**TSGAC September 2019 Meeting Summary**

**Attendance:**

|  |  |
| --- | --- |
| **Area** | **Present** |
| Alaska | X |
| Albuquerque | X |
| Bemidji  | X |
| Billings  | X |
| California | X |
| Great Plains |  |
| Nashville  | X |
| Navajo | X |
| Oklahoma 1 | X |
| Oklahoma 2 | X |
| Phoenix | X |
| Portland | X |
| Tucson |  |

**Committee Business:**

• A quorum was established.

• Minutes from the July 2019 TSGAC meeting were approved.

• A nomination letter from the Confederated Salish and Kootenai Tribes was presented to the committee that requested Charmel Gillin serve on TSGAC in the alternate for the Billings area. W. Ron Allen made a motion to accept the nomination. The nomination was approved.

• Stewart Ferguson was nominated to continue his role representing TSGAC on ISAC. Motion made by W. Ron Allen and approved by the committee.

**Office of Tribal Self-Governance Update**

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

Director Cooper began with an update on where the IHS Office of Self-Governance is at concerning the end of the fiscal year and what has been accomplished over the past year. Three new self-governance agreements were completed during FY 2019. Work continues creating a succession plan for area lead negotiators (ALNs). There will be an all-feds IDEAA meeting in November, which will be the first time such a meeting has been held in around three years.

**Key facts provided by Director Cooper:**

* 104 compacts 130 agreements
* 83 fiscal year tribes
* 47 Tribes with calendar year agreements
* Approximately $3 billion transferred to tribes and tribal organizations

**OTSG Priorities:**

* Processing Title V payments as soon as possible
* Filling OTSG vacancies
* Finalization of FY 16 – 18 reports for Congress

Director Cooper’s presentation is available at <https://www.tribalselfgov.org/tsgac-october-2019-meeting/>.

**Patient Protection and Affordable Care Act (ACA) Implementation Update**

 *Cyndi Ferguson, Self-Governance Specialist/Policy Analyst, SENSE Inc.*

*Doneg McDonough, Consultant, TSGAC*

Ms. Ferguson provided an update on efforts made by tribes to implement the ACA. A webinar training is scheduled for November 15 in conjunction with the CMS regarding Medicare payment options for freestanding tribal clinics. They will be sending out a survey to obtain input regarding areas of interest for future trainings to help support efforts to expand implementation of the ACA. Ms. Ferguson opened up the floor for participants to provide suggestions for training topics or areas of interest regarding the ACA.

**Key, Comments, Questions, and Responses**

A recommendation was made to develop and present material to illustrate how the ACA has impacted tribes and expanded tribal self-governance.

An interest was expressed in exploring ways to utilize the flexibility of ACA and IHCIA to include Medicaid and Medicare sponsorship to tribal members that may be residing in other places.

Purchased and referred care information has been anecdotal and we need data to illustrate and articulate the impact of Medicaid expansion.

A recommendation was made to review presentations compiled by the National Advisory Committee on Rural Health and Human Services and the Veterans Rural Health Advisory Committee for guidance in considering reimbursement agreements and other issues.

A suggestion was offered to identify funding streams available for long-term care and perfect an MOU between agencies to transfer money into self-governance for demonstration projects to address the aging population within tribal communities.

***Doneg McDonough, Consultant, TSGAC***

Mr. McDonough provided an update on Medicaid expansion. Tribes are increasingly recognizing the value of the federal resources coming in from Medicaid expansion. Mr. McDonough was recently contacted by direct service tribes (through Title I) who are interested in sponsorship. He is also witnessing more tribes engaged in sponsorship for their elders under Medicare Parts B and D.

**Medicaid expansion facts presented by Mr. McDonough:**

* In the 24 states that have expanded Medicaid, there has been a 40% increase in enrollment in Medicaid for AI/ANs.
* Eleven states that have federally recognized tribes have not expanded Medicaid.
* If South Dakota and Oklahoma expanded, 70% of the population of AI/Ans that could be covered would be made eligible.
* There is a 20% increase in enrollment in the marketplace by AI/ANs every year.

**Key, Comments, Questions, and Responses**

A request for an update on the National Data Warehouse IHS data that the IHCA workgroup recommended for utilization was made.

**Legislative Update**

*Stacy Bohlen, Executive Director, National Indian Health Board*

Stacy Bohlen and NIHB staff provided an update on appropriations and few legislative priorities of Indian Country. Two of the twelve appropriations bills that are immediately relevant to the tribes (HHS and Interior) are subject of great concern. Both of the bills passed the House in June. The IHS is funded at $6.3 billion.

**House**

**Interior**

* Hospitals and clinics increased to $2.24 billion
* $63 million to help address 105(l) leases
* $62.9 million for the CHR program

**Labor & HHS**

* Good Health and Wellness in Indian Country program funded at $21 million
* Tribal behavioral health grants funded at $40 million

**Senate**

The Senate did not begin work on the appropriation bills until September because they did not know how much funding would be available. The budget deal that set the spending levels was not approved until August 1. The Bipartisan Budget Act of 2019 raises defense and non-defense spending caps, raises the debt limit through July 2021, and ends sequestration. The Senate will begin working on finalizing the appropriations bills now that the 302(b) allocations have been determined. Interior allocations were increased by around $200 million over 2019, the Labor & HHS allocations were increased by roughly $1.9 billion.

**Labor & HHS**

* Zeros out Good Health and Wellness program

**105(l) leases funding differences between chambers**

* **House -** funding increased to around $63 million.
* **Senate -** funding increased to around $97 million

Neither proposed funding amount meets the current or projected shortfall. The language on the Senate side is much more detailed. It directs the IHS to work with the DOI and the OMB to then report back to Congress regarding whether or not 105(l) lease contracts should be an appropriated entitlement.

**Advance Appropriations Legislation**

There are two bills in the House and one in the Senate that would authorize advance appropriations. H.R. 1128 would authorize advance appropriations for both the BIA and IHS (services and contract support costs). H.R. 1135 would provide advance appropriations for the IHS only. The bill on the Senate side (S. 229) is a companion bill (identical) to H.R. 1128.

H.R. 1135 amends section 825 of the Indian Healthcare Improvement Act and would provide advance appropriations for services and facilities; whereas, H.R. 1128 is more of a broader authorization bill for advance appropriations. H.R. 1128 will provide advance appropriations for the IHS services line item and contract support costs, not for facilities. Senator Murkowski introduced a companion bill (S. 2541) to H.R. 1135 and would provide advance appropriations for all three IHS accounts (services, facilities, and contract support costs). S. 2541 has been referred to the Senate Committee on Indian Affairs.

**Reforming SDPI Structure**

NIHB has approved a formal resolution in the past supporting moving SDPI into contracting and compacting and is currently reviewing and discussing strategies to move forward with efforts.

The legislative & litigation update presentation is available at <https://www.tribalselfgov.org/tsgac-october-2019-meeting/>.

***IHS Ongoing Tribal Consultation Issues***

*Tamara James, Acting Director, Division of Behavioral Health, IHS filling in for*

 *Darrell LaRoche, Director, Office of Clinical & Preventive Services, IHS*

**Behavioral Health Consultation**

Director James provided an update on the three on-going consultations. The first consultation discussed was the Behavioral Health Funding consultation. Between May and August of 2018, IHS initiated consultation and confer regarding the Behavioral Health Initiative funds. Between October 2018 and March 2019, the DBH met quarterly with the National Tribal Advisory Committee (NTAC) to review and discuss consultation comments. On March 14, the NTAC forwarded recommendations to RADM Weahkee and requested an in-person meeting to consider suggestions. The requested meeting was held on June 17. On August 2, it was decided to extend the deadline for the comment period to October 1. The recommendations will be reviewed and utilized to develop a summary report.

**Key, Comments, Questions, and Responses**

**Q:** So, does that mean there will not be a decision until after January?

**A:** It does not mean that. We expect the summary report to be completed by November, discuss the report throughout November, then share with community members immediately following.

**Opioid Grant Consultation**

On June 19, a “Dear Tribal Leader” letter was issued regarding consultation sessions for opioid grant funding. Consultations and urban confers were conducted, and the consultation period ended on September 3. DBH has been working to collect and summarize the notes that they have received. The comments received are available on their Adobe Connect sessions that have been recorded.

They are making efforts not to duplicate efforts made by SAMHSA. They expect to have a summary report ready for review within the next couple of weeks. We are aware that these are limited funds available over a limited period of time.

They expect the solicitation of the funding opportunity to be released in the spring of 2020.

**Key, Comments, Questions, and Responses**

There are so many different grants that it becomes cumbersome. Finding a way of consolidating different funding streams into some manageable fund would be helpful.

There is a lot of pilot program money, but when we find something that is successful, there isn’t sufficient funding to sustain the operations of the successful pilot programs.

For anyone who is going to receive the funding, whatever is in their proposal, they should tell you how they are going to measure results.

Only 5% of the funding should go to the national level for the administration of this program.

**Community Health Aide Program (CHAP)**

*Minette C. Galindo, Public Health Advisor, Office of Clinical and Preventive Services, IHS*

*Christina Peters, Tribal Community Health Provider Project Director, Northwest Portland Area Health Board*

Ms. Galindo provided an overview of the larger three goals of the IHS Strategic Plan and how CHAP aligns with those goals. When adequately funded, the CHAP will increase access to care and highlight the quality of management of operations. Ms. Galindo briefly explained the three different provider types and the differences between the community health aide, behavioral health aide, and dental health aide positions. All providers will operate under the supervision of a licensed physician. Minette discussed the possibility of transitioning CHR personnel to CHAP if they are interested in continuing their education and career development.

Consultations were held regarding the expansion of CHAP in 2016. The three biggest concerns gleaned from the consultations were as follows:

* Make sure the program is regional and has regional flexibility
* Do not disrupt Alaska
* Do it in partnership with Tribes

In 2018, the IHS established the CHAP TAG. The CHAP TAG was charged with providing real-time feedback to the IHS regarding the best methods for the CHAP expansion. Outside of Alaska there is no context for how the program would work.

On May 7, IHS initiated a 30-day comment period on the draft policy. A request for a 30-day extension on the comment deadline was submitted on the last day, and the extension was granted. The extended comment period closed on July 8. The CHAP TAG reconvened in September to review the comments received and produce two sets of recommendations (one regarding the policy, and one regarding the future of the group). The IHS is currently awaiting the recommendations. Once the recommendations are received, the necessary changes will be incorporated, and a summary of the recommendations will be published, followed by the issuance of a “Dear Tribal Leader” letter.

**Key, Comments, Questions, and Responses**

**Q:** Is there a targeted number for the lower 48?

**A: I**n the FY 2020 budget, there is a $20 million proposal for the expansion of the CHAP. It would include $10 million for tribal shares, $5 million to support the training and $5 million for management and operations.

**Update from the House Committee on Veteran’s Affairs**

*Sarah Dean, Democratic Professional Staff Member, Subcommittee on Health,*

*House Committee on Veterans’ Affairs*

Ms. Dean provided an update on the MISSION Act and efforts to perfect the MOU between the IHS and VA. There will be a hearing before the House Subcommittee at the end of October regarding Native veterans’ access to healthcare – the first of its kind ever. Ms. Dean also wanted to hear concerns and recommendations from meeting attendees about how the federal government could better serve Native American vets.

**Key, Comments, Questions, and Responses**

One concern shared with Ms. Dean was the lack of reimbursement for PRC by the VA as mandated by statute.

Tribes are still waiting for the implementation of the Mission Act. Coordination of care issues continues to persist.

There is a need for tribal veteran service officers (VSOs).

**TSGAC October 1, 2019 Meeting**

**Indian Health Service Budget Update**

*Ann Church, Acting Director, Office of Finance and Accounting, IHS*

*Melanie Fourkiller, Policy Analyst, Choctaw Nation*

Ms. Church began by providing an update on the continuing resolution (CR) approved by Congress that will fund the government until November 21. The CR included a couple of anomalies for staffing of new facilities and additional funding for SDPI. For the first time, the IHS requested and was approved for an exception apportionment. The purpose of exception apportionment is to authorize special authority for IHS to pay ISDEAA contractors and compactors for the majority of their fiscal year contract and compact amounts. With the new authority, the agency may be able to transfer funds above the level allowed by the CR to ISDEAA contractors and compactors; however, the special authorization only pertains to contractors and compactors who operate on a fiscal year cycle. If the Congress seeks an extension to the CR in November, HHS will seek an apportionment that would also cover contractors and compactors on a calendar cycle.

Congress is making progress on the budget. The Senate mark was not as generous as the House. The House mark was $6.3 billion, and the Senate mark was $6 billion. Both retained all of the 2019 funding levels, and they explicitly rejected all of the administration’s proposals for program decreases. Both bills include funding for the newly recognized tribes located in the state of Virginia and additional funding for quality and oversight within the IHS. The chambers will still have to conference on differences (e.g. electronic health records modernization, CHAP, and proposed amounts).

Distributions from the IHS Director’s Emergency Fund have not been released yet, because they are holding off until they identify if the funds are needed to cover the 105(l) leases. If funds are not required, everyone will be notified, and funds will be distributed following the standard process.

**Key, Comments, Questions, and Responses**

**Q:** Where does the funding for the exception apportionment originate from?

**A:** This is special authority that OMB can provide. We are not impeding the discretion of Congress to set budgetary limits. Essentially, we are saying that Congress has given enough indication of what the funding level is going to be that we have a higher rate of spending authority. So, they are giving us more access to the funding that we would ordinarily have.

**Q**: Where do you think the conversations regarding making sure that the funding for 105(l) leases are segregated in the budget (similar to CSCs) are going?

**A:** I think the committees are hearing the tribal recommendation to move in that direction, and they are seeing some parallels in CSCs and how that issue was resolved to ensure full funding. Although, in the marks, in the House and the Senate they have not proposed a separate budget line.

**HHS Health Information Technology Modernization Project**

*Maia Z. Laing, HHS Optimization Team, Office of the Chief Technology Officer*

*Mitchell Thornbrugh, Chief Information Officer and Director, IHS*

Ms. Laing provided an overview of the HIT project and a summary of the final report. The RPMS users express frustration with their disjointed user experience, limited functionality across multiple areas of care, lack of training, and under-resourced facilities. The RPMS code cannot be supported over the next decade. Lack of inter-and intra-operability negatively impacts the patient experience. Inadequate reporting functionality negatively impacts both public and population health analytics as well as funding for facilities that rely heavily on grant funding. IHS HIT modernization options include stabilizing the RPMS, renewing the RPMS, selective replacement, or full replacement.

Mr. Thornbrugh reiterated that there are three main documents that will come out of the HIT modernization project. The documents are the legacy assessment, the analysis of alternatives, and the technology roadmap. Those will be sent out with a “Dear Tribal Leader” letter and posted to the relevant websites.

**Project Highlights:**

* Completed HIMSS Analytics Electronic Medical Record Adoption Model (EMRAM) and Outpatient Electronic Medical Record Adoption Model (O-EMRAM) Pilot Program with 7 IHS sites
* Completed the Legacy Assessment to understand RPMS architecture and a potential path forward for RPMS modernization
* Completed the Data Call / Qualitative Survey
* Completed Site Visits and Listening Sessions – 25 sites visited across 12 IHS areas; 13+ listening sessions have been held with groups including attendees at the TSGAC Annual Conference, Tier 2 Area IT Support, and various IHS groups and Councils
* Completed and submitted the Analysis of Alternatives (AoA) to the HHS Secretary to support the FY2021 budget ask to support IHS HIT modernization efforts
* The Technical Advisory Commission is preparing to make its final recommendations to the project team on considerations for IHS HIT modernization
* Kicked-off the Roadmap workstream; the project team is closely collaborating with IHS and ONC
* Kicked-off the Human-Centered Design workstream to generate User Stories and Journey Maps to understand interactions with HIT and support future modernization efforts
* Community of Practice Whitepaper is being composed to provide support on how to enhance HIT peer support and the training infrastructure throughout the I/T/U

**HHS Operational Division Access to IHS Patient Data**

*Robert Pittman, Deputy Director, Office of Public Health Support, IHS*

Mr. Pittman provided an overview of the agreements between IHS and other HHS operational divisions and access to patient data. IHS and urban data are used for the budget process. The data is also used to developing the user population and workload numbers. They also provide aggregate data to HHS and other agencies for a variety of different purposes. Access to the data is determined by HIPAA and the Privacy Act. Those laws determine how IHS can share data.

To access data for research purposes, an entity will submit a research protocol to one of the IRBs. The protocol is then reviewed, modified if needed; subsequently, the data use agreement goes into effect. The National Institute of Health (NIH) is working towards a system where they can get one IRB approval for many sites and different types of sites. IHS does not accept IRB approvals from other organizations. It must be approved by one of the IHS IRBs.

**Key, Comments, Questions, and Responses**

**Q:** If an entity requests data from you, is the tribal data sets included in the data submitted to the requestor?

**A:** It depends on what they are asking for. For instance, if the CDC is asking for public health data, and the tribe is reporting data to the national data warehouse, HIPAA allows us to share that data with the CDC for public health activities.

**Q:** How often do you have consultations with tribe regardingpublications or any type of data that is being released?

**A:** We don’t have a lot of consultations with tribes. We probably need to do that more.

**Q:** Do you have tribal representation on your IRB?

**A:** We do not have tribal representation on the National IRB. There is tribal representation on some of the area IRBs.

**IHS Tribal Consultation Policy and Process**

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

Mr. Smith provided an update on consultation efforts. ISDEAA, 25 U.S.C § 5325(i) requires the Secretary to consult with tribes regarding the development of the budget. There are various definitions and interpretations of what constitutes meaningful consultation. One thing that has been consistent within the HHS and IHS is the policy goal and accomplishment of defining what consultation means. The way that IHS defines it is as follows:

An enhanced form of communication that emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

IHS Circular 2006-01 Tribal Consultation Policy (1/18/06).

Tribal budget consultation and area instruction webinars will be held in September, October, and November. Area report webinars will be held on January 29 and 30, 2020, and the National Tribal Budget Work Session will be held on February 13-14, 2010. More information can be found on the IHS website.

The following consultations were held in 2019:

* **I**HS Contract Support Costs Policy – Section 6-3.2E(3) – [Indian Health Manual Part 6, Chapter 3](https://www.ihs.gov/ihm/pc/part-6/p6c3/)
* IHS Sanitation Deficiency System *–* [*A Guide for Reporting Sanitation Deficiencies for American Indian and Alaska Native Homes and Communities*](https://www.ihs.gov/sites/dsfc/themes/responsive2017/display_objects/documents/Final_SDS_Guide_v2.pdf)
* IHS Purchased/Referred Care Policy – [Indian Health Manual Part 2, Chapter 3](https://www.ihs.gov/ihm/pc/part-2/chapter-3-purchased-referred-care/)
* Draft IHS Strategic Plan – [Fiscal Years 2019-2023](https://www.ihs.gov/sites/strategicplan/themes/responsive2017/display_objects/documents/IHS_Strategic_Plan_FY%202019-2023.pdf)
* Proposed Realignment of IHS Headquarters Offices – [*Federal Register*, Vol. 83, No. 246, December 26, 2018](https://www.ihs.gov/sites/ihm/themes/responsive2017/display_objects/documents/functionalstmts/CFR_12-26-2018.pdf)

**Joint TSGAC and IHS Principal Deputy Director Discussion**

*RADM Michael D. Weahkee, Principal Deputy Director, IHS*

*Benjamin Smith, Deputy Director for Intergovernmental Affairs, IHS*

*Ann Church, Acting Director of the Office of Finance and Accounting, IHS*

• **Use of the IHS Director’s Emergency Fund**

There has been one request for emergency funds from the Alaska Area and two from the lower forty- eight in this fiscal year. One of the requests has been paid out, and the others are pending review. They are trying to find funding sources for the 105(l) leases and have been looking at every account available to them – including the emergency fund.

The definition of an emergency that they follow is found in the PSFA manual which essentially says “an unexpected occurrence that can’t be for routine administrative activities or construction.”

• **Contract Support Cost Policy – outstanding issues for resolution**

They have heard multiple requests to pull the CSC workgroup together to work on these lingering issues. Roselyn Tso has been appointed as the director of the Navajo Area of the IHS, but she has agreed to remain involved in this activity. A CSC workgroup meeting will be held; however, the date is to be determined. They need to refill the federal co-chair position and the tribal co-chair position. They have taken an inventory of the tribal leaders who were identified to serve on the workgroup. They have a number of vacancies that need to be filled. They are going to reach out to the area directors for help with filling the vacant positions. The workgroup does not have a charter that details how vacancies will be filled.

**• Pharmacy Benefits Management (PBM) Claims Update**

The IHS is continuing to work CVS Caremark and Express Scripts; however, contracts will be coming up for renewal soon. They are in the final stages of the “Dear Tribal Leader” letter. It is crucial to continue communicating with the IHS the issues that you are having with pharmacies.

**• 105(l) Lease Funding and Consultation Update**

RADM Weahkee stated that they have been telling the appropriations staff, internal stakeholders, the assistant secretary for financial resources, and the OMB that tribes desire a sperate indefinite appropriation similar to CSC. Congressional staff is looking for the formation of technical workgroup to project future 105(l) lease-funding needs. Letters were hand-delivered today, asking for individuals to be identified to serve on workgroups.

• **Office of Inspector General Reports and Recommendations**

There are three recently released from the OIG. One of the reports was a retrospective review of the work that the agency did after the Rosebud Hospital emergency department was closed and the effort that went into reopening the department. Another report was focused on quality of care. The third report was focused on health information technology. Many of the recommendations were focused on the inability to recruit and retain staff in rural areas. In addition to working on recruitment efforts, they are working on building headquarters management and capacity and performance science capacity throughout the agency. They are not just focusing on the clinical aspects of care but also the administrative and financial side of operations as well.

They continue to work hard to get off of the GAO high-risk list. They started with fourteen open recommendations, and they are now down to three. They have requested closure for one of the three open recommendations. They have also made strides in filling executive level management positions.

• **IHS Quality Activities**

Jonathan Merrell provided a brief update regarding the Quality, Assurance, and Risk Management Program (QARM) as a new component of the IHS Office of Quality was provided. They are reviewing high-risk issues, clinical issues, business impact, and financial integrity. They are working to put new governance processes and oversight systems in place at the Rockville level. The QARM is probably the most significant of the systems that they are designing.