IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

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INDIAN HEALTH SERVICE TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE
AND TECHNICAL WORKGROUP QUARTERLY MEETING
Wednesday, October 26, 2016 (1:00 pm to 5:00 pm)
Thursday, October 27, 2016 (8:30 am to 4:30 pm)

Embassy Suites Washington DC - DC Convention Center
900-10th Street NW
Washington, DC 20001
Phone: (202) 739-2001

Meeting Summary

Wednesday, October 26, 2016 (1:00 pm to 5:00 pm)
Meeting of IHS Tribal Self-Governance Advisory Committee (TSGAC) and Technical Workgroup with IHS Principal Deputy Director Mary Smith

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Tribal Caucus
Facilitated by: Tyson Johnston, Vice President, Quinault Indian Nation, Member, Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC)

Welcome
Invocation: Blessing offered by Lt. Governor Keel of Chickasaw Nation

Roll Call

Alaska	Jerry Moses, Senior Director, Intergovernmental Affairs, Alaska Native Tribal Health Consortium
Albuquerque	Clyde Romero, Proxy for Governor Benito Sandoval, Pueblo of Taos
Billings	Beau Mitchell, Council Member, Chippewa Cree Tribe
California	Robert Smith, Chairman, Pala Band of Mission Indians Danny Jordan, Proxy for Chairman Ryan Jackson, Hoopa Valley Tribe
Eastern	Richard Randolph, Vice Chairman, Proxy for Chairman Vanderhoop, Wampanoag Tribe of Gay Head (Aquinnah)
Navajo	Ramona Antone Nez, Proxy Vice President Jonathan Nez, Navajo Nation
Oklahoma	Jefferson Keel, Lt. Governor, Chickasaw Nation Kay Rhoads, Chief, Sac & Fox Nation Rhonda Butcher, Proxy for Chairman John Barrett, Jr., Citizen Potawatomi Nation Melanie Fourkiller, Proxy for Chief Gary Batton, Choctaw Nation
Phoenix	Lindsey Manning, Chairman, Shoshone-Paiute Tribes of the Duck Valley Indian Reservation
Portland	W. Ron Allen, CEO/Chairman, Jamestown S'Klallam Tyson Johnston, Vice President, Quinault Indian Nation
Rocky Mountain	Beau Mitchell, Council Member, Chippewa Cree Tribe
Southern Plains	Rhonda Butcher, Proxy for Chairman Barrett, Citizen Potawatomi Nation

Introductions – All Participants & Invited Guests

Veterans Administration's Tribal Consultation on Plan to Consolidate Programs to Improve Access to Care

Dr. Richard A. Stone, Principal Deputy Under Secretary for Health, Veterans Administration (VA)

- Opening remarks
  - Thank you for working with the VA to improve health for Tribal veterans
  - Currently in a consultation phase, with the comment period ending on November 5, 2016. Once closed the VA will look at all comments and consider recommendations with the hopes of improving care.
  - In the first consultation there was a prevalent feeling that the VA had already made their decisions, which Dr. Stone assures is not the case.
    - Dr. Stone also informed the committee that he is the highest non-appointee official and as a result, will bridge the upcoming presidential transition.
- Current VA-IHS MOU
  - There is Tribal concern that the VA won't honor the current MOU.
    - Reimbursements should be available for care provided to Tribal veterans, no matter who provides that care.
    - Because of the nature of ITUs, if they don't recover the rate for care they won't be able to continue operating.
  - Confusion about these agreements has been greatly expressed.
  - VA Response: The current agreements expire in 2017. Currently there are 94 different agreements. As a result of this large number the VA is asking if these agreements should be bundled together? Is making agreements this many different times beneficial? Would Tribal health programs be interested in extending existing reimbursement agreements between VA and Tribal health programs through December 2018 and ensuring any new reimbursement agreements between VA and Tribal health programs extend through December 2018, as VA works in collaboration with Tribes and other VA stakeholders on implementing a consolidated community care program?
    - Tribal Leaders believe these agreements shouldn't be discussed for change often. Instead their terms should be extended or automatically renewed; however, if they do need to change, provide a provision to do so.
    - VA Question: Would simply extending these agreements harm Tribes? Could it be a feasible solution in the short term?
    - Tribal Response: An extension could be a good option to allow Tribes to work with the VA in improving these issues. The Purchased/Referred Care (PRC) and related costs could at some point be included in it.
    - VA agreements and extensions of agreements also need to work with IHS so that Direct Service Tribes are covered.
  - Tribal leaders have also expressed concern with the impact the new Administration will have on the 2018 agreements.
    - VA Response: This is also a concern for the VA. That is why these relationships need to be improved and solidified now.
- VA Questions for Tribes:
  - Would Tribal health programs be interested in expanding direct care services under this next structure to include reimbursements for care provided to all Veterans enrolled in VA health care, regardless of whether they are eligible for IHS-funded health care or not?
    - Tribes would like to be able to do this, because regardless of where a Veteran lives, they should have access to quality care, even if that is a Tribal facility.
    - As long as there is a reimbursement agreement in place, this shouldn't be an issue.
    - Tribal Concerns: Doing this would only be as effective as the ability of a facility to provide care to an exponentially increased population.

            - This is primarily on a facility-by-facility basis.
            - Some facilities simple don't have the capacity to serve that amount of people.
    - Expansion and use of the Consolidated Mail Out-Patient Pharmacy (CMOP) by Tribes.
        - The opportunity to use CMOP is currently not being extended to Tribes.
            - For new Self-Governance Tribes this is an issue, because as soon as they take over a service, the mail order pharmacy that veterans were using immediately ceases to operate and will not provide medications to Veterans.
- There needs to be more emphasis on the coordination of care with VA facilities, especially when it comes to referrals for specialty services.
    - VA response: What should a model of this look like?
    - Tribal providers should be able to refer patients out without having to meet VA credentialing or submitting confusing forms for the request.
    - This relationship between VA facilities and ITUs should be more informal.
- Reopening the discussion of PRC would help to improve Veterans' care.
    - The current required pre-approvals are a barrier to patients receiving the specialty care they are referred out for.
- Tribal Veteran Co-pays.
    - Veterans shouldn't have to pay copays, especially since they qualify for Indian Health Care, which doesn't require co-pays.
    - VA Response: Co-pays don't apply to IHS Direct Service facilities.
        - Historically IHS would pay for the co-pays of Veterans referred to the VA; however, there is now legislative inquiry about authorizing Tribes to use PRC dollars to pay for these co-pays.
    - IHS Response: No veteran should have to pay co-pays; however, IHS has been told that Native veterans who go to VA facilities are issued co-pays and ultimately it is an issue that does require a legislative fix.
    - We need to look for other solutions to fix this issue and the short-term fix should not be the use of PRC dollars.
- Dr. Stone's Final Thoughts:
    - Dr. Stone expressed that he needs to work towards gaining more understanding of all of these issues and by granting a one-year extension, this could be accomplished, as well as, providing the opportunity for holding more consultations with Tribes.
    - Tribes are not vendors. They hold a special role and should be treated as such. Because of that there is a need to come to a better understanding so that the VA can better assess what the rates should be. Additionally, these rates need to be thought about in a different way than the rates for everyone else, because of the special role Tribes hold.

TSGAC Opening Remarks

W. Ron Allen, Tribal Chairman/CEO, Jamestown S'Klallam Tribe, and Co-Chair IHS TSGAC

- We must stay engaged and continue to work with IHS, even if we don't agree with what they are doing or the decisions they are making.

Mary Smith, Principal Deputy Director, Indian Health Service

- TSGAC and Self-Governance are very important.
- Recently been traveling to visit many Tribal regions.
- Personal Announcements:
    - Deputy Director – Capt. Chris Buchanan
    - Deputy Director for Intergovernmental Affairs – P. Benjamin Smith

- Acting Director, Office of Tribal Self-Governance – Jennifer Cooper
- Acting Deputy Director of Field Operations – RADM Kevin Meeks (Continues to serve as Oklahoma City Area Director)
- Acting Director, Office of Urban Indian Health Programs – Raho Ortiz
- Great Plains Acting Area Director (90 day assignment) – Capt. Francis Frazier
- Great Plains Chief Medical Officer – Dr. Lee Lawrence

TSGAC Committee Business

- Approval of Meeting Summary (July 2016)
  - Jamestown S'Klallam Tribe made a motion to approve the July 2016 Meeting Summary.
  - The motion was seconded by Citizen Potawatomi Nation.
  - The motion was approved without objection.
- TTAG Representative and Alternate Representative
  - Citizen Potawatomi Nation made a motion to approve Chairman Allen and Melanie Fourkiller to serve as primary and alternate representative, respectively, to the TTAG.
  - Hoopa Valley Tribe seconded the motion.
  - The motion was approved without objection.
- Level of Need Funding Workgroup (Strategy Session Discussion)
  - If interested in participating please contact Kasie Nichols or Terra Branson.
  - Goal is to find something that resonates for improving LNF
- Tucson IHS Area Primary and Alternate Representative
  - Primary Representative: Daniel L.A. Preston, III, Councilman, Tohono O'odham Nation
  - Alternate Representative: Anthony J. Francisco, Jr., Councilman, Tohono O'odham Nation
  - Chickasaw Nation made a motion to approve the Tucson Area Primary and Alternate Representative to the TSGAC.
  - Navajo Nation seconded.
  - The motion was approved without objection.

Office of Tribal Self-Governance Update

P. Benjamin Smith, Deputy Director for Intergovernmental Affairs, IHS

- It has been an honor serving in the position of OTSG Director and he's is confident that Jennifer Cooper will continue the good work and ultimately raise the OTSG to the next level.
- In order to accomplish things and have positive outcomes you have to work together in partnership and we need to spread these kinds of conversations throughout the Federal Government as a whole.

Jennifer Cooper, Acting Director, Office of Tribal Self-Governance, IHS

- Looks forward to continuing the work that Ben has been doing.
- Welcome to two new Self-Governance Tribes:
  - Seminole Nation of Oklahoma
  - Quapaw Nation
- With new tribes, there are now over 90 compacts and 117 funding agreements with Tribes across the nation, which shows that this program is growing and becoming a larger, better program.
- In the near future, will be looking at the operations of OTSG and how they align with the mission and goals of the office.
- Position Announcements:
  - Steve Plumer – Promotion to Financial Analyst
- OTSG is also very concerned with workforce recruitment, retention, and development.

- FY2015 Tribal Self-Governance Report to Congress
    - OTSG appreciates all Tribal comments and will be looking at those with the hopes to solicit more feedback on analysis issues within the report.
    - OTSG received three comments and while one of those was from TSGAC, who does represent hundreds of Tribes.

Patient Protection and Affordable Care Act (ACA) Implementation Update

Cyndi Ferguson, Self-Governance Specialist/Policy Analyst, SENSE Incorporated
Doneg McDonough, Consultant, Tribal Self-Governance Advisory Committee

- Overview:
    - Funding was approved for another year.
    - Many of the current deliverables will continue.
    - Creating a new toolkit for Marketplace Enrollment.
    - Encourages those who participate in webinars to submit feedback.
    - Melanie Fourkiller will continue as a webinar instructor.
    - Doneg McDonough will continue as a tech advisor.
    - For more and updated information please look at the Health Care Reform tab on the Self-Governance website. Additionally, if you have questions please feel free to contact them and ask.
- They will be putting together a workgroup to pull together information about Tribal citizens enrolling in the Health Care Marketplace and sponsorship.
    - Don't let the notion that premiums will be increasing drive you away from looking into enrolling in the Marketplace. In some cases, despite the increase, Tribes still pay less.
- TSGAC input on ACA Outreach and Education activities for 2016-2017
    - Requesting feedback on annual work plan.
        - Surveys are located in TSGAC meeting packet, but can also be completed online on the health reform website www.tribalselfgov.org/health-reform

Self-Governance Transition Plan Review and Approval

TSGAC and Technical Assistance

- Overview:
    - These are topics that were brought up at the Strategy Session in September 2016.
    - We have submitted comments to NCAI for their comprehensive transition document.
    - HHS Priorities
        - Assign high-level Tribal-Federal Taskforce to provide recommendations for the redesign of IHS;
        - Implement a Self-Governance Demonstration Project according to the 2013 Self-Governance Federal Workgroup;
        - Equalize Medicaide access and benefits in Indian Country;
        - Update the IHS Facilities Construction Plan to include broad Tribal input; and
        - Establish a taskforce to identify resources and administrative policy changes to identify additional housing options for health care providers in rural and underserved areas.
    - Also included a section for VA to bring more awareness and importance to those issues, including:
        - Full implementation of the National VA-IHS MOU;
        - Improving coordination of care between the two health systems; and
        - Utilizing the National VA-IHS MOU to provide care to non-Native veterans.
    - We will also update our Strategic Plan to reflect these identified priorities.
    - This is a transition document, which reflects short-term priorities, rather than the long term ones within our Strategic Plan.

- Discussion:
    - Is it best to request and advisory committee within OMB? Would it be better to request an individual person, Indian desk, etc.?
        - It may be more realistic and attainable to request the creation of a position and recruit a single person who has the expertise needed to operate and advise within OMB.
        - Navajo supports a full committee
        - To attain interdepartmental collaboration, the best way may be to reach out to and work with the White House Council.
            - White House Council on Native American Affairs (WHCNAA) wants Tribal leaders to get involved. This is more with the subcommittees than with the larger council.
            - We may need to look into and request a review of the original charter used to establish the Council.
            - We need to request more staff, because it is impossible to cover all of the issues without a larger staff.

Preparation for Discussion with IHS Principal Deputy Director

- Ben's Suggestions on what to look at when planning for discussion:
    - Principal Deputy Director Smith wants to hear feedback on IHS realignment.
        - Tribal Question: How does this make IHS more efficient?
            - Response: Bulk of realignment is within the functional statements and you have to pay attention to these to understand what they are trying to do.
        - Tribal Concern: The functional statement makes it difficult to track whom answers to whom.
            - Response: Will have to check and cross-reference some of the things, titles, and people in positions to make sure it's accurate.
        - Tribal Question: Has IHS talked with the current workforce about this? Are they in favor? How will it be implemented?
            - Response: When the DTLL went out it was the first time many of the ALNs had seen it also. Ultimately, there will have to be deep discussion and thought about how this will actually be implemented.
        - Tribal Question: How will this implementation make IHS more efficient?
            - Response: It's realigning current functions to improve how they operate.
    - Solutions for Workforce Issues.
        - Held a world café to explore solutions, but would like to hear more from TSGAC.
    - Finding a way to promote and document best practices.
        - The last time this was brought up to TSGAC it resulted in the funding of Sovereign Nations Newsletter. Currently, IHS is looking to do something similar.
- Tribal Discussion:
    - IHS Realignment: What will operations look like in the next 90 days?
        - What changes are actually taking effect on the regional or local level?
        - We need to communicate that the Chief Information Officer (CIO) is a higher priority and needs more resources.
        - OTSG and Office of Direct Services placement in organization.
            - OTSG was deliberately placed at a high level within the Office of the Director.
            - Indian Health Care Improvement Act (IHCIA) created Office of Direct Service and Contracting Tribes (ODSCT) and requires that it be in the Director's office.

- According to IHS Principal Deputy Director Mary Smith, these offices don't currently answer to the Director anyway.
- Does the line of authority/communication go straight to the Director or is it routed through several other people?

▪ Is there a CIO position in the new realignment structure? What resources do they have? What level of priority and importance is IHS placing on this position and technology development?

- Resource and Patient Management System (RPMS) and Information Technology issues
  - ▪ IHS has to be with VA at the discussion table about RPMS.
  - ▪ Strategies need to be created about what will happen with RPMS, whether it updating, continuing, revamping, etc.
  - ▪ How do we strategically address this issue?
  - ▪ RPMS is the backbone of everything Tribes do when it comes to patient care. I.e. data collection,
  - ▪ If we are going to continue to provide quality health care we have to keep RPMS updated as technology improves.
  - ▪ Under current system Tribes are unable to meet meaningful use II.
    - This is due to the requirement to sign the IHS Multi-purpose Agreement (MPA), which as is requires a partial termination of sovereignty.
    - The requirement still hasn't been fixed and needs to be addressed.
- Asked for an update on the Quality Framework Draft. Where does it currently stand? What is the plan for moving forward?
- Revenue Generation:
  - ▪ More emphasis has to be placed on this in order to provide quality care.
  - ▪ Has to be maintained to ensure IHS continues to operate and improve.
- Medicare like rates:
  - ▪ Grand Traverse Band in Michigan has had issues where the hospital won't accept Medicare like rates for Tribal citizens who have a non-Tribally provided insurance plan, i.e. Insurance provided through a private employer organization.
    - This should be accepted as a paid in full via third party vendors, but it's not and as a result, the Tribal citizens are receiving bills for these services.
    - CMS will take a look into it and see what needs to be done to remedy the issue.

Recess until October 27, 2016

Thursday, October 27, 2016 (8:30 am – 4:30 pm)

Meeting of IHS Tribal Self-Governance Advisory Committee (TSGAC) and Technical Workgroup with IHS Principal Deputy Director Mary Smith

Welcome and Introductions

Mary Smith, Principal Deputy Director, IHS

- Provided opening remarks.

Indian Health Service Budget Update

Rosetta Tracy, Division Director for Budget Formulation, IHS
Caitrin Shuy, Director of Congressional Relations, National Indian Health Board

- IHS Fiscal Year (FY) 2017 Funding:
  - Still in progress

  - House and Senate did mark ups this summer and finished in June; however, there are differences between the two, so there will have to be some work done to overcome those.
    - Senate Bill includes:
      - Proposed $4.9 billion for IHS.
    - House Bill includes:
      - Proposed $5.07 billion for IHS;
      - Report language requesting a GAO study; and
      - Requests an amount for funding for the Indian Health Care Improvement Act New Authorities that were passed in 2010.
  - Both house and Senate budget proposals are offering less than what was requested in the President's Budget, but are still increases compared to last year.
- FY 2018 Budget Request:
  - Is under the rules phase, also known as the embargoed or pre-decisional phase.
  - Different than normal years, because of current presidential election.
- FY 2019 Budget Formulation
  - Instructions were sent to the Areas on September 8, 2016.
  - There has been consideration for a new way to budget. Tribal leaders have expressed a desire for Area budgets.
    - IHS Response: This is the first they've heard about it, but in any case, you have to think critically about what will actually benefit all Tribes, rather than just a specific area, and how you can balance those things with the current IHS situation and then work together to achieve those things. A few examples of the areas in which this type of critical thinking has to be applied, include:
      - Lack of increases that match the current rate of population growth, which is a major determent to providing Native Americans with the good, quality health care they deserve;
      - The current state of housing within Indian Country;
      - IT/RPMS, which IHS doesn't currently have funding for;
      - Behavioral Health;
      - Level of specialty providers who are physically located in the communities; and
      - Telemedicine, which has transformed medicine in recent years and should be a national priority for everyone; however, every year it never makes the top of the national priority list.
- Tribal Question: Has IHS included in their budget request the Catastrophic Health Emergency Fund (CHEF) threshold cap that the PRC Workgroup was in agreement with? Is there something in place that prevents it from going higher each year?
  - IHS Response: Don't believe it's required in legislation, but is required in regulation. In regards to preventing it from rising, IHS will follow up on it and get back to TSGAC.
- Tribal Question: Because of the heavy restriction in place when it comes to construction and housing, is there an opportunity to establish a blanket authority that allows IHS to utilize third party on some of those restricted things?
  - Response: Yes, any flexibility is good; however, with the current system there are issues that don't allow for the amount of flexibility needed when working with those third parties.
  - TSGAC Members echoed that IHS should have more flexibility to move funding around in several different areas of the budget.
- NIHB has been working on a HHS labor budget.

TSGAC Agency Lead Negotiator (ALN) Survey Results and Update

Melanie Fourkiller, Policy Analyst, Choctaw Nation and TSGAC Tribal Technical Co-Chair

- Update and highlights of TSGAC ALN Survey Results:
  - Had Tribes respond in 7 of 12 areas.
  - Over 2/3 of Tribes had responsive ALNs.
  - Over 2/3 were satisfied with their in person meetings.
  - 50% believe that ALN should be serving in that position only.
  - The majority of respondents indicated that they believe ALNs should reside in the area they work in.
  - Overwhelming Tribal responses saying ALNs should continue to lead the negotiation.

Jennifer Cooper, Acting Director, Office of Tribal Self-Governance, IHS

- OTSG is excited to see these results.
  - Feedback from the survey highlights many of the issues present with ALNs.
    - One such issue is that many of the current ALNs are beginning to retire.

P. Benjamin Smith, Deputy Director for Intergovernmental Affairs, IHS

- The ALN program is a huge program and the decisions surrounding it shouldn't be taken lightly.
- Very concerned with the future of these negotiator positions.
  - There is a large need around the sustainability of these individuals.
- Areas don't have budgets specifically designated for self-governance.
- Currently there are only one or two ALNs that report to an Area Director.
  - For the most part they report to an exec officer.
- Tribal Question: Can you do reverse IPAs to fill these roles? Could it be used as an option to bring in someone from the field, who knows both sides, and can work with both?
  - IHS Response: Every suggestion is good to have. For self-governance the negotiation process is a complete shift from what contracting used to be.
- Discussion:
  - Having ALNs report to the Director would help to ease the concerns of many Tribes.
    - It appears that ALNs don't have the authority to make the decisions, which could be improved if they are reporting directly to the person making the decisions.
    - It would also be an effort to ensure that the things Tribes are saying are getting reported to the Director accurately.
  - When looking into making changes or improving, don't cut off the ability of ALNs to access and bring other needed people to the table.
  - Ms. Smith indicated that more ALN training and leadership training is needed throughout the Agency.
  - If Indian Health Care is going to move forward we can't let the limitations of IHS impede the ability to deliver services.

<u>Housing Opportunities to Support Tribal Health Initiatives</u>

Heidi J. Frechette, Deputy Assistant Secretary, U.S. Department Housing and Urban Development

- Overview of HUD Programs:
  - Overall HUD programs infuse about $2 billion into Indian Country annually.
  - Some of these Programs include:
    - Formula block grant program – The Indian Housing Block Grant;
    - Community development block grant program – Indian Community Development Block Grant, which infuses $60-$70 million annually into Indian Country;
    - Title VI Program under the Indian Housing Block Grant, which is used for projects in infrastructure; and

        - Loan guarantee program – 184 Program – with no income limitation that both Tribes and individual Tribal members can use to build new housing.
- HUD Initiatives:
    - Will be publishing the final rule for their updated Block Grant Formula soon.
        - Additionally, as a result of these efforts, HUD recently updated their Tribal Consultation Policy, which allows Tribes to enter into the conversation much sooner.
    - Looking into establishing a Tribal Intergovernmental Advisory Committee.
    - Tribal Youth Summit, which brought in 100 youth to discuss what they could do in their own communities to address major issues in Indian Country.
    - 184 Program for housing professionals in your communities:
        - Loan guarantee program that Tribes can utilize for housing.
        - Doesn't have an income requirement so it has the ability to work well with professionals.
    - Tribal Department of Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) Pilot Program for Indian Veterans:
        - It is a housing plus services program for Native Veterans and was created, because the currently established VASH program didn't reach veterans who lived on reservations.
        - This also provides HUD with an opportunity to look at ways to get services out to rural locations.
        - It will be renewed annually, but hopefully HUD will be able to show improvement so they can request additional funding.
- One issue HUD faces while trying to implement programs to address the housing issues in Tribal communities is the Interior Appropriation Language, which prohibits the use of IHS funds for infrastructure for HUD funded programs.
    - Looking to change this.
- Tribal Question: What can Alaska do to be included in the opportunities for pilot programs?
    - Response: Had to be aware of limited funding when making the decisions of where to implement this pilot program.
- Tribal Question: How can Tribes partner with HUD Health Facilities Development and what can be done to work with those programs to create housing for providers?
    - Response:
        - Have previously used the Indian Community Development Block Grant Program for facility development.
        - The 184 Program has been used to help with housing issues.
            - Under this program you can construct or acquire, along with a lot of other flexibility.
                - As a result, there are several examples of rent-own programs in Oklahoma.
            - There's been an expansion in the number of transactions done by Tribes, because Tribes are leveraging the program to increase access.
                - About 20% of all loans or Tribal transactions are lease to purchase models.
            - Tribes are most interested in bringing in this opportunity to offer something to service providers and as long as this is affiliated with the Tribe, this flexibility is much easier.
    - Pueblo of Jemez has used the 184 Program for Tribal members, however there are limited number of banks who accept the 184 Loan Program to increase home ownership. What is HUD doing to increase the number of banks that accept 184?

        - Response:
            - HUD is working to automate the lending process so that higher tier and more lenders to be available in the program.
            - Lenders don't want to bring 184 on because the paper process requires too many resources – human and financial.
    - Oklahoma has faced a lot of issues because of policies. The Sac and Fox Nation in particular cannot build homes because HUD has policies that prohibit building near pipelines. We cannot even build on trust land because of these restrictions. It is a disabling economic development. Any Tribe near these pipelines is going to struggle as long as the environmental restrictions remain.
        - Response:
            - Are aware of the challenges with environment and have been working across agencies in order to find ways to alleviate the difficulty.
            - HUD already has a good structure in place to look at these issues, because they have already had to deal with it in Hawai'i.
    - On Navajo Nation, infrastructure is very important and they encourage HUD to continue to visit and work with TSGAC. Infrastructure is so important because it is the base for how you have healthy people and families. HUD should continue to work with IHS to collaborate and provide quality Health and Health Care for Native people.
        - Response:
            - HUD has done a housing needs/impacts study within Indian Country, that highlights the detriments of overcrowding and poor quality housing, which will come out in January. Along with it, HUD will be publicizing the methodologies used so that Tribes have access and can perform their own studies.
- Tribal Question: How is HUD addressing the issues of using both IHS and HUD resources for housing and wastewater issues?
    - Response:
        - These issues are included in the reporting the Office of Management and Budget (OMB) uses in developing the numbers on crosscutting budget shared annually.
    - Lummi has recently had to evict several people from housing due to Meth contamination, even though they were constructed according to HUD's containment requirements.
        - Response:
            - Very aware of the issue.

<u>Contract Support Costs (CSC) Policy Workgroup Update</u>

Rhonda Butcher and Mickey Peercy, CSC Workgroup Members
Roselyn Tso, Acting Director, Office of Direct Service and Contracting Tribes, IHS

- IHS surprise announcement:
    - Finalizing and rolling out the IHS CSC policy today, October 27th.
        - Will streamline the process
    - Promised not to do anything unless it was agreed upon by both IHS and Tribes.
        - Weren't able to agree on everything, but made sure to note differences within the policy.
    - Additionally IHS will be applying the medical inflation rate to CSC.
- Highlights of Policy:
    - Duplication Trigger:
        - Couldn't come to an agreement on the definition of duplication.
            - Tribes say it's a dollar to dollar duplication,

        - IHS says that if they've given any funding for a position, you can't put it in a CSC proposal because they have already paid for it.
        - Depending on what decision is made, there will be a huge monetary implication.
        - If Tribes can pay for administration positions through CSC, it would free up a lot of Tribal money that can then be used for providing patient services.
    - The continued work and meeting of the workgroup is important as they begin to implement this policy.
    - This has been a major joint effort between Tribes and IHS.
    - With this Policy, if it's followed, IHS will be treating Tribes fairly and consistently
- IHS should be transparent and upfront about how they are calculating CSC.
- As they move forward on the CSC Policy it is extremely important for IHS to set up opportunities for Tribes to comment and give feedback on the Policy.
- IHS is looking into creating webinars for Tribes to increase opportunities to learn and fully understand the Policy, as well looking into making all of the data more understandable for Tribes.
- Tribal Discussion:
    - Can we eliminate Interior Business Center (IBC) from the process?
        - Response:
            - Will add it to list of conversations to have after first of the year.
    - The meaning of existing Tribes with no rate.
        - Response:
            - IHS is willing to simplify the steps.
    - Tribes and IHS need to lockdown rates in long-term agreements. Tribes do not want to be forced into renegotiating rates all the time.
        - Response:
            - Currently, the CSC Policy requires that the Tribe have rate that is from within the last three years.
    - How will the new rates be included in the FY 2017 Budget?
        - Response:
            - IHS has been working with past reports, which will help them begin the conversation on the needs vs. the requests.
- Audits should reflect the consistency of Tribes' rates.
- Training is an issue.
- The low number of Tribes that have a current, updated rate is concerning.

Joint TSGAC and IHS Principal Deputy Director Discussion

- Outstanding IHS Consultation Issues
    - Draft Quality Framework
        - No significant changes made in the Quality Framework and most of the changes are on the implementation side.
        - First priority was to establish an Office of Quality at IHS HQ.
        - Finalized a draft of Governing Body procedures.
        - Currently have all of the hospitals working with an accrediting body.
        - Does IHS not have the expertise and ability to train and create an accrediting system? Is that why you're going to outside sources? Does this Framework apply to Tribal facilities?
            - Response:

- Does not apply to Tribes, but would love for everyone to operate under the same Framework eventually.
- IHS isn't trying to impose one accrediting organization onto Tribal facilities.
- The overall goal is to get all IHS facilities accredited by one body.
- This particular contract isn't to bring IHS up on the training for accrediting.

- Only one facility has been terminated as of now. This was largely due to a lack of permanent staff in the facility.
- IHS wants to allow Tribes to have flexibility, but the standards are wildly different throughout Indian Country, which is why there is a desire to create a baseline standard.

- IHS will release a report from the world café held right before NCAI in the next week.

Lunch

TSGAC Members' Executive Session with IHS Principal Deputy Director

- TSGAC Members' and IHS Principal Deputy Director Smith saw no need for an executive session.

Announcement from Sac & Fox

- DOJ's Office on Violence Against Women, a research taskforce, has openings and are now taking nominations, until November 10, 2016, for those who are interested in sitting on their committee.
- Does TSGAC want to submit a nomination?

Special Recognition of Rhonda Butcher

- This is her last meeting and she will be greatly missed.

Joint TSGAC and IHS Principal Deputy Director Discussion (Continued)

- IHS Workforce Concerns
  - Many students today are moving away from using the IHS Scholarship system because of the stipulations that are put on students, as well as, the fact that those students have other offers out there.
    - A solution for this could be to allow Tribes to have more input on it.
  - There was also an issue with a lack of negotiation and flexibility when it came to the payback. Specifically in terms of placement, salary, etc.
  - Lack of Medical institutions for Native students
  - IHS Response:
    - Have hired people to look at the scholarship program
    - Looking at contract issues
    - Have talked with Cherokee Nation
    - In long term would love to see an IHS Med School
    - Oklahoma has a program to help students with applications for loan repayment
- IHS Realignment
  - Background of how IHS got to the decision of a realignment:
    - Reports have come out showing a major deficient in quality of care.
    - These issues aren't specific to the Great Plains, which means this isn't entirely being done as a reaction to the Great Plains
    - Major issues that are across the IHS system as a whole

- Lack of workforce
- Difficulty recruiting new providers
- Issues with scholarship
- Competition with the VA
- IHS isn't able to hire nurses right out of school because most of the facilities don't have the capacity to train them and provide the experience they need. Even if they are given a scholarship and are required to work for IHS they first have to go work somewhere else for two years first.

▪ Current plan doesn't impact Areas at all. Originally IHS wanted to realign everything, but that wasn't a feasible thing to do.
▪ There is a lot of room for improvement in many of the functions the IHS provides.
- These functions need to be ramped up and this should be reflected in the new IHS organizational chart.

o Overview/Comparison of realignment and proposed changes
▪ In current org chart it is difficult to see lines of authority and accountability.
- One huge box with no direction.

▪ New org chart recognizes the lines of authority and clarifies responsibilities.
▪ New positions and offices are also being added.
- Office of Hospital Management
- Associate Director (AD) of Health Care Workforce Development
  - Someone solely dedicated to working through the issues of creating new Native providers. Reviewing scholarships, long and short term solutions, etc.
- IHS Office of Information Technology
  - Priority should be on the development of telemedicine.
  - Currently the IT people report to the Chief Medical Officer (CMO), which is not who they should probably be reporting to. CMO is already handling so many other huge jobs. IT doesn't need to be added on to that.

▪ OMS has been eliminated in the new org chart. Will still perform the same functions under the Chief Operating Officer (COO), but it won't be in its own separate office.

o New chart is a lot clearer
o When does IHS plan on advertising the new and currently vacant positions?
▪ Response:
- Will get that out as soon as possible.
- Need to fill some of the proposed positions now
  - If comment period extension is granted then they will either create new positions or try to get reverse IPAs to begin that work.

o What is the status of the joint letter requesting an extension on the IHS Realignment comment period? What is the status of that request?
▪ Response:
- Some concern with not having enough time left in the current administration to implement this once it is finalized.

▪ There are missing operation statements for several of the offices in the functional statement, as well as, confusion on what some of the other offices roles based on what it says in the functional statement.
- IHS Response:
  - They will have to look into it.

        - Request for delay is reasonable, but it should cause things to be dragged out longer than they should.
    - This new organization looks more like a health care system than the old one did.
    - There has been a huge gap in IHS for reviewing proposed regulations. The new org addresses this and it is encouraged to make sure that aspect is implemented.
        - Response:
            - IHS doesn't spend enough time looking these over and that is something that needs to be improved.
            - Need to add people to that office, as well as, IHS as a whole because they are currently stretched very thin.
    - Concerns with OIT
        - Technology is very important and a crucial part of most of IHS operations. The functional statements of this office needs to show how it relates to and is used by all the offices.
            - Response:
                - Functional statement needs to reflect the depth and breadth of what they actually do.
                - Will keep that in mind when updating after comment period.
    - Addition of specific office for billing. It is a critical operation that needs to be prioritized.
        - Response:
            - Have already heard that and will try to incorporate it.
    - CMO should be focusing on providers and quality.
        - Response:
            - Agree that quality is an important issue.
            - IHS doesn't want to disrupt things that are working well, but there are areas where it can't be avoided; for example, credentialing, especially since there are areas in the Great Plains who are still credentialing with paper.
    - Other IHS comments
        - Encourages everyone to read the OIG report.
        - Does IHS need a separate quality consortium if they have the quality office at headquarters?
        - IHS is setting standards and looking at the issue of quality from a global perspective.
    - Tribal Question: Is the Associate Director of Analysis and Evaluation a new position or is it something that currently exists?
        - Response:
            - Currently it is the Office of Public Health Support
            - Is another elevation, because there isn't a current Deputy Director for that office; however, IHS feels that data and information is important enough to warrant this action.
        - Was there ever a consideration about the relationship between IT and this group, and how the CIO will be involved?
            - Response:
                - Have previously heard this comment and will have to discuss and think about it some more.
                - Should the CIO be part of the leadership team?
    - IHS has reassured that realignment won't impede on Tribal shares, but there isn't anything showing how these new offices will be funded. Could IHS do a crosswalk between new and old chart to show that?

        - Response:
            - It's hard to do that.
            - IHS tried and that's how they got the chart with black and green, which was included in the realignment materials.
        - Ben Smith's Response:
            - This doesn't provide for changes in Tribal shares and the current Tribal shares table will stay the same.
            - IHS will need to update their PSFA Handbook so Tribes are aware of the new points of contact and to learn about the programs and shares they're entitled to.
- Health IT
    - Multipurpose agreement
        - Response:
            - Wasn't intended to impede on sovereignty. Could have been a misreading or misunderstanding.
            - Will respond with an update by Monday, October 31, 2016.
- Would IHS consider doing a webinar to explain and show the changes and affects?
    - Response:
        - Yes, they would be happy to do that.
        - They want to be completely transparent and take into account all comments they receive.
        - Will possibly be doing regional things as well.

Closing Remarks

Mary Smith, Principal Deputy Director, IHS

- Expressed IHS appreciation for the partnership and dedicated work of the members of the TSGAC.

Tyson Johnston, Vice President, Quinault Indian Nation, Member, Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC)

- Appreciates all of the work and effort that has been shown this week.

Adjourn TSGAC Meeting