**IHS Self-Governance Advisory Committee (TSGAC)**

**Meeting Minutes**

**July 22-23, 2024**

**Embassy Suites**

900 10th Street NW

Washington, DC, 20001

**Monday, July 22**

**Attendance**

A quorum was not established for the TSGAC meeting.

**DDIGA and Office of Tribal Self-Governance (OTSG) Update**

*Stacey Ecoffey, Deputy Director for Intergovernmental Affairs (DDIGA), IHS*

*Jennifer Cooper, Director, OTSG, IHS*

There are 114 active compacts and 141 funding agreements (88 fiscal year and 53 calendar year). The OTSG will transfer over $2.8 billion to Tribes by the end of this fiscal year.

The OTSG has awarded the first round of planning and cooperative agreements. The second round of payments is pending internal review. They are anticipating the award notice in August.

The DDIGA and OTSG are focused on increasing knowledge and awareness of the Indian Self-Determination and Education Assistance Act (ISDEAA). They have been hosting training on a monthly basis. IHS staff, other federal government agencies, tribal leaders and staff, and ISDEAA negotiators have all participated in the training.

The FY 2016-2017 report to Congress has been finalized and should be available online as a final report. The OTSG seeks input and consulting with Tribe regarding the FY 2018-2019 report. The FY 2020-2021 and FY 2022-2023 are being prepared to start the consultation process.

**IHS One HR and Strategic Plan**

*Dan Frye, Acting Director, Office of Human Resources, IHS*

*RDML Francis Frazier, Office of Public Health Support, IHS*

**One HR**

The IHS has approximately 15,000 employees, and approximately 72% are AI/AN employees. The IHS human resources initiatives include expansive use of Title 5 and Title 38 compensation authorities. The IHS also seeks to improve classification, hiring and outreach, housing subsidies, and training. Additionally, the IHS offers scholarships and loan repayment programs. The IHS now offers the IHS Development Program (EDP). Scholarships included preparatory & pre-graduate scholarships and health professions scholarships. The FY 2024 budget includes $17.6M for scholarships.

The IHS Loan Repayment Program now has initial contracts up to $50,000 in exchange for 2-year full-time, and they also offer qualified clinical practice and continuation/extension contracts up to $25,000 in exchange for an additional year of service until all qualified education loans are paid. The awards are taxed at a rate of 24%; however, the IHS pays this additional cost.

The Commission Corps has over 5,000 officers, of which over 1,200 (414 at federal facilities and 861 at tribal/urban facilities) are detailed to the IHS. The IHS ranks the recruitment category prioritization in the following order:

1. Underserved Populations
2. Critical
3. Hazardous and Health Safety
4. Difficult to Retain
5. Deployment and Leadership

**Strategic Plan**

The draft strategic plan FYs 2024 – 2028 contains a background section and outlines strategic goals 1, 2, and 3. Goal 1 is to provide comprehensive, culturally grounded personal and public health services to American Indian and Alaska Native people. Goal 2 is transforming the IHS into a High-Reliability Organization (HRO). Goal 3 is to improve communication, program management, and operations.

The plan was developed based on feedback received from Headquarters Offices. The IHS is reviewing input from Tribes, tribal advocates, IHS employees, and several advisory committees. The current status of the IHS Strategic Plan can be viewed at [www.ihs.gov/strategicplan/](http://www.ihs.gov/strategicplan/). Tribal consultation, urban confer, and IHS employee town halls were completed by June 28, 2024. The TSGAC recommended that the IHS develop a public Strategic Plan Scorecard, an evaluation or monitoring mechanism, and add tribal consultation requirements to the plan's objectives/activities.

The IHS will now compile and review all feedback on the revised draft IHS SP. The revised draft will be submitted to the IHS Executive Leadership Team for review and approval. The plan will go to the HHS for review. Finally, the IHS will publish the DTLL/DUIOLL with the Strategic Plan for FYs 2024-2028.

**Tuesday, July 23**

**Joint Venture Construction Program**

*Steven E Raynor, P.E., Director, Division of Facilities Planning and Construction, Office of Environmental Health and Engineering, Indian Health Service*

The Indian Health Service Joint Venture Construction Program (JVCP) was authorized by the Indian Health Care Improvement Act (IHCIA). The JCVP establishes projects where AI/ANs Tribes can acquire a tribally owned healthcare facility in exchange for the IHS providing the initial equipment and operating and maintenance funding for 20 years.

All federally recognized Tribes are eligible to participate in the JVCP; however, the Tribe must demonstrate the administrative and financial capabilities to complete the facility promptly. The Tribe must also expend Tribal, private, or other available non-IHS funds to complete the facility. This year, the long-term care facilities introduced will be evaluated separately from the inpatient and outpatient facilities, and at least one long-term care facility will be awarded.

**Tribal Leader Question:** How much funding is available? How many projects will be awarded?

**Federal Response:** The JVCP is not a funded program because the Tribes build the facilities, and then the IHS requests funding from Congress to staff the facilities. We rank all the projects in the second phase each time we go through the process. Seven to twelve projects usually go into the second phase. Once the projects are completed, the IHS evaluates the staffing needs and requests funding from Congress. The determination of how many projects will be awarded depends on the level of staffing needed to complete the projects.

**Tribal Leader Question:** Do you have to have the facility constructed or have sufficient evidence that it will be ready for O&M?

**Federal Response:** In fact, it is required that there be no construction begun. There is a provision in the law that the facility can't be an established building. It can be a building that you purchase and renovate to become a healthcare facility. Or it can be one you build from the ground up, but it can't be one you have already built.

**Tribal Representative Comment:** The FAAB transmitted several letters to the IHS Director about recommendations to improve the Joint Venture Construction Program. Many of those issues have already been vetted in the respective IHS areas. The recommendations are as follows:

* The IHS should make all facility types eligible for JCVP funding.
* The IHS should allow past and future JCVP facilities to participate in the 105(l) program.
* The IHS should eliminate the scoring criteria that penalized Tribes for adding facility space to HSP.
* Tribes should not be penalized for constructing facilities when the IHS can't fund them.
* The IHS should work collaboratively with Tribes to be more transparent about the staffing package and how it is developed through the resource requirements methodology and allow Tribes to receive funding before the beneficial occupancy date.
* There should be only one solicitation for both current and new eligibility criteria. The FAAB is concerned that a phased approach would result in only one round of projects being funded.

For a full FAAB recommendations list, please see the July 3 letter at <https://www.tribalselfgov.org/advisory-committees/tsgac/#materials>.

**Budget Update**

*Julian Curtis, Director, Office of Finance and Accounting, IHS*

The FY 2025 President's Budget aims to address the longstanding underinvestment in the IHS.

In FY 2025, the House bill provides $8.6 billion in discretionary funding for the IHS, which is +$1.6 million above the FY 2024 enacted. The bill fully funds the staffing of newly constructed facilities through a $91 million increase.

The House bill provides a significant increase above FY 2024 enacted overall; however, it also includes a critical reduction of -$115 million for the Electronic Health Record modernization project.

The House bill provides a significant increase for the IHS in FY 2025, which comes from reductions to other agencies in the interior appropriation. The Senate is unlikely to accept reductions of that magnitude. The Senate Mark-up is scheduled for July 25.

**Impact of CSC SCOTUS Decision**

The cost impact for new CSC proposals will appear as early as FY 2025. The impact of funding CSC increases within the Fiscal Responsibility Act caps in FY 2024 already resulted in funding reductions to critical facilities programs and EHR modernization. In FY 2025, direct health services and critical priorities could be at significant risk.

If Congress has to reduce funding for IHS Services or Facilities activities to pay for CSC increases in FY 2025 and beyond, that will reduce funding to ISDEAA Tribes, Direct Service Tribes, and Urban Indian Organizations.

**Unobligated Balances Update**

19% ($440M) of prior year unobligated balances is for health care services & related activities, 13% ($291M) is for purchase referred to care, and 69% ($1.6B) is for project-based activities.

A comparison of the prior year's (July 2023 to July 2024) unobligated balances shows that the IHS has managed to get an approximately 20% reduction in PRC balances. This is the lowest IHS' PRC balance has been in years. They are experiencing normalization of the balances as they catch up from the pandemic. The COVID balances are exhausted, spending more typical appropriation again.

**ACA/IHCIA Update**

*Cyndi Ferguson, SENSE Inc. (ACA Project Lead)*

The ACA team conducted two break-out sessions at the 2024 Annual Tribal Self-Governance Conference in Chandler, AZ. The team discussed Medicaid unwinding and Tribal sponsorship. The team also conducted a 2-day in-person ACA/IHCIA training session in Portland, OR. A total of 88 people representing 52 Tribes/Tribal organizations attended.

The team plans to host another in-person ACA/IHCIA training in a different region. They are also exploring a special project working with SGCETC to develop a segment on an ACA/IHCIA story. They will continue to circulate the updated survey on Medicaid Unwinding to gather updated information from Tribes. They plan to review the ACA/IHCIA Work Plan and host a webinar on a priority topic.

You can request additional information from [cyndif@senseinc.com](mailto:cyndif@senseinc.com).

**Implementation of Executive Order 14112**

*Devin Delrow, Principal Advisor for Tribal Affairs, Department of Health and Human Services*

The Office of Intergovernmental and External Affairs (IEA), along with the HHS Assistant Secretary of Financial Resources, is leading the implementation of EO 14112 at the HHS. They have established an internal HHS workgroup. They are focusing on Section 5 of the EO and searching for funding flexibility, streamlined opportunities, access to funding opportunities, and reduced reporting burdens.

They plan to conduct further Tribal engagement regarding the EO at each of the ongoing regional Tribal consultations. They are creating a fact sheet for presentation at the September STAC meeting. They have worked on a cross-government pilot to reduce reporting burden and improve customer experience. The pilot project released its final report, which is available at <https://www.hhs.gov/about/agencies/asfr/grants-quality-service-management-office/index.html>.

**Update and Discussion on Self-Governance Expansion for HHS Agencies**

Several STAC members met with the Secretary after the budget consultation to discuss self-governance. It requested his support in standing up and engaging the STAC subcommittee to focus on expanding self-governance at the HHS. The Secretary expressed his support for self-governance, but some significant details need to be considered for self-governance expansion.

**Tribal Representative Comment:** It was a great idea to form sub-workgroupsbecause they get to dig into the technical details. I understand the initial approach to taking the LIHEAP case study example. The questions that we received made sense from the agency's perspective. However, it also demonstrated a lack of understanding of self-governance and that this is a demonstration project with a limited five-year time of the legislation being introduced to figure out all the details. There seems to still be a push from HHS that we need to know the answers to how this will look exactly from day one – even though it's intended to be a demonstration project.

I would love to see OTSG more involved in some of the meetings because they possess the memory and knowledge to participate in a demonstration project and can help explain what that means. On our reporting call, there were a lot of questions regarding LIHEAP reports. We already know that the agency is addressing this through 477. More education regarding the Single Audit Act also needs to be provided.

**Wrap-Up Discussion with the IHS Leadership**

*Ben Smith, Deputy Director, IHS*

**Priorities**

The IHS' top priorities remain providing safe, quality care, putting the patients first, and protecting their partnerships with Tribes, Tribal Organizations, Urban Indian Organizations, and others. The IHS is undergoing a few organizational realignments. The Office of Quality is one of the newest components of their system. The realignments also included the Office of Human Resources (One HR) and the Office of Information Technology.

The next iteration of the IHS strategic plan also remains a top priority. The current strategic plan includes over 70 objectives that speak to different tasks but are not action-oriented. The next iteration, currently out for consultation, looks more action-oriented. The agency's biggest change of note is that it is looking into becoming a high-reliability organization (HRO).

**GAO High-Risk List**

The IHS leadership has been very direct in its communications with oversight bodies and ambitious in scheduling follow-up conversations with the GAO. IHS leadership will continue to meet with the GAO to continue the conversations and work towards implementing recommendations. The IHS is changing its approach to telling its story and preparing for activities when the GAO or IG does come in to audit or review reports.

**Behavioral Health Funding Update**

Previously, the IHS decided that the behavioral health initiatives would remain grants. However, they received many requests to reconsider. They have engaged in consultation and urban confer on this topic, and the comment period just recently closed. The IHS will evaluate the comments and make a decision.

**VA – IHS Reimbursement**

The IHS and VA have updated their reimbursement agreement. The agreement covers about 73 of the IHS federally operated sites. The updated agreement consolidated the initial agreement from 2012 and the subsequent amendments. The revised agreement does contain retroactive terms.

The VA is now negotiating independent agreements with Tribal health programs.

**Tribal Representative Comment:** Our Tribal agreements did expire on June 30, and we received the new agreement on June 25, which is unfair. Our workgroup has been reviewing the agreements

and there are numerous in the Tribal reimbursement agreement that they propose that we agree to that aren't in the IHS reimbursement agreement.

**Completing the Section 105 Guidance**

The IHS is making progress, but it is coming at a cost. The staff is accumulating overtime with no time off. They planned to move CSC and 105(l) into the Office of Finance & Accounting; however, it is now being realigned into the existing Tribal offices.

They have updated delegation authority #56. This establishes that the Deputy Director, Deputy Director of Intergovernmental Affairs, and the Office of Direct Service and Contracting Tribes have the authority to sign the 105(l) leases in the future. Guidance documents include a policy, FAQ document, and a detailed guide are under development. The goal is to complete those by the fiscal year's end.

**Tribal Representative Comment:** Regarding the Indian Healthcare Improvement Fund, In the FY 2025 House appropriations, It looked like it shifted to advance appropriations. I also noticed that in the House report, an explicit statement says that while you requested that the Indian Healthcare Improvement Fund be moved to HNHC, we disapprove.

**Federal Response:** I was surprised to see that report language. It's confusing because it seemed like we were all clear and on the same page with the staff that this was just an error from 2018 when this line was created. We got the advanced, and if that gets enacted, I don't know how concerned we will be about it moving into the agency.