INDIAN HEALTH SERVICE/CALIFORNIA AREA OFFICE

TRIBAL ADVISORY COMMITTEE MEETING

March 23, 2015/March 26, 2015

Approved June 9, 2015.
Yes: 9
No: 0
Abstain: 0

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EXECUTIVE SUMMARY

CATAC Members:		Region Represented:
Mr. John Green	Present	Northern
Mr. Peter Masten Jr.	Present	Northern
Mr. Stacy Dixon	Present	Northern
Mr. George Gholson	Present	East Central
Ms. Bonnie Hale	Absent	East Central
Mr. Robert Marquez	Absent	East Central
Ms. Glenda Nelson (A)	Present	East Central
Mr. Silver Galleto	Present	West Central
Ms. Elizabeth Hansen	Absent	West Central
Ms. Crista Ray	Absent	West Central
Mr. Chris Devers	Present	Southern
Ms. Teresa Sanchez	Present	Southern
Ms. Diana Chihuahua	Present	Southern
Ms. Lisa Elgin	Absent	NIHB
Vacant	-	Urban
Ms. Beverly Miller	Present	IHS

All are primary representatives unless otherwise indicated-Alternate (A)

IHS Staff in Attendance:

Dr. Charles Magruder	Chief Medical Officer
Mr. Ed Fluette	Associate Director, Office of Environmental Health and Engineering
Ms. Jeanne Smith	Acting Human Resources Director, Western Region
Mr. Travis Coleman	Acting Indian Self-Determination Program Manager

The California Area Tribal Advisory Committee (CATAC) meeting began at 1:00PM on March 23 in the Sierra Room at Thunder Valley Casino Resort, 1200 Athens Boulevard, Lincoln, California 95648. In addition to the tribal officials listed above, the meeting was attended by additional Indian Health Service (IHS) staff.

Ms. Beverly Miller, California Area IHS Acting Director welcomed all members of the CATAC. She said there is an aggressive agenda for this meeting, but she wanted the committee to be aware of the topics before the main consultation.

Review Executive Summary – December 15, 2014

Mr. Travis Coleman, California Area IHS Acting Indian Self-Determination Program Manager, explained that the prior executive summary were approved at the Budget Formulation and the executive summary from December 15, 2014 include the name for the southern youth regional treatment center (YRTC).

Mr. Silver Galleto, Vice Chairman, Cloverdale Rancheria, motioned to approve the minutes and Ms. Teresa Sanchez, Tribal Representative, Morongo Band of Mission Indians, seconded the motion. All were in favor of approving the executive summary. All nine CATAC members present approved the executive summary with the exception of Chairperson Glenda Nelson, Enterprise Rancheria, who abstained from the vote because she was not present at the last meeting.

Review California Representatives to National IHS and HHS Workgroup listing

All committee members were provided a handout listing all of the national IHS and HHS workgroups and representatives. Mr. Coleman informed the group of one change to the document – Ms. Lisa Elgin, Tribal Representative, Manchester Point Arena Band of Pomo Indians, is the California representative to the National Indian Health Board.

For those committee members who are not tribal officials, the IHS requires a letter from the tribe stating the individual may represent the tribe. Mr. Coleman offered to e-mail a template to all members that require it.

Mr. Chris Devers, Tribal Representative, Pauma Band of Mission Indians, asked that the names of the California Area IHS representatives to each national workgroup be added to this listing.

All committee members were provided a ballot with the name suggestions for the northern YRTC. Mr. Devers asked if the northern tribes have discussed the names and Mr. Coleman said they have not. Mr. Galleto said the northern tribes have not had a fraction of the time that the south had. He said the CATAC should not discuss this until the northern tribes have a chance to discuss it.

ACTION ITEM:

Mr. Coleman will revise the California Representatives to National IHS and HHS Workgroup listing to include Ms. Elgin and the California Area IHS representatives.

Review California Representatives to National IHS and HHS Workgroup Reports

Contract Support Cost Workgroup (CSC):

Representatives: Mr. Chris Devers and Mr. Preston Pete

Mr. Devers deferred to Mr. Preston Pete, Finance Director, Consolidated Tribal Health Project, Inc., who has been involved with the workgroup. Mr. Pete said there have been a couple of meetings in the last couple of months and there is another workgroup meeting tomorrow. There will be a training in May with Area staff and IHS Headquarters staff to discuss calculations. Mr. Pete has been on the workgroup for just over a year. Mr. Devers is also relatively new as he has attended just one meeting in Washington D.C. Mr. Pete further explained that CSC is very complex. Since the CSC workgroup was reestablished, the primary goal is to make the policy more efficient for tribes and the IHS. This is not an easy task. The workgroup has been trying to streamline parts of the process. CSC is not processed the same way in each Area. Last year, CSC was fully funded for the first time, but Congress did not appropriate enough funds for the line item and ultimately used program funds from IHS Headquarters. The workgroup has not seen documentation of this, but the Area Office was told that the majority of the funds came out of Headquarters shares to lessen the effect on direct service tribes. The workgroup believes there is enough funds in the line item for Fiscal Year 2015. The workgroup is still unsure what will happen to those tribes that assume additional programs causing an influx of CSC that has not previously been allocated. The IHS has asked that tribes that want to expand their programs inform the agency. The United States President added CSC as a mandatory line item in the 2016 budget, to go into effect in 2017.

Ms. Miller explained that services appropriations include hospitals & clinics (H&C), mental health, dental, and other categories. This mandatory apportionment would put CSC into a completely different category. In 2015, CSC was considered part of this whole services appropriation and when the line item exhausted the funding, the agency was required to utilize funding from other line items such as H&C and dental. Although the Acting IHS Director used some IHS Headquarters funding, some Area funding was also used. At the end of the year, it is very difficult to come up with extra funding. The California Area provided $75,000 which is minor compared to other Areas and IHS Headquarters. When CSC has its own category, funding for it cannot be taken out of services appropriations. In order to make this happen, tribal support is needed. Mr. Devers believes it will take the work and support of all California tribal facilities to ensure there is always enough money in that line item.

Mr. Pete said the mandatory line item is different than Medicare/Medicaid since it is a three-year line item. Whether good or bad, this is a step forward. After three years, Congress could decide that it should be discretionary rather than mandatory. For now, the workgroup believes the year one funds will be sufficient. The workgroup is concerned, however, that the IHS believes it has the authority to review and audit

financials after five years. All of the tribal workgroup members objected to this because tribes want to close out the year without worrying that the agency will ask for funding back in five years. The workgroup members are discussing how to resolve this. Everyone agrees CSC needs to be fully funded, but this should be done efficiently and timely without reconciliations up to five years down the road.

Mr. Coleman asked if the workgroup is aware of the process conducted by the Department of Interior (DOI). Mr. Pete said they were not at that meeting, but he knows that tribes can get an indirect cost rate from either DOI or the IHS. There is a complicated spreadsheet and formula to calculate that indirect cost rate. Several of the consortium clinics in California and Alaska use provisional final population in their calculations which is a variable in the overall policy. This is another concern of the workgroup. If the IHS bills the clinics four years from now, after they have already submitted the calculations, this will be double dipping on either side. This is not currently built into the calculation so IHS and the workgroup will need to look at this.

Mr. Devers is concerned that tribes audit and close out funds at the end of the year so there might not be money left if IHS audits them five years later. Mr. Pete said this is a significant issue because nobody wants IHS in 2019 to look at CSC funds paid in 2014. The workgroup is researching various resolutions for this, such as an agreed upon lump sum starting at the beginning of the fiscal year. This amount would not be increased throughout the year, but tribes may receive modifications or amendments. The agency is open to this, but is unsure about the logistics since they do not have the staff to reconcile contracts for up to five years across the whole nation. There are only a handful of staff working on this at IHS Headquarters.

Mr. Galleto asked if the lump sums would be for one year or two years and if all tribes would be required to agree on them. Mr. Pete explained that there was a lump sum pilot project and it is in the current policy. This would not be new to the policy. The pilot project stopped five or ten years ago. Not everyone would be required to do this. Rather, this would be at the discretion of the tribes. This may be a reasonable solution, especially for mature tribes with stable programs. Many California tribes might be suitable for this and the Area Office might have a better idea about this. California does not have a federal facility whereas other Areas have facilities that can assume additional services.

Mr. Jess Montoya, Chief Executive Officer, Riverside/San Bernardino County Indian Health, Inc. (RSBCIHI), said that the IHS recommendation asks for 2% which he assumes would be used to offset the staffing cost to do analysis. Also, on a national level there are 66 tribes working with the attorney who won the lawsuit. RSBCIHI sent a letter asking that the funds are authorized for 5 years rather than 3 years. The Special Diabetes Program for Indians (SDPI) was originally set up for 5 years, was then authorized for only 3 years, and is now having to be reauthorized every year. Tribes do not want this to happen to CSC funding. Instead, CSC funding should be authorized 5 years as an automatic part of the annual process. A RSBCIHI board member will be providing testimony on this in Washington D.C. this week.

Mr. Pete concluded by saying there are many positive activities occurring related to CSC. The IHS is determining whether they are required to conduct an audit in five years and that is a concern or the workgroup. The workgroup is requested better communication between tribes, the clinics, and the agency. Mr. Pete and Mr. Galleto have asked for a federal representative on the workgroup. California is one of the only Areas that does not have one. Full funding for CSC last year was a significant change, and the workgroup is guidance. This is a new subject for many tribal representatives. IHS should send information to the tribes regarding what will happen going forward. There will be a template for calculating the full amount (the need) for CSC.

Ms. Miller agreed that CSC is technical and is aware that there are several different ways of calculating it. It will take much manpower for the agency to recalculate the amounts after five years. She believes the activities of the workgroup are very important.

HHS Secretary's Tribal Advisory Committee (STAC):

Representatives: Chairperson Elaine Fink (not present) and Chairman Stacy Dixon

Chairman Stacy Dixon of the Susanville Indian Rancheria was unable to attend the last meeting, but attended the meeting in December when the Department of Health & Human Services (DHHS) Secretary was not yet official.

Mr. Coleman said Chairperson Fink will present on this workgroup during the Annual Tribal Consultation tomorrow.

IHS Budget Formulation Workgroup (BFWG):

Representatives: Chairman Stacy Dixon and Chairman Mark Romero

Chairman Mark Romero of the Mesa Grande Band of Diegueno Mission Indians was unable to attend the last few meetings. Chairman Dixon attended the meeting on February 9-12 wherein the budget formulation was presented to the 12 regions. He presented California's top 5 priorities to the budget formulation committee. Overall, he thinks the budget went well. The tribal members spoke on behalf of urban programs also. There are over 10,000 Native Americans being treated at urban Indian healthcare programs. In addition, three California tribes (Koi Nation, Tejon, and Wilton) were added to this year's budget.

Chairman Dixon presented his concerns to DHHS Secretary Sylvia Burwell in February. That was the first time he met with her. He presented the same top 5 items that he presented to the workgroup and explained some of the issues California is facing, including the drought. The drought will be a major issue again this year.

Chairman Dixon is unsure when the workgroup will meet again, but believes it will meet in conjunction with the Tribal Self-Governance Meeting in Reno at the end of April.

Tribal Leader's Diabetes Committee (TLDC):

Representatives: Ms. Rosemary Nelson and Ms. Dominica Valencia

Ms. Rosemary Nelson, TLDC primary representative, noted that for the past three years SDPI has only been authorized one year at a time. The agency will be lucky to receive patch funding this year. There has been a 43% reduction in End Stage Renal Disease among American Indians/Alaska Natives. This means SDPI is resulting in positive results, including lives saved and upwards of $90,000 saved per year for dialysis. Dr. Yvette Roubideaux, former Acting IHS Director, established a workgroup last fall to look at the budget for the possibility of reauthorization. She was not happy with the three conclusions of the workgroup. The workgroup presented the same findings in February and Dr. Roubideaux was going to distribute a Dear Tribal Leaders letter. The tribes will be vote on this on Wednesday because the letter was not sent out. Ms. Nelson and Ms. Dominica Valencia, TLDC alternate representative, met with six Congressmen and Ms. Nelson sat next to Representative Doug LaMalfa, California 1st District, on the airplane from Washington D.C. to Chicago. During that time, Ms. Nelson spoke to him about reauthorization. Although he was polite, she is unsure whether he will support it.

Ms. Nelson said the TLDC is educating new IHS Headquarters staff. Chairman Dixon said Acting IHS Director McSwain is from California and may benefit the Area.

Ms. Nelson said there has been a high level of frustration among the TLDC. Ms. Valencia agreed that the last two meetings were frustrating for everyone. The representatives were not cooperating with one another and some would not even talk. The facilitator did not know what was happening. The confusion started during a meeting in Albuquerque in September when the TLDC initially agreed to allow new tribes to receive SDPI funding, but then some representatives became confused and disagreed with the resolution.

Ms. Valencia said she and Ms. Nelson met with the following Congressmen in Washington D.C.: Steve Pearce (New Mexico), Jaime Herrera (Washington), Ben Ray Lujan (New Mexico), Tom Cole (Oklahoma), Representative LaMalfa (California).

Ms. Nelson said more transparency is needed. Tribes cannot make informed decisions without all of the information. Fortunately, California has been helpful and tribes will receive material on Wednesday.

Ms. Valencia said the National Indian Health Board is hosting their national conference in Palm Springs in April. She will be on a panel presenting on SDPI. She encourages tribal and urban Indian healthcare programs to display posters showing how well California is doing. Tribes should invite their Congressional representative to this event to show them how the funding is being used and why tribes need their support.

IHS Purchased/Referred Care (PRC) Workgroup:

Representatives: Chairman Mark Romero and Mr. Chris Devers

Mr. Devers said the PRC workgroup met in Denver in January and examined the Medicare-Like Rate (MLR) proposal. The consensus of California tribes is the MLR proposal is amenable with some exceptions. There needs to be a way clinics or Areas can negotiate a different rate. With this proposal, some tribes have diminished leveraged with providers, who are not required to accept the MLR. Some areas have limited options and this may hurt a clinic or tribe. In addition, California representatives do not agree with the existing formula or the program funding increase allocated to sites through the national formula. Tribal consultation is necessary to address any further changes to the formula. The closing date for comments was extended to February 4, 2015. Of the 54 comments, nine supported the proposed regulation, 38 supported the proposed changes, 58 did not support the changes, and four provided general comments. The tribes requested provisions to allow them to opt out of the proposal and provisions allowing for the flexibility to negotiate higher rates. The IHS is giving full consideration to adding this flexibility to the proposal. In the absence of a negotiated amount, the amount will be that which the supplier accepts from its most favored customer.

The workgroup received a brief presentation on the budget formula and would like it to stay as is until there can be consultation. The workgroup also requests that consultation occurs in the beginning.

Mr. Devers said California's representatives to the PRC workgroup will be presenting to tribal leaders about the MLR. California representatives must portray a succinct message to the workgroup. If California tribes want an opt-in/opt-out clause, the representatives need to be able to argue and fight for this. The representatives need input from California tribal leaders so they are able to respond on behalf of California with a moment's notice.

Ms. Valencia added that representatives from the Navajo Area, for example, already know what their Area wants because all of the tribes are under one umbrella. Of the 100+ tribes in California, the same 35 tribes continually respond to requests for input. Ms. Valencia said she knows some tribes have issues with IHS, which she is aware of because she participated as Chair of her tribe's health board for four years. She now realizes the importance of providing this information.

Ms. Miller said California could have a powerful presence with over 100 federally recognized tribes. Chairman Robert Smith, Pala Band of Mission Indians, said California tribal leaders need to open their mail. Ms. Valencia said other Areas also have this issue.

Chairman Dixon said the amount of tribes in California is disrupting the formula. Currently, the formula is based on the twelve regions receiving an equal share.

Mr. Pete asked how the changes impact the allocations that are currently being determined. He also asked how the MLR proposal will impact California as opposed to the rest of the country. Chairman Romero said California is amenable to the MLR but

there are areas within California that it will negatively affect if there are no exceptions to negotiate a higher rate. In southern California, for example, there are many doctors from which to choose, but in some areas that is not the case. Also, there are not enough staff in Washington D.C. to oversee this. Providers may insist on two times the MLR. It is up to each facility to negotiate with each provider. There is nothing in the language that mandates providers to accept the MLR.

Mr. Pete asked about the allocation formula and Chairman Romero said it is okay for now, but if there are any changes, there needs to be consultation.

Mr. Montoya clarified that, right now, when a patient without insurance is admitted to a hospital, the program receives the discounted MLR. Healthcare programs want the ability to receive the MLR for specialty care services, such as rheumatology and cardiology provided outside of the clinic's four walls. Currently, programs may receive the MLR or they may receive 10% above or below the MLR. Originally, the proposed rule required the MLR, but some tribes had already negotiated lower rates. Tribes want the flexibility to negotiate with providers. Programs need the ability to pay a slightly higher rate for certain specialists.

Mr. Montoya also commented on the formula, which was originally established so that California would benefit if there was ever an increase in revenue from the IHS since there are no hospitals. There has not been any money to support increases. In 2012, $100 million was allocated and California received a disproportioned share. Although the formula had been established, there was not sufficient funding to support it. For this reason, California does not want to change the formula. Mr. Pete agreed. Mr. Montoya said California has not benefited from this until recently, but other Areas with hospitals have been receiving additional funds.

Mr. Inder Wadhwa, Executive Director, Northern Valley Indian Health, asked the group to imagine a tribal healthcare program in the middle of nowhere such as Pit River Tribal Health, where there is only one local provider. It is easy to refer to the local provider, but he/she may not accept the MLR so the program must transport the patient elsewhere. There are expenses involved with this for the program and the patient. Mr. Wadhwa commended the workgroup for their work implementing the MLR, but said there must be a flexibility piece. Mr. Wadhwa encourages tribal leaders to spread this message and support the PRC group.

Mr. Pete added that specialists in isolated areas are able to charge whatever they want. Isolated programs were hoping to save PRC funding if the providers were required to charge the MLR.

Ms. Toni Johnson, California IHS Information Technology Specialist/Business Office Coordinator/PRC Officer, is the federal technical advisory representative to the workgroup. She explained that the proposed rule, as it is written, allows providers to opt-out. They are not required to accept the MLR. This puts the tribes in a bind as far as access to care. In addition, the Medicare participating buyers are required to accept

MLR, but there is nothing in the proposed rule about Medicare participation and no oversight from Centers for Medicare & Medicaid Services (CMS). This causes difficulty for tribes and healthcare programs.

Dr. Charles Magruder, California Area IHS Chief Medical Officer, said that although he does not have an opinion on this matter, several clinics that operate in rural or frontier areas have indicated that there are very few specialists to which they can refer their patients. Many of these programs are fearful that this will make matters worse for them. He has also received complaints about Medicare expansion and patients being assigned to different clinics. Many of these clinics get saturated and patients are becoming stuck finding alternative care. This means, the MLR proposal could impact a number of people in rural and frontier areas.

Mr. Montoya commented that many programs are implementing tele-health and telemedicine so this may be a short-term issue. As programs become more technologically advanced, they can negotiate with a specialist in another county or part of California, and negotiate the rate. For example, RSBCIHI negotiated with a provider in Santa Barbara to provide the care via tele-health, within their walls. The future may be to negotiate MLR rates for outpatient and specialty services via tele-health.

IHS Facilities Appropriation Advisory Board (FAAB):

Representatives: Mr. Peter Masten, Jr. and Mr. Michael Garcia (not present)

Mr. Peter Masten, Jr., Tribal Representative, Hoopa Valley Tribe, said the new FAAB was associated with the reauthorization of the Indian Health Care Improvement Act (IHCIA). The FAAB is aware that the construction needs of the agency exceeds $8 billion. They are compiling a report due in March 2016 which includes all of the needs of tribes. For the report, the FAAB has established a sub-committee to develop the criteria for this. The sub-committee will also create the letter that will request updates to the master plans as well as guidelines for implementing the new authorities in the IHCIA. The FAAB is also developing the Board's charter, specifying how it will operate. They will be contacting other committees that have taken similar action. The FAAB has also been discussing facility renovation and expansion. This is specified in the legislation for urban programs, but is not explicitly mentioned for tribal programs. This will need to gain authorization and appropriation. There are many new authorities in the IHCIA, but many require an allocation. Mr. Masten thinks it will be difficult to gather information from tribes before the March 2016 deadline. There will be a Dear Tribal Leader letter requesting the two or three priorities of each tribe distributed in April. Responses will be needed as soon as possible. The draft of the report must be submitted a few months prior to March in order to pass through the IHS approval system before being submitted to the Congressional committees.

The FAAB appointed Mr. Charles Grimm as Board Chairman. There are several FAAB members that have provided advice and recommendations to the IHS for over 15 years.

IHS National Behavioral Health Workgroup (BHWG)

Representatives: Mr. Robert Marquez (not present)

No report.

Tribal Self-Governance Advisory Committee (TSGAC):

Representatives: Mr. Ryan Jackson (not present) and Chairman Robert Smith

No report.

IHS Director's Advisory Workgroup on Tribal Consultation (DAWTC):

Representatives: Chairman Charlie Wright (not present) and Ms. Teresa Sanchez

There have been no meetings.

CMS Tribal-Technical Advisory Group (TTAG)

Representatives: Dr. Mark LeBeau (not present) and Mr. Inder Wadhwa

Dr. Mark LeBeau, PhD, Executive Director, California Rural Indian Health Board, attended the last meeting in February. He also presented during a symposium in February regarding the Medicare expansion and a PRC workgroup update.

The former CMS TTAG Chairperson retired and Chairman Allen from Washington State is the new Chairperson of the group.

Mr. Wadhwa asked about the federal representative for CMS TTAG and Ms. Miller said she will assign someone. Mr. Wadhwa said some Areas have an attorney representing them and suggested the Area Office consider this.

Tribal Leaders' Consultation Conference Agenda Moderator Instructions

Ms. Miller reviewed the agenda for the Annual Tribal Consultation and all members were provided moderator instructions. Youth are the focus of the first morning. Dr. LeBeau will then speak before lunch because he must leave for another meeting after that. Wednesday is devoted to updates from national workgroups and committees. On Thursday, Acting IHS Director McSwain will be present starting at 9:00am.

Mr. Devers asked about a follow-up CATAC meeting and Ms. Miller suggested meeting at 11:30am, following the retiring of the colors on Thursday.

Ms. Miller said there will be a court reporter for the IHS listening sessions so tribal leaders must introduce themselves and identify their tribe prior to speaking.

Mr. Pete asked if names can be added to the YRTC naming ballot and Mr. Coleman said there will be several tribal caucuses wherein names can be discussed.

Review Federal Advisory Committee Act (FACA) for Regional CATAC elections

Mr. Coleman said the CAO will be distributing templates for renewing tribal representatives to all CATAC members. The letters must be updated every other year. This week, each region will elect new members, as applicable, to the CATAC. Following elections to the CATAC, each region must elect representatives for the IHS Area Director Selections Committee. The interviews for the California Area IHS Director will occur on Wednesday with staff travelling from IHS Headquarters.

Mr. Pete asked who screened the applications for the California Area IHS Director position and Mr. Coleman said SES/Human Resources out of IHS Headquarters completed this task some time ago.

Mr. Galleto asked about the number of representatives needed for the committee and Mr. Coleman said two from each region and one urban representative for a total of 9 members on the Selections Committee.

Youth Regional Treatment Centers Update

Mr. Gary Ball, California Area IHS Staff Architect, presented on behalf of CDR Paul Frazier. He said the construction of the southern YRTC is on schedule. The budget was planned for completion during the second quarter of this fiscal year, but the completion date is now in the fourth quarter. Beneficial occupancy is the point when construction is complete and the building is passed onto IHS as the owner. The California Area IHS cannot enter the building until the contractors are finished. Following beneficial occupancy, the California Area IHS must furnish the buildings and install equipment that has been purchased.

Ms. Miller clarified that the $3.2 million for staffing is pro-rated based on beneficial occupancy. This means the California Area IHS will not receive any of this funding until construction is complete and beneficial occupancy occurs. This will affect when the doors can open for operation. The facility will consist of 70 full-time equivalents (FTEs)

at full capacity. There will be a "ramp-up" period with core staff. The California Area IHS does not want to rush this process and wants to ensure quality staff are hired. Mr. Devers asked if Indian preference will be followed when hiring staff for the facilities and Ms. Miller said yes.

Chairman Dixon asked if northern youth could go to the southern facility while the northern one is constructed and Ms. Miller said yes. Both facilities are for all youth, including those from western Arizona and Nevada.

Mr. Wadhwa asked about the total anticipated budget. Ms. Miller said the only budget right now is for staffing and that is for $6.4 million.

Ms. Nelson asked if there is a professional listing of Indians looking for jobs in the medical field. Ms. Miller said the agency uses USA JOBS to advertise positions.

Mr. Pete asked if tribes can submit a formal request for the staffing funding and Mr. Ball said yes. Ms. Miller suggested the tribes mention this to Mr. McSwain on Thursday.

Mr. Devers said the request should be submitted in advance of beneficial occupancy so the money will be available when needed. Ms. Miller suggested the tribes discuss this during their caucus.

Mr. Ball offered the following suggestions for the pond area: a labyrinth path, rope course, or sweat lodge. The rope course is a treatment modality.

Mr. Ball noted that all of the infected trees have been removed from the property, including their stumps which were also infected.

Mr. Montoya commented that although youth from northern California may go to the southern YRTC, the California Area must continue to push for the northern facility. Mr. Ball said $17.1 million has already been approved for design & construction of the northern facility. For the southern facility, design was approved before construction was funds were approved. Jess asked about staffing funding for the northern facility and Mr. Ball said approximately 3 ½ years from now.

Mr. Wadhwa asked about the YRTC Risk Pool once the southern YRTC is in operation. Ms. Miller said that funding would be put back into the YRTCs. Youth would not be sent out of state unless the southern YRTC was full. Mr. Wadhwa asked if that funding could still be used for transportation costs and Ms. Miller said this has not yet been discussed. Mr. Montoya asked if the YRTC Risk Pool funds can be used for youth who cannot stay at the southern YRTC to attend a facility out of state. Ms. Dawn Phillips, California IHS Behavioral Health Consultant commented that she hopes the youth will stay in state. For example, Yuki trails maintains a license and may be able to treat males. She added that current services will not be stopped. Mr. Montoya said the YRTC in the south is not locked down and some youth need that. Ms. Phillips said there are several youth who are sexually deviant and would not be appropriate for California YRTCs.

These youth would be need to be treated out of state and the YRTC Risk Pool could be used for that.

Drought Discussion

Mr. Donald Brafford, California Area IHS Director of the Division of Sanitation Facilities Construction, presented on the drought.

Mr. Devers asked if the well was drilled with mud or air and Mr. Brafford said the well was drilled using air because there is no risk of the well caving in. He said sediment material is usually used to drill, but that was not available due to the drought. Mr. Brafford said there are some variations in the water near fault lines. For example, at Mesa Grande, seismic activity periodically changes the water flow from 50 gallons per minute (GPM) to 5 GPM.

Mr. Montoya asked if the California Area IHS is considering contingencies and Mr. Brafford said yes. It is easy to seal off a zone. He said the water sample is not yet available and is the only way to confirm quality.

Ms. Nelson asked if there is a bill before Congress regarding the drought. She said people with private wells are going to put meters on their wells. Mr. Brafford said the State is moving forward with legislation, but do not have authority over tribal land. Other states do regulate ground water.

Mr. Devers asked about formulating an emergency plan in case anything happens. He does not know if the southern property is large enough for an additional well. Mr. Brafford said, based on current measurements, there are other possibilities, but the water may be too old. There are tests to find out if that water has been there since the 1930s or 1940s. It is important to keep shallow wells ready.

Ms. Nelson asked if you the water is tested when drilling and Mr. Brafford said yes. The water is tested to ensure it is safe.

Mr. Brafford said the area surrounding the southern property is known for problems with iron. Fortunately, no indication of this has been seen during drilling. Usually, iron problems will result in discoloration or an odor.

Ms. Miller agreed to keep the committee updated on this.

Aftercare Discussion

Dr. David Sprenger, California Area IHS Psychiatric/Behavioral Health Consultant, was unable to attend the meeting due to illness. His presentation will be provided to the tribal leaders tomorrow.

Emerging Issues

All were provided a letter dated June 6, 2011 discussing the federal government's position on marijuana.

Chairman Romero commented that he attended the meeting in Washington D.C. with the Department of Justice. They emphasized the meeting was intended to be a consultation rather than approval for tribes to grow and sell marijuana. Marijuana is not legal for recreational use in all states. The Department of Justice suggested that tribes that are jumping ahead and going into business need to consult with a state attorney, the state Department of Health Care Services, and law enforcement. Even though law enforcement cannot prosecute on reservations, tribes need to be careful because the marijuana cannot leave the reservations. Tribes opening dispensaries will find that they invested money in something that they should not be doing. That was a helpful meeting and there will be more meetings going forward. Many tribes do not seem to care about the consequences and are only considering the income. Tribes should get together and have a tribal leaders meeting on this topic and meet with the Attorney General. The Department of Justice also noted that although this administration will not prosecute, the next administration may have a different view on this. This is a hot topic in Indian country right now.

Ms. Phillips added that marijuana requires a great deal of water. Chairman Romero said neighbors are concerned about this so also so there will be a huge effort by local communities to stop this. Mr. Pete said pesticides are used as well. Chairman Romero said tribes need to investigate before moving forward. He advised tribes to look at the whole picture. He realizes tribes want to have a stable economy, but there are other options that are not as controversial.

Ms. Miller thanked everyone in attendance and reminded the group that the Consultation begins tomorrow at 8:00am.

The committee recessed at 4:00pm.

The committee reconvened on March 26, 2015 at 11:35am.

Northern Youth Regional Treatment Center

Chairperson Glenda Nelson motioned to approve the name Sacred Oaks Healing Center for the northern California YRTC, based on discussion during the tribal caucus on March 25, 2015. Mr. Galleto seconded her motion and all approved the name.

Ms. Miller confirmed with the committee that they prefer to focus on the art for the southern YRTC first and then focus on the art for the northern YRTC separately. Ms. Miller agreed to establish a committee for this.

The meeting adjourned at 11:45am.

Additional Tribal members, Indian Health Service staff, and guests in attendance during the CATAC meeting included:

Name	
Elaine Fink	Tribal Chairperson, North Fork Rancheria
Katrina Guitierez	Tribal Council Secretary, North Fork Rancheria
Maryann McGovran	Tribal Council Vice-Chairperson, North Fork Rancheria
Jess Montoya	Chief Executive Officer, Riverside/San Bernardino County Indian Health, Inc.
Rosemary Nelson	Tribal Leaders Diabetes Committee Representative
Virgil Oyos	Vice Chairman, Mesa Grande Band of Mission Indians
Preston Pete	Finance Director, Consolidated Tribal Health Project, Inc.
Mark Romero	Tribal Chairman, Mesa Grande Band of Mission Indians
Cheryl Seidner	Tribal Council, Wiyot Tribe
Robert Smith	Chairman, Pala Band of Mission Indians
Dominica Valencia	Alternate Tribal Leaders Diabetes Committee Representative
Inder Wadhwa	Executive Director, Northern Valley Indian Health
Tonya Walker	Tribal Member, North Fork Rancheria

IHS/CAO staff	
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Donald Brafford	Director, Division of Sanitation Facilities Construction
Preston Dohi	Staff Engineer
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Dawn Phillips	Behavioral Health Consultant
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