surcharge for all Co-Signers using buyback is .285%

This sheet not to be included in Appendix A - Provided to assist in completing Section 4 of the FA then disca

Norton Sound Health Corporation	
Recurring base	$49,782,874
Non Recurring base	$13,907,501
Subtotal recurring and non recurrir	$63,690,375
Area tribal Share	$1,049,412
HDQ TSA Tribal Share	$735,846
HDQ program formula tribal share	**$0**
Subtotal tribal shares	$1,785,258
TOTAL Funding Agreement	$65,475,634

non recurring includes M & I $1,462,821

FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

Amendment Effective December 30, 2018

In accordance with Section 14.1 of the Norton Sound Health Corporation (NSHC) FYs 2018-2020 Multi-Year Funding Agreement (MFA), as amended, the NSHC and IHS agree to the following revision:

Appendix B (as previously amended) is hereby further amended and restated by the version of Appendix B attached.

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

Angie Gorn 12/9/20

By: _____ _____
Angie Gorn, President/CEO Date

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S Digitally signed by Evangelyn L. Dotomain -S Date: 2021.01.05 14:53:56 -09'00' _____
Director, Indian Health Service Date

Norton Sound Health Corporation Funding Agreement - Appendix B
Fiscal Years 2018-2020

This non-exhaustive list of Tribal Facilities and Locations identifies the sites where Norton Sound Health Corporation owns, leases, occupies, or otherwise used real property to carry out its responsibilities under the Alaska Tribal Health Compact and its Funding Agreement. Each description of facilities and locations is intended to include surrounding and adjacent grounds.

Additionally, the cross references to specific PSFAs are not intended to limit the scope of PSFAS that may be performed at a facility or for which a facility may be used; rather, cross references are intended as an example of the type of PSFA that may be performed at the facility or of the manner in which a facility may be utilized. Cross references are not exhaustive and may not be construed to be exclusory of other PSFAs that may be performed at a facility or of the uses of the facility.

LOCATION	FACILITY NAME	TRIBAL PROGRAMS (including but not limited to)
Nome	Norton Sound Regional Hospital-Main Campus (Replacement Facility)	Section 3.1; Sections 3.2.1-3.2.7; Sections 3.2.9-3.2.13; Section 3.2.15; Section 3.2.16; Section 3.3.6; Sections 3.4.1-3.4.4; Sections 3.4.6-3.4.8; Sections 3.4.11-3.4.14; Section 3.5; Section 3.6; Section 3.7; Section 3.8.
Nome	Quyanna Care Center	Section 3.2.8
Nome	Hostel	Section 3.2.14
Nome	BIA EMT Training Center/Drug and Alcohol Rehabilitation Center	Section 3.2.13; Sections 3.3.1-3.3.3, 3.3.5-3.3.7; Section 3.4.6, 3.4.12
Nome	Kusgi House	Section 3.3.5, 3.3.6
Nome 607 Division Street	NSHC Behavioral Health Clinic	Section 3.3.1-3.3.3, 3.3.5-3.3.7; Section 3.4.10; Section 3.8
Nome	Health Aide Training	Section 3.4.5
Brevig Mission	Brevig Mission Clinic	Section 3.2.5, 3.2.10, 3.2.11; Section 3.3.1-3.3.3; Section 3.4.1-3.4.4, 3.4.12; Section 3.7; Section 3.8
Diomede	Diomede Clinic	Section 3.2.5, 3.2.10, 3.2.11; Section 3.3.1-3.3.3; Section 3.4.1-3.4.4, 3.4.12; Section 3.7; Section 3.8

All Villages	Village-Based Counselor Office Space	Section 3.3
All Villages	Village Based Morgues	Section 3.4.17

AMENDMENT TO
FUNDING AGREEMENT
BETWEEN
THE NORTON SOUND HEALTH CORPORATION
AND
THE SECRETARY OF HEALTH AND HUMAN SERVICES
FISCAL YEARS 2018-2020

In accordance with Section 14.1 of the FY's 2018-2020 Funding Agreement made and entered into by Norton Sound Health Corporation and the Secretary of the Department of Health and Human Services of the United States of America, effective October 1, 2017, the funding agreement, as amended, is hereby further amended as follows:

1. **Appendices.** The following appendices are incorporated by reference and attached:

   - Appendix C – FY 2020 Continuing Services Agreement

2. **Effective Date**. This amendment is effective October 1, 2019.

Norton Sound Health Corporation - on Behalf of Itself and Certain Alaska Native Tribes Identified in Exhibit A of the Compact

By: Angie Gorn 3/29/21
Angie Gorn, President/CEO Date

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S Digitally signed by Evangelyn L. Dotomain -S Date: 2021.04.27 16:07:52 -08'00'
Director, Indian Health Service Date

MEMORANDUM OF AGREEMENT DESCRIBING THE CONTINUING SERVICES OF THE INDIAN HEALTH SERVICE, ALASKA AREA NATIVE HEALTH SERVICE TO NORTON SOUND HEALTH CORPORATION FOR FY 2020

I. INTRODUCTION

This agreement provides for the continuation by the Indian Health Service (IHS) of certain services from the Alaska Area Office for the benefit of Norton Sound Health Corporation under its Funding Agreement (FA) under the Alaska Tribal Health Compact (ATHC) Self-Governance Compact.

This agreement is limited to the programs, services, functions, and activities (PSFAs) performed by the residual and transitional federal staff of the Alaska Area Office.

This agreement should be interpreted in conjunction with Norton Sound Health Corporation's FA and Appendix A to that FA, which may provide for additional detail on "restrictions" of funds at the Area or Headquarters level to ensure that specific services are continued to the individual Co-Signer.

In FY 2020, funding for these continuing services and activities will be from the funds, which have been designated as residual and from funds, which have been designated in support of temporary transitional federal PSFAs. In addition funding to purchase specific services, i.e., use of IPA/MOA assignees and Village Built Clinic leases, may be provided through reimbursement by Norton Sound Health Corporation to the IHS.

II. DEFINITIONS

The following definitions are in common usage in the Alaska Area:

A. ATHC Tribal Restricted Share - Used in Alaska to refer to those retained Tribal shares all compacting Tribes jointly initially agreed to leave in the Area Office in support of Alaska Area state wide PSFAs. Pursuant to Section 325 of PL 105-83, these shares now are in the Alaska Native Tribal Health Consortium (ANTHC) FA or are used for transitional federal PSFAs.

B. Buyback - The process by which Co-Signers use cash to purchase Area services from the Area Office. Requires accurate description and pricing of service, and mechanism for Area to invoice and receive payment.

C. Co-Signer Restricted Shares - Used in Alaska to refer to "retained Tribal shares" that have been left at the Area Office or Headquarters on an individual basis by a Co-Signer to allow the Area, Headquarters or ANTHC to provide specific services to the Co-Signer. Pursuant to Section 325 of PL 105-83, these Area shares now are in the ANTHC FA or are used for transitional federal PSFAs.

D. Residual - The resources necessary to support the PSFAs required for the United

A. OFFICE OF THE DIRECTOR

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Director	Provides overall executive direction and support on behalf of the Secretary.	R	1
Deputy Director, Chief Medical Officer	Provides public health advocacy; clinical consultation (CMO); legally required certification of health aide credentials and oversight of CHAP certification process; consultation in CHAP/Rural Health program management.	R	1
Executive Officer	Serves as principal advisor to the Director on overall management policies and procedures.	R	1
Attorney	Provides Region X attorney support and consultation.	R	1
EEO	Provides EEO support. 1		
Support Staff	Secretarial, clerical and administrative support to inherent and transitional federal functions at all levels of the Area Office.	R T	3 1
Planning, Evaluation & Statistics	Prepare statistical reports and publications in support of planning, evaluation and resource allocation requirements.	R	2
	Total		10

The Office will provide the specific PSFAs defined below:

1. Executive direction on behalf of the Secretary to the remaining inherently federal functions.
2. Advocacy at national level on behalf of the Tribes of Alaska including: legislative, policy, resource allocation, and appropriation advocacy.
3. Policy formulation and interpretation; supervision of non-IPA/MOA federal employees; negotiate, execute and administer compacts and FAs; resource allocation.
4. Public health coordination with Tribal, state and federal governments.
5. Provide legal advice and consultation on behalf of the Secretary.
6. Provides representation on the Executive Committee and Planning Committee of the Alaska Federal Health Care Partnership (AFHCP). Through the government-to-government relationship with Tribes and Tribal organizations, provides the mechanism for Tribal membership on the AFHCP.
7. Eligibility determinations assistance.
8. Equal Employment Opportunity program management in support of federal employment rights.
9. Oversight of certification of Community Health Aides as outlined by law and the *IHS Community Health Aide Program Certification Board Standards and Procedures*.
10. Consultation and technical assistance to Tribes and Tribal organizations staff and programs including
    a. Program review or evaluation at the request of the Area Director or the invitation of Tribal programs;
    b. Submission of electronic health record data to IHS National Data Warehouse; and
    c. Maintain current Area statistics to provide statistical analysis in support of resource needs and allocations.

1 The EEO function is provided under an intra-agency agreement among the IHS Alaska, California and Portland Area Offices.

B. OFFICE OF ACQUISITION AND PROPERTY MANAGEMENT [2]

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Federal Contracting ,, Personal Property, and FOIA Coordinatio n	Responsible for federal acquisitions to support the Alaska Area Office, including the federal credit card program. Maintains the federal personal property inventory. Provides or coordinates various administrative services for the Alaska Area Office.	R	1
	Total		1

The Office will provide the specific PSFAs defined below:

1. Negotiate, award and administer federal acquisitions.
2. Maintain or develop Alaska Area Interagency and Cooperative Agreements in close partnership with appropriate IHS or other federal, state or Tribal entity(s).
3. Coordinate various administration functions including Freedom of Information Act requests and IHS delegations and directives.
4. Maintain the federal personal property management inventory, including excess and disposal.
5. Provide technical assistance to Tribally managed facilities on procurement issues as requested regarding procurement issues and acquired federal excess property.
6. Maintain the federal credit card program.

2 Residual (1) FTE moved to Office of Tribal Programs in support of Title 1 contracts and audit resolution.

a. Overall direction of resources and related environmental surveillance for statewide public health impacts.

b. Continue to carry out functions related to serving as one of the health and medical representatives to the Alaska Federal Emergency Response Group.

c. Provide management and verification of tribal input data in the IHS Environmental Health Services data system known as the Web-based Environmental Health Reporting System (WebEHRS).

d. Provide safety assurance, compliance and reporting relating to federal workers, and professional programmatic support for staff.

e. In the event of a national disaster situation as defined in the Federal Response Plan, IHS is the lead agency for emergency response related to water and sewer damage assessment and mitigation.

3. **Health Facilities:** PSFAs include:

a. Perform budget allocation;

b. Support and approve project or resource allocations derived through a priority system developed through the Maintenance & Improvement Resource Allocation Committee (MIRAC) and ANTHC process consistent with IHS national project eligibility criteria. Verify data submittals and manage IHS facilities databases in conformance with IHS national project and health facilities space eligibility criteria.

c. Respond to Congressional inquiries;

d. Review Project Justification Document/Program Of Requirements (PJD/POR) documents prepared by others;

e. Review and approve national priority systems applications, including Tribal Equipment Funds and Dental Facilities Funds;

f. Maintenance of Alaska portion of the IHS Healthcare Facilities Data System (HFDS) including the Facilities Maintenance and Improvement/Equipment database for federally and Tribally owned health facilities;

g. Support for new health facility construction project funds distribution and project development;

h. Stewardship responsibility for oversight of environmental cleanup of federally owned real property;

i. Approve workload statistics;

j. Advocate statewide and nationally for the DEHE program and facilitates its implementation.

4. **Realty:** PSFAs include:

a. Monitor and manage real property assets in accordance with Executive Order 13327, "Federal Real Property Asset Management" and existing authority under law or by executive order for real property, capital improvements, square footage, use or disposal.

b. Maintain the IHS Real Property Inventory by updating the asset book values with costs relating to acquisition of real property, capital improvements, square footage, use or disposal.

c. Verify construction project closeout documentation for capital improvements made to federal facilities prior to adjusting the real property subsidiary ledger.

d. Perform annual review of real property.

e. Warranted Lease Contracting Officer authorized to lease Village Built Clinics

Co-Signers and contractors to maintain accurate records of funding allocations, reconciliations and cash management issues.

8. Reconciliation, billing and amendment management related to contractor and compactor use of federal resources including but not limited to IPA/MOA employees and the Village Built Clinic lease program. Reconciliation includes transaction verification of buyback services with corrections and reports.

9. Support withhold and buyback management including payment for continuing government contracts for goods and services, permanent change of station moves, etc.

10. Monthly general ledger reconciliation including cash management related to Prompt Pay Act, Treasury, cash and others.

11. Process reimbursement requests including Beneficiary Medical Program (BMP), Interagency Payment and Collections (IPAC), quarters collections, CHEF and others. Make deposits and transfers of such reimbursements to Co-Signers no less often than monthly.

12. Assist Tribes during annual Budget Formulation for the second succeeding year's annual budget, including preparation for the National Budget Formulation meeting.

E. OFFICE OF HUMAN RESOURCES

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Civil Service Staffing, Classification & Employee/ Labor Relations	Advertise and recruit for federal, direct and IPA/MOA replacements; process personnel and pay actions; provide job information; maintain official records; rate applicants, appoint new employees, and provide HR consultation; Title 38 and Physician's Comparability Allowance, Market Pay & Locality Pay maintenance; process Reduction in Force and counseling; provides transportation services and relocation assistance for federal employees and consultation re: Tribal direct hires as requested; administers Workers' Compensation program; grievances, discipline/adverse actions; Merit Systems Protection Board, appeals and agency representation; performance management; retirements; payroll; benefits; outside activities; ethics program; suitability adjudication; manage Federal Employee Assistance program and Family Medical Leave and Family Friendly Acts consultation; conducts desk audits; applies Classification Standards and consultation. Initiate and assure completion of suitability investigations as needed on federal employees and personal services contractors.	R T	2 0
	Total		2

Under the direction of the IHS Western Region Human Resources Director, the Office of Human Resources will provide the specific PSFAs defined below for the current approximately 340 federal employees employed either directly or through Civil Service IPAs (58) or Commissioned Corps MOAs (254):

1. Advertise and recruit for direct federal employees. Replacement IPA positions may be filled with a current IPA already on board (such as by reassignment) or a new or replacement MOA. Process Reductions In Force (RIF). Provide counseling on RIF.

2. Maintain official personnel files (electronic and paper) and records for Civil Service employees.

F. COMMISSIONED CORPS PERSONNEL[4]

P/S/F/A	MAJOR FUNCTIONS	Buyback	Staffing (FTE)
Commissioned Corps Personnel	Orient and assist officers and their families to include: recruitment support, liaison between areas, TRICARE advice, wage verifications, grievances, leave programs, COERs and COSTEP. As necessary, Corps-specific personnel discipline advice to CEOs and HR staff of 638 awardees with MOA assignees and supervisors of MOAs.	B	2
	Total		2

Under the direction of the IHS Division of Commissioned Personnel Support, the Commissioned Corps Personnel component will provide the specific PSFAs defined below for the approximately 259 USPHS Commissioned Officers in the Alaska Area:

1. Provide general orientation to new Commissioned Officers.
2. Counsel Commissioned Officers; provide Corps-specific discipline advice to appropriate Co-Signer managers.
3. Maintain unofficial files and records for Commissioned Officers.
4. Process required federal personnel actions for Commissioned Officers including orders for deployment.
5. Assist and consult with officers and their supervisors.

G. OFFICE OF TRIBAL PROGRAMS

P/S/F/A	MAJOR FUNCTIONS	Residual Transitional	Staffing (FTE)
Director	Management of Area Title V responsibilities for Self-Governance and Title I review, approval and technical assistance. Managing CHEF submissions, and fund distribution; clerical and secretarial support.	T	1
Health Care (Management) Consultation	Title V compacts/FAs (including amendments and database management of same), cooperative agreements, and grants; negotiate and administer CSC funds.	T	3
Health Care [5] (Management) Consultation	Negotiate, manage, and execute Title I contracts. Review audit findings and work with Tribal contractors to resolve as needed.	R	1
	Total		5

The Office will provide the specific PSFAs defined below:

1. Provide or facilitate technical assistance to Tribes which may or may not lead to the preparation of proposal(s) to assume PSFAs for Title I contracting, Title V compacting and Tribal Management grants for Tribes and Tribal organizations
2. Evaluate P.L. 93-638 proposal(s) to determine acceptance, declination or rejection; if

4 During FY 2005 this PSFA was centralized under the Division of Commissioned Personnel Support at IHS Headquarters. Effective FY 2006, it is funded by assessing the locations that use Commissioned Officers. See, also, Appendix A.

5 Formally P/S/F/A: Federal Contracting Title I awards, (1) Residual FTE moved from the Office of Acquisition and Property Management; to support Title I contracts and audit resolution.

United States of America
Secretary of
Department of Health and Human Services

By: Evangelyn L. Dotomain -S
Digitally signed by Evangelyn L. Dotomain -S
Date: 2021.04.27 16:06:22 -08'00'

Director
Alaska Area Native Health Service, IHS

Date: _____

Norton Sound Health Corporation
on Behalf of Itself and Certain Alaska Tribes,
Identified in Exhibit A to the Compact.

By: Angie Gorn

Angie Gorn, President/CEO
Norton Sound Health Corporation

Date: 10/30/2020

Appendix D
Buyback/Withhold Agreement
between
the Indian Health Service
and
Norton Sound Health Corporation

Section 1. Generally. Pursuant to Section 5.3 of the Funding Agreement between Certain Alaska Native Tribes Served by Norton Sound Health Corporation (hereinafter "NSHC") and the Secretary of the Department of Health and Human Services of the United States of America (hereinafter "Secretary"), NSHC has determined that it wishes to carry out its responsibility to provide certain programs, activities, functions or services (e.g. salaries of IPA/MOA employees, and Village Built Clinics Program) included in its Funding Agreement utilizing services, personnel or other resources of the Federal Government, (hereinafter "services") under Article V, section 22 of the Compact, as permitted by law. These services may include some that are expected to be used throughout the year and some incidental services to be identified by NSHC on an as needed basis, and provided by the Indian Health Service (hereinafter "IHS") when IHS has the capacity to do so. The cost of providing the purchased services to NSHC shall be determined under section 2 below. NSHC's purchase of services is contingent upon the availability of IHS resources to provide those services. In addition, services must be paid for in advance, in order to avoid violation of the Anti-Deficiency Act and are subject to full cost recovery in accord with 25 USC 458aaa-7(f) and 31 USC 9701.

Section 2. Determination of Cost.

2.1 Generally. NSHC may acquire services from the IHS by either providing for full year withhold (with appropriate reconciliation) under terms agreed upon in this funding agreement, in which case the administrative surcharge provided for under section 2.2.4 shall not apply. In the alternative, NSHC may acquire services by authorizing partial year withhold amounts, as provided for in section 2.2, in which case the payment schedule and administrative surcharge provided for in section 2.2.4 shall apply. Whether full or partial year withhold is authorized, the full costs of IPA/MOAs including those detailed in section 2.3, Determination of IPA/MOA Costs, shall be paid by NSHC.

2.2 Conditions for Partial Year Withhold and Buyback.

2.2.1 IPA/MOA.

2.2.1.1 Advance withhold. The funds for IPA/MOA salary and other costs detailed in section 2.3, "Determination of IPA/MOA Costs," will be paid as a lump sum in accord with Section 5(a) of the Funding Agreement, except that an amount equal to three monthly payments based on the initial mutually agreed upon estimate of the annual IPA/MOA salary costs and related surcharges, as provided in section 2.2.4, will be withheld and retained by the Indian Health Service pending final disbursement for the last three months of the fiscal year as provided in section 3.2.2.2.

services to NSHC.

2.3 Determination of IPA/MOA Costs.

2.3.1 List of Costs. It is agreed by the parties that the entire cost of IPA/MOA assignments, including costs associated with the initiation, maintenance, and termination of the assignments are the responsibility of NSHC. The IHS must be reimbursed for all such costs which include but are not limited to the following:

2.3.1.1 Permanent change of station costs including the cost of moving replacement IPAs from the lower forty-eight to Alaska and the cost of moving IPA employees who separate back to the lower forty-eight.

2.3.1.2 Recruitment, relocation and retention bonuses if such funds are necessary to attract or retain employees.

2.3.1.3 Severance pay for employees who are released by NSHC and separated without cause.

2.3.1.4 Payment of turnaround leave travel expenses. All individuals who are eligible for these expenses shall be identified in the IPA negotiated between the parties. The IHS will retain liability for existing IPAs. NSHC assumes the liability for new IPAs and upon renewal of an existing IPA.

2.3.1.5 Lump sum leave payments for employees who leave federal service. All leave accrued prior to the employee becoming employed by NSHC shall be identified in the IPA/MOA negotiated between the parties. The liability for accrued leave on existing, renewing, and new IPA/MOAs shall be the responsibility of NSHC.

2.3.1.6 Costs associated with settling or resolving employment related disputes, subject to the terms specified in section 2.3.2 below.

2.3.1.7 Centrally paid expenses, subject to the terms specified in section 2.3.3 below.

2.3.1.8 The cost of paying unemployment benefits assessed to the Area in FY 2002 and thereafter on behalf of an employee who was employed by NSHC under an IPA immediately prior to voluntary or involuntary separation from IHS regardless of the year in which unemployment benefits were paid. The NSHC is not responsible for unemployment costs that were assessed to the Area in Fiscal Years 2000 and 2001.

2.3.2 Costs Related to Employment Related Disputes.

2.3.2.1 Responsibilities of the IHS. The Indian Health Service shall be responsible for the payment of all costs of the IHS Office of Human Resources and any other section of the Indian Health Service, the Office of General Counsel, and the Department of

2.3.3 Costs Related to IPA/MOA Centrally Paid Expenses. Certain costs associated with IPA and MOA employees are paid centrally by Headquarters from Area funds. These include costs detailed in columns 6, 7, and 8 of the spreadsheet entitled "Allocation of Centrally Paid Expenses (Excluding FTS)," Corrected May 11, 1998, that was prepared by David Mather. These are costs associated with Commissioned Corps, Personnel and Payroll, and Balance of Human Resources. The Alaska Area Native Health Service may pay for or recover assessments from Headquarters to cover these identified costs by including in the monthly charge for each IPA or MOA the monthly cost to the IHS of such Centrally Paid Expenses. The cost charged NSHC for each IPA/MOA may not exceed the average cost per federal employee actually paid by IHS. For purposes of calculating the initial withhold amount and estimated monthly payments, the estimated average cost per month for each IPA or MOA is shown in Appendix A of the Funding Agreement.

2.4 Limitation on Obligations and Notice.

2.4.1 Obligations. IHS shall within 30 days provide notice to NSHC of the best available estimate of the costs that may be incurred under this Agreement of leases, contracts, salaries and related expenses and permanent change of station.

2.4.2 Content of Notices of Best Available Estimates and Costs. Notice of best available estimates under section 2.4.1 and full accounting of all costs due under section 3.3.1 shall include the amount, vendor and reason for obligation or expenditure, including the name of the employee, if any.

Section 3. Method of Payment.

3.1 Full Year Withhold. Payment for services being purchased from the IHS may be made by NSHC authorizing a withhold of the full year's initial mutually agreed upon estimate of the annual cost of each category of services NSHC proposes to purchase from the IHS. In such case, no monthly payments are due from NSHC. Upon periodic reconciliation, provided for under section 3.3.1, excess withheld funds will be paid by the IHS to NSHC and adjustments in the amount of withhold or payments needed to pay for all services NSHC has purchased, or proposes to purchase, will be made to the IHS by NSHC. *See* "Summary of Withhold/Buyback" page of Appendix A for calculation of the amount NSHC hereby authorizes for full year withhold, if any.

3.2 Purchases through Buyback under section 2.2.

3.2.1 Calculations.

3.2.1.1 Of Initial Estimated Monthly Payment. The initial estimated monthly payment is determined by estimating the annual cost of services to be purchased from IHS, including the surcharge on all services under section 2.2.4, and dividing by 12. *See* "Summary of Withhold/Buyback" page of Appendix A for calculation of the amount of the initial estimated monthly payment.

reconciliation is due any under recovery must be paid by NSHC.

3.3.2 For Administrative Surcharge.

3.3.2.1 Use and Rebate. The administrative surcharge shall be used exclusively for administration of the buyback provisions under this Buyback/Withholding Agreement. All income from the administrative surcharge will be accounted for separately and compared on an annual basis to the cost of administering buyback at the Area Office. This accounting and reconciliation shall be complete within 60 days of the end of the last day of the fiscal year. Any surplus in administrative surcharges shall be returned to the Co-Signers who participated in the buyback option on a pro rata basis depending on the amount of administrative surcharge paid.

3.3.3 Adjustment in Estimated Monthly Payment. In addition to adjustments in estimated payments that may occur under sections 3.3.1 and 3.3.2.1, the parties may at any time mutually agree, based on a change in circumstances, to change the estimated monthly payment due from NSHC.

3.4 Use of Other Funds Due NSHC to Avoid Default or Satisfy Obligations to IHS and other Remedies.

3.4.1 Avoiding Default. Default may be avoided to the extent funds are held by the IHS from other funds due to NSHC, which may be withheld to satisfy the amount of the payment, which would otherwise be in default or to satisfy amounts due IHS after reconciliation of costs and payments when an amount is due to IHS.

3.4.2 Recoupment. Any amount due to the IHS by reason of NSHC's failure to pay in full all amounts owing under the buyback provisions of the Funding Agreement for the immediately preceding fiscal year shall be recouped by the IHS from any funds due to NSHC under this funding agreement.

3.4.3 Full Year Withhold as Penalty for Default. Notwithstanding any other provision of this Buyback/Withholding Agreement, the IHS may require "full year withhold" as permitted herein as a condition of permitting a Co-Signer who was in arrears at the end of the immediately preceding fiscal year to buyback services from the IHS under the terms of this Agreement.

Section 4. Dispute Resolution. The parties shall endeavor to resolve any disputes concerning amounts due by NSHC under this Agreement in a manner agreeable to NSHC and to the IHS. In the event of a failure to reach agreement on the resolution of any such dispute, NSHC may, after providing written notice to the IHS, choose not to include the disputed amount in any subsequent payment due. Payment in such a manner shall not be considered as a resolution of the dispute. The parties shall thereafter attempt to resolve the dispute through Alternative Dispute Resolution following, as appropriate, the principles and processes set forth in Executive Order 12988 signed by President Clinton on February 5, 1996, and made effective as of May 5, 1996. NSHC shall have the option of resolving the dispute in accordance with Article

Funding Agreement Appendix E

P.O. BOX 966
NOME, ALASKA 99762
(907) 443-3311

NORTON SOUND HEALTH CORPORATION

Norton Sound Health Corporation

RESOLUTION # 2010-16
Services for Non-Eligible Individuals

WHEREAS, the Norton Sound Health Corporation (NSHC) is a tribal organization that is a Co-Signer of the Alaska Tribal Health Compact (ATHC) and has negotiated a Funding Agreement (FA) with the Indian Health Service (IHS) under Title V of the Self-Determination Education and Assistance Act (ISDEAA); and

WHEREAS, the ATHC authorizes Co-Signers to provide services to non-eligible individuals provided Section 813 of the Indian Health Care Improvement Act (IHCIA) is complied with (*See* ATHC Article III, Section 4), and Section 813, as amended at 25 U.S.C. § 1680c(c)(2), provides that a tribe or tribal organization which operates a health facility under an ISDEAA agreement may make its own determination whether to provide health services to persons not otherwise eligible (i.e. non-beneficiaries) to receive IHS-funded health services; and

WHEREAS, NSHC is authorized to determine whether it will provide health services under its IHS-funded programs to persons who are not eligible beneficiaries under federal law, provided that NSHC gives consideration to whether the provision of such services will result in a denial or diminution of health services to eligible beneficiaries; and

WHEREAS, NSHC has determined that the provision of health services on a fee-for-service basis to non-beneficiaries, in an amount not less than the actual costs of providing such services, will not result in a denial or diminution of health services to beneficiaries; and

NOW THEREFORE, BE IT RESOLVED, that NSHC has decided to extend all available health services under the ATHC and its FAs to non-beneficiaries on a fee-for-service basis; and

BE IT FURTHER RESOLVED, that whenever significant evidence is presented to NSHC Board of Directors that services to non-eligible, non-beneficiaries have resulted in a denial or diminution of health services to beneficiaries, NSHC may suspend the delivery of such services to non-beneficiaries.

DATED this 25 day of June, 2010.

CERTIFICATION

The above Resolution was passed at a regular meeting of the Norton Sound Health Corporation Executive Board held on this 25 day of June, 2010 at Nome, Alaska at which a quorum was present. 8 FOR, 0 AGAINST, 0 ABSTAIN.

Attest: _____ Attest: Berda Willson
Emily Hughes, Board Chair Berda Willson, Board Secretary

"Serving the communities of: Brevig Mission, Council, Diomede, Elim, Gambell, Golovin, King Island, Koyuk, Mary's Igloo, Nome, St. Michael, Savoonga, Shaktoolik, Shishmaref, Solomon, Stebbins, Teller, Unalakleet, Wales, White Mountain"

Norton Sound Health Corporation

APPENDIX F

PROJECT SUMMARY DOCUMENT

requirements. Cite specific, code or JCAHO references by standard clause, chapter, paragraph, etc.]

III. DEFICIENCIES

The following deficiencies will be corrected as part of this project:

[List and describe only those facility deficiencies this project will address. The types of deficiencies include BEMAR, JCAHO, NFPA, HFPM, Public Law compliance items, ADA, etc.]

IV. COST ESTIMATE

Provide a budgetary cost estimate and the funding sources for the proposed project, including separate line items for design Architect/Engineer fees, project construction, construction contract administration fees, and project contingency.

V. PROJECT SCORE SHEET DOCUMENT (*only required for BEMAR competitive pool funds*)

Complete a project score sheet further detailing the scope, impact and benefits of this project. Provide the information required by the project score sheet.

VI. OTHER PROJECT ITEMS TO BE ADDRESSED

Supporting Documents: Drawings, Photos, Estimates, Etc.

Norton Sound Health Corporation

APPENDIX G

ENVIRONMENTAL INFORMATION AND DOCUMENTATION

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

6. Does the proposed action have significant adverse direct or indirect effects on park land, other public lands, or areas of recognized scenic or recreational value?	Yes or No. Explanation.
7. Does the proposed action include construction of a new municipal solid waste landfill at a new solid waste disposal site?	Yes or No. Explanation.
8. Will the proposed action create a need for additional capacity at solid waste disposal facilities?	Yes or No. Explanation.
9. Does the proposed action include construction of a new wastewater treatment facility that will discharge treated sewage effluent to the waters of the U.S.	Yes or No. Explanation.
10. Will the proposed action create a need for additional capacity at wastewater treatment facilities?	Yes or No. Explanation.
11. Will the proposed action create a need for additional capacity in the drinking water supply?	Yes or No. Explanation.
12. Are there other considerations about the proposed action that could adversely affect the environment and/or public health and safety?	Yes or No. Explanation.

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

19. Will the proposed action require major sedimentation and erosion control measures?	Yes or No. Explanation.
20. Will the proposed action violate a storm water permit or a wastewater discharge permit either for construction or on-going operations?	Yes or No. Explanation.
21. Safe Drinking Water Act: Will the proposed action impact an EPA designated sole source aquifer?	Yes or No. Explanation.
22. Wetlands and Water Resources (lakes, rivers, ponds, streams, etc.): Will the proposed action violate a Section 404 (Clean Water Act) permit for actions in a wetland and/or Section 10 (Rivers and Harbors Act) permit for actions in a stream or river?	Yes or No. Explanation.
23. Floodplains: a. Is the proposed action located in either a 100-year or, for critical actions, a 500-year floodplain? (If Flood Insurance Rate Maps do not exist for the project site, a floodplain survey or consultation may be required. Also may need to consider if the facility will require flood insurance).	Yes or No. Explanation.
b. Will the proposed action adversely impact flood flows in a floodplain or support development in a floodplain?	Yes or No. Explanation.

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

27. Does the proposed action involve the sale or transfer of real property, on which any hazardous substance was stored for one year or more, known to have been released, or disposed of? (Provide relevant documentation for any hazardous substance releases. See 40 CFR 373.2(b), 302.4, and 261.30 for reportable quantities.)	Yes or No. Explanation.
28. Does the proposed action involve the sale or transfer of real property, on which underground or above ground storage tanks are located?	Yes or No. Explanation.
29. Will the proposed action violate Tribal, local, state, or federal law on the use and storage of hazardous substances or the transportation, storage, and disposal of hazardous wastes or medical wastes? (Activities that may generate reportable quantities include air conditioning repair and service, pesticide application, motor pools, automobile repair, welding, landscaping, agricultural activities, print shops, hospitals, clinics, & medical centers. Repair, renovation, or demolition activities can generate waste that has asbestos-containing materials, asbestos, lead-based paint, PCBs, CFCs, etc.)	Yes or No. Explanation.

Tribe:	Reservation:
Project, Program, Grant Description & Location:	

36. Wild and Scenic Rivers Act: Will the proposed action affect a wild, scenic, or recreational river area or create conditions inconsistent with the character of the river? (A consideration for activities that are in or near any wild and scenic waterway including construction of stream/river crossings, intake structures, outfalls, etc.)	Yes or No. Explanation.

I certify that to the best of my knowledge and ability the information presented above is true and correct. The record was examined to identify potential extraordinary or exceptional circumstances which would require further environmental review.

Review by:

Title Date Environmental Coordinator Date

Norton Sound Health Corporation

APPENDIX H

ACTIONS REQUIRING IHS ENVIRONMENTAL REVIEW AND DETERMINATION

[]	Pg 571 (K)(4): Those involving the use of technology where the possible effects are highly uncertain or involve unique or unknown risks and where such technology has not been assessed previously for environmental impact;
[]	Pg 571 (K)(5): Those which have adverse effects on unique geographic characteristics (e.g. historic, archeological, or cultural resources, park recreation or refuge lands, wilderness, areas, wild or scenic rivers, sole or principal drinking water aquifers, prime farmlands, wetlands, floodplains, coastal management zones, or ecological or critical areas including those listed on the Department of Interior National Register of National landmarks);
[]	Pg 571 (K)(6): Those which establish a precedent for future action or represent a decision in principle about future actions with potentially significant environmental effects;
[]	Pg 571 (K)(7): Those which have adverse effects on properties listed or eligible for listing on the National Register of Historic Places;
[]	Pg 571 (K)(8): Those which have adverse effects on species listed by the Federal Government as Endangered or Threatened Species, or which have adverse effects on any designated critical habitat for these species;
[]	Pg 571 (K)(9): Those which require assessment in accordance with Executive Order 11988 (Floodplain Management), or Executive Order 11990 (Protection of Wetlands), or the Fish and Wildlife Coordination Act; and
[]	Pg 572 (K)(10): Those which involve the use, transfer, or lease of real property which has been determined, after investigation in accordance with the provisions of CERCLA 120 (h), to have been used as a storage facility for hazardous waste for more than 1 year; and
[]	Pg 572 (K)(11): Construction projects which are significantly greater in scope or size than normally experienced for a particular category of action.

Any action NOT categorically excluded per Federal Register Vol. 58, No. 3, pg 569-572, dated January 6, 1993 attached hereto.	**The Environmental Review and Determination Process for this group of actions ranges from 60 to 180 days from the receipt by the IHS of the proposal package.**

* The time needed to complete Environmental Reviews is highly dependent on required consultations with other Federal and State Agencies. As an example, the NHPA Section 106 Process requires the State Historic Preservation Officer (SHPO) be allotted 30 days to review and comment on a proposed action (36 CFR Part 800.3(c)(4)). Furthermore, additional time beyond the 30 days may be required for consultation with SHPO to adequately review and determine the effects of the proposed action on existing historical resources. Coordination early in the planning phase of the project can help identify these potential issues and allow NSHC and IHS to resolve them early.

employed varies from Area to Area. Population, health indices, and facilities and services available from sources other than the IHS are evaluated to determine the methods IHS uses to provide services.

The IHS program consists of two major systems: (1) A Federal health care delivery system, administered by Federal employees, and (2) a tribal health delivery system, administered by tribes and tribal groups under grants, contracts or cooperative agreements. The categorical exclusions apply to IHS program actions whether carried out directly by the IHS, or funded or otherwise sponsored by the IHS. The IHS contracts, grants, and cooperative agreements are actions defined in NEPA and are subject to the IHS review procedures established to ensure NEPA compliance, including provisions covering extraordinary and exceptional circumstances. The NEPA compliance for the tribal health care delivery system is ensured through IHS administrative procedures for contracts, grants, and cooperative agreements.

The selection of IHS program actions to list as categorical exclusions has been determined, in part, by agency experience in complying with NEPA, during the past 10 years. Actions required to provide health care services will not have significant impact on the environment except when exceptional or extraordinary circumstances exist. The IHS has categorically excluded these actions, since enactment of NEPA; however, actions involving construction normally have required completion of an environmental review/assessment.

The IHS administers programs for the construction of domestic sanitation facilities (water, wastewater, and solid waste) for Indian homes and communities, construction of new or replacement health care facilities and staff quarters, and renovations to existing health care facilities and quarters units.

Environmental reviews/assessments of construction projects undertaken during the past 10 years have concluded that an EIS was not required for any of them. Approximately 2,300 sanitation facilities construction projects and fewer than 60 health care facilities/staff quarters construction projects have been approved during this time.

The type of program and procedures employed to administer the construction of sanitation facilities for Indian homes and communities, and the consistent determinations that these projects do not have a significant impact on the environment, are the basis for the decision to list most sanitation facilities projects are categorically excluded.

Factors considered in making this determination include:

1. Projects are undertaken to improve health and/or environment.

2. Projects are untaken at the request and with approval of the tribal governing body, which provides for discussion and evaluation of the project and its impacts.

3. Projects are normally constructed on tribally owned or individually owned tribal land within reservation boundaries.

4. Projects are constructed to comply with all current applicable environmental regulations and plans and specifications are submitted to State and Federal agencies as necessary for review and comment.

5. Projects are constructed to provide utilities (water, sewer, solid waste) either for existing American Indian or Alaska Native homes or for new homes constructed with Federal, tribal, State or other resources. New homes are constructed at sites and locations approved by the Tribal Governing Board. Utilities are not provided for future development or undeveloped parcels, and capacity provided is limited to that routinely provided by standard engineering practice for the current design population.

6. The IHS projects fall into the category of minor construction projects based on cost. During the last 10 years, 85 of the 2,300 projects exceeded $1 million, and the average estimated cost was $250,000.

7. Standard IHS procedures require documentation of an environmental review of each construction project to identify any exceptional or extraordinary circumstances and to ensure compliance with all environmental laws, regulations, and executive orders; e.g., those concerning floodplains, wetlands, endangered species, etc. This review is required early in the project planning process.

The categorical exclusion for construction of health care facilities and staff quarters has been limited to renovation or new construction at existing health care delivery sites, and construction or development of relatively small facilities at new locations. The procedures noted in item 7 above for sanitation facilities construction projects also apply to all health care facility and staff quarters construction projects. Most health care facility and staff quarters renovation projects can be classified as minor construction projects based on cost. Fewer than 200 major renovation projects have been undertaken and only a few were funded at a level exceeding $1 million.

Categorical Exclusions

A. Health Services

Direct delivery of medical, dental, nursing, and other related health services; e.g., patient care/counseling administered from hospitals, health centers, health stations, satellite clinics, and in private homes by IHS staff or contract providers to authorized recipients.

B. Research

Research activities that are consistent with the mission of IHS including: (a) Biological and behavioral studies conducted in laboratories, clinics, and the field; (b) studies on the development and delivery of prevention and treatment services and their administration and financing; and (c) evaluations of prevention and treatment.

C. Pesticides

Application of pesticides which are not classified for restricted use under provisions of the Federal Insecticide, Fungicide and Rodenticide Act when used for routine pest control purposes.

D. Contracts, Grants, and Cooperative Agreements

Contracts, grants, and cooperative agreements and continuations, supplements, extensions, and amendments of these documents for IHS programs or actions that are categorically excluded. (Includes Self-Determination Act contracts, Contract Health Care contracts, etc.)

E. Technical Assistance

Action involving the provision of technical assistance to American Indian and Alaska Native tribes and groups. other Federal agencies, State and local governments, and non-profit organizations are excluded. These actions include but are not limited to:

1. The provision of technical assistance to American Indian and Alaska Native tribes and groups for the purpose of developing management capabilities needed to enable eventual tribal assumption of health program operation;

2. The provision of technical assistance to American Indian and Alaska Native tribes and groups for the purpose of developing capabilities in the areas of epidemiology, disease reduction, injury prevention, environmental improvement, and the operation and maintenance of sanitation facilities; and

3. The assignment of IHS personnel to agencies/organizations for the purpose of providing technical expertise (e.g.,

Order 11990 (Protection of Wetlands), or the Fish and Wildlife Coordination Act; and

10. Those which involve the use, transfer, or lease of real property which has been determined, after investigation in accordance with the provisions of CERCLA 120 (h), to have been used as a storage facility for hazardous waste for more than 1 year; and

11. Construction projects which are significantly greater in scope or size than normally experienced for a particular category of action.

Dated: December 29, 1992.

Michel T. Lincoln,

Deputy Director.

[FR Doc. 93-172 Filed 1-5-93; 8:15 am]

BILLING CODE 4160-16-M

ADDENDUM I

MEMORIALIZATION OF HISTORICAL LEVEL OF PFSA'S PROVIDED BY ANMC AND AANHS TO THE NORTON SOUND HEALTH CORPORATION

The ANMC and the Alaska Area Native Health Services, Area Office, subject to available appropriations, has historically provided the following PFSAs to Norton Sound Health Corporation as of October 1, 1997 and continued to provide such services through December 31, 1998:

- Coordination and support for the NSHC dental clinic, including dental specialty referral services, and the annual Alaska dental chiefs meeting. Commissioned Corp recruitment assistance including transportation costs of the recruiter to and from Nome, any applicable documentation, award information for Commissioned Officer promotions, and career counseling for officers desiring long term affiliation with IHS.

- Specialty care field clinics, consultation to Norton Sound Health Corporation physicians, arrange contracts for reference laboratory services, routine reading of x-rays, medivacs support for neonatal emergencies patient travel support for NSHC patients returning home from treatment at the ANMC.

- Accepting all referrals of Alaskan Natives from the Norton Sound Regional Hospital.

- The ANMC EMS program provided specialized training such as ACLS, ATLS, PALS, including hypothermia, cold water drowning and frostbite.

- The NSHC Laboratory received the following services from ANMC: (a) pathologist consultation and visitation twice a year; (b) Anatomical tissue analysis and reporting; and (c) Access to TDY Services as needed and available.

- The ANMC provided consultation and informational support for the NSHC Social Services program, including JCAHO standards and other licensure issues.

- The ANMC provided support including screening, diagnosis, consultations, referrals, personnel training, information, network and recruitment assistance for the FAS program at NSHC and for its Maternal Child Health Program.

- The ANMC provided recruitment assistance to the Mental Health program as needed.

- STD/HIV testing, counseling, partner notification, education and consultation as requested by NSHC.

- Nutrition education and counseling services from the statewide Diabetes program based at ANMC.

- Environmental Health /Sanitation services including, but not limited to, appropriate village visits for environmental services, injury prevention, institutional services.

- Diabetes patients tracking and registration.

- Engineering services inclusive of maintenance and improvement for federal facilities and projects;

- Purchasing activities under GSA contracts;

- Office of Environmental Health Services and activities, health facilities support, real property support especially for village built clinics; projects for health facilities management, special projects and sanitations facilities.

- Administration and management of IPA/MOAs;

- Certain contract health services, not otherwise contracted under Title I;

- Region X legal consultation.

ADDENDUM II
NORTON SOUND HEALTH CORPORATION
MEMORIALIZATION OF MATTERS REMAINING IN DISPUTE

(1) Norton Sound Health Corporation (NSHC) does not agree with the IHS' position that Area Office tribal shares that were restricted by individual Co-Signer decision or by a consensus decision of all Co-Signers from FY 1995 through FY 2000 are not available for inclusion in FY 2002 because of Section 325, P.L. 105-83. NSHC believes it has the right to include such tribal shares in its FY 2002 funding agreements notwithstanding Section 325. NSHC reserves any remedies it may have under law.

ALASKA TRIBAL HEALTH COMPACT

BETWEEN

CERTAIN ALASKA NATIVE TRIBES

AND THE

UNITED STATES OF AMERICA

OCTOBER 1, 1994

—

AMENDED AND RESTATED

OCTOBER 1, 2017

ALASKA TRIBAL HEALTH COMPACT

OCTOBER 1, 1994

AMENDED AND RESTATED
OCTOBER 1, 2017

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ALASKA TRIBAL HEALTH COMPACT
BETWEEN
CERTAIN ALASKA NATIVE TRIBES
AND THE
UNITED STATES OF AMERICA
OCTOBER 1, 1994
AMENDED AND RESTATED
OCTOBER 1, 2010

This Compact of Self-Governance, which under Title III of Public Law No. 93-638, as amended, became effective October 1, 1994, was amended and restated effective October 1, 1995, October 1, 1996, October 1, 1997, October 1, 1998, October 1, 2000, and was further amended and restated in FY 2001, effective October 1, 2000, to conform with Public Law 106-260, Title V of the Indian Self-Determination and Education Assistance Act, as amended (hereinafter Title V), October 1, 2003, October 1, 2006, October 1, 2008, and October 1, 2010 is made and entered into by and between the Secretary of Health and Human Services of the United States of America, represented by the Director of the Indian Health Service, and certain Alaska Native Tribes recognized by the United States acting collectively, and the Alaska Native Tribal Health Consortium, as set forth in Exhibit A. This Compact is entered into under the Title V, which authorizes the Secretary to enter into Compacts and Funding Agreements with the governing bodies of participating Tribal governments. The Secretary has delegated the authority to enter into this Compact and funding agreements to the Director, Indian Health Service (hereinafter IHS). This Compact reflects the United States' special trust responsibility and legal obligations to Indians and Alaska Natives, as stated in 25 U.S.C. section 1602, and the unique tribal cooperation that has developed in Alaska to assure that all Alaska Natives have access to a comprehensive, integrated, and tribally-controlled health care delivery system. The parties are committed to ensuring that the essential statewide functions of the Alaska Native Medical Center in Anchorage remain intact, whether operated by the Indian Health Service, the Alaska Native Tribal Health Consortium or by Alaska Native Tribes recognized by the United States.

WITNESSETH:

WHEREAS, the Alaska Native people have governed themselves and lived in the area known as Alaska since time immemorial;

WHEREAS, federally recognized tribal governments in the State of Alaska

> . . . have the same governmental status as other federally acknowledged Indian tribes by virtue of their status as Indian tribes with a government-to-government relationship with the United States; are entitled to the same protection, immunities, privileges as other acknowledged tribes; have the right, subject to general principles of Federal Indian law, to exercise the same inherent and delegated authorities available to other tribes; and are subject to the same limitations imposed by law on other tribes;

(*Indian Entities Recognized and Eligible to Receive Services from the United States Bureau of Indian Affairs*, 58 Fed. Reg. 54364 (October 21, 1993));

WHEREAS, for the purposes of ensuring that all Alaska Natives and America Indians in Alaska can receive the services provided by the Federal Government through an Alaska Native provider, the Congress has defined the term, "Indian Tribe," to mean:

> . . . any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(Indian Self-Determination and Education Assistance Act, as amended, 25 U.S.C. § 450b(e));

WHEREAS, to prioritize between the entities eligible to authorize contracting under the Indian Self-Determination and Education Assistance Act, as amended, the Indian Health Service has established in the Alaska Area the following order of preference:

> If there is an Indian Reorganization Act (IRA) Council, and it provides governmental functions for the village, it will be recognized.
>
> If there is no IRA Council, or it does not provide governmental functions, then the traditional village council will be recognized.
>
> If there is no IRA Council and no traditional village council, then the village profit corporation will be recognized.
>
> If there is no IRA Council, no traditional village council, and no village profit corporation, then the regional profit corporation will be recognized for that particular village.

(*Alaska Area Guidelines for Tribal Clearances for Indian Self-Determination Contracts*, 46 Fed.

Reg. 27178);

WHEREAS, the United States of America has recognized certain entities in Alaska as American Indian Tribes for purposes of the Indian Self-Determination and Education Assistance Act (*See* 25 U.S.C. § 450b(e); *Indian Entities Recognized and Eligible To Receive Services from the United States Bureau of Indian Affairs*, 58 Fed. Reg. 54364 (October 21, 1993); and *Alaska Area Guidelines for Tribal Clearances for Indian Self-Determination Contracts*, 46 Fed. Reg. 27178, (hereinafter "the Tribes");

WHEREAS, certain Tribes of Alaska have formed and authorized certain Tribal Organizations and Inter-Tribal Consortia as defined in 25 U.S.C. § 450b(*l*) and section 501(a)(5) of Title V, for the purpose of providing health care to Alaska Natives and to contract with the Indian Health Service and other federal and non-tribal agencies for such purpose as well as to provide health care to the other residents of their respective service areas, as permitted by section 813 of the Indian Health Care Improvement Act, as amended, or other applicable law;

WHEREAS, the Congress has declared its commitment to the maintenance of the Federal Government's unique and continuing relationship with, and responsibility to, Alaska Native and American Indian Tribes and to the Alaska Native and American Indian people as a whole through the permanent establishment of a meaningful Indian self-governance policy, which will permit an orderly transition from the federal domination of programs for, and services to, Alaska Natives and American Indians to effective and meaningful participation by the Alaska Native and American Indian people in the planning, conduct, and administration of those programs and services; 25 U.S.C. § 458aaa(note);

WHEREAS, the Congress has declared its commitment to strengthening the government-to-government relationship and to supporting and assisting Alaska Native and American Indian Tribes in the orderly transition from the federal domination of programs and services to provide Alaska Native and American Indian Tribes with meaningful authority, control, funding and discretion to plan, conduct, redesign and administer programs, services, functions and activities (or portions thereof) that meet the needs of the individual tribal communities, 25 U.S.C. § 458aaa(note);

WHEREAS, Federal health services to maintain and improve the health of the Indians and Alaska Natives are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian and Alaska Native people, 25 U.S.C.§§ 1601(1), (2);

WHEREAS, in accordance with 25 U.S.C. § 1601(2) a major national goal of the United States is to provide resources, processes and structures that will enable Indians and Alaska Natives to obtain the quality and quantity of health care services and opportunities that will eradicate health disparities between Indians and Alaska Natives and the general population of the United States;

WHEREAS, the Congress has declared that it is the policy of the United States as stated in 25 U.S.C. § 1602, in fulfillment of its special trust responsibilities and legal obligations to the American Indian and Alaska Native people, to ensure the highest possible health status for Indians

and Alaska Natives and to provide all resources necessary to effect that policy; to raise the health status of Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives; and also the ensure maximum Indian and Alaska Native participation in the direction of health care services so as to render the person administering such services and the services themselves more responsive to the needs and desires of Indian and Alaska Native communities;

WHEREAS, for the purposes of this Compact,

"ANTHC" shall mean only the Alaska Native Tribal Health Consortium;

"Co-Signer" shall mean all Tribes and tribal organizations or Inter-Tribal Consortia, including the ANTHC, participating in the Compact;

"Signatory Tribe(s)" shall mean all Tribes participating in the Compact either directly or through a tribal organization or Inter-Tribal Consortium that has been authorized to participate by resolution;

"Tribal Co-Signer" shall mean only those Tribes, tribal organizations and Inter-Tribal Consortia authorized by resolution of a Tribe, as defined in 25 U.S.C. § 450b(*l*) and sections 501(a)(5) and (b) of Title V, to participate in the Compact and shall not include the ANTHC; and

WHEREAS, under authority from the Tribes, certain Tribal Organizations and Inter-Tribal Consortia in Alaska have provided health services for many years under self-determination contracts with the Indian Health Service and have been recognized by the Indian Health Service as tribally-operated service units;

WHEREAS, pursuant to section 325 of P.L. 105-83, the Alaska Native Tribal Health Consortium (herein "ANTHC"), a tribal organization and Inter-tribal Consortium, as defined in section 501(a)(5) of Title V, was organized and is controlled by the Alaska Native tribes and tribal organizations which are represented on its Board of Directors;

WHEREAS, Tribes, Tribal Organizations and Inter-Tribal Consortia throughout Alaska are reliant on the services to be provided by the ANTHC;

WHEREAS, participation by the ANTHC in the Alaska Tribal Health Compact promotes the commitment of Alaska Native Tribes, Tribal Organizations and Inter-Tribal Consortia to maintain the unique tribal cooperation that has developed in Alaska to assure that all Alaska Natives have access to a comprehensive, integrated, organized, tribally controlled health care delivery system in which Alaska tribal health providers participate in numerous joint activities including utilization review and provide their health services in a clinically integrated care setting in which individuals typically receive health care from more than one of these Alaska tribal providers;

WHEREAS, in furtherance of the federal policy of Alaska Native and American Indian tribal self-determination and self-governance, Congress has directed the Secretary of Health and Human Services (herein the "Secretary") to carry out the Tribal Self-Governance Program under Title V.;

WHEREAS, Congress, in Title V, has authorized the Secretary to negotiate and implement a Compact of Self-Governance and Funding Agreements with the governing bodies of participating Tribal governments of qualified Alaska Native and American Indian Tribes that have completed a planning activity;

WHEREAS, Congress has directed that the Funding Agreements, which the Secretary negotiates with Alaska Native and American Indian tribes, shall authorize the Co-Signers to plan, conduct, consolidate, administer, receive full tribal shares of funding, redesign programs, and reallocate funds for programs, services, functions and activities as provided in sections 505(b)(1) and, (b)(2) and 506 (e) of Title V;

WHEREAS, each Funding Agreement shall specify the programs, services, functions or activities to be performed or administered, the funds to be provided, and the responsibilities of the Co-Signer and the Secretary in accordance with section 505 of Title V;

WHEREAS, the Funding Agreement shall specify the authority of the Co-Signer to redesign or consolidate programs, functions, services and activities (or portions thereof) and to reallocate or redirect funds or modify budget allocations pursuant to section 506(e) of Title V;

WHEREAS, to the extent to which, funding is provided to a Co-Signer, as authorized by Alaska Native Tribes, pursuant to a Funding Agreement, such Co-Signer shall be responsible for administration of programs, services, functions and activities pursuant to the Agreement, consistent with section 505 of Title V;

WHEREAS, nothing in this Compact or associated Funding Agreements shall be construed to limit or reduce in any way the funding for any program, project or activity serving an Indian Tribe under Title V or any other applicable Federal law, pursuant to section 515(a) of Title V;

WHEREAS, in Title V, Congress has directed that the Funding Agreements, which the Secretary negotiates with Co-Signers shall contain certain provisions and, at the option of the Co-Signers, apply to certain programs, activities, functions and services of the Indian Health Service (including construction) as specified in sections 505, 507(a)(2)(A), and 509 of Title V;

WHEREAS, Congress has directed that, at the request of the governing body of qualifying Tribes and the ANTHC and under the terms of a Funding Agreement, the Secretary shall provide funding to the Tribes and the ANTHC to implement the Funding Agreement in accordance with section 508 of Title V;

WHEREAS, Congress has directed that the Secretary shall interpret federal laws and regulations in a manner that will facilitate the implementation of a Compact of Self-Governance and Funding Agreement authorized by section 512(a) of Title V;

WHEREAS, Congress has directed that the Secretary shall interpret federal laws and regulations in a manner that will facilitate the inclusion of activities, programs, services, and functions (or portions thereof) in Compacts of Self-Governance and Funding Agreements authorized by section 512(a) of Title V;

WHEREAS, it is the intent of certain Alaska Native Tribes to collectively enter into a single Compact with the Secretary. To carry out that intent, such Tribes (hereafter referred to as signatory Tribes) enter into this Compact either by individual signature or by means of a delegation of signature authority as authorized by resolution of the Tribal government. Such resolutions are attached as Exhibit "A".

WHEREAS, it is the intent of the signatory Tribes that this Compact will be carried out either by the Tribe itself, by tribal organizations or Inter-Tribal Consortia, as authorized by resolution of Tribe(s) as defined by 25 USC § 450b(e), section 501(b), and by the ANTHC under section 325 of P.L. 105-83. These Tribes, tribal organizations and Inter-Tribal Consortia, including the ANTHC, are bound by the terms of this Compact and are signing separately as Co-Signers.

WHEREAS, it is the intent of the parties that each Tribal Co-Signer Funding Agreement entered into under this Compact shall be executed by the Tribes, either by individual signature or by means of a delegation of signature authority as authorized by resolution of the Tribal government. Each such Funding Agreement also will be signed by a Tribal Co-Signer, designated by the Tribal governing body. The Tribal Co-Signer will carry out the terms of the Funding Agreement for the signatory Tribe(s) from which it has obtained a resolution of authority and be bound by its terms;

WHEREAS, the ANTHC may enter into this Compact and into Funding Agreements under this Compact as authorized by the Board of Directors of the Alaska Native Tribal Health Consortium; and

WHEREAS, for purposes of clarification, and to recognize the government to government relationship between the signatory Tribes and the Secretary, the parties agree that the signatory Tribes, by entering into this Compact, do not relinquish any aspects of Tribal sovereignty to the Co-Signers. The Tribal Co-Signers act only for and on behalf of the signatory Tribe(s) within the scope of the authority granted to them by tribal resolution or by law and the ANTHC has only the authority granted to it under section 325 of P.L. 105-83. Tribal Co-Signers and the ANTHC by carrying out the terms of this Compact and the associated Funding Agreements do not gain the status of a sovereign tribal government;

WHEREAS, the parties have determined that all of the provisions of this Compact are authorized by Title V or other provisions of federal law and the parties have executed this Compact in reliance on this representation;

NOW, THEREFORE, the Secretary, signatory Tribes and the Co-Signers do hereby agree to enter into, undertake, and be bound by this Compact in accordance with the foregoing principles.

ARTICLE I — AUTHORITY AND PURPOSE

Section 1 – Authority. This Compact of Self-Governance, which became effective October 1, 1994, was amended and restated effective October 1, 1995, October 1, 1996, October 1, 1997, October 1, 1998, and October 1, 2000, and was further amended and restated in FY 2001 effective October 1, 2000, to conform with Title V, October 1, 2003, October 1, 2006, October 1,

2008, and October 1, 2010 (hereinafter the "Compact"), is authorized by Title V of the Indian Self-Determination and Education Assistance Act, as amended, and is hereby entered into by the Secretary of the Department of Health and Human Services of the United States of America (hereinafter the "Secretary"), represented by the Director of the Indian Health Service, certain Alaska Native Tribes, as identified in Exhibit A, recognized by the United States, acting individually or collectively, and the Alaska Native Tribal Health Consortium (hereinafter the "ANTHC"). The Director of the Indian Health Service by signing this Compact commits the Secretary to the extent and within the scope of the Secretary's delegation of authority to enter into Compacts and Funding Agreements pursuant to Title V or as otherwise authorized.

Section 2 – Purpose. This Compact shall be liberally construed to achieve its purposes:

(a) This Compact is to carry out a Self-Governance Program authorized by Title V, and is intended to transfer to tribal governments, at a tribe's request, the power to decide how federal programs, services, functions and activities (or portions thereof) shall be funded and carried out. Title V is meant to strengthen the government-to-government relationship and to uphold the United States trust responsibility for each Indian Tribe. This Compact promotes the autonomy of the Tribes in Alaska in the realm of health care.

(b) This Compact is to enable the signatory Tribes and the Co-Signers to re-design health programs, activities, functions, and services of the Indian Health Service; to reallocate funds for programs, activities, functions, or services according to the priorities of the signatory Tribes and Co-Signers; to enhance the effectiveness and long-term financial stability of the Tribes and the Co-Signers; and to streamline the federal Indian Health Service bureaucracy.

(c) This Compact is to enable the United States to maintain and improve its unique and continuing relationship with, and special trust responsibilities and legal obligations, pursuant to 25 U.S.C. 1602 of the IHCIA, to the Tribes through tribal self-governance and to permit an orderly transition from federal domination of programs and services.

(d) This Compact and Funding Agreement shall transfer to signatory Tribes, acting individually or collectively, and the ANTHC the responsibility for the programs, activities, functions and services of the Indian Health Service included in the Funding Agreement. This Compact allows signatory Tribes, acting individually or collectively, and the ANTHC to exercise meaningful authority to plan, conduct, and administer those programs and services to meet the health care needs of the Alaska Native Tribes. In fulfilling its responsibilities under the Compact and consistent with 25 U.S.C. §§ 1602(5), (6), and the November 5, 2009 Memorandum for the Heads of Executive Departments and Agencies, the April 29, 1994, Memorandum from the President of the United States of America for the Heads of Executive Departments and Agencies, attached hereto as Exhibit B, Executive Order 13175 on Consultation and Coordination with Indian Tribal Governments, the September 23, 2004, Memorandum from the President of the United States of America for the Heads of Executive Departments and Agencies, and the Department of Health and Human Services Tribal Consultation Policy, the Secretary hereby pledges that the Indian Health Service will conduct all relations with the Tribes on a government-to-government basis.

ARTICLE II — TERMS, PROVISIONS AND CONDITIONS

Section 1 – Term and Resolutions.

(a) Term. The term of this Compact begins as to each Co-Signer on the effective date of the Co-Signer's first Funding Agreement and shall extend thereafter as to each Co-Signer throughout the period authorized by Title V of the Indian Self-Determination and Education Assistance Act, and any subsequent amendment thereto, provided the Co-Signer has a Funding Agreement in effect, and shall remain in effect for so long as is permitted by Federal law or until terminated by mutual written agreement, retrocession, or reassumption pursuant to section 504(d) of Title V.

(b) Resolutions from Signatory Tribes. Those Tribes which intend to participate in this Compact and the applicable Funding Agreement through delegation of signature authority as provided in this Compact must have issued a written resolution authorizing the Tribal Co-Signer, on their behalf, to enter into this Compact and Funding Agreement on or before the date the Compact and the applicable Funding Agreement is signed by the Tribal Co-Signer for that Tribe, provided that if a Tribal Co-Signer negotiates a Funding Agreement prior to obtaining an authorizing resolution from a Tribe, nothing herein shall be construed to limit or impair in any way a tribal government's sovereign right to decide whether or not to sign such a resolution.

(c) Resolution from the Board of the ANTHC. The ANTHC may participate in this Compact and the applicable Funding Agreement upon receipt of an authorizing resolution of the Board of Directors of the ANTHC, attached hereto as a part of Exhibit A.

Section 2 – Effective Date.

(a) Once this Compact and the Funding Agreements, attached hereto as Exhibit C, are approved and signed by the Co-Signers and the Secretary, they shall be effective as of October 1, 2008. Subsequent Funding Agreements will be effective on the date signed by the Secretary and Co-Signer or another date mutually agreed upon.

(b) During the term of this Compact any Co-Signer which has not previously negotiated a Funding Agreement may do so. All Funding Agreements shall be subject to, and all the activities thereunder shall be governed by, the terms of this Compact to the same extent as the initial Funding Agreements. New Funding Agreements will be effective on the date signed by the Secretary and Co-Signer or another date mutually agreed upon.

(c) Each Funding Agreement and subsequent Funding Agreement of a Co-Signer is deemed to be incorporated, as negotiated, by reference into this Compact, for the purposes only of that Co-Signer and the United States. In the event of inconsistency between the Compact and any subsequent Funding Agreement, the provisions of the Compact shall prevail.

Section 3 – Funding Amount. Subject only to the appropriation of funds by the Congress of the United States and in accordance with section 508 of Title V, the Secretary shall provide the total amounts specified in the Funding Agreements.

Section 4 – Payment.

(a) Payment Schedule. Payment shall be made expeditiously and shall include financial arrangements to cover funding during periods under continuing resolutions to the extent permitted by such resolutions. For each fiscal year covered by the Compact, the Secretary shall make available the funds specified for that fiscal year under the Funding Agreements by paying the respective total amount as provided for in each Funding Agreement in advance lump sum, as permitted by law, or such other payments as provided in the schedule set forth in each Funding Agreement. The first payment shall be made on or before ten calendar days after the date on which the Office of Management and Budget (hereinafter "OMB") apportions the appropriations for that fiscal year for the programs, activities, functions and services subject to the Compact. The Prompt Payment Act, Chapter 39 of Title 31, United States Code, shall apply to the payment of funds due under this Compact and to each Funding Agreement negotiated thereunder.

(b) Interest on Advances. Co-Signers receiving funds under applicable Funding Agreements pursuant to this Compact shall be permitted to retain interest earned on funds advanced pending disbursement as authorized by law. Interest earned on advances shall not diminish the amount of funds the Co-Signer is authorized to receive under its Funding Agreement in the year earned or in any subsequent fiscal year. All funds transferred under Funding Agreements pursuant to this Compact shall be managed using the prudent investment standard pursuant to section 508(h) of Title V.

Section 5 – Reports to Congress. In accordance with section 514 of Title V, the Secretary shall submit to the Senate Committee on Indian Affairs and the House Resources Committee a written report not later than January 1 of each year on the administration of Title V. Each report shall include a detailed analysis on the level of need being presently funded or unfunded for each signatory Tribe and Co-Signer. The contents of each report shall comply with section 514(b). In compiling the reports, the Secretary may not impose any reporting requirements on Co-Signers not otherwise provided in Title V. The Secretary shall provide each Co-Signer with a draft of each report required to be submitted to Congress under this provision for a thirty (30) day comment period prior to the submission of the report to Congress so that the Co-Signers may comment on the report. The Secretary shall include each Co-Signer's comments in the final report to Congress.

Section 6 – Audits

(a) Single Audit. Each Co-Signer that has executed a Funding Agreement pursuant to this Compact shall provide to the National External Audit Review Center (or its successor), which is the designee of the Secretary for the purposes of this section, an annual single organization-wide audit as prescribed by the Single Audit Act of 1984, as amended, 31 U.S.C. § 7501, *et seq*. A copy of this audit will be sent simultaneously to the Indian Health Service Area Office, the cognizant agency, and the Federal Audit Clearinghouse.

(b) Cost Principles. Each Co-Signer shall apply cost principles under the applicable OMB Circular, except as modified by section 106(k) of the Indian Self-Determination and Education Assistance Act, as amended, which section is hereby incorporated into this Compact, or by any exemptions subsequently granted by OMB. To the extent that OMB Circular A-87 or its successor, or other applicable circulars, permit agency pre-approval of allowable costs,

the agency hereby grants that pre-approval. The Secretary will assist the Co-Signers in obtaining such additional waivers from OMB as are requested by the Co-Signers. No other audit or accounting standards shall be required by the Secretary. Any claim by the Federal Government against any Co-Signer receiving funds under a Funding Agreement based on any audit under this section shall be subject to the provisions of section 106(f) of the Indian Self-Determination and Education Assistance Act, as amended.

Section 7 – Records. Each Co-Signer's practices relating to document disclosure and record-keeping associated with this Compact shall, in accordance with applicable law, be set forth in the respective Funding Agreement.

Section 8 – Property.

(a) In General. The provisions of section 512(c) and section 1(b)(8) of the Model Agreement set forth in section 108(c) of the Indian Self-Determination and Education Assistance Act, as amended, are hereby incorporated into this Compact.

(b) Property Management. Management of property under this Compact shall be in accordance with additional provisions included in each Co-Signer's Funding Agreement.

(c) Access to Property Subject to Destruction. Prior to the destruction of federal property which would otherwise be declared surplus or excess and which is located within the service area of a Co-Signer, the Secretary, if previously requested by the Co-Signer, shall provide notice of such proposed destruction to the Co-Signer. Such notice shall inform the Co-Signer of the name and address of the official responsible for determining whether such property will be destroyed or declared surplus or excess. If the Secretary is the responsible official, the Secretary will consider information provided by the Co-Signer regarding transfer of the property, rather than destruction, and, if not the responsible official, the Secretary will assist the Co-Signer in communicating information to the responsible official.

(d) Leases. Upon the request of a Co-Signer, the Secretary shall enter into a lease with the Co-Signer in accordance with section 105(*l*) of the Indian Self-Determination and Education Assistance Act, as amended.

Section 9 – Regulatory Authority. The Secretary and the Co-Signers agree to utilize the following procedures governing the establishment and application of program rules and regulations under this Compact:

(a) Program Rules. No Co-Signer is required to comply with any agency circular, policy, manual, guidance or rule adopted by the Indian Health Service other than those identified in this section or expressly incorporated by reference in the individual Co-Signer's Funding Agreement in carrying out the programs, services, activities and functions under the Compact, except for the eligibility provisions of section 105(g) of the Indian Self-Determination and Education Assistance Act, as amended, and regulations promulgated under section 517 of Title V.

(b) Federal Regulations.

(1) Applicable Federal Regulations. The Co-Signers, in carrying out the provisions of this Compact and applicable Funding Agreements, will be required to comply only with applicable federal regulations, which include regulations promulgated under section 517 of Title V unless waived as provided in section 512(b) of Title V.

(2) Waiver of Federal Regulations.

(A) The Secretary and the Co-Signer will seek to identify federal regulations promulgated pursuant to section 517 or under the authorities specified in section 512(b) of Title V which may require waiver in order to effectively carry out this Compact or any Funding Agreement.

(B) Waivers of regulations shall be submitted and addressed in accordance with the procedures set forth in section 512(b).

(c) Title I Section Incorporated by Reference. Section 105(a)(1) of the Indian Self-Determination and Education Assistance Act, as amended, 25 U.S.C. § 450j(a)(1), is hereby incorporated in this Compact and shall have the same force and effect as if it were set forth in full in Title V of the Act.

Section 10 – Disputes.

(a) All disputes between the Indian Health Service and any Co-Signer or between the Indian Health Service and all Co-Signers under this Compact shall be subject to Title V and the provisions of section 110 of the Indian Self-Determination and Education Assistance Act, as amended, and all remedies provided for therein shall be available to each Co-Signer of this Compact. Actions and proceedings to enforce the Co-Signer's rights and the Secretary's obligations under this Compact shall be subject to the Equal Access to Justice Act, Public Law 96-481, as amended, to the same extent as are actions and proceedings involving Public Law 93-638 contracts.

(b) In the alternative, the Indian Health Service and the Co-Signers may use the processes authorized and encouraged in the Administrative Dispute Resolution Act, 5 U.S.C. § 581 note, for more informal resolution of disputes arising under this Compact and associated Funding Agreements.

Section 11 – Retrocession and Withdrawal

(a) Retrocession. Section 506(f) of the Act is herein adopted. A Co-signer may retrocede, fully or partially, to the Secretary programs, services, functions, or activities (or portions thereof) included in the compact or funding agreement. Unless the Co-signer rescinds the request for retrocession, such retrocession will become effective within the timeframe specified by the parties in the compact or funding agreement. In the absence of such a specification, such retrocession shall become effective on

(1) the earlier of

(A) one year after the date of submission of such request; or

(B) the date on which the funding agreement expires; or

(2) such date as may be mutually agreed upon by the Secretary and the Co-signer.

(b) Withdrawal. Section 506(g) of the Act is herein adopted. Unless prohibited by law and in accordance with Section 506(g) of the Act, a Tribe may fully or partially withdraw from a participating inter-tribal consortium or tribal organization its share of any program, function, service, or activity (or portions thereof) included in a compact or funding agreement. The withdrawal shall become effective within the timeframe specified in the resolution which authorizes transfer to the participating tribal organization or inter-tribal consortium. In the absence of a specific timeframe set forth in the resolution, such withdrawal shall become effective on

(1) the earlier of

(A) one year after the date of submission of such request; or

(B) the date on which the funding agreement expires; or

(2) such date as may be mutually agreed upon by the Secretary, the withdrawing Indian tribe, and the participating tribal organization or inter-tribal consortium that has signed the compact or funding agreement on behalf of the withdrawing Indian tribe, inter-tribal consortium, or tribal organization.

Section 12 – Discontinuance. Co-signer may discontinue its participation in the Alaska Tribal Health Compact after written notice to each authorizing Tribe or Village and the IHS. Notice must be provided one year in advance of the effective date of the request except that the effective date of a request may be less than one year upon approval of all authorizing Tribes and Villages and the IHS.

Section 13 – Subsequent Funding Agreements.

(a) Negotiations for subsequent Funding Agreements, as provided for in Article VI, section 2, shall begin no later than 120 days in advance of the conclusion of the preceding Funding Agreement. Each Co-Signer is hereby assured that future funding of the Co-Signer's subsequent Funding Agreements shall only be reduced pursuant to the provisions of section 508(d) of Title V provided, however, that future funding for each Co-Signer's non-recurring funds and tribal shares shall be subject to adjustments in accordance with a yearly reallocation decision by the Co-Signers. The Secretary agrees to prepare and supply relevant information, and promptly to comply with the Co-Signers' requests for information reasonably needed to determine the funds that may be available for a subsequent Funding Agreement as provided for in Article VI, Section 2 of this Compact.

(b) If the parties are unable to conclude negotiation of a subsequent Funding Agreement, the terms of this Compact and the existing Funding Agreement shall, at the option of the Co-Signer, continue on in 30-day, 90-day or longer increments until a subsequent Funding Agreement is agreed to. As provided in section 505(e) of Title V, the terms of the subsequent Funding Agreement will become retroactive to the end of the term of the preceding Funding Agreement. Any increases in funding to which Tribes are entitled by law or which have been made available by Congress, or increases which Co-Signers subsequently negotiate, shall be included in each Co-Signer's subsequent Funding Agreement.

Section 14 – Health Status Reports. In accordance with section 507(a)(1), Co-Signers shall provide the Secretary a health status and service delivery report to the extent that relevant data is not otherwise available to the Secretary and specific funds for this purpose are provided to the Co-Signer in its Funding Agreement. Such reporting may impose only minimal burdens on the Co-Signer and shall be consistent with regulations promulgated under section 517 of Title V.

Section 15 – Secretarial Approval. For the term of the Compact, the provisions of 25 U.S.C. § 81 and 25 U.S.C. § 476 shall not apply to attorney and other professional contracts of signatory tribal governments of Alaska Native Tribes operating under the Compact pursuant to section 511(b) of Title V.

Section 16 – Transportation and Other Supply Sources.

(a) Use of Motor Vehicles. Subject to agreement of the General Services Administration, the Secretary hereby authorizes each Co-Signer to obtain Interagency Motor Pool vehicles and related services for performance of any programs, activities, functions and services under this Compact.

(b) Other Supply Sources. Federal supply sources (including lodging, airline transportation, and other means of transportation) shall be available to each Co-Signer in accordance with sections 508(e) and 516(a) of Title V.

Section 17 – Limitation of Costs. Each Co-Signer shall not be obligated to continue performance that requires an expenditure of funds in excess of funds awarded under the Funding Agreement. In accordance with section 508(k), if, at any time the Co-Signer has reason to believe that the total amount required for performance of a Funding Agreement, or a specific activity conducted under the Funding Agreement, would be greater than the amount of funds awarded under the Funding Agreement, the Co-Signer shall provide reasonable notice to the Indian Health Service and affected Tribes and tribal organizations. If the Indian Health Service does not take such action as may be necessary to increase the amount of funds awarded under the Funding Agreement, the Co-Signer may suspend performance of the Funding Agreement until such time as additional funds are transferred.

ARTICLE III — OBLIGATIONS OF EACH CO-SIGNER

Section 1 – Consolidation. Each Co-Signer will be responsible for performing the health programs, activities, functions and services as specified in Section 3 of this Article III and in their respective Funding Agreements, as provided for in Article VI, Section 2 of this Compact. To the extent a program, activity, function, or service included within a contract or grant entered into pursuant to sections 102 or 103 of the Indian Self-Determination and Education Assistance Act, as amended, is included within a Funding Agreement, that contract or grant shall be modified or terminated as appropriate. The parties' obligations shall be governed by this Compact and all funds previously obligated under contracts or grants (including carry-over funds) will be re-obligated to the Co-Signer under the applicable Funding Agreement. Such terminated contracts shall be identified by contract number in each Funding Agreement.

Section 2 – Amount of Funds. The total amount of funds covered by the consolidation and redesign provided for in Section 1 of this Article that the Secretary shall make available to the Co-Signers shall be determined in accordance with section 508(c) of Title V and shall be set forth in the respective Funding Agreements between the Secretary and each Co-Signer.

Section 3 – Compact Programs. The health programs, activities, functions and services will be the responsibility of each Co-Signer under this Compact and shall be identified in each Co-Signer's Funding Agreement.

Section 4 – Eligibility for Services. In determining eligibility for services, the Co-Signers shall comply with applicable eligibility provisions set forth in the Indian Health Care Improvement Act, as amended, applicable regulations, and other statutory law.

Section 5 – Reallocation, Redesign and Consolidation. In accordance with section 506(e) of Title V, a Co-Signer may redesign or consolidate programs, services, functions, and activities (or portions thereof) included in a Funding Agreement and reallocate or redirect funds for such programs, services, functions, and activities (or portions thereof) in any manner in which the Co-Signer deems to be in the best interest of the health and welfare of the Indian community being served, only if the redesign or consolidation does not have the effect of denying eligibility for services to population groups otherwise eligible to be served under applicable federal law.

Section 6 – Consolidation with Other Programs. Each Co-Signer may consolidate programs, services, functions, and activities and associated funds identified in its funding agreement with other programs, services, functions, and activities provided with its own funds or funds from other sources, provided that the programs, services, functions, and activities are allowable for inclusion in a funding agreement under Section 505 of Title V. When programs, services, functions, and activities are consolidated in a funding agreement by a Co-Signer in accordance with the terms of the Funding Agreement and Title V, the Co-signer and its employees carrying out those programs, services, functions, and activities may receive Federal Tort Claims Act coverage in accordance with the statutory provisions and regulations cited in the Compact. Whether the Federal Tort Claims Act applies in any particular case is decided on an individual case-by-case basis by the United States Department of Justice and subsequently by the Federal courts. In cases in which a Co-Signer consolidates programs, services, functions, and activities under this section, the Co-Signer shall not be required to separate dollars or programs, services, functions, and activities so long as the Co-Signer can provide sufficient data to permit an acceptable program and financial audit to be conducted.

Section 7 – Program Income, including Medicare/Medicaid. All Medicare, Medicaid or other program income earned by a Co-Signer shall be treated as additional supplemental funding to that negotiated in the Funding Agreement and the Co-Signer may retain all such income, including Medicare/Medicaid, and expend such funds in the current year or in future years, nor shall such funds result in any off-set or reduction in the negotiated amount of the Funding Agreement. Medicare/Medicaid collections of a Co-Signer under Title IV of Public Law 94-437, as amended, shall be used by the Co-Signer in accordance with any applicable statutory restrictions on the use of such funds.

Section 8 – Carry-over. Congressionally appropriated funds allocated in accordance with

a Funding Agreement under this Compact are "no year" funds and may be expended by the Co-Signer in accordance with its budget for the year for which the funds are appropriated or carried over and expended in any subsequent fiscal year, and such carry-over shall not diminish the amount of funds the Co-Signer is authorized to receive under its Funding Agreement for any such subsequent fiscal year.

Section 9 – Matching Funds. Funds may be used to meet matching and other cost participation requirements under any other federal or non-federal programs pursuant to section 512(d) of Title V.

ARTICLE IV — OBLIGATIONS OF THE UNITED STATES

Section 1 – Trust Responsibility. In accordance with sections 507(g) and 515(b) of Title V, nothing in this Compact waives, modifies, or diminishes in any way the trust responsibility of the United States with respect to the Alaska Native Tribes or individual Alaska Natives and American Indians which exists under treaty, executive orders, and acts of Congress.

Section 2 – Programs Retained.

(a) The Secretary hereby retains the responsibility for the programs, activities, functions and services with respect to the signatory Tribes that are not specifically assumed by the signatory Tribes, acting individually or collectively, or by the ANTHC through their applicable Funding Agreements and they shall continue to be entitled to the full benefit of those programs, activities, functions, and services retained by the Indian Health Service. In accordance with section 506(h), each Co-Signer shall be eligible for new programs, activities, functions and services of the Secretary and the Indian Health Service on the same basis as other Tribes and Tribal Organizations. The Indian Health Service, in consultation with the Tribes, may reorganize to sustain its ability to provide, in the most effective and efficient manner, all programs, activities, functions, and services that have not been included in the Funding Agreement.

(b) No later than 120 days prior to the end of each fiscal year, the Indian Health Service shall provide each signatory Tribe and Co-Signer with a written list of the retained programs, activities, functions, and services relevant to Native health care in Alaska for the upcoming fiscal year. To the fullest extent permitted by law, the Secretary shall provide any requesting signatory Tribe and Co-Signer access to, and copies of, all documents and other information relevant to any ongoing retained programs, activities, functions, or services, and shall cooperate with any evaluation which the Co-Signer or signatory Tribe may wish to conduct. The Secretary will cooperate with each Tribe and Co-Signer to facilitate the inclusion of programs, activities, functions and services in future Funding Agreements of those Tribes and Co-Signer.

Section 3 – Financial and Other Information.

(a) To assist the Tribes and Co-Signers in monitoring compliance with section 508(c) of the Indian Self-Determination and Education Assistance Act, as amended, the Secretary shall provide to Co-Signers:

(1) all monthly reports of obligations and allowances, including all reports from Central Office, Headquarters, the Office of Tribal Self-Governance and the Alaska Area Office, concerning funds provided to support programs, activities, functions and services provided by Tribes or Tribal Organizations under this Compact and funds retained by the Indian Health Service to support programs, activities, functions and services retained by the Indian Health Service; and

(2) prompt notice of any new programs, activities, functions and services for which the Tribes or Co-Signers are eligible, including the funding available for such programs, activities, functions and services.

(b) The Secretary shall prepare and promptly supply relevant financial information and comply with each Co-Signer's request for information needed to determine funds that may be available for a successor Funding Agreement.

Section 4 - Savings. If the programs, services, functions and activities carried out under Title V Funding Agreements and this Compact result in a reduction to the administrative or other responsibilities of the Secretary, with respect to the operation of Indian programs, and thereby result in saving that have not otherwise been included in the amount of tribal shares and other funds determined under section 508(c) of Title V, the Secretary shall make such savings available to the Co-Signers for the provision of additional services in accordance with section 507(f) of Title V.

ARTICLE V — OTHER PROVISIONS

Section 1 – Designated Officials/Agent.

(a) Parties. On or before the effective date of this Compact, both the Secretary and each Co-Signer shall provide a written designation of an individual as their representative/liaison. The Secretary shall direct all communications about the Compact, and relevant Funding Agreement to the Co-Signer's designee, except in the case where the Compact or Funding Agreement requires notice to the signatory Tribes, in which case notice shall also be sent to the Tribes. Reference herein to Co-Signers or the Secretary shall include the respective Designated Official thereof.

(b) Agent for Notice. If Co-Signers assign an agent to accept and distribute notices, those Co-Signers shall provide the name and address of the agent and a description of the limited powers and duties of the agent.

Section 2 – Indian Preference in Employment, Contracting and Sub-Contracting. The Co-Signers will comply with the Indian and Alaska Native preference provisions of sections 7(b) and 7(c) of the Indian Self-Determination and Education Assistance Act, as amended. The parties agree that any Co-Signer may comply with any Indian or Alaska Native preference established by their respective Tribes, including preference based on tribal affiliation.

Section 3 – Federal Tort Claims Act Coverage; Insurance.

(a) The Tribes and Co-Signers are deemed by statute to be part of the Public Health

Service (PHS), and the employees of the Tribes and Co-Signers are deemed by statute to be part of or employed by the Public Health Service, for purposes of coverage under the Federal Tort Claims Act, while performing programs, activities, functions or services under this Compact and described in the Co-Signer's Funding Agreement (including new and existing programs, services, functions and activities as provided under Article III, Section 5 or 6, or supported with income received in accordance with Article III, Section 7), including coverage for claims of medical malpractice, as is more fully described in 25 C.F.R. Part 900 Subpart M, attached hereto as Exhibit E, and incorporated by reference herein, and section 102(d) of the Indian Self-Determination and Education Assistance Act, as amended, as required by section 516(a).

(b) The above status of a Tribe or Co-Signer, or an employee's status as an employee of a Tribe or employee of a Co-Signer, is not affected by the source of the funds used by the Tribe or Co-Signer to carry out the programs, services, functions or activities or to pay the employee's salary and benefits as long as the employee does not receive any additional compensation for the performance of covered services from anyone other than the Tribe or Co-Signer.

(c) The Tribe's employee or the Co-Signer's employee may, while performing under this Compact and any applicable Co-Signer's Funding Agreement and as a condition of employment, be required by the Tribe or Co-Signer to provide services to non-Indian Health Service beneficiaries in order to meet the obligations under this Compact either in facilities of the Tribe or Co-Signer or in facilities other than those of the Tribe or Co-Signer.

(d) Funds provided under a Funding Agreement may be used to purchase such additional liability and other insurance as is prudent in the judgment of a Co-Signer performing under this Compact and Funding Agreement for its protection and the protection of its employees.

(e) Personal services contracts shall be covered under this provision to the extent provided under section 102(d) of the Indian Self-Determination and Education Assistance Act, as amended.

(f) Coverage shall also apply in accordance with Section 813(e) of the IHCIA, as amended.

Section 4 – Compact Modifications or Amendments.

(a) Any request for a modification of this Compact must be communicated in writing to all signatory Tribes and Co-Signers and to the Indian Health Service. To be effective any modifications of this Compact shall be in the form of a written amendment to the Compact, and shall require written consent of each of the signatory Tribes, acting directly or through an agent authorized by resolution, and the Secretary.

(b) This provision shall not apply to amendment of the Compact to include additional Tribes and/or Co-Signers. Such amendment shall only require the concurrence of the additional Tribe and/or Co-Signer, and the Secretary.

Section 5 – Construction. This Compact shall apply to funds included in the facilities category of Indian Health Service appropriations. A Co-signer may assume construction projects or programs in accordance with Titles I or V or P.L. 86-121. In doing so, the Co-Signer elects to comply with the regulations of the elected statutory provision.

Section 6 – Officials Not To Benefit. No member of or delegate to Congress shall be admitted to any share or part of any Compact executed pursuant to this Compact, or to any benefit that may arise there from; but this provision shall not be construed to extend to any contract under this Compact if made with a corporation for its general benefit.

Section 7 – Covenant Against Contingent Fees. The parties warrant that no person or selling agency has been employed or retained to solicit or secure any contract executed pursuant to this Compact upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial or selling agencies maintained by the contractor for the purpose of securing business.

Section 8 – Penalties. The parties agree that the criminal penalties set forth in 25 U.S.C. § 450d apply to all activities conducted pursuant to this Compact.

Section 9 – Use of Federal Employees. Section 104 of the Indian Self-Determination and Education Assistance Act, as amended, shall apply to this Compact and to any individuals assigned or detailed to any Co-Signer performing functions under this Compact or leaving federal employment to perform services under this Compact, including assignments either on detail or on leave without pay and with or without reimbursement by the Co-Signer for the travel and transportation expenses to or from the place of assignment and for the pay, or supplemental pay, or a part thereof, of the employee during assignment.

Section 10 – Extraordinary or Unforeseen Events. This Compact is intended to obligate each Co-Signer to carry out all usual and ordinary functions respecting the programs, activities, functions and services that it is undertaking to assume responsibility for under its Funding Agreement. In the event major unforeseen or extraordinary events occur, as jointly identified by each Co-Signer and the Secretary, with consequences beyond the control of the Co-Signer, that the Co-Signer shall have access to additional services and funding amounts for its Funding Agreement as described in its Funding Agreement. The parties will seek to ensure that funds available to the Co-Signer to deal with the unforeseen circumstance will not be less than would have been available to non-Compact Tribes or the Indian Health Service had they encountered a similar circumstance. Each Co-Signer's participation in the Indian Health Service Catastrophic Health Emergency Funds will be identified in the Co-Signer's Funding Agreement.

Section 11 – Mature Contractor Status upon Compact Termination. In accordance with section 506(g)(3) of Title V, should any signatory Tribe, tribal organization at the direction of a signatory Tribe or Tribes, or the ANTHC, elect to convert all or some of the programs operated under the Compact back to contract status under Public Law 93-638, as amended, such conversion shall not affect the Co-Signer's or the Tribe's status as having operated a mature contract within the meaning of section 4(h) of the Indian Self-Determination and Education Assistance Act, as amended. Such conversion would occur only at the end of the Compact term, on another date mutually acceptable to the Tribe, the Co-Signer and the Secretary, or as otherwise provided in this Compact, and will be implemented in a manner which avoids any interruption of services to

individual tribal members. If the Compact is terminated or a Tribe determines that it will retrocede any program, activity, function or service operated under the Compact, neither the Tribe nor the Co-Signer shall lose its mature contractor status under section 4(h) as provided above.

Section 12 – Startup Costs. In accordance with section 508(c) of Title V, startup costs may be separately negotiated by each Co-Signer and shall be included in each Co-Signer's Funding Agreement, if available. Startup costs are designed to compensate the Tribe for costs associated with implementing this Compact which the Co-Signer would not normally incur. Upon agreement to such costs on an annual basis, funds for such costs shall be included in the Funding Agreement, if available.

Section 13 – Limitation of Liability. Any liability to the United States or to any third party incurred by a Co-Signer arising out of its performance of or expenditure of funds under this Compact and each Co-Signer's Funding Agreement shall be the obligation only of that Co-Signer and shall not be the obligation of any Co-Signer of this Compact which did not participate in such performance or expenditure.

Section 14 – Contracting Rights. Nothing in this Compact or in any Funding Agreement shall be construed to preclude a Co-Signer from contracting with the Secretary to perform a program, activity, function, or service under Title I of P.L. 93-638, as amended, subject, however, to constraints against duplication pursuant to section 506(h) of Title V.

Section 15 – Sovereign Immunity. Nothing in this Compact or in any Funding Agreement shall be construed to affect the sovereign immunity, to the extent that it may exist, of any Tribe or Co-Signer.

Section 16 – Interpretation of Federal Law. In the implementation of this Compact, the Secretary, to the extent feasible, shall interpret all federal laws, executive orders, and regulations and this Compact in a manner that effectuates and facilitates the purposes of this Compact and achievement of the Co-Signers' health goals and objectives in accordance with section 512(a) of Title V.

Section 17 – Inadequacy of Program Funding. The parties to this Compact understand that the Indian Health Service budget is inadequate to fully meet the special responsibilities and legal obligations of the United States to assure the highest possible health status for American Indians and Alaska Natives and that, accordingly, the funds provided to the Co-Signers are inadequate to permit the Co-Signers to achieve this goal. The Secretary commits to advocate for increases in the Indian Health Service budget to further the ability of the Co-Signers to provide the full range of services that are the responsibility and obligation of the United States to make available to American Indian and Alaska Native people and to meet the goals of the Indian Health Care Improvement Act.

Section 18 – Effect on Non-Signatory Tribes.

(a) Nothing in this Compact or associated Funding Agreements shall be construed to limit or reduce in any way the service, contracts or funds that any Indian tribe, inter-tribal

consortium or tribal organization is eligible to receive. It is the intent of the parties to this Compact that the Compact will not have an adverse impact on any tribe choosing not to participate in this Compact directly or through a tribal organization.

(b) The Compact shall not be construed to limit or curtail the right of any Tribe to pursue a contract under Title I of the Indian Self-Determination and Education Assistance Act, as amended, individual participation in this Compact under Title V, or an independent compact under Title V.

Section 19 – Gaining Mature Contractor Status. Subject to Secretarial approval, a tribe that participates in this Compact by authorizing a tribal organization or inter-tribal consortium to be a Co-signer and receive funds on its behalf, which enters into a Memorandum of Agreement with the Co-Signer, for three years manages a program, activity, function or service identified in the Co-Signer's Funding Agreement and obtains three audits with no material unresolved audit exceptions, shall be deemed a mature contractor for all purposes, including entering into a Compact under section 503(c) of Title V. Nothing in this section precludes the right of a tribe to become a mature contractor under other provisions of law.

Section 20 – Severability. This Compact shall not be considered invalid, void or voidable if any section or provision of this Compact is found to be invalid, unlawful or unenforceable by a court of competent jurisdiction. Should such a court make such a finding, the parties will seek agreement to amend, revise or delete any such invalid, unlawful or unenforceable section or provision, in accordance with the provisions of this Compact.

Section 21 – Applicability of Title I Provisions. At the request of a Co-Signer, any provision of Title I, not already specified in section 516(a) of Title V, to the extent such provision does not conflict with a provision in Title V, shall be made a part of a Funding Agreement. The Secretary is obligated to include such provision at the option of the Co-Signer. If such provision is incorporated it shall have the same force and effect as if it were set out in full in Title V and in the Funding Agreement. Should the Co-Signer request such an incorporation sometime other than during the negotiation stage of the Funding Agreement, the Co-Signer will present the proposed incorporated Section to the Indian Health Service, OTSG, with a copy to the Alaska Area IHS Director. The Director of the Indian Health Service shall approve a written addendum to the Funding Agreement within 30 days after verifying that the provision is in Title I. In the case of any such provision, it shall be deemed incorporated in the Funding Agreement at the end of the 30 day period unless the Co-Signer receives a written notice from the Indian Health Service stating that the provision is not in Title I. In the event a Co-Signer requests such incorporation at the negotiation stage of this Compact or a Funding Agreement, such incorporation shall be deemed effective immediately and shall control the negotiation and resulting Compact and Funding Agreement.

Section 22 — Purchases from the Indian Health Service. With respect to functions transferred by the Indian Health Service to a Co-Signer under this Compact or an applicable Funding Agreement, the Indian Health Service shall provide goods and services to the Co-Signer, on a reimbursable basis, including payment in advance with subsequent adjustment. The reimbursements received from those goods and services, along with the funds received from the Co-Signer pursuant to this section, may be credited to the same or subsequent appropriation account which provided the funding, such amounts to remain available until expended.

ARTICLE VI — ATTACHMENTS

Section 1 – Approval of Compact. The resolutions of the Tribes approving this Compact for each Co-Signer are attached as part of Exhibit A. Additional resolutions for each Co-Signer may be filed with the Indian Health Service and included in Exhibit A up to the effective date of each Co-Signer's Funding Agreement. The resolution of the Board of Directors of the ANTHC is attached as part of Exhibit A.

Section 2 – Funding Agreements. Each Co-Signer's Funding Agreement shall be attached hereto as Exhibit C.

ARTICLE VII — COUNTERPART SIGNATURES

This Compact may be signed in counterparts.