IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

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INDIAN HEALTH SERVICE TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE
AND TECHNICAL WORKGROUP QUARTERLY MEETING
Tuesday, January 24, 2017 (8:30 am to 5:00 pm)
Wednesday, January 25, 2017 (8:30 am to 12:45 pm)

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

Minutes

Tuesday, January 24, 2017 (8:30 am to 5:00 pm)

Meeting of the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC) and Technical Workgroup with RADM Chris Buchanan, Indian Health Service (IHS) Acting Director

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Tribal Caucus

Facilitated by: Marilynn "Lynn" Malerba, Chief, Mohegan Tribe, and Chairwoman, Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC)

Meeting Called to Order

Welcome
Invocation: Cheryl Andrews-Maltais, Chairwoman, Wampanoag Tribe of Gay Head (Aquinnah)
Roll Call:

Alaska:	Gerald Moses, Senior Director, Intergovernmental Affairs, Alaska Native Tribal Health Consortium
Albuquerque:	Delbert Chisholm, Lt. Governor, Taos Pueblo Shawn Duran, Tribal Administrator, Taos Pueblo
Bemidji:	Vacant
Billings:	Calvin Jilot, Council Member, Chippewa Cree Tribe
California:	Ryan Jackson, Chairman, Hoopa Valley Tribe
Great Plains:	Vacant
Nashville:	Marilynn "Lynn" Malerba, Chief, Mohegan Tribe (TSGCA Chair) Cheryl Andrews-Maltais, Chairwoman, Wampanoag Tribe of Gay Head (Aquinnah)
Navajo:	Patrese Atine, Proxy for Jonathan Nez, Vice President, Navajo Nation
Oklahoma 1:	Kasie Nichols, Proxy for John Barrett Jr., Chairman, Citizen Potawatomi Nation Kay Rhoads, Principal Chief, Sac & Fox Nation
Oklahoma 2:	Mickey Peercy, Proxy for Gary Batton, Chief, Choctaw Nation
Phoenix:	Lindsey Manning, Chairman, Shoshone-Paiute Tribes of the Duck Valley
Portland:	W. Ron Allen, Chairman/CEO, Jamestown S'Klallam Tribe
Tucson:	Anthony J. Francisco Jr., Councilman, Tohono O'odham Nation

Introductions – All Participants & Invited Guests

TSGAC Opening Remarks

Marilynn "Lynn" Malerba, Chief, Mohegan Tribe, and Chairwoman, Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC)

RADM Chris Buchanan, Acting Director, Indian Health Service

- IHS Acting Director Buchanan fully supports and believes in the mission of the Indian Health Service (IHS); He understands the importance of working with and listening to Tribal Self-Governance Advisory Committee (TSGAC).
- Personnel Updates:
    - Acting Chief of Staff: RADM Kelly Taylor
    - Acting Director for Quality Health Care: RADM Nicole Lurie
    - Acting Chief Medical Officer: CAPT Michael Toedt
    - Albuquerque Area Director: Dr. Leonard Thomas
    - Acting Director Office of Clinical and Preventive Services: RADM Sarah Linde
- Indian Health Service (IHS) Priorities:
    - Quality; Using the Quality Framework, standardizing accreditation, and providing leadership and accountability.
    - Telemedicine; Developing infrastructure to provide telemedicine, which they expect will move forward at the end of March or early April.
    - Strengthening Workforce, Staffing, and Leadership; Submitted the Indian Health Service (IHS) headquarters realignment paperwork to the Department of Health and Human Services (HHS) and Congress on January 19, 2017. Congress doesn't have to approve the realignment, but they do have to be notified and are waiting on Department of Health and Human Services (HHS) approval.
    - Scholarships; Approximately $13.7 million will be available for scholarships and approximately $30 million will be available for loan repayment. Through work with the Health Resources & Services Administration (HRSA), there are 27 new Indian Health Service (IHS) and Tribal facilities eligible for the National Health Services Corp. The Indian Health Service (IHS) has also partnered with Purdue, Howard, and University of Southern California to participate in the Indian Health Service (IHS) Advanced Pharmacy Practice Experience Program.
    - Behavioral Health; Committed to working with Tribes to advance the behavioral health agenda.
- In June 2016, IHS requested comments on a draft policy for the expansion of the Community Health Aide Program (CHAP) at Indian Health Service (IHS) facilities.
- Announced the National Veterans Administration-Indian Health Service Memorandum of Understanding (VA-IHS MOU) has been extended through June 30, 2019 and an interagency agreement was signed, which authorizes use of the Consolidated Mail Outpatient Pharmacy (CMOP).
- Tribal Comment: Mentioned scholarship funding; however, this funding is not new money, but a flat-line budget amount.

TSGAC Committee Business

- Approval of Meeting Summary (October 2016)
    - Choctaw Nation made a motion to approve the October 2016 Meeting Summary.
    - Wampanoag Tribe of Gay Head (Aquinnah) seconded the motion.
    - The motion was approved without objection.

Patient Protection and Affordable Care Act (ACA) Implementation Update

Cyndi Ferguson, Self-Governance Specialist/Policy Analyst, SENSE Incorporated

- Next webinar scheduled for February 2, 2017 and will be covering updates on the 100% Federal Medical Assistance Percentages (FMAP) and the Trump Administration and Congressional Affordable Care Act (ACA) work.
- Currently looking at reorganizing the website to make the webpage more user friendly.

- All information can be found under Indian Health Care Improvement Tab of the Self-Governance Communication & Education (SGCE) webpage under 2017 Health Care Actions.
- Recently met with a small workgroup and developing a Fast Track Toolkit for how to start a Tribal Sponsorship Program and is currently pulling together the information and will share is as part of the website update.

Doneg McDonough, Consultant, Tribal Self-Governance Advisory Committee

- Administration and Congressional Health Care Actions in 2017. What degree is the Affordable Care Act (ACA) relevant right now?
    - Through the marketplace if you identify as American Indian or Alaskan Native (AI/AN) 40% of the cost of your insurance is passed to the Federal government.
    - Currently there are 16 states that haven't chosen to expand Medicaid; however, the funding for them to do so is still there. This means there is funding available for approximately 240,000 American Indians and Alaskan Natives (AI/AN) to receive comprehensive coverage under Medicaid if those states were to expand.
    - Tribal Question: Have you been able to quantify how much savings goes back to the Tribe for additional care and whether or not Tribes have been able to move Purchased/Referred Care (PRC) priorities downward?
        - Response: Benefits of this fall into three categories: revenue coming directly in for those who were uninsured and are now getting covered; reduction in Purchased/Referred Care (PRC) that was used to cover them previously; and the care that wouldn't have been authorized through Purchased/Referred Care (PRC).
    - Nationally, uninsured rate of AI/ANs is down 30% since 2010 and they have requested data from the Indian Health Service (IHS) to get a better idea about insurance status based on service unit and the number of users.
- Potential Action on Major Health Care Legislation in 2017:
    - Medicaid expansion; High risk for defunding and congress can overturn it with a simple majority vote through reconciliation. Both Representative Price and Speaker Ryan's plans are based on getting rid of Medicaid expansion; however, we have potential allies in republican leadership from states that have expanded.
        - Tribal Question: What are thoughts on the disagreement regarding the repeal of Medicaid expansion among state Governors?
            - Response: It's a difficult issue for Governors who expanded Medicaid in their states, because a repeal would cause their constituents to lose coverage.
        - Tribal Question: Does either of these plans protect the Federal Medical Assistance Percentages (FMAP) incentive that comes with expansion?
            - Response: Many republicans never thought they would actually have the opportunity to repeal the Affordable Care Act (ACA) so they didn't think about the details of actually repealing it. Ultimately, Congress is in a learning process and they're beginning to look at what's not working rather than just getting rid of it completely.
- Comparison of Affordable Care Act (ACA) vs. Representative Price's plan:
    - Under Representative Price's plan a family of four, making $50,000 per year would be paying $18,000 more per year on average, whereas under the Affordable Care Act (ACA), they would be paying $0 per year. There are deficiencies in the Affordable Care Act (ACA) in regards to high cost/risk people and a better way to address that would be to reinstate the high-risk adjusters so that the pool represents and average cost rather than a high risk cost. The bottom line is the repeal and replacement has to happen at the same time to prevent any loss of funding.

        - Tribal Question: Do any of these plans address the insurance companies and the fact that they continue to raise the costs of having private insurance?
            - Response: There are two approaches: 1) You put federal dollars into the pool so that people don't have to pay the full amount, which combats the raise in costs that are a result of the higher risk people, who were excluded before, now being covered; and 2) Pulling high cost/risk people from the normal marketplace and placing them into a high cost/risk pool, which is part of republican plan.
        - Tribal Question: Isn't there a penalty for not having insurance? How would that work if those people are placed in a position where they can't have insurance?
            - Response: The republican plan is to eliminate the insurance requirements; however, this ends up driving up the cost.
        - Tribal Question/Comment: With the new Administration the insurance and pharmaceutical companies aren't going to be hurt, which leads to the problem of "Who is going to treat this person if there is no incentive to take them?" Representative Price's plan looks good to people who make over $150,000 per year, but how many of our Tribal people make that much?
    - Marketplace Provision; Through reconciliation Congress can eliminate premium tax credits, cost sharing protections, and the individual and employer mandates.
        - Tribal Comment: This would cause there to be no regulations on insurance companies.
    - Indian Health Care Improvement Act (IHCIA); Low risk for being overturned, because it can't be overturned through the reconciliation process; however, they could still try to privatize certain parts of it.
    - Section 9021 exclusion from income; At risk for repeal and is an important provision we need to focus on
    - Medicare; Speaker Ryan is favorable of a proposal for a basic package available at any health care provider. To do so they propose creating a fixed dollar amount based on current average costs and will increase that every year by another fixed amount. The risk of this proposal is that it will lower the value of coverage as time goes on. In the process this proposal would convert everything into private plans.
    - Block granting Medicaid to the states; This can be established through reconciliation and would turn over current Federal funding to the states. Speaker Ryan would want to do this because the yearly increase would be smaller. The big question is if you are going to do block grants and lock in an amount, whom do you base it off of? For example would you base it on Florida where spending is twice as much as other places, somewhere else where spending is lower, or will they try to equalize it across the states? Block grants would also cause enrollees to lose the entitlement to coverage and would allow states to peel away its share and rely on the block grant. There is also the question of how American Indian and Alaskan Native (AI/AN) relations will be addressed. Currently no block plan proposal has language addressing 100% Federal Medical Assistance Percentages (FMAP) or maintenance of an entitlement for certain populations.
    - Overall these items are complex and our best plan is to articulate the importance of Indian specific provisions and how much it will affect American Indians and Alaskan Natives (AI/AN).
    - Tribal Comment: Has there been thoughts on how block grants through the states would undermine Tribal sovereignty? This is a big issue for Native people, especially since there is talk about changing or strengthening the U.S. boarders. It's important that the idea of states having power over Tribes not get traction. It's also important to remember that with the current Medicaid expansion, Tribal members get benefits based on where they live, which sets up an inherent inequality. Perhaps an alternative would be to look at

a separate Medicaid plan that is for American Indians and Alaskan Natives (AI/AN). There was a feasibility study done with Navajo Nation, which means there is opportunity.
- Timeline for Administration and Congressional Action:
    - Federal debt limit hits its cap on March 16, 2017.
    - Federal spending hits its limit on April 28, 2017.

Melanie Fourkiller, Policy Analyst, Choctaw Nation and Tribal Self-Governance Advisory Committee (TSGAC) Tribal Technical Workgroup Co-Chair

- There has been a workgroup developing white papers for your use in the advocacy and education on Indian Health Care Improvement Act (IHCIA).
    - Constitutional Foundation for Indian Specific Health Care Legislation; Quick legal foundation document that gives the answer to "Why Indians should be treated differently for health care purposes?"
    - Indian Specific Provisions in the Affordable Care Act (ACA); Outlines the Indian specific provisions within the Affordable Care Act (ACA) that we would like to preserve.
    - Medicaid and Impacts on Indian Health; Outlines how Indians should be treated differently when it comes to block granting. Also addresses the issue of shifting of responsibility from federal to states in terms of cost matching and funding.
    - Next steps are to develop some protection pieces regarding things like the notion that Indians are getting paid twice for services. These letters are initial steps for advocacy, rather than the final product we would like to see.
    - Tribal Comment: We can't let them forget that we should be regarded as a 51st state rather than as part of States. We do have a formal white paper, which can be put back up on the website.

Special Presentation To Max Tahsuda on His Retirement

Lunch

TSGAC Members' Executive Session with the Indian Health Service (IHS) Acting Director

Indian Health Service Budget Update

Elizabeth Fowler, Deputy Director for Management Operations, Indian Health Service (IHS)

- Indian Health Service (IHS) Fiscal Year (FY) 2017 Funding and Continuing Resolution (CR)
    - Even though we are in a Continuing Resolution (CR), there is a possibility that the Indian Health Service (IHS) will be funded at a higher rate.
- President's Fiscal Year (FY) 2018 Budget Request is normally submitted in February; however, this year will be different and will more than likely submit a broad outline sometime in February.
    - Agencies will then submit their reconciliation sometime in May.
    - This is all speculation, but is usually how it goes.
- Fiscal Year (FY) 2019 National Budget Formulation meeting will be held February 16-17, 2017 in Crystal City, Virginia.
    - There was some confusion with the budget formulation directions sent to the Areas. They were asked to submit data to help with the formulation of a national budget.
        - The second set of instructions is requesting them to look at the budget as if it were just an Area budget.
            - This was done because the workgroup wanted to make sure that the Area specific priorities would get included, rather than overridden because they

are not present in other Areas. These instructions are just for the workgroup and don't supersede the original, first set of instructions.

- Other priorities
  - It is a priority to fully fund current services.
  - When you look at just the operating budgets of the Areas, all of them are funded under the 2012 sequestration level. This is something they are trying to raise awareness about and will be discussing with the budget formulation workgroup.
- Tribal Comment: Keep in mind that the last sequestration derailed three years of growth within Tribal Health Care that we will never be able to recover from. It is important to let Leaders on the Hill know that any form of sequestration for Indian Health Services (IHS) has tremendous impacts on Indian Health Care.

Melanie Fourkiller, Policy Analyst, Choctaw Nation and Tribal Self-Governance Advisory Committee (TSGAC) Tribal Technical Workgroup Co-Chair

- Every time we do a budget formulation, we build the justification with the rationale that we are only funded at 57% Level of Need (LNF); however, this data has not been updated since 2010 and the Indian Health Service (IHS) staff person who worked on this is now gone along with all of his knowledge. To compensate we have inflated the number for the February meeting, but we must get someone in to update this, especially while we are educating new people in Congress.
- Tribal Comment: The last time we looked at Level of Need Funding (LNF), we used the marker of the Federal Employee Health Benefits plan; however, we should really be looking at the average amount spend per person on health care.
- Tribal Comment: Suggest in a letter to recommend the reformulation of a workgroup to look into Level of Need Funding (LNF) and how it is measured.
- Tribal Comment: Not only do we need to look at the benchmark, we also need to put it in context with all of the things Tribes do, including all of the public health related services, so we can show how Tribes are still underfunded even with third party revenue.
- Tribal Comment: We also need to take in to account and think about the housing situation many Tribes face and how that affects Tribal Health. The Department of Housing and Development (HUD) released a survey they conducted, which highlighted some of the issues with housing, sewer, water, etc.
- IHS Response: Will be bringing these issues up to the Department in a meeting that he is currently stepping out for.

Office of Information Technology Update

LCDR Andrea Scott, Chief Information Officer and Deputy Director, Office of Information Technology (OIT), Indian Health Service (IHS)
Randall Hughes, Tribal Liaison, Indian Health Service (IHS) Office of Information Technology (OIT)

- Information Technology (IT) Service Catalogue
  - Copies of the catalogue were published on www.ihs.gov/oit
  - Looked at services that are currently being provided, which include:
    - Infrastructure, Office Automation, and Telecommunications (IOAT), National Patient Information Reporting System (NPIRS), Resource and Patient Management System (RPMS)
    - Translated these services into a catalog form with technical and business versions available.
  - This catalogue was finished in June 2016 and are currently finalizing details.
  - The largest sections in the catalog are the National Patient Information Reporting System (NPIRS) and Resource and Patient Management System (RPMS) sections.

- Tribal Question: If there is data needed for supporting a budget formulation, is the National Patient Information Reporting System (NPIRS) how we make that formal request?
  - Response: Yes, Vanessa Weaver is the person that handles those requests.
- Tribal Question: Does someone at Indian Health Service (IHS) have a list of what Tribes are no longer using RPMS?
  - Response: We will take that question back to Vanessa and see if she has that information.
- Currently, they have done their internal review and completed the business draft of the catalogue, which has also been approved by the Information Systems Advisory Committee (ISAC). The version online will remain a draft until it is approved by all parties and will be left open for comment for 90 days.
- Tribal Question: Tribes and Agency Lead Negotiators (ALN) have been asking for values to be placed on the services within the catalogue, but the cost still isn't included. Is there another version of the catalogue that will provide that information?
  - Response: Looking to take the investment of each and create a single percentage. This is due to the fact that these things are very difficult to separate from each other.
- Tribal Comment: Many Tribal agreements were negotiated a long time ago and left a percentage of IT shares at the headquarters level, but no one really knows what they were for.
  - Response: Have been working on that and looking to remedy those issues by working with Infrastructure, Office Automation, and Telecommunications (IOAT) and National Patient Information Reporting System (NPIRS), but did have a slow down with Resource and Patient Management System (RPMS) due to contract issues.
- Tribal Comment: Perhaps if you look at the program, services, functions, and activities (PSFA) manual it could be used as an example for how to include more of the information that Tribes need.
- Tribal Comment: Taos had an issue, because they did have some shares left and wanted to see if those could be use to perform an internal audit. These turned out to be shares that couldn't be used, which brought up the question of what are they for?
  - Response: It's important that you consider how much information technology (IT) impacts everyone in the entire system, including the Area Offices. We need to get the total cost out there and determine what is and isn't available, because it is a huge operational issue at the Area level.
- Tribal Comment: There are many things that Tribes have developed, like Choctaw Nation's Health IPhone application, that they would be willing to share, if Indian Health Service (IHS) were more willing to share information.
- Tribal Comment: There needs to be full disclosure of where and how these functions are being paid for. Many times Tribes continue to be sent back and forth between the Area and headquarters levels without actually receiving an answer when they are trying to compact these services.
  - Response: They have tried to identify services and price them accordingly using the information technology (IT) services buy back formula, which is very old, but Indian Health Care Services (IHS) will work to update this and incorporate it with the catalog.
- When this goes up for comment, please submit your comments. Indian Health Care Services (IHS) is eager to hear back so that they an improve it and ultimately improve negotiations.

- Multi-Purpose Agreement

- Workgroup had a conference call last week and are currently trying to work through several of the issues. One issue is that part of the Data Use and Reciprocal Support Agreement (DURSA) has a sovereignty waiver, which has kept several tribes from signing it. This could occur if a Tribe starts to share information outside of Indian Health Services (IHS).
- Will be hearing from Indian Health Services (IHS) soon on a final decision regarding this.

Centers for Medicare & Medicaid Services Concepts for Regional Multi-Payer, Regionally-Based Payment Model

Terri Schmidt, Acting Director of the Office of Resource Access and Partnerships, IHS

- Quality payment programs have two tracks currently. These are:
  - Merit-Based Incentive Payment Systems (MIPS), which have minimal requirements for participation and no determents for not participating; and
  - Advance Alternative Payment Models (APM)
- There are several current Advance Alternative Payment Models (APM):
  - Comprehensive ESRD Care (CEC)
  - Comprehensive Primary Care Plus (CPC+)
    - 2 federal programs
    - 1 tribal program
  - Medicare Shared Saving Programs
  - Next Generation Model
  - Oncology Care Model
  - Vermont Model
  - Maryland Model
- Advance Alternative Payment Models (APM) will be affected by the current work of congress and the Centers for Medicare & Medicaid Services (CMS) is supportive of developing a Tribal specific Advance Alternative Payment Models (APM).
- Tribal Question: Is this an extension of meaningful use?
  - Response: Merit-Based Incentive Payment Systems (MIPS) is an extension of meaningful use. Advance Alternative Payment Models (APM) are more about paying for the quality of service versus paying for quantity of care.
- Tribal Comment: What if you already provide quality health care? Can you still apply for funds?
  - Response: The Centers for Medicare & Medicaid Services (CMS) believes there is opportunity out there for partnerships between them, Tribes, or states to provide that funding and support good quality programs.
- Tribal Comment: Will this affect the all-inclusive rate?
  - Response: If you go with an Advance Alternative Payment Models (APM), yes it will affect the rate.
- It's good to focus on quality, but Tribes are so underfunded that they are hesitant to put funds at risk for something they are unsure of.
  - Response: Would it be better to do a lump sum vs. billing or is there something else all together?

Stephen Cha, M.D., Director, State Innovation Group, Center for Medicare and Medicaid Innovation, Centers for Medicare and Medicaid Services

- There is some understanding of the concerns from a clinician standing and he is hoping to look at what works for the population, because there are needs for rural populations. Every model is voluntary and will not force any state or organization into one of these programs.
- The Centers for Medicare & Medicaid Services (CMS) believe there is an opportunity to develop or build on something that revolves around the rural residents in their other models and are

happy to take any Tribal comments back to the Centers for Medicare & Medicaid Services (CMS) leadership.

- Tribal Question: One of the unique things with Indian Country is that we aren't a hospital centralized system and in many cases, don't have the funds to hospitalize patients unless necessary. Because of this how would one of these models apply to us, especially since most of our income comes from billing Part B and when you talk about stakeholders, are you talking about providers or patients?
    - Response: We include patients, consumers, and beneficiaries in the category of stakeholders and it is critical that they we see evidence from the states that they are engaging with all stakeholders, not just clinics and providers. Although we started in the hospitals, we are pushing the models in a direction to represent the full range of health care. If this can be done there is opportunity for providers and their Part B expenditures to come into the system under an Advance Alternative Payment Models (APM), which is important because there is a 5% bonus on Medicare dollars and relief from the reporting burdens under the Merit-Based Incentive Payment Systems (MIPS) and the up-side down-side risks, if you are in an Advance Alternative Payment Models (APM).
- Tribal Comment: While this is all good, it seems like we are becoming more focused on the hospitalization and institutionalization of health care, rather than the long-term of what is actually happening in the community.
    - Response: There are two answers to how this is different than what has been done before; 1) The priority is to put the control of these programs in the hands of physicians, not the insurance companies, which cuts through the lines of bureaucracy and gives the incentives directly to those how have the most potential to influence care; and 2) Our ways to think about how we incentivize health have made dramatic steps forward.
- Tribal Question: There was an Indian component included in Oklahoma's State Innovation Model (SIM) Grant report and we believe there is opportunity for better coordination of care between all the different facilities patients visit.
    - Response: Were excited to see the Indian component and agree that there could be better coordination of care. Ideally we look at it as a way to get the incentives to the providers and get the managed care plans to work in partnership to transform care.
- Tribal Question: Are you requiring States to hold Tribal consultation when they decide to change their programs?
    - Response: We require that Medicaid be a strong partner and all of the regulations in regards to Medicaid remain in place.
- Tribal Question: Is there a request in either your Fiscal Year (FY) 2017 or Fiscal Year (FY) 2018 budget request to Congress to fund State Innovation Model (SIM) Grants? Can you explain where the outcomes that Congress would like to see to fund one a request like this are at?
    - Response: The round one, year one evaluation is posted online now. There is some lag time in creating these reports due to difficulty with collecting Medicaid data; however, we are working to improve on that. It's reasonable for a new Administration to set priorities and it is reasonable for us to get some understand as to what that means and what might be in next year's budget commitment.
- Tribal Question: Is there some way to make State Innovation Model (SIM) grants available to Tribes? In the current climate is there any speculation on this? As an alternative would it be possible to use the Encounter Rate as an Advance Alternative Payment Models (APM)?
    - Response: They don't really know, but they look forward to having the conversations and trying to answer the questions that have been brought up.

Office of Environmental Health and Engineering

Gary Hartz, Director, Office of Environmental Health and Engineering (OEHE), Indian Health Service (IHS)

- Facilities Appropriations Status
  - There are five line items within the facilities appropriations: Health care facilities construction; maintenance and improvement; sanitation facilities construction; equipment; and facilities and environmental health support.
  - There is a $14.5 billion need for facilities across Indian Country as outlined in the Facilities Report to Congress, which is comprised of data previous to the passage of the Indian Health Care Improvement Act (IHCIA). If you look at the level of facilities needed for health care delivery, it is 3 times more than the last reported level of need.
  - They collectively provide support to maintain the 18 million square feet of facilities that are used to provide health care through the maintenance and improvement fund and in Fiscal Year (FY) 2011, nationally, they dropped below the sustainment level. In Fiscal Year (FY) 2016 there were increases in the appropriation level for facilities: $20 million for health care facilities construction, increasing the total to $105 million; $20 million for maintenance and improvement, increasing the total to $73 million; and $20 million for sanitation facilities construction, increasing the total to $99 million. So, there is an effort to identify and address priorities. This increase for maintenance and improvement brought the funding amount back up above sustainment level; however, if we don't maintain funding levels there won't be funding to do Tribal facilities projects.
  - Tribal Question: Do you have the projection of what it will take to reassess and redo all of our facilities, similar to what the Bureau of Indian Education (BIE) had to do? If that document is available it will help to show the disparity between the funding that is appropriated and what the true need is.
    - Response: In the last year, there has been an opportunity to brief the career people with in the Department of Health and Human Services (HHS) and the Facilities Appropriations Information Package has been the main source of information for doing just that.
  - Tribal Comment: We need good numbers from the Office of Environmental Health and Engineering (OEHE) so that we take the back to Congress and advocate for increases in appropriations.
    - Response: The number today, looking at asset inventory, is $179 million, which is at 4% and if you go to 5% it would increase to over $200 million.
  - Currently we replace medical equipment on a 6-year cycle, which is way behind the rate at which we should be replacing equipment to keep up with today's expectations of clinicians and the quality health care we should be delivering for diagnostics.
- Joint Venture Update
  - There are a number of projects that are in the queue and have been notified to proceed with planning, as well as, several projects that aren't moving quite as fast as originally planned. There are also projects that were notified in 2015 that will be opening will be opening in less than a month and 6 projects that have yet to be notified. Currently the Office of Environmental Health and Engineering (OEHE) is in an assessment mode and will be looking at those and other projects to see what happens as we move through 2017 and into 2018. There is a large financial responsibility that comes with running and staffing these joint venture facilities and Indian Health Service (IHS) has a responsibility to partner with Tribes in staffing these joint ventures, which means they need to be cautious to make sure Tribes aren't put in a position where they are unable to staff one of these facilities.
  - Tribal Comment: Many Tribes have submitted a letter requesting the joint venture competition be reopened and what is the status of that request?
    - IHS Response: Currently they are in a holding pattern and as of now it will be several years out before they get through the queue.

- Tribal Comment: The projects that are still in the queue was addressed in a letter from Choctaw Nation and it is concerning because it harkens back to the list of facilities projects that can never be completed and we would prefer that you would compete it and if those leftover projects need to submit applications again allow them to do so. That way we can keep moving forward and not get stuck in a holding pattern.
  - Response: They are working on that issue and will be following up with Tribes and the projects on their list so that they can continue to move forward.
- Tribal Comment: For this to be beneficial for Tribes we need to streamline the process so that it doesn't take several years to get everything together for the project to move forward.
- Tribal Comment: Tribes are the ones doing the construction, so why should they have to be regulated to a process that is burdensome and a detriment to Tribes? If it's a Tribal facility why do we have to use a Federal design system?
  - Response: The step-by-step approach is archaic and if you have a package ready, you can sign the Joint Venture Agreement (JVA) and turn ground the next day. We are also revamping the HSP into a web based system that will be much more user friendly and adaptable. As of now it is still tied to Federal appropriations and requirements so the regulations do have to be carried out.

- Small Ambulatory Health Center Grants
  - Tribal Question: There was talk about some Small Ambulatory Clinic grants, because there are some Tribes that don't need a large clinic. Could creating a staffing package with a Small Ambulatory Clinic be an option?
    - Response: In Fiscal Year (FY) 2017 resources were requested for the Small Ambulatory Program; however, the current authority for this doesn't come with a staffing package in the same manner as a joint venture. They have also not been funded under the Small Ambulatory Program since 2008 and all of the projects that were funded under this program have now been completed, but none of those had a staffing package. In working to revise our priority system it came up that perhaps we could do a 50% staffing package; however, we would still need support from Congress.
- Sanitation
  - There is still a need of about $3.4 billion across the country in water and sewer facilities. Within this, there is a feasible need of $1.5 billion.
  - Tribal Comment: When thinking about providing sewer and water you have to keep in mind the uniqueness between on-reservation and off-reservation Tribes, especially when it comes to the distribution of eligible and non-eligible people within a certain area.
    - Response: Essentially that wasn't taken into account until around 20 years ago so they could address service to non-Indian communities, because you can't just skip a section of waterline. Now they work in collaboration with the rural water districts in the area to try and address those situations.
- Facility Environmental Health Support Appropriations
  - Currently runs at $222 million and pays for Tribal and Federal staff and some utilities and operations costs. Of the $222 million appropriated in Fiscal Year (FY) 2016 and what they are currently on track to receive in Fiscal Year (FY) 2017, $133 million is for the facility support account, $73 million in environmental health support, and $16 million for the Office of Environmental Health and Engineering (OEHE) support. If you take out the big projects like joint ventures, there has been less than .4% of an increase per year in the last 10 years.
  - It's important to show these disparities because there is so much more to public health and prevention than just the people involved.

Randall Gardner, Acting Deputy Director, Office of Environmental Health and Engineering (OEHE), Indian Health Service (IHS)

- 3F & 4F Tables
    - How are we preparing for the negotiations?
        - Unfortunately when developing these tables you need a budget resolution, which means it's difficult when we're on a Continuing Resolution (CR); however, they will go through the line items from the previous year and use those to update the Fiscal Year (FY) 2017 budget numbers. They are trying to be proactive and will be ready. Currently they are just waiting for the budget resolution.
        - The headquarters residuals, continued commitments, and field pass through are what feed the 4F Table. At the headquarters level they take the appropriation and break it into the components, residual, continued commitment, field pass through, and program formula. There haven't been many changes or increases in the amounts, but many of the issues that arise come from applying the resources to workload.
    - Tribal Comment: The relationship between the Area and headquarters is of some concern because they tend to each mark up the document, which then leaves Tribes wondering what the actual numbers are.
        - Response: We're all in this together and it takes a lot of good communication between everyone to make sure everything is clear.
    - Tribal Comment: At this time it's far to hard for Tribes to follow the line of shares from headquarters to the Tribal level. It would be more beneficial if it were better documented so that Tribes could see the formula and their resulting shares from the formula.
        - Response: We do need to write it out and ensure that someone will be able to learn it and then train everyone else on it.

Preparation for Discussion with IHS Deputy Director

- Indian Health Services (IHS) Realignment:
    - It seems that Indian Health Services (IHS) submits their plan, but Congress isn't allowed to weigh in unless there is an objection.
    - What is the status and what was changed in response to Tribal comments before it was submitted?
    - When would this start and has there been evaluation on whether or not the hiring freeze would affect it?
    - How are the realignment and new offices being funded?
- Catastrophic Health Emergency Fund (CHEF) Proposed Rule
    - Haven't received a response yet.
    - There is still the payer of last resort issue.
- Community Health Aide Program (CHAP)
    - There has been a letter received, but what would the timeline of establishing a workgroup be? What are the next steps?
- Tribal Premium Sponsorship
    - What is the status on this?
- Level of Need Funded (LNF)
    - Haven't received a response to the comment letter we submitted.
    - What is the process of establishing a workgroup?
- Contract Support Costs (CSC)
    - Request for training and technical support.
    - When is the next Contract Support Costs (CSC) workgroup meeting?
    - Mary Smith promised to follow up on the rest of the templates.

- Resource and Patient Management System (RPMS)
    - In California they are highly affected by Resource and Patient Management System (RPMS). In order to compete and provide quality care Resource and Patient Management System (RPMS) needs to be changed.
- Federal Hiring freeze
    - Whether there is opportunity to exempt Indian Health Services (IHS) from this and how we go about working together on getting an exemption.
    - The Veterans Administration (VA) has been exempted and we are the other program that also provides health care.
    - Initially public health was one of the things that would be excluded; however, that is no longer listed in the current memo.
- Facilities
    - SAD report isn't publicly available. Perhaps we should make a request for that information.
- Medicaid
    - What has been done and what should Tribes expect from this?
    - Took a budget reconciliation bill that said it would be repealed. So it hasn't been repealed yet, but is still causing the issue. We must make a case for Medicaid and get as many Democrats and Republicans to vote with us on providing good quality health care to Indian people. We have to believe that rational minds will prevail and perhaps with the interest in infrastructure we can get hospitals and clinics built.

Recess until January 25, 2017

Wednesday, January 25, 2017 (8:30 am – 12:30 pm)

Meeting of IHS Tribal Self-Governance Advisory Committee (TSGAC) and Technical Workgroup with RADM Chris Buchanan, IHS Acting Director

Invocation: Delia Carlyle, Councilmember, Ak-Chin Indian Community

Welcome and Introductions

Marilynn "Lynn" Malerba, Chief, Mohegan Tribe, and Chairwoman, Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC)
RADM Chris Buchanan, Acting Director, Indian Health Service (IHS)

Office of Tribal Self-Governance Update

Jennifer Cooper, Acting Director, Office of Tribal Self-Governance, Indian Health Service (IHS)

- Fort McDermitt Paiute and Shoshone Tribe has joined Self-Governance; 94th agreement for IHS marking 62% of all Tribes are now involved in Self-Governance.
- Would like to thank Jamestown S'Klallam Tribe, Choctaw Nation, and Self-Governance Communication & Education (SGCE) for all of their help and support
- Fiscal Year (FY) 2013 & Fiscal Year (FY) 2014 Reports to Congress have been submitted. The Office of Tribal Self-Governance (OTSG) is thankful for the comments that were submitted in regards to the Fiscal Year (FY) 2015 report and look forward to taking those comments to improve the Fiscal Year (FY) 2015 and future Reports to Congress.
- The Office of Tribal Self-Governance (OTSG) is still in the process of recruiting a Financial Analyst and is currently looking to see if there are any areas that need to be improved.
- Tribal Question: With Kevin Quinn's retirement, how does The Office of Tribal Self-Governance (OTSG) plan to fill that capacity?

  - Response: Long term they are looking for a person with the background to provide the same level of assistance, but in the interim they are using the knowledge and training Kevin gave them to tackle it as a team.
- Tribal Comment: There is an increasing concern with the loss of historical knowledge on both the Federal and Tribal side, which occurs when people retire. It is important to capture that knowledge before it is lost.
  - Response: The Office of Tribal Self-Governance (OTSG) is fully aware of this and shares the desire to capture that knowledge. They also welcome any partnerships with Tribes to do just that. The process and opportunities for knowledge transfer is there and now is the time for it to occur, but they also want to know if that isn't working currently so that something can be done to make sure it does happen.

Indian Health Service-Veterans Administration (VA) National Consolidated Mail Outpatient Pharmacy (CMOP) Agreement

Ken Siehr, Director, Consolidate Mail Outpatient Program (CMOP), Veterans Administration (VA)

- General Overview:
  - There are difference between private sector mail order pharmacy and the National Consolidated Mail Outpatient Pharmacy (CMOP).
  - For Tribes there is a hand-off in care between the Tribal pharmacy and the National Consolidated Mail Outpatient Pharmacy (CMOP), which is clearly outlined in the agreement. The National Consolidated Mail Outpatient Pharmacy (CMOP) doesn't change anything on the prescription. They either fill it as is or sends it back to the Tribal pharmacy for review.
  - The National Consolidated Mail Outpatient Pharmacy (CMOP) doesn't fill schedule II drugs or low volume prescriptions and the average mailing time is 2.5 days.
  - For further explanation visit https://www.pba.va.gov

CAPT Robert W. Hayes, RPh, USPHS, Director, Indian Health Services (IHS) National Supply Service Center

- Why did the Indian Health Service (IHS) want to utilize the National Consolidated Mail Outpatient Pharmacy (CMOP)? What are the advantages?
  - Improves adherence to chronic medication therapy, especially for patients that can't make it to a clinic on a regular basis.
  - Makes things easier on pharmacists.
  - The National Consolidated Mail Outpatient Pharmacy (CMOP) is more effective and efficient.
  - The National Consolidated Mail Outpatient Pharmacy (CMOP) gives IHS buying power, which lowers the cost of the prescription for both the pharmacy and the patient.
- Requirements for participation:
  - Use the Resource and Patient Management System (RPMS) & meet the minimal technical requirements.
  - Sign site-specific agreement with the Indian Health Service (IHS) National Supply Service Center (NSSC).
- Timeline for the National Consolidated Mail Outpatient Pharmacy (CMOP) implementation.
  - Sites which formerly used CMOP: 2-4 months
    - Sites where the Resource and Patient Management System (RPMS) server has already been configured to utilize the National Consolidated Mail Outpatient Pharmacy (CMOP): 6-12 months
    - Sites where the Resource and Patient Management System (RPMS) server has not yet been configured to utilize the National Consolidated Mail Outpatient Pharmacy (CMOP): 9-48 months.

- Tribal Question: What's the cost to the Tribal clinics that want to use the National Consolidated Mail Outpatient Pharmacy (CMOP)? Does that include startup and reconfiguration costs?
    - Response: There aren't any added costs beside the charge of prescriptions and management fees. Now, you are required to use the Resource and Patient Management System (RPMS), which means the Veterans Administration (VA) isn't using an interface and the cost would fall on the Tribes to develop that interface; however, there isn't a specific dollar figure for that currently.
- Tribal Question: Is there a minimum amount of prescriptions that must be used for the National Consolidated Mail Outpatient Pharmacy (CMOP) to be utilized?
    - Response: There is a minimum required by the Veterans Administration (VA) before the National Consolidated Mail Outpatient Pharmacy (CMOP) facility will stock it, which means there does have to be an amount that will be utilized and won't just sit on a shelf; however, there isn't a minimum amount for participation.
- Tribal Question: The Wampanoag Tribe of Gay Head (Aquinnah) is in a rural area and currently has a contract with a private pharmacy to provide prescriptions to their citizens, would this type of contract be eligible for the Consolidated Mail Outpatient Pharmacy (CMOP) Program?
    - Response: No, they would first have to go through the Pharmaceutical Prime Vendor and apply to be a customer of the Indian Health Service (IHS) and then go through several other requirements. It doesn't prohibit them, but you would have to have your own pharmacy to participate.
- Tribal Question: What are options for the Tribes that don't us the Resource and Patient Management System (RPMS)?
    - Response: That would require an interface and as of now, it is in the agreement that you have to use the Resource and Patient Management System (RPMS). It's possible that it could be an option later.
- Tribal Question: Since there are minimum technical qualifications, would it be possible for Tribes to qualify even if they don't use the Resource and Patient Management System (RPMS), but do meet the other requirements? Also is the National Consolidated Mail Outpatient Pharmacy (CMOP) compliant with the Drug Enforcement Administration's (DEA) regulations from 2010 regarding the electronic prescription of controlled substances?
    - Response: The National Consolidated Mail Outpatient Pharmacy (CMOP) doesn't process any controlled substances. That is handled at the individual medical facilities and by the pharmacy that is sending the prescriptions to the National Consolidated Mail Outpatient Pharmacy (CMOP), but the Veterans Administration (VA) does comply with the Drug Enforcement Administration's (DEA) regulations. As for Tribes that don't have the Resource and Patient Management System (RPMS), they are willing to connect Tribes to their experts who can further discuss this.
- Tribal Comment: It seems like it would be helpful to provide a technical webinar to help Tribes understand how to access this program.
    - Response: They are willing to work with Self-Governance Communication & Education (SGCE) on this.
- Tribal Comment: There was an understanding that the Resource and Patient Management System (RPMS) was supposed to be upgraded so that it would synchronize with the other systems being used in health care facilities. What is the status of that and what are the next steps?
- Tribal Comment: There is connectivity between the National Consolidated Mail Outpatient (CMOP) program and how we deal with issue related to the Resource and Patient Management System (RPMS) so there is more that needs to be done on that.

National IHS-VA Memorandum of Understanding Extension

P. Benjamin Smith, Deputy Director of Intergovernmental Affairs, Indian Health Service (IHS)

- The collaborative discussion regarding the Memorandum of Understanding (MOU) will be deferred to the next Tribal Self-Governance Advisory Committee (TSGAC) Meeting, which will be held in March.
- The Deputy Directory of Intergovernmental Affairs serves as an ex officio member of the Veterans Administration's (VA) Veterans Rural Health Advisory Committee, which is tasked with identifying and discussing barriers to providing rural health care services. A lot of the issues they raise are like those heard during Tribal Self-Governance Advisory Committee (TSGAC) Meetings: the implementation of the Veterans Access, Choice and Accountability (Choice) Act and the disparity in training for the rural health care population.
- The Veterans Administration (VA) has had a partnership with medical schools and is the second largest funder of graduate medical education. This is a great opportunity for the Indian Health Service (IHS).
- Reimbursement Agreement Update:
    - 83 plans have been signed, which is a total of 105 Indian Health Service (IHS) facilities. Currently, there are 99 signed agreements for the Tribal health programs, with another 40 Tribes in the process of signing an agreement.
    - Veterans Administration (VA) has reimbursed over $47 million.
    - While we have done well so far, it is good to begin thinking about next steps.
- We expect to hear, by March, the results of recent Tribal consultations in regards to the reimbursement agreement, the Veterans Access, Choice and Accountability (Choice) Act, and a few other topics.
- There are some important points of contact within the Indian Health Service (IHS); for the reimbursement agreement contact Terri Schmidt, Acting Director, Office of Resource Access and Partnerships.
- Tribal Comment: We request that Acting Director Buchanan go to the Secretary and request that Indian Health Service (IHS) be exempted from the hiring freeze just like the Veterans Administration (VA) has been and if there is talk of sequestration, we need to request an exemption from that as well. It's important that we stress the urgency in this, because when you have a 20% vacancy rate you don't have the option to move people around like the Administration has suggested.
    - Response: You have our commitment to continue to stress those things as much as we possibly can.
- Tribal Comment: The small step on the extension is meaningful, but those 18 months are going to go by quickly; however, we're hopeful that the data regarding veterans will be meaningful and will allow us to show how well Tribes serve veterans. The key to this however, is to be provided with that data as early and often as possible. Furthermore, it's important to push the issue of the Veterans Administration (VA) reimbursing Tribes for treating non-Indian veterans, because Tribes have the capacity and quality services to do so.
    - Response: In terms of transparency, the monthly Veterans Administration (VA) reports about the reimbursement agreements are posted on the website, which lists all the Tribes that do have agreements.

Joint TSGAC and IHS Deputy Director Discussion

- Level of Need Funded (LNF):
    - Tribal Comment: In this climate we are going to need good data to support our budget justifications and it's not only about level of need funded (LNF) it's about what happens if we don't fund programs, because it seems like we should be engaging health economists in these conversations.

        - Response: This is an important topic and we agree that health economists need to be included. Currently Indian Health Service (IHS) is working to fill that capacity to help with those reports through bringing Cliff Wiggins back, as well as, putting someone in place so that they can grow their own, but will have to see how that will be affected by the hiring freeze.
    - Tribal Comment: The Indian Health Care Improvement Fund (IHCIF) was the only line item used to bring Tribes that were lower on the level of need funded (LNF) scale back up to parity. It is important that we can use that fund so that we can continue to help those Tribes who are on the lower end. We would also recommend that a workgroup be formed to take a look at the level of need funded (LNF). There needs to be more information and data, both collected and made available, so that Tribes can have the resources they need.
        - Response: Not familiar with the history, but do agree that is seems like a helpful tool for Tribes and is data that needs to be provided. Placing the data back on the website also seems like something that will be straightforward and easy to do.
    - Tribal Comment: Quite a lot of information has been removed from the website, including the Dear Tribal Leader Letter (DTLL) from Dr. Roubideaux. Having these back up would provide a lot of that historical knowledge and information that is needed for both the Tribes and the internal historical knowledge within Indian Health Service (IHS).
        - Response: We can look into doing this.
- Resource and Patient Management System (RPMS):
    - Tribal Comment: California is struggling with the Resource and Patient Management System (RPMS) and wants to meet the requirements of the meaningful use clause. They are asking for help to fulfill these requirements.
        - Response: They hear the comments. Currently have heard that it will take millions of dollars to replace the Resource and Patient Management System (RPMS) and are looking into ways to update the Resource and Patient Management System (RPMS) or look at other alternatives for Electronic Health Records (EHR) in places like California.
    - Tribal Comment: If the Resource and Patient Management System (RPMS) is so old we need to send a report to Congress telling them that this is an essential part of Indian Health Service (IHS) operations and needs to be addressed so that quality health care can be provided.
        - Response: We can't be reactive and need to address this by creating a process and plan before hand. Indian Health Service (IHS) and Tribes have to work together and come up with a plan to take to Congress and show the importance of updating the system.
    - Tribal Question: Have there been conversations with the VA about collaborating or sharing information about their system?
        - Response: No, those conversations haven't really happened, but they will look into it.
    - Tribal Comment: Can we use telemedicine to help with issues?
        - Response: They will ask the Office of Information Technology (OIT) and see if that is possible.
- Federal Hiring Freeze:
    - The Indian Health Service (IHS) and the Tribal Self-Governance Advisory Committee (TSGAC) will make a formal request for exemption.
    - Tribal Comment: There are some Federal Indian Health Service (IHS) facilities that should be opening up in March, but the freeze will stop it in its tracks if nothing is done.
        - Response: They will try to get an answer.

- Medicare and Medicaid:
    - Tribal Comment: In the Affordable Care Act (ACA) Department Secretaries were given the authority to remove any negative burdens to health care, which includes the employer mandate and Cadillac tax. This is an opportunity for us to pitch the idea that they do have this power. We also need to have a strong message that rolling back Medicaid will have a major negative impact on Indian Country. The concern with Medicare is the extent of the roll back plans they are entertaining.
        - Response:
- Catastrophic Health Emergency Fund (CHEF) Proposed Rule:
    - Tribal Questions: We requested that the Indian Health Service (IHS) only keep the part of the rule that established the threshold at $19,000 and recommended that you make a Congressional request to do so. What is the status on this?
        - Response: They are still looking at the comments and Acting Director Buchanan is not caught up on the issue yet.
- Indian Health Service (IHS) Realignment Proposal:
    - Tribal Questions: How were the comments incorporated? How would the hiring freeze affect this? How does the current state affect funding?
        - Response: Held a follow up meeting internally and wants the Tribes to see that proposal before they move forward with it. Currently expecting to be in a holding period until they receive further instruction from this administration. They will make sure that Self-Governance Tribes see the proposal again now that it has been submitted to Congress.
            - Comments submitted and changes made in regards to those:
                - Will be retaining the Deputy Director titles;
                - Regulatory affairs functions will be maintained as a separate office;
                - Have maintained Purchased/Referred Care (PRC) and Office of Business as separate divisions under one office.
                - Instead of placing the Office of Information Technology (OIT) under a deputy director they have raised the level of the Chief Information Officer (CIO) to that of a deputy director.
- Community Health Aid Program (CHAP) Proposal
    - Tribal Questions: What is the timeline for assembling a workgroup and completing their recommendations?
        - Response: Would like to get a workgroup together as soon as possible, especially since the Indian Health Service (IHS) has heard comments requesting area specific things.
    - Tribal Comment: Would like to have regular updates from this workgroup and see what the program will include.
        - Response: The workgroup would be established to develop policy, not impose regulations and they will work to have someone present to give an update at the next Committee meeting.
- Indian Health Service (IHS) Circular on Tribal Premium Sponsorship Proposed Rule
    - Tribal Comment: What is the status of the proposed rule? The objections we have include over limitation of what can be done in terms of contracting and how it will be applied to Self-Governance Tribes. Overall, we believed it was best that the proposed rule be withdrawn.
        - Response: Did receive letters and heard the comments very loudly, but need to update Acting Director Buchanan so that he can decide.
- Contract Support Costs (CSC)

  - Tribal Question: Will there be training and technical assistance? Will the workgroup reconvene?
    - Response: Acting Director Buchanan is still trying to get up to speed. Training will be provided; however, they aren't ready yet.
  - Tribal Comment: The differences between the Tribal and Federal side need to be pointed out, and what was done so that we can get the policy done. It also needs to be made aware that if they aren't happy, there are litigation opportunities.
    - Response: That is a good point, but they don't want it to overshadow that this is how Contract Support Costs (CSC) are being calculated now.
- Sequestration:
  - Tribal Question: We will work to make sure Indian Health Service (IHS) is exempt. What do we need to say and how can we work together on this?
    - Response: They will be happy to partner on this issue and determine what needs to be done.
- Pharmacy Issues
  - Tribal Comment: Tribal facilities are being treated as a non-network pharmacy and none of their claims are being paid.
    - Response: They have been made aware, but aren't getting any feedback either. They will look into it again.

Closing Remarks
Marilynn "Lynn" Malerba, Chief, Mohegan Tribe, and Chairwoman, Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC)
RADM Chris Buchanan, Acting Director, Indian Health Service (IHS)

Lunch

TSGAC Technical Workgroup Working Session

Adjourn TSGAC Meeting