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MEMORANDUM

March 1, 2018

TO: Tribal Health Clients

FROM: Hobbs, Straus, Dean & Walker, LLP Geoff Strommer (by TAE)

RE: ***Tribal Leaders Diabetes Committee Meeting February 2018***

On February 21 and 22, 2018, we attended the Tribal Leaders Diabetes Committee (TLDC) meeting in Reno, Nevada. Below we report on several matters discussed at the meeting.

Status of the Special Diabetes Program for Indians

As we previously reported, the Special Diabetes Program for Indians (SDPI) was recently reauthorized and funded through FYs 2018 and 2019 at the mandatory level of $150 million each year. Dr. Ann Bullock, Director, Indian Health Service (IHS) Division of Diabetes Treatment and Prevention (DDTP), reported that the Notice of Grant Awards (NoAs) were sent to the SDPI grantees on January 1, 2018 at the start of the new budget period, which operates on a calendar year basis, along with the first quarter of funding. The NoAs will be amended by April 1 to provide at least the second quarter's funding, and may possibly include the rest of the funding for the year if the IHS receives the SDPI funds by then. She emphasized the IHS would not allow any gaps in SDPI funding to grantees.

The IHS Division of Grants Management has implemented several "expanded" authorities for grantees to rely on for calendar year 2018. These include the authorization to use unobligated carry-over funds without needing to seek the IHS's specific approval, even if the total amount exceeds 25% of the usual annual grant awarded amount. Additionally, grantees now have increased flexibility for using the 2018 funds, including not needing prior approval to make budget changes for program expenses that fall within the grantee's scope of work, though changes to the scope of work still need IHS's approval. The Division of Grants Management has held several webinars and communicated with grantees about these expanded authorities.

Even though SDPI is now funded at the level of $150 million a year for both 2018 and 2019, the IHS Division of Grants Management is leaving these expanded authorities in place throughout 2018. They are also considering extending them into 2019. The Division of Grants Management has received a lot of positive feedback, as the expanded authorities have reduced the burden on the tribal grantees and on the Division's level of approval requests.

For SDPI in 2019, the funds are currently a mandatory appropriation at the $150 million level. However, as we previously reported to you, the Administration's 2019 budget proposes to move SDPI funding and a lot of other funding under the Department of Health and Human Services (HHS) from mandatory to discretionary status. The FY 2019 Administration's proposal recommended $150 million for SDPI in discretionary funding in the Indian Health Service budget, meaning that this funding would come out of the House and Senate Interior Appropriations Subcommittees' allocations. The change from mandatory to discretionary funding would require Congress to amend the law establishing SDPI, and it would also mean an end to multi-year authorizations. Acting IHS Director Rear Admiral (RADM) Michael Weahkee explained that the Administration is putting an emphasis on reducing "big government" and has pitched this proposal as one that would create greater flexibility for the IHS. Although he did not endorse this plan or condemn it, he said there is concern about reducing HHS's mandatory funding in the future and that the appropriators—not the Administration—will be the ones to make a decision. Stacy Bohlen, Chief Executive Officer of the National Indian Health Board (NIHB), promised that NIHB would help tribes advocate before Congress for retaining mandatory SDPI funding, if that is what tribes want.

Relatedly, Ms. Bohlen explained that the Administration's proposed budget for FY 2019 would discontinue funding for Community Health Representatives (CHRs) and health education; eliminate the Low Income Home Energy Assistance Program (LIHEAP) and the Community Services Block Grant (CSBG); make major cuts to the Supplemental Nutrition Assistance Program (SNAP); and make a $10 billion investment in opioid funding at HHS (with a $45 million set-aside for tribes). The narratives that are supposed to explain the Administration's budget proposals were, in Ms. Bohlen's view, very limited and internally contradictory, with very few details about how the budget would be implemented. Tribal leaders, through the February 16, 2018 Tribal Budget Formulation Workgroup meeting, wrote to the Director of the Office of Management and Budget asking for consultation on the budget and emphasizing support for CHRs and health education.

Consultation on SDPI Funding Formula

SDPI is currently in the middle of a five-year grant cycle made up of five budget periods from FYs 2016–2020. The TLDC decided to recommend that the IHS Director hold a tribal consultation on the allocation of the $150 million in funding for FY 2019. They do not plan to request consultation for the 2018 funding, which has already been allocated in part to grantees, in order to avoid any potential delays in distributing the remaining funding for 2018. TLDC members stated that they generally support continuing the $130 million per year to grantees as well as the $8.5 million to urban Indian programs in 2019 but that they would like consultation to discuss potentially restructuring the distribution and use of the remaining $11.5 million, in order to move more of the funding directly into helping people with diabetes. The funds have been divided as follows:

- $130 million to tribal grantees
- $8.5 million to urban Indian programs

- $11.5 million to IHS—of this, $5.2 million is for data infrastructure/information technology (the $5.2 million includes $2.6 million for National Office of Information Technology, $2 million divided among the 12 IHS Area Information Technology programs (proportional to the number of grantees in the Areas), and $600,000 for the IHS Division of Diabetes to conduct audit and diabetes prevalence work around data), and some funding is used to support IHS's administration of the SDPI grant program.

The TLDC raised a number of questions for the IHS about its the use of the $5.2 million, slated for use for data infrastructure and information technology. Dr. Bullock promised to obtain more information from Captain Mark Rives, Director of the IHS Office of Information Technology, to see how the IHS might be able to use those funds to increase the SDPI grantees' access to information technology assistance.

Issues for the consultation will thus include gaining a better understanding of what the IHS's portion of the SDPI funding is buying the tribal diabetes programs and whether any of the $5.2 million in data funding could be transferred to or shared with the grantees. The TLDC will work together over the next few weeks to develop potential questions that could be sent to the IHS Acting Director for the consultation. The TLDC will be requesting that the Acting Director hold Area meetings, which will help facilitate gathering information from each of the Areas about how they are spending the funding they receive out of the SDPI allocation for information technology.

Presentation By The Acting Director of IHS

RADM Weahkee spoke with the TLDC about the new priorities of HHS Secretary Alex Azar, which include lowering drug prices, making health care more affordable and available, improving health outcomes, and ending the opioid epidemic. Regarding the IHS's own strategic plan, the IHS received over 135 separate comments and plans to finalize a complete draft within the next few days. He said the IHS would like to add more steps for meaningful tribal input, so the agency will have a 30-day comment period and will hold tribal leader and urban program teleconferences, with the goal of finalizing the plan by sometime in April 2018.

In addition to his comments about the Administration's proposal to shift SDPI funding from mandatory to discretionary, RADM Weahkee also raised the Administration's proposal to discontinue funding for CHRs and health education. He said the IHS is currently gathering data to justify the continuation of both programs so that Congress will have a better understanding of how critical they both are to health status in Indian country. He said the IHS is also looking globally at the effective use of funds for all IHS programs, to avoid the situation of not being able to justify any single IHS or tribal program.

Update From IHS DDTP

The DDTP has several new diabetes education tools that can be accessed through its website at https://www.ihs.gov/diabetes/. These include tip sheets and patient education

materials, primers on case management as related to best practices, and outlines of diabetes education lesson plans. Patients can also go online at that same website to request a copy of the book called "Using Our Wit and Wisdom to Live Well With Diabetes," written by Barbara Mora (Paiute/Diné).

Dr. Bullock announced that DDTP has hired a new staff member named Dr. Lani Desaulniers, who is a long-time IHS physician who recently retired from the IHS. She is now part of the DDTP contract staff and will work primarily on diabetes and pregnancy.

Dr. Bullock also spoke about the Diabetes in Indian Country Conference held last September in Albuquerque, New Mexico. The highlights of the conference, as well as selected presentation slides and recordings, are available on the DDTP's website. Dr. Bullock said that the conference was much in demand and that not everyone who wanted to attend could go, given the space constraints of the venue for the conference. Many people participated online, for a total of around 950 participants. DDTP is tentatively planning to host another diabetes conference in the spring or summer of 2019, and Dr. Bullock stated they will ensure that the space is suitable for accommodating everyone who would like to attend.

Centers for Medicare and Medicaid Services (CMS) Diabetes Prevention Programs

In November 2017, CMS issued a final rule implementing the Medicare Diabetes Prevention Program (MDPP), which nationally expanded the CMS Innovation Center Diabetes Program, and which involves health professionals and community health workers who provide prevention services to individuals at risk of developing Type 2 diabetes. The MDPP, which is administered by the CMS Innovations Center, follows the curriculum approved by the Centers for Disease Control and includes weight loss goals to be met by the participants. The program covers up to two years of sessions for eligible beneficiaries, without any co-payments. CMS enrolls the MDPP suppliers, such as physicians and hospitals, tracks the compliance of the program, and ensures the eligibility of the beneficiaries. Tribes have previously objected to the lack of consultation in designing the MDPP, the low payment available under the program, and the use of culturally insensitive mandatory weight-loss benchmarks. We have attached a tribal template letter to CMS regarding MDPP implementation. The letter is based off a NIHB letter voicing tribal concerns over accreditation requirements and lack of consultation, and it requests that CMS grandfather in SDPI Diabetes Prevention programs so that they may bill for services under Medicare Part B.

The Division of Quality, Evaluation and Health Outcomes (DQEHO) at the Center for Medicaid and CHIP Services (CMCS), implements another CMS program that works with states to improve delivery of preventive services through Medicaid. Dr. Dierdra Stockmann of the DQEHO mentioned that diabetes prevention services can be covered by Medicaid as an optional service for adults, such as screening for elevated blood glucose levels and other risk factors, diet or nutritional counseling, physician activity counseling and medication. Medicaid covers medical services—not programs—and states have flexibility in how they wish to design and

implement the benefits, including determining who can provide and bill for the services and how the services would be delivered.

TLDC Charter

The TLDC is revisiting its Charter, in part to consider whether it is possible and desirable to add additional technical advisors. The IHS does use a portion of the SDPI funding it receives to pay for NIHB assistance with setting up and administering the TLDC meetings, and it also provides some travel expenses for the technical advisors. Another question to be resolved is whether members of the TLDC can participate and vote by teleconference, or if they or their alternates must be present in person in order to vote. Dr. Bullock and NIHB will assist with providing the TLDC proposed revisions to the Charter, for their consideration at the next meeting, and Dr. Bullock also promised to outline the procedural steps required to change the Charter.

The TLDC also briefly discussed its inability to send positional letters to agencies, other than writing letters to IHS Acting Director Weahkee. Dr. Bullock promised to gather additional information about the TLDC's exemption from the Federal Advisory Committee Act and the federal guidelines under which the TLDC operates. She will present that information to the TLDC at its next regular meeting.

Conclusion and Next TLDC Meeting

The TLDC will hold its next regular teleconference on March 21st at 4pm Eastern. They are also having a virtual meeting on March 23rd at 3pm Eastern time to discuss the potential questions for the tribal consultation on the FY 2019 SDPI funding allocation. The next regular, in-person meeting of the TLDC is to be held in conjunction with the NIHB Public Health Summit in Prior Lake, Minnesota on May 21–22, 2018. For additional information, please contact Geoff Strommer (gstrommer@hobbsstraus.com or 503-242-1745) or Akilah Kinnison (akinnison@hobbsstraus.com or 202-822-8282).