

# **IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE (TSGAC)**

## **DRAFT MEETING SUMMARY**

**Meeting Dates:** December 10–11, 2025

**Location:** Embassy Suites, 900 10th Street NW, Washington, D.C.

**Format:** In-person with virtual participation via Zoom

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### **I. MEETING OVERVIEW**

The Tribal Self-Governance Advisory Committee (TSGAC) convened on December 10–11, 2025, in Washington, D.C., for its regular meeting with senior leadership of the Indian Health Service (IHS). The purpose of the meeting was to receive detailed briefings, engage in policy dialogue, and provide tribal guidance on the administration of tribal self-governance within IHS, particularly as it relates to funding stability, Contract Support Costs (CSC), Contract Disputes Act (CDA) claims, agency realignment, and health system modernization initiatives.

Throughout the two-day meeting, tribal leaders and technical advisors emphasized the practical, operational consequences of federal policy decisions on tribally operated health systems. Discussion consistently returned to themes of predictability, transparency, accountability, and meaningful consultation as foundational elements of effective self-governance. In accordance with direction from TSGAC leadership, these minutes are presented in a narrative format that prioritizes substantive discussion and policy analysis, while minimizing ceremonial or procedural detail.

### **II. DAY ONE – WEDNESDAY, DECEMBER 10, 2025**

#### **Committee Business and Governance Matters**

The meeting began with committee business required to maintain TSGAC's formal governance. Members reviewed the minutes from the July 2025 meeting, which had been circulated in advance and made publicly available. After confirming that no corrections or amendments were requested, the Committee approved the July 2025 minutes by unanimous consent.

The Committee then addressed nominations for TSGAC representation. Nominations were presented from the California (Brandin Paya, Chairman, Paskenta Band of Nomlaki Indians) and Nashville Areas (Michele Scott, Councilor, Mashantucket Pequot Tribal Nation). Both nominations were approved by the Committee. The Committee also considered re-nominations for TSGAC representatives (Chairman Ron Allen and Melanie Fourkiller)

-serving on the Tribal Technical Advisory Group (TTAG), recognizing the importance of continuity and institutional knowledge in intergovernmental advisory processes. Following the discussion, all nominations were approved.

During this discussion, TSGAC leadership again raised concerns regarding inconsistent nomination procedures across IHS Areas. Members emphasized that the absence of written, tribally driven nomination processes continues to create confusion. While some Areas have adopted and submitted formal procedures, others have not. The Committee strongly encouraged all remaining Areas to document and submit their nomination processes prior to the next meeting.

### **Opening Remarks and IHS Leadership Update**

Clayton Fulton, Chief of Staff of the Indian Health Service, delivered opening remarks on behalf of IHS leadership. He began by outlining recent leadership transitions within the agency, including the temporary delegation of the IHS Director's authorities and duties to the Chief of Staff pending Senate confirmation of a permanent Director. He explained that this delegation was intended to ensure continuity of operations and timely decision-making during a period of transition and acknowledged the efforts of senior leadership in maintaining stability across the agency.

Mr. Fulton provided a detailed overview of the federal budget environment, noting that the government was operating under a continuing resolution scheduled to expire on January 30, 2026. He explained that advanced appropriations had allowed IHS clinical operations to continue uninterrupted during the recent federal government shutdown; however, several critical programs—including Contract Support Costs, section 105(l) leases, and the Indian Health Care Improvement Fund—do not benefit from advance appropriations and therefore require exception apportionments. He emphasized that IHS financial staff were actively coordinating with the Department of Health and Human Services and the Office of Management and Budget to mitigate delays and ensure that tribes receive payments as promptly as possible.

Workforce challenges were identified as a central concern affecting healthcare delivery across Indian Country. Mr. Fulton emphasized that stable funding alone is insufficient without an adequate workforce, noting persistent challenges related to recruitment, retention, housing, and lengthy hiring timelines. He described ongoing initiatives to expand clinician housing in remote areas, modernize human resources systems, streamline hiring processes, and strengthen education and scholarship pipelines.

Mr. Fulton also addressed the ongoing IHS realignment initiative, framing it as a necessary step to improve accountability, reduce administrative burden, and clarify leadership roles

in an agency where a majority of program funding flows directly to tribes at the beginning of each fiscal year. He emphasized that realignment is intended to better align IHS's organizational structure with the realities of a predominantly tribally operated healthcare system and reiterated that meaningful tribal consultation would continue to inform final decisions.

Finally, Mr. Fulton announced the establishment of the Office of Indian Veteran Support within IHS. This office is intended to strengthen coordination between IHS and the U.S. Department of Veterans Affairs and to ensure that the healthcare needs of Native veterans are addressed consistently across tribal, federal, and urban health systems. He noted that this initiative reflects IHS's broader commitment to addressing populations whose needs can fall between agency boundaries.

### **Office of Tribal Self-Determination and Self-Governance (OSD)**

Rena Macy, Acting Director of the Office of Tribal Self-Determination and Self-Governance (OSD), provided a substantive update on the administration of Title V self-governance agreements. The presentation emphasized the increasing complexity of self-governance as tribal health systems expand in scale, sophistication, and financial integration with third-party payers and other revenue sources.

OSD leadership explained that the continued growth in Title V participation has fundamentally altered IHS's operational landscape. With a significant portion of IHS funding transferring to tribes at the outset of each fiscal year, OSD's role has evolved beyond basic contract administration to encompass complex fiscal, legal, and policy coordination. This includes managing the downstream impacts of CSC litigation, program income accounting, and indirect cost methodologies.

Ms. Macy emphasized the importance of maintaining fidelity to the Indian Self-Determination and Education Assistance Act (ISDEAA) while adapting agency practices to reflect current operational realities. She acknowledged that many existing policies, templates, and administrative processes were developed in a substantially different funding environment. Ms. Macy reiterated OSD's commitment to updating guidance through consultation, advisory committee engagement, and negotiated solutions rather than unilateral agency action.

### **Tribal Self-Governance Update**

Jay Spaan, Executive Director of Tribal Self-Governance, provided an update on recent activities from the Consortium, including an update on the annual conference, the new certificate program, and TSG's role providing technical assistance to agencies and Congress on the implementation and enhancement of Self-Governance authority.

### **Community Health Aide Program (CHAP)**

Tasha Mousseau, Vice President of the Wichita and Affiliated Tribes and a member of the National CHAP Board, provided a detailed narrative update on the development of CHAP governance and policy for implementation outside Alaska. She described the National CHAP Board as an evolution from earlier advisory structures. She explained that the Board is currently engaged in foundational work, including developing bylaws, governance protocols, and aligning policies.

Ms. Mousseau discussed challenges that have emerged during this process, particularly regarding closed federal meetings that limited the participation of tribal technical advisors. She emphasized that tribes view technical advisors as extensions of tribal leadership and expressed concern that excluding them undermines meaningful consultation. While acknowledging incremental progress toward partially open meetings and improved collaboration with IHS staff, she stressed that additional work is necessary to ensure CHAP governance fully reflects self-governance principles.

She further explained that Alaska CHAP standards and procedures are currently being used as an interim framework for the Lower 48, recognizing that long-term implementation will require regionally appropriate adaptations. Throughout her remarks, Ms. Mousseau emphasized the need for sustainable funding and formal consultation if CHAP is to serve as a transformative workforce model for tribal health systems.

### **Office of Resource Access and Partnerships (ORAP)**

Tracy Sanchez, Acting Director of the Office of Resource Access and Partnerships (ORAP), provided a narrative update on several resource access mechanisms that directly affect tribal health program financing. She discussed ongoing efforts to improve administration of the Catastrophic Health Emergency Fund (CHEF), noting both the importance of timely reimbursement and the challenges associated with increasing demand.

Ms. Sanchez also addressed improvements to Purchased/Referred Care (PRC) unmet need reporting, emphasizing that accurate data is essential for demonstrating the scale of unmet healthcare needs in Indian Country and for informing future funding decisions. She provided updates on PRC Delivery Area redesignations and acknowledged the administrative burden these processes can impose on tribes, reaffirming ORAP's commitment to improving clarity and consistency. Finally, she discussed progress toward

publication of the All-Inclusive Rate in the Federal Register and its importance for tribal budgeting and reimbursement predictability.

### **Affordable Care Act and Indian Health Care Improvement Act Update**

Cyndi Ferguson of SENSE Inc., joined by Elliott Milhollin of Hobbs Straus Dean & Walker, presented a comprehensive narrative update on Affordable Care Act and Indian Health Care Improvement Act implementation activities since the Committee's July 2025 meeting. Ms. Ferguson noted that the project supporting TSGAC entered a new fiscal year, ensuring continuity of technical assistance and policy support.

The presenters reviewed recent regulatory developments, training activities, and ongoing advocacy priorities. They emphasized that while many ACA and IHCA provisions are now well established, continued vigilance is necessary to protect Indian-specific authorities and funding streams, particularly amid shifting federal priorities and budget negotiations. They reaffirmed their commitment to providing tribes with timely analysis, training, and strategic guidance.

### **III. DAY TWO – THURSDAY, DECEMBER 11, 2025**

#### **Contract Support Costs (CSC) – Program Income Implementation**

Rena Macy, Acting Director of the Office of Tribal Self-Determination and Self-Governance, provided a comprehensive narrative update on the implementation of Contract Support Costs related to third-party program income following the *Becerra* decision. She explained that this work represented nearly a year of intensive policy development, advisory committee engagement, and negotiation with tribes across multiple IHS Areas.

Ms. Macy reported that more than thirty tribes operating under both Title I and Title V agreements have successfully negotiated CSC associated with program income. As of the meeting date, approximately \$223 million in new CSC funding had been negotiated for fiscal year 2025 alone, with individual agreements ranging from modest amounts to awards exceeding \$100 million. She emphasized that for many tribes, program income CSC represents a significant increase over previously received CSC levels.

Ms. Macy explained the revised CSC certification process and updated templates, detailing how the agency now distinguishes between secretarial funding and program income for both direct and indirect costs. She stressed the importance of accurate documentation, particularly with respect to excluding section 105(l) lease costs and avoiding duplication within indirect cost pools. She clarified that the agency's decision to limit negotiated program income CSC to fiscal years 2025 and 2026 at this time, while directing earlier years to the CDA claims process to maintain clear legal and administrative separation.

Looking ahead, Ms. Macy outlined next steps, including national webinars, additional training for federal negotiators, sessions at the Alaska pre-negotiation meeting, and the reconvening of the CSC Advisory Committee. She emphasized that while the agency has established the necessary infrastructure, meaningful progress depends on early and proactive tribal engagement.

### **Budget and Contract Disputes Act (CDA) Claims**

Jillian Curtis, Director of the Office of Finance and Accounting, provided an extensive narrative briefing on the status of Contract Disputes Act claims related to Contract Support Costs. She reported that IHS is currently managing 756 claims totaling approximately \$4.6 billion, with 71 claims closed and the remainder in various stages of analysis, negotiation, or litigation.

Ms. Curtis explained that IHS has shifted from revenue-based to expenditure-based methodologies in evaluating claims, aligning CDA settlements with the approach used for ongoing CSC payments. She described the agency's preference for global settlements where feasible, while acknowledging that some claims are proceeding through individualized resolution. She also clarified the distinction between claims handled administratively by IHS and those filed in federal court, noting that Department of Justice involvement necessarily affects timelines and decision-making authority. Ms. Curtis acknowledged tribal frustration with the pace of resolution but confirmed that statutory interest will be paid on delayed settlements.

### **GAO High-Risk List and Action Plan**

Michelle Boylan, Deputy Director for Quality Healthcare and Enterprise Risk Management, provided a detailed narrative briefing on IHS's status on the Government Accountability Office High-Risk List. She traced the designation to initial GAO findings in 2017 and described subsequent agency efforts to address identified deficiencies.

Ms. Boylan emphasized that recent GAO feedback has focused the agency's efforts on addressing root causes rather than symptoms. These root causes include weak governance structures, inconsistent policy execution, fragmented communication, and insufficient accountability mechanisms. She introduced a public-facing GAO Action Plan aligned with the IHS FY 2025–2029 Strategic Plan and described new expectations for senior leadership ownership and quarterly reporting. She emphasized that the Action Plan is intended to be iterative, transparent, and durable.

## **Electronic Health Record Modernization**

Mitchell Thornbrugh, Chief Information Officer of IHS, provided a detailed narrative update on the Electronic Health Record modernization initiative. He explained that the governance structures for EHR were intentionally established before deployment to ensure meaningful participation by end users, including tribal and federal healthcare staff.

Mr. Thornbrugh reported that the Lawton Indian Hospital pilot has progressed through design and entered integrated testing, with baseline acceptance scheduled for February 2026 and a target go-live date of August 2026. He emphasized that PATH EHR is intended not merely as a technology upgrade but as a foundational transformation of healthcare delivery, documentation, and coordination across IHS and tribal systems. He acknowledged the scale of the investment, estimated at approximately \$6.2 billion, and noted that funding constraints primarily affect the pace rather than the direction of implementation.

## **IHS Leadership Discussion and Agency Realignment**

During the final leadership discussion, IHS officials engaged with TSGAC members on the proposed agency realignment, advisory committee consolidation, staffing challenges, and infrastructure needs for facilities. Leadership acknowledged long-standing concerns regarding the outdated healthcare facilities construction priority list and the disconnect between current funding levels and documented needs.

TSGAC members emphasized that realignment and modernization efforts must be grounded in meaningful tribal consultation and must strengthen, rather than dilute, self-governance authorities. IHS leadership reiterated that realignment is intended to improve coordination, clarify responsibility, and better align agency structure with the realities of a predominantly tribally operated healthcare system.

## **IV. ADJOURNMENT**

Following final comments from Committee members, the Chair noted that technical workgroup matters would continue via email. The meeting was adjourned upon completion of all agenda items.