

**Department of Health and Human Services
Secretary's Tribal Advisory Committee Meeting**

June 5-6, 2013 – Washington, DC

Summary Report

The Secretary's Tribal Advisory Committee (STAC) Meeting was held on June 5-6, 2013, in Washington, DC. The meeting provided an opportunity for the STAC to converse in-person; hear updates on the Department of Health and Human Services (HHS) budget, Tribal consultation, human service issues, Indian Health Service (IHS), Tribal State relations, Affordable Care Act (ACA), and Intradepartmental Council on Native American Affairs (ICNAA); and learn about staff and operating divisions' work on American Indian and Alaska Native (AI/AN) issues and initiatives. The STAC also prepared for a discussion on its priorities with HHS Secretary Kathleen Sebelius; met with the Secretary; and addressed its business items. Throughout the meeting, the STAC was afforded numerous opportunities to engage with HHS leadership, program staff, and agency officials. The meeting was facilitated by the STAC's Chairman, Gary Hayes.

Members Present: Gary Hayes, Ken Lucero, Aaron Payment, Steve Cadue, Roger Trudell, Cathy Abramson, Tracy King, Larry Curley, Arlan Melendez, Cheryle Kennedy, and Chester Antone. (Quorum Met)

Action Items:

1. Norris Cochran agreed to give his presentation to Stacey Ecoffey for distribution among the STAC.
2. Cheryle Kennedy agreed to provide Dr. Yvette Roubideaux with information on how her area's Federally Qualified Health Center (FQHC) rate compares to the patient all-inclusive rate. In return, Dr. Roubideaux agreed to surface challenges with the agreement when she meets with the U.S. Department of Veterans Affairs (VA) on the contract health service issue.
3. Per Arlan Melendez's request, Lisa Wilson agreed to work with the Navigator team to pull together data on how Tribes fared in the Navigator application process.
4. Gary Hayes asked that Lisa Wilson email Stacey Ecoffey regarding what each state is doing with Tribes regarding outreach, education, and enrollment.
5. Per Ken Lucero's request, Mayra Alvarez agreed to provide a list of resources that Tribes are eligible for related to the Affordable Care Act (ACA) and the Marketplaces.
6. Per Cheryle Kennedy's request, Donna Cohen Ross agreed to follow-up with Cindy Mann to get information on the "Arkansas model" and whether other states are following it.

7. Per Cheryle Kennedy's request, George Sheldon agreed to find out who is in charge at the U.S. Department of Justice (DOJ) concerning civil rights authority related to the Indian Child Welfare Act (ICWA).
8. Bryan Samuels agreed to look into IV-E plans submitted by Tribes that have been rewritten without their consent, provided that Robert McGee gives him specifics.
9. Per Aaron Payment's request, Kim Romine agreed to post a version of the Grants Eligibility Matrix as a PDF online.
10. Per Cheryle Kennedy's request, Dr. Roubideaux agreed to make the Report on Self-Governance available at the Indian Health Service (IHS) Self-Governance meeting.
11. Per Commissioner Sparks' request, the STAC agreed to provide feedback on the Intradepartmental Council on Native American Affairs' (ICNAA) new data priority.
12. Per Ron Allen's request, Cynthia LaCounte agreed to provide a copy of the conference report from last year's annual National Title VI Training and Technical Assistance Forum.
13. Per Ron Allen's request, Mary Wakefield agreed to provide the exact dollars going to Tribes for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program.
14. Gary Hayes and Ron Lucero requested a letter from the Substance Abuse and Mental Health Services Administration (SAMHSA), to be given to the National Indian Health Board (NIHB) for distribution throughout Indian Country, which can be used to garner support for the Behavioral Health - Tribal Prevention Grant.
15. Per Chester Antone's request, Lawrence Tabak agreed to provide a copy of the National Institutes of Health's proposed draft policy updating the Genome-Wide Association Data Sharing Policy.
16. Ken Lucero agreed to provide Paul Dioguardi with communiqués that require a response from the Center for Consumer Information and Insurance Oversight (CCIIO).
17. Paul Dioguardi will follow-up on the issue of Tribal Epi Centers having difficulty getting data from states, upon delivery of information on specific states from Cathy Abramson.
18. Secretary Sebelius agreed to review the recommendations on self-governance received from the Self-Governance Workgroup in order to be prepared to discuss next steps. She also agreed to take the messages about mental health and economic development forward.
19. Roger Trudell agreed to provide Commissioner Sparks with a nomination from Region 7 for the Administration for Children and Families (ACF) Assistant Secretary's Tribal Advisory Committee (ASTAC).
20. Dr. Nadine Gracia requested that Stacey Ecoffey follow-up with the Centers for Medicare & Medicaid Services (CMS) on Ken Lucero's question about if Tribes and Tribal organizations are being included in discussions about evaluating the effectiveness of Marketplace outreach activities.
21. STAC members interested in joining the Tribal State Workgroup and/or the ACA Workgroup agreed to email Stacey Ecoffey about their interest.
22. Lisa Wilson agreed to take Ken Lucero's concern about Tribes being at a disadvantage in New Mexico because of the state's improbability of forward-funding outreach activities related to the Marketplace back to the Navigator team to see if technical assistance can be provided.
23. Per Chester Antone's request, Lisa Wilson agreed to provide information on the eligibility process for Qualified Health Plans (QHPs) in Arizona.

24. Lisa Wilson agreed to take back Larry Curley's comment/request about the Navajo Nation being considered a state for the purpose of the Navigator program.
25. Per Ron Allen's suggestion, Stacey Ecoffey agreed to consider recording issues raised during the quarterly ACA outreach calls for tracking purposes.
26. Donna Cohen Ross agreed to take back Ron Allen's question about what will be done to expand coverage for Tribal members that are eligible for Medicaid expansion but live in states that are not going to expand Medicaid.
27. Per George Sheldon's direction, Commissioner Sparks agreed to provide information on the government-wide Victims Plan for Human Trafficking to the STAC.
28. Secretary Sebelius agreed to follow-up on Chester Antone's concern about who should do certification and licensure of non-638 facilities on Tribal lands. [Councilman Antone requested that Arizona Health Care Cost Containment System (AHCCCS) reimbursements be continued until they can come up with something everyone can agree with.]
29. Dr. Roubideaux agreed to distribute IHS' ACA Business Plan Template to the STAC.

DAY 1

(June 5, 2013)

Welcome and Meeting Logistics

The first day of the meeting began with STAC Chairman Gary Hayes welcoming the group and inviting Chester Antone, Council Member, Tohono O'odham Nation, to give the opening invocation. After the blessing, Chairman Hayes proceeded to call the roll. The following STAC members were identified as present: Gary Hayes, Ken Lucero, Aaron Payment, Steve Cadue, Roger Trudell, Cathy Abramson, Tracy King, Larry Curley, Arlan Melendez, Cheryle Kennedy, and Chester Antone. The quorum was met.

Paul Dioguardi, Director, Office of Intergovernmental and External Affairs (IEA), welcomed the new and returning committee members and thanked them for their attendance. He commented that major milestones were forthcoming, noting specifically that October 1, 2013, will begin the open enrollment period for the newly expanded health care coverage. He indicated that issues raised during the HHS Regional Tribal Consultations would be discussed; and he reminded the group that Secretary Sebelius would join them the following day. Following Mr. Dioguardi's remarks, Chairman Hayes also acknowledged the new STAC members (Aaron Payment, Tracy King, Arlan Melendez, and Steve Cadue), asking them to provide brief self-introductions.

Before moving to the next agenda item, Chairman Hayes announced that the next two STAC meetings will occur on September 17-18; and December 5-6, 2013.

HHS Budget Updates

The Office of Budget's Norris Cochran provided the STAC with updates on the HHS budget, commenting on fiscal years 2013-2015:

FY 2013 – The sequester is in place. A Continuing Resolution (CR) will be in effect through the end of the year, which includes a 0.2% cut across the board for all discretionary budgets (inclusive of IHS). Congress did, however, provide additional funding for staffing of new and replacement facilities. The net loss to IHS is 3% or \$165 million below last year's budget. Operating plans, showing spending levels by program activity, are on the internet and hard copies can be made available. ACF's release of the final funds for the Low Income Home Energy Assistance Program (LIHEAP) is June 5, 2013.

FY 2014 – The President submitted his FY 2014 budget request and remains hopeful that Congress will enact it. The IHS budget is a priority, with the \$5.7 billion discretionary request representing \$400 million over the final 2013 level. Budget discussions are tenuous, as the revenues for the Federal Government have improved, but a large deficit still looms; and the House and Senate differ on their approaches to fix the budget. Namely, the Senate is agreeing with the perspective of the Administration in saying that the sequester is the wrong way to fix the budget and a return to pre-sequester spending levels, the passage of appropriations bills at those higher caps, and generation of revenue increases and targeted reductions are what's needed. The House, conversely, wants to write spending bills at the lower spending caps that assume the sequester doesn't go away. For the bill that funds the IHS, the House is almost 20% below the FY 2013 level, before the sequester. For the bill that funds most of the rest of HHS's budget, they are over 20% below the FY 2013 level, pre-sequester. The Administration has announced that the President will veto spending bills at the lower levels until the Administration and Congress work out a bigger budget deal. The pressure to reach a deal has seemingly dissipated as revenues increased and the deadline for the debt limit has drifted out. It is likely that there will be another CR at the beginning of the next fiscal year.

FY 2015 – The operating divisions are coming up with budgets for FY 2015, but it is unclear from what base they should be operating in order to submit a budget to Congress in February. The Office of Management and Budget's (OMB) guidance is for them to submit budgets 5% below what was assumed for FY 2015 in the 2014 budget. OMB also asked for budgets at 10% below the earlier assumptions.

Other items of note included the launching of the Marketplaces with enrollment beginning October 1, 2013, and services beginning on January 1, 2014; and progress with the VA on the provision in the ACA to ensure veterans served by IHS get the reimbursement that is appropriate.

Following Mr. Cochran's presentation, the floor was opened for questions. Comments, questions, and answers are denoted below and throughout the document by "C," "Q," and "A," respectively.

Q: (Steve Cadue) Can we talk with you over the next couple of days?

A: (Norris Cochran) Yes.

Q: (Gary Hayes) In terms of the FY 2014 budget proposal and the hit IHS took, you are saying \$400 million. Many Tribes have been asking their congressional delegation to bring back the loss due to sequestration. It was \$217 million that was taken. If you minus that, from looking at

FY 2014, it's about a \$283 million increase for IHS. This Administration has done well, but we need to emphasize that the health care of our people is a priority. The cuts of FY 2013 contradict us being a priority. It's like we take a step forward and then take another back. We know the disparities we have in health care. During the Tribal caucus this morning, we noted this as a concern. You mentioned you are working with IHS to try to offset some of these reductions. How are you doing that?

A: (Norris Cochran) The \$400 million increase, you are right, it's relative to the lower level in 2013. The budget is very tight and we have numerous operating divisions that have the totals going down by quite a bit. We don't have a lot of great options. We have made some pretty substantial cuts elsewhere within HHS in order to increase the IHS budget. I will take your observation as encouragement that we shouldn't give up, that we should try to do more. In terms of how we are helping for 2013, it's really figuring out how to manage at those lower levels. We are trying to understand what flexibilities IHS has under the law to make adjustments. There is not a lot of flexibility because of the way the sequester is designed to rebalance the budget.

Q: (Gary Hayes) How are you supplementing and trying to help with funding services that IHS is cutting? It's not fair, as other help programs were exempted from sequestration. The cuts impact our programs. We now have to do "less with less." I'm hoping that IHS can be exempt from sequestration, but Congress will have to act on that. If not, what is HHS going to do to help, whether through regulations or something else? Maybe there are some administrative policies that can help us overcome these hurdles.

A: (Norris Cochran) We will continue to look at this. I hadn't really thought about regulations.

C: (Aaron Payment) It must be incredibly frustrating to have to come in front of us to say, "We are doing the best we can, but we know we are not really scratching the surface." We are actually going backwards. I'm here as a team member, to help you make the right message and make the right impact when talking to Congress. We have a treaty obligation; we prepaid for everything we are getting. It's not charity; it's not reparations; it's not for all of the atrocities that have been done to our people, although there have been a lot of horrible things done that the government should make up for. The reason we have funding is because we negotiated it. The treaties go into perpetuity. In my Tribe's case, 68% of our members don't live in the service area. They get nothing from IHS. So, be prepared for us to be critical; but we stand ready to help you. We have the worst statistics on everything: suicide, alcoholism, diabetes, heart trouble, and morbidity. Please advise us appropriately so we can help you.

C: (Ron Allen) [Cheryle Kennedy yielded her seat.] You probably have seen correspondence that has asked the Secretary and the President to exempt Indian programs. Congress and the President have agreed to exempt Social Security, Medicare, and Medicaid. Medicaid is for the underserved. We fit into that category. We think we have a compelling argument for being exempt. We have unmet needs that we serve in our communities. We ask that you and the Secretary say to the President, "As you negotiate with Congress, even if it has to be a CR, that you help to serve Indian people." [Seat returned to Cheryle Kennedy.]

C: (Steve Cadue) In yesterday's Washington Post, it said Secretary Sebelius and President Obama met with a national mental health group. The Washington Post said that the highest suicide rate in the population is with the Native American people. It is a real problem. Several years ago Dr. Roubideaux spoke about the crisis in Indian Country. Native Americans have the greatest need in terms of health care. Native Americans will die 7 years before others. In order to make a difference we must be heard. With your help we hope to make a difference.

C: (Gary Hayes) As Tribal leaders, it's our responsibility to continue speaking for our people; please don't take it personally.

C: (Cheryle Kennedy) A priority of the STAC is to eliminate health disparities among Native Americans; we are going the other way. The Secretary needs to look at this. The IHS and Bureau of Indian Affairs (BIA) funding needs to be considered as we look for solutions in terms of overcoming the budget issues. Also, in the scientific arena, we know data is what people look at. Many data sets have been dropped from the way that Tribes and the IHS collect data. In the old days systems had to be set up manually to collect information on level of need funding and unfunded needs, and calculating contract support deficits. Those things are no longer intact. There are major data deficits that would help tell our story.

C: (Norris Cochran) Absolutely, you should be critical; I don't take it personally. It's productive for us to hear your realities and I encourage you to continue to advocate your position. We know we are talking about real people and lives are being cut short. We will take your message back to OMB and talk about what can be done.

C: (Tracy King) We are billing the VA, but the money isn't coming over yet to pay for those services. IHS facilities depend on third party billing and sequestration may impact that. As far as psychotropic meds go, the Children's Bureau's regulations will basically have judges being psychiatrists (in terms of the decisions they make) when kids in foster care go to court. I have a problem with that. Kids are being kicked out of school if they don't go on Ritalin. Superintendents and principals should not be acting like psychiatrists. Schools off the reservation often don't understand Indians. Our kids are traumatized in that system. BIA social services are more of a detriment when it comes to helping our kids in the system.

C: (Chester Antone) The ability to use HHS grants flexibly, specific to your area, is key. If we have a code to allow or disallow costs, that should be reviewed because we could get rid of a lot of wastes. Food costs, if there is no other establishment in the area, it's not allowed. In our area it takes 80 miles to get to the grocery store. Those regulations don't work for Tribes. You need to look at things [in a way that is] culturally specific. If you relax those regulations you might reduce costs and give Tribes more flexibility to formulate grants according to their need; that was one of the key things about 638. The question of Tribal sovereignty needs to be key when it comes to grants, because in there lies cultural specificity. Head Start should be priority; it engulfs the Tribal Development Fund. Our schools systems have to comply in order to bring on children. When it comes to Tribal waivers, Tribal sovereignty has to be considered.

Q: (Roger Trudell) If there is a CR for 2014, do you have to go back to the last year where there was an actual budget for your base?

A: (Norris Cochran) Typically, yes. If it was a “clean” CR, it would just continue the prior year’s spending rate. They might put in a percentage that goes up or down, and/or they could say “You can spend no more than you did for this period last year.” Either way, Congress will have to deal with the sequester; will the 2014 CR assume this lower level we are now under and assume the lower caps that the House intends to write spending bills to, or will it bounce back up to the pre-sequester levels?

Q: (Roger Trudell) What is worst case, percentage wise?

A: (Norris Cochran) I would hope that the worst case scenario would have us flat with the 2013 level that includes the sequester.

C: (Roger Trudell) I’ve heard that we could be 18% less than where we are now. That would have a critical impact. Regarding veterans, I come from an area where there is a lot of concern about the treatment of veterans at IHS facilities. One of our Tribes was co-paying the VA and now the VA won’t accept their co-pay. I don’t understand it. If we are looking at the VA assisting the IHS with its budget shortfall, there will have to be better treatment for veterans at IHS facilities before they will go back there. Youth mental wellness is a concern in the Great Plains. I’m beginning to understand how historical trauma could have an impact on our young people, as they are going through an identity crisis. Right now there are not enough dollars to do an effective job on mental wellness for our youth. Somebody is going to have to put money in to address the mental health issues of our young people, so they can be healthy.

Q: (Cathy Abramson) How will what we’ve said here help us? I know your office deals with the budget, the numbers.

A: (Norris Cochran) It depends on what we are trying to accomplish. Washington, D.C., in general, has a short attention span. Part of your job is to continually remind us and others of the real consequences of our decisions. In terms of things like the VA, it’s important for us to be aware when something that we think is starting to come together isn’t, e.g., if no reimbursements are coming. With regard to making decisions within totals, taking Chairman Trudell’s description of youth suicide, it’s important for us when we go through our process. Sometimes we have opportunities to think across our funding divisions in terms of working together. So knowing your priorities and your pressure points is helpful to us.

A: (Yvette Roubideaux) It really does make a difference. It’s a fight to get to where we end up in the President’s budget. Your input helps because we take your priorities and use them in our arguments. We hear you when you say this is a crisis.

C: (Gary Hayes) It’s good to hear information from the source, so thank you.

Mr. Cochran agreed to give his presentation to Stacey Ecoffey for distribution among the STAC.

Indian Health Service Issue Discussion

Dr. Yvette Roubideaux, Director, IHS, served as the presenter for the *Indian Health Service Issue Discussion* session. She first explained that her term as the IHS Director ended on May 6, 2013, and she has been nominated for a second term. On May 7, 2013, she said she received a memo from the President directing her to continue working; the Senate will consider her nomination the following week. She expressed her frustration regarding the sequestration, saying she will continue to “fight the fight.” Among her highlights included the following items:

- IHS received its final apportionment from OMB to get the money out to all areas and service units, but it included cuts for the sequester.
- The final budget numbers for FY 2013 are on the IHS website.
- IHS is trying to minimize the local impact [of the budget cuts]; and Tribes desire to be exempt from the cuts is under discussion.
- Increases in FY 2014 for IHS are proposed for contract health service, staffing, contract support costs, and facilities.
- Regarding the appropriations language change for contract support costs, IHS is open to consultation to bring the issue to resolution.
- Tribal budget recommendations for FY 2015 are in and the internal budget process is underway.
- Upcoming plans include attending the NIHB Public Health Summit the week of the 17th; turning a lot of meetings into webinars; and possibly having a virtual Tribal consultation summit in the summer.
- Contract support costs (CSC) is a big issue and Tribes will be updated on past claims and appropriations soon. IHS is working to settle claims as quickly as possible.
- The first payment was received on the federal side for the VA reimbursement agreement; the next step on the federal side is to complete all of the implementation plans on all of the federal sites, send them to the VA and wait for the VA to sign them, and then bill the entire system. Tribal programs have been working on agreements directly with the VA; there is still a need to talk about contract health services (CHS) with the VA, as the reimbursement agreement is just for direct service.
- Improving patient care (IPC)/patient-centered medical home is becoming a bigger thing in the U.S. health care system and the IHS system. There are 127 IHS sites that are doing IPC and IHS is hoping to expand it to everybody.

Dr. Roubideaux ended her presentation by telling the Tribal leaders that by working together she believes they can “get back on track,” and she said a primary goal is to get more resources for IHS.

Q: (Roger Trudell) Can you expand on the VA agreement; is it being phased in?

A: (Yvette Roubideaux) My idea was the first phase was to get the first 10 sites up. After that, I’ve encouraged all my sites to sign the plan, send it to the VA, and bug them to get it going. The VA was worried that it would take a long time, but it hasn’t. I would encourage you to push them to sign the Implementation Plan, so you can start billing. The basic reimbursement

agreement says if the veteran is eligible for both VA and IHS and walks into an IHS facility and gets direct care, then the VA is supposed to reimburse for that. The challenge is when we have VA providers in IHS facilities then there needs to be a different arrangement.

Q: (Roger Trudell) What about medications, will IHS keep a short-term supply on hand?

A: (Yvette Roubideaux) Yes. The IHS will always have a pharmacy. The goal of the VA reimbursement agreement is to basically get everyone enrolled with the mail order pharmacy and the VA will take care of those medications for veterans that come to IHS. They will pay us for the first 30 days, while we get that in place.

Q: (Gary Hayes) So we can get meds filled at our clinics?

A: (Yvette Roubideaux) Right. You would give your prescription to the IHS pharmacy and then the VA pays us for the first thirty days, and then you get enrolled in the mail order pharmacy. Then you just call to get your refills.

C: (Roger Trudell) You are supposed to allow 7 to 10 days for the mail order, but my understanding is sometimes the order takes longer than that to arrive and you could be without medicine for a few days. I thought the IHS was going to have similar medications for veterans to fill in those gaps.

C: (Yvette Roubideaux) IHS and VA pretty much have the same formularies; they should be able to fill in those gaps. If not, it's something to talk to the local CEO and pharmacy about, and the area director, to make sure we are getting that medicine that is not available nationally to you.

C: (Cheryle Kennedy) There was a letter sent on May 31st from the Northwest Portland Area Indian Health Board (NPAIHB) regarding continued support for the Domestic Violence Prevention Initiative. The other piece of it was for the Methamphetamine and Suicide Prevention Initiative. I just wanted to acknowledge that. You have our comments. We signed our agreement with the VA on June 3rd. Our only distress about it was that the team that worked on it wanted IHS to help more with the FQHC rate versus the rate we ended up with. You mentioned there may be a second round where the FQHC rate will be looked at with a better view. I know they are negotiated and will vary because of the formula process, but it does represent what it takes to treat a patient. We were a little distressed that that didn't come forward. In Alaska they were able to apply their FQHC rate different from the lower 48 [states]. Maybe Tribes who haven't applied will be more successful than we were in getting that rate.

C: (Yvette Roubideaux) If you could give me more information on how the FQHC rate compares to the patient all-inclusive rate for you, that would be appreciated. It seems that in some areas the FQHC rate is better and in some areas it is not. We decided on the all-inclusive rate based on overall Tribal input. We are hoping the VA will be willing to negotiate differences. We will go back to the VA on the contact health service issue soon, so I can bring up challenges we are experiencing with the agreement.

C: (Cheryle Kennedy) We'll get the difference to you.

Q: (Ken Lucero) Where is the money for settlements for contract support costs coming out of? Is IHS creating a new line item that is separate from other IHS allocations? I don't want to see resources meant for direct services reallocated to pay for contract support costs, for which we don't participate.

A: (Yvette Roubideaux) That's a good observation about the money going for settlement. People wonder why the Administration supports the appropriations cap that Congress has set for contract support costs. The appropriations cap says we'll fund CSC up to the amount that is in the final budget. That protects the rest of our budget from being used for CSC. Right now, it's not an issue. It's particularly not an issue in the settlements. The cap is in place; and most of the claims that Tribes are filing are under the Contracts Disputes Act. Once we settle on a number and a judge agrees, the DOJ will authorize payment to the Judgment fund—which is a separate fund of money that is available for settlements. Every month we get a bill from the Judgment fund that we file in a drawer, because we don't have the money to pay it. We are hopeful that no one will ever make us pay it, but you never know.

C: (Ron Allen) [Cheryle Kennedy yielded her seat.] CSC has a direct line item for the contracts and the compacts and we want to make sure the approximately \$160 to \$180 million shortfall is added to the budget and doesn't reduce services. Also, one of the problems with the CR process is if you have a project that requires full funding, like a new clinic, you can't do it under a CR. You can't issue a contract if you don't have the resources to carry it forward. [Seat returned to Cheryle Kennedy.]

Affordable Care Act Update

Co-presenters for the Affordable Care Act Update session included Mayra Alvarez, Director of Public Health Policy, Office of Health Reform; Donna Cohen Ross, Center for Medicaid and Children's Health Insurance Program (CHIP) Services; Lisa Wilson, Senior Policy Advisor, CCIIO/CMS; and Dr. Roubideaux. Ms. Alvarez began the presentation, providing an update on the implementation of the ACA. She reminded the group that the ACA is intended to do away with the worst insurance company abuses; make health insurance more affordable for all Americans; strengthen the Medicare program; and improve access to care and options for coverage. Highlights of her remarks included the following:

- End of April announcement that the application for health coverage in the health insurance Marketplace has been simplified and significantly shortened.
- March announcement that 6.3 million people with Medicare saved over \$6 billion dollars on prescription drugs.
- May announcement about a \$1 billion initiative out of the Center for Medicare & Medicaid Innovation to fund awards and evaluation for projects to transform the health care system by delivering better care and lower costs.
- March announcement update that about 71 million people with private insurance today have access to free preventive services.
- In 4 months there will be a health insurance Marketplace in every state.
- The Administration is focusing on outreach, education, and eventually enrollment in the Marketplaces.

- Later in June a call center for the Marketplace will be launched.
- Re-launch of the healthcare.gov website will occur in late June.
- Work continues with the IHS and the Office of External Affairs to ensure people are informed of the Marketplace and the basic concepts of health insurance.
- An announcement for opportunities to train people to be part of the In-person Assistance program will occur later in the summer. (\$150 million will be available for community health centers.)

Ms. Ross updated the group on a set of outreach grants awarded in April 2010, under Children's Health Insurance Program Reauthorization Act (CHIPRA). She noted that \$100 million was set aside for outreach and enrollment activities aimed at reaching out to children who were eligible for Medicaid and CHIP, but not enrolled. The awards were divided: \$10 million for national outreach activities; and \$90 million for grants to states and local communities, of which \$10 million was put aside for AI/AN grantees. Forty-one AI/AN grantees were allocated \$9.9 million for 3-year grants that ranged from \$90,000 to \$300,000. Data from 35 grantees' reports indicate that 14,250 children were enrolled or had their enrollment renewed because of the grant (reflecting participation rates pre- and since the grants of 68.4% and 74%, respectively). Ms. Ross said another round of grants will be available in the fall, with \$4 million coming from the ACA to focus on school-based outreach and enrollment, and building application assistance opportunities in local communities. Finally, she stated that recruitment for grant reviewers will begin in the fall; and she said guidance to State Medicaid Agencies on facilitating enrollment in Medicaid and CHIP (offering 5 strategies to facilitate enrollment) was released on May 17, 2013.

Ms. Wilson told the group that 1.1 million AI/ANs are covered by Medicaid and CHIP and she reminded them that the Marketplaces will be available as of January 1, 2014—giving individuals and small employers a place to compare plans for quality, affordable, health care insurance. She noted the following items:

- QHPs will be sold and run by private companies and will offer essential health benefits. Application submissions began in April and over 120 issuers have applied to be a part of the Marketplace.
- Help to consumers will be available online, via call centers, through Navigators, and via other mechanisms.
- Twenty-four states have been conditionally approved to run or partially run their own Marketplace. (In 2015 and annually, states can apply to operate or partner with the Federal Government to operate a Marketplace.)
- The single streamlined application was finalized in April 2013. Online applicants will get eligibility determinations almost immediately, including tax credit information.
- Open enrollment into the Marketplaces will begin in October 2013, with coverage starting January 1, 2014.
- In late March a Notice of Proposed Rulemaking was published concerning training, certification, conflict of interest, and others things related to Navigators and will be finalized soon.
- Last month a funding opportunity announcement was issued for \$54 million to fund Navigators in Federally-Facilitated Marketplace (FFM) and partnership states. The applications are due June 7, 2013.

Dr. Roubideaux wrapped up the presentation, stating that IHS's focus is on implementation at its facilities and the ability to help enroll its patients and educate them. She said a business plan template was sent to all Tribal and Urban IHS sites that contained suggestions on what to do to prepare for enrollment, Medicaid expansion, and the Marketplace, as well as information on the availability of insurance. She also said they are working on a checklist for local facilities contracting with QHPs to use, in addition to the ITU Addendum. Finally, she said training for IHS staff is forthcoming; the IHS Annual Partnership Meeting will be in August 2013 (tentatively); and hopes to have more information then. NIHB's Public Health Summit will include an all-day training on the ACA on June 20, 2013; National Congress of American Indians (NCAI) will have a training that is focused on Tribal employers on June 24, 2013; based on the CHS workgroup recommendations the distribution formula is not going to change; the draft Urban Confer Policy will hopefully be out soon; and comments are coming in on the Sexual Assault Policy.

Q: (Ron Allen) [Cheryle Kennedy yielded her seat.] The IHS data system is the most accurate and it's my understanding that there is a way to access it and retain the confidentiality factors that are important to this process. Is that dialogue being engaged? What direction are you going? You don't need to recreate the wheel when it comes to identifying AI/ANs. There are a number of our people that aren't identified in the IHS system; the system can be built on to include them. [Seat returned to Cheryle Kennedy.]

A: (Lisa Wilson) We've examined the data set from IHS and we actually don't think it contains the elements that are necessary to determine AI/AN status for the purposes of the ACA.

C: (Yvette Roubideaux) The challenge is related to the definition of Indian issue. IHS doesn't gather "Member of Tribe," we just say if you are eligible for IHS or not. We are constantly talking about this and trying to figure out how the data source can be used.

C: (Ron Allen) [Cheryle Kennedy yielded her seat.] We know the definition of an Indian is an issue and it has to be resolved. It's not our fault that somebody in this town screwed it up. The definition that Medicaid uses works for us; and it works for IHS. Whether we need a technical amendment or not, the concern is that it needs to be resolved. You think you will create a system independent of IHS. Why can't the IHS system be modified? IHS has responsibility of its own. We don't want to let AI/ANs fall through the cracks. We are the most underserved and so the system has to work. We urge you to work with IHS on this issue. [Seat returned to Cheryle Kennedy.]

Q: (Ken Lucero) In the FFM and State Partnerships they have the ability to have Navigators, but that ability is not there in the state-based model. In the Establishment grants there was no funding to states to create Navigator programs. In states that have Tribes that are state-based, like New Mexico, we don't think they will have a Navigator program—even though it's part of their Establishment grant. They are not being very open in terms of communicating their plans to educate and enroll people. What can HHS/CCIIO do to encourage them to create a program similar to the Navigator program?

A: (Lisa Wilson) The statute says the Navigator program has to be funded through the Exchange. In another section of the ACA it says the Exchange has to be self-sustaining. In many states we can't use 1311 grant funding to fund the Navigator program; it has to come out of the self-sustaining Exchange. Some states have done forward funding and others are relying on the concept of In-person Assistance. States can fund In-person Assistance personnel concept through 1311 grant funding, they just can't use it to fund the Navigator program.

Q: (Ken Lucero) That puts us at a disadvantage in New Mexico. We don't think the state is going to do that. It may be part of their Establishment grant, but I don't think they have a desire to forward fund this. Discussions are happening, but no decisions are being made. New Mexico will not be ready to go in 2014. Technology is holding them up. In the meantime it will operate as a FFM or federally-assisted Partnership. We have an inquiry into your office asking about this. If that's the case, are Tribes or Tribal organizations going to be eligible to apply for the Navigator program, knowing that New Mexico is not operating as a state-based Exchange at this time?

A: (Lisa Wilson) We are working with New Mexico and right now they are still a conditionally-approved state-based Marketplace. I will take your concerns back to the Navigator team and the state team to see if we can provide some technical assistance.

C: (Ken Lucero) That would be great because we have inquired and we have not heard back from any CCHIO people.

Q: (Chester Antone) Lisa, is the Federal Government going to be training Navigators for FFMs?

A: (Lisa Wilson) Yes.

Q: (Chester Antone) What relationship do you have in Arizona with the Arizona Health Care Cost Containment System to facilitate that?

A: (Lisa Wilson) Right now the entities are applying, i.e., different organizations or individuals are applying for the Navigator program. We will make selections in mid-August and work directly with them for the training. Are you asking how we will incorporate the Medicaid side of the house in the training?

C: (Chester Antone) Yes. We understand that [unintelligible] is not going to apply for the Navigator grant, and I assume that IHS is providing that.

C: (Yvette Roubideaux) We will do certified application counselor training for all of our staff, so our staff will get the same training in the general area of enrollment.

C: (Chester Antone) In Arizona we have one entity that is applying for almost the whole pot. We have community assistors that do applications and then we have the conflict of interest with the federal Navigator grant. We understand the business part of it, with the community assistors, because you have the broker right there with them—with the person applying. We understand where the government comes in, to prevent that from occurring with their funds. We are looking

at how we are going to do that because, as the book says on the airplane, you don't get what you deserve, you get what you negotiate. I assume the IHS will be contracting over the long haul with the big six in Arizona.

C: (Lisa Wilson) The certified application counselors are an important part of the "ground game" for people applying in-person. These folks are likely already doing this as part of their job, enrollment assistance work. Perhaps they are referring people for Medicaid and CHIP. We know they will want to get trained and do their job right. That's the idea behind the certified application counselors, making sure training is available to them.

C: (Yvette Roubideaux) IHS can't apply for the Navigator program, so it's the only option.

Q: (Chester Antone) On the Essential Health Benefits (EHBs), the IHS as a provider, currently the insurance carriers would have to cover the essential health benefits. Is IHS going to be recommending above and beyond additional services to be covered in a contract?

Q: (Lisa Wilson) You mean does the EHB apply to IHS?

A: (Chester Antone) Yes.

C: (Yvette Roubideaux) I'm not sure about your question.

Q: (Chester Antone) In the area of contracting with the insurance carrier, although you are not required to, my understanding of the EHBs is as long as those benefits are covered, they have to be in there. If IHS has additional services that are billable, can they add to that or is it limited strictly to the EHBs?

A: (Yvette Roubideaux) We have normal relationships with these health plans, most of our facilities do, for patients that have the health coverage. As of 2014, the health coverage offered through the Exchange (if a person purchases it) has to have a minimum level of benefits. If a patient goes to IHS, then the plan will pay for those services. It's going to be contracts that will be put in place between our facilities and those health plans. That's why we are developing this checklist of all the things a facility needs to make sure it's in the contract with the QHP. So when those patients come to IHS they get all the benefits of the ACA, which is how the addendum helps. Also, the reimbursement issues and rates and regulations and provisions get taken care of as well.

C: (Chester Antone) It was mentioned that the due date for the EHBs had passed and you were in the process of reviewing the QHPs.

C: (Lisa Wilson) The QHPs started submitting their applications in April and now we go into the process of reviewing them, e.g., looking at network adequacy, compliance with EHBs, and justifiable rates.

Q: (Chester Antone) For a QHP to go through this federal review, in the case of Arizona for example, would the QHP be required to go through the Arizona Insurance Board? In the

consultation in Denver, it was mentioned that states retain eligibility and the Federal Government has to work with the structures that already exist within the state.

A: (Lisa Wilson) That's right. We definitely are deferring to the states for their review on a lot of portions of this. Different states are taking us up on the offer in different ways. I would have to get back to you on specifics about Arizona.

C: (Yvette Roubideaux) Gary just helped me figure out your original question. The level of services that the plan will pay for depends on when the patient goes to the Marketplace and decides to purchase the plan. There are different levels of plans and different levels of services. IHS will offer whatever services it can at its local facility, and that's what the insurance plan will pay for if the patient goes to IHS. If IHS doesn't have that service they have insurance, so they can go elsewhere and get that paid for too. The levels of services that are paid for depends on what the patient chooses when they go to the Marketplace and enroll. With all of the cost sharing reductions, most of our patients will get plans with minimum coverage, minimum premiums, and don't have co-pays. If they get a higher service level plan, then they are eligible to have other insurance cover a lot of other services over the minimum; it just depends on whether IHS provides those services or not. The QHP will pay us for the services that we provide. If we don't offer the service then the person can go somewhere else, because they have insurance. Based on the cost sharing being free for those under 300% of FPL, and if they come to IHS facilities, we think many AI/ANs will pick the bronze or minimum coverage level plans. If they want to pay for the higher level plan then they can come to IHS or go other places. If they have insurance and we do offer the service, the plan will pay for it. That will be extra revenues for us.

Q: (Chester Antone) That's what I was asking, if IHS will be contracting for the services it provides? Will that revenue enhancement be able to provide more services that will be reimbursable under IHS?

A: (Yvette Roubideaux) It would, because actually if a patient comes to IHS and we can't provide the direct service, we normally would use contract health. We are the payer of last resort, so we would use that insurance plan before IHS would pay; so you're right, it's going to save our money. It is better if our patients get the higher level plans because it would cover more of the referred care.

Q: (Arlan Melendez) In Nevada they will expand Medicaid. We were fortunate to be at the table with the state through this whole change. My Tribe was the only one at a meeting for the deadline for the Navigator application in our state. We asked if the Inter-Tribal Council could submit a grant, and so they did and we did. My point is, we just about missed that opportunity. It would be good to measure how Indian Country did nationwide.

A: (Lisa Wilson) I will work with Navigator team to see what we can pull together.

Q: (Arlan Melendez) Is the scope of work for the Navigator program going to be done before the January 1st deadline?

A: (Lisa Wilson) In the FFM it's a year-long grant and so we would expect it would go for the full year. We recognize that different communities will start at different paces. These will be cooperative grants, allowing us to have frequent contact with the grantees and to do a lot of technical assistance.

Q: (Cathy Abramson) Will Tribal leaders and Tribal experts review the call center scripts?

A: (Lisa Wilson) We will be making a determination on that request. We are reviewing the request.

Q: (Ken Lucero) On the certification training, will it be directed by CCIIO and given to the state to certify the training of their private insurance people? The people equivalent to the Navigators in the state-based Exchange?

A: (Donna Cohen Ross) There will be training that CCIIO will offer to everyone who is going to be a certified application counselor, but states want and need to do their own training because there will be some state-specific information that counselors may need to know.

Q: (Ken Lucero) But you won't require the state to do that?

A: (Lisa Wilson) No.

C: (Ken Lucero) Folks here are talking about applying for the Navigator program and we want that opportunity too in New Mexico. We think we are at a disadvantage now in terms of enrollment and education for our people in New Mexico and other state-based Exchanges because we don't have that availability to apply for a Navigator grant or In-person Assistor programs. I'd like to see if there is a workaround for Tribes to apply directly, no matter what state you are in, for the In-Person Assistor and Navigator grants.

Q: (Ron Allen) [Cheryle Kennedy yielded her seat.] With regard to Navigators, we are curious if Tribes or Tribal organizations, or Tribal Urban Centers are applying. We'd like, once the application period closes and you make decisions, to know who gets them. We want to know how we fare. Even if they are non-Tribal, they need to be required to engage with Tribes on their proposal. On the call center, you referenced earlier about making sure AI/ANs who are eligible know how to secure a plan. On one hand, Cathy is asking if you are engaging with us. Are you putting together a team of Tribal leaders that can advise you? The people you train to respond to the Indian caller need to know how to respond. There are cultural factors and conditions that they need to be aware of. We would like to be on the front end of that process. Our people in our clinics are already getting these questions. We will need assistance in carrying out that federal function. [Seat returned to Cheryle Kennedy.]

A: (Lisa Wilson) We are aware of the need for people to be proficient in responding to AI/AN communities in culturally competent ways, so we are thinking about that. That will be part of our trainings. I hear clearly that you want to see metrics on how Tribes fared in the Navigator process.

C: (Larry Curley) I'm thinking about the Navajo person in Arizona, where there will be a FFM; the Navajo in New Mexico, where New Mexico has decided to go with theirs; and then the Utah Navajo, where Utah is trying to figure out what they want to do. In the midst of all of this is the activity called Navigators. Where do we go? We have a Navajo Nation composed of 300,000 Navajos. What would you recommend that Navajo do? My thought is that Navajo ought to be treated as a state for the purposes of a Navigator program. I heard that is not possible because the law is not written in that fashion. Yet, earlier today, Mr. Antone was mentioning flexibility. One of the ways to deal with this sequestration is to be a little more flexible about the rules and regulations. Navajo is not the only one that transcends state lines. If it is possible to treat the Navajo as one, I'd like to request that.

C: (Lisa Wilson) I will take your comment back. The current reading of the statute doesn't allow that. Your articulation of the issue is what I'll share; it was done well. The implementation differences in the three states shine a light on how difficult this is for Indian Country.

C: (Mayra Alvarez) A lot of the questions have focused on the Navigator program; but it's not an "either or" situation. We are looking at every opportunity to inform and engage people. One way is to have certified application counselors onsite and every community health center hire a person to help in this enrollment effort. In addition to that, I would hope that every member of the Navajo Nation would have somewhere to go where they get health care, e.g., an Indian clinic or an IHS clinic, where they trust someone. And I hope at that clinic we have people trained and ready to enroll people in this Marketplace. We need you all to work with us to identify who those people are going to be and to work with us to make that happen.

C: (Gary Hayes) The frustration a lot of Tribes are having stems from the relationship between states and Tribes. Some relationships are better than others. Maybe you can email Stacey [Ecoffey] and say what each state is doing for the Tribes in these areas [around outreach, enrollment, and education].

Q: (Cheryle Kennedy) Is there a Tribal workgroup you are using to come up with some of these solutions? If not, I would recommend that one be setup. The STAC was setup to help remove barriers, to eliminate administrative barriers. We would be willing to sit with you to work on solutions.

Q: (Ron Allen) [Cheryle Kennedy yielded her seat.] With the FFM it states, are you using the Centers for Medicare and Medicaid Services Tribal Technical Advisory Group (CMS TTAG) to advise you on options for the federal system? On Medicaid, when it gets expanded, what provisions are you making for Indians eligible for expansion that reside in states that don't expand? [Seat returned to Cheryle Kennedy.]

A: (Lisa Wilson) We engage with Tribes regularly. We have monthly outreach calls and continue to do Tribal consultations; we recently had the regional consultations and we convene TTAG meetings.

A: (Stacey Ecoffey) We have been talking about this in the last few weeks, on moving this forward. We did talk about the call center; Kitty [Marx] has been working on scripts. We have

to separate policy implementation from outreach and education to people. We have to have an up-to-date website. We have monthly national calls and we have talked about changing them a bit to give actual education. Kitty will tie the conversations back in with the TTAG in July.

Q: (Ron Allen) [Cheryle Kennedy yielded her seat.] Are you recording the issues that are raised in those calls? It would be helpful to have a document that shows how issues are being addressed. [Seat returned to Cheryle Kennedy.]

A: (Stacey Ecoffey) We try to answer them on the spot. On the next month's call we address what was raised, but that is a good idea.

Q: (Ron Allen) [Cheryle Kennedy yielded her seat.] If a person is in a state that doesn't do the Medicaid expansion, but our people are eligible, what are you going to do to expand coverage for them? [Seat returned to Cheryle Kennedy.]

A: (Donna Cohen Ross) I don't know what the process will be or if there will be a process, but I'll take that back.

Q: (Ken Lucero) Mayra, can you put together a list of resources Tribes are eligible for? Also, we need a better line of communication with CCIIO. We have asked CCIIO for responses and did not get any.

A: (Mayra Alvarez) Yes.

C: (Larry Curley) My concern is the Navigator is critical to how a Tribe does outreach. On Navajo we have large distances. People go to the hospital or clinic when they are sick. We have chapters that have a Community Health Representative (CHR) at each site and that are a source for a Navigator to me. We need a Navigator program, regardless of what the state or Federal Government is doing.

Q: (Cathy Abramson) What is the best way to reach someone in CCIIO to get a response? It is important that items raised from Tribes are tracked formally.

A: (Lisa Wilson) My email is lisa.wilson@hhs.gov. You can also contact Lisa Marie Gomez and other colleagues are also useful resources.

Q: (Cheryle Kennedy) The Arkansas model, could you talk about it and if other states are following that?

A: (Donna Cohen Ross) I don't know enough about the specifics to talk about it. I'll take that request back to Cindy Mann.

C: (Ken Lucero) I recommend that we form a workgroup on the STAC to look into issues raised here.

[An official motion was made and seconded.]

C: (Kitty Marx) The CMS TTAG does have a ACA subcommittee and we have an Outreach and Education subcommittee, so maybe for those on the STAC that are interested in participating, we can invite them to the calls; and we have records of the subcommittee calls.

Q: (Gary Hayes) Are there questions? We have a motion and a second.

C: (Cathy Abramson) We are not trying to duplicate things, we are just trying to work with the TTAG.

C: (Ron Allen) [Cheryle Kennedy yielded her seat.] What Ken [Lucero] is getting at is getting more Tribal leaders engaged in the process. The TTAG is really more practitioners, not many are Tribal leaders. A small committee could compliment what they are doing; it couldn't hurt. [Seat returned to Cheryle Kennedy.]

C: (Stacey Ecoffey) We meet on a regular basis. We can work with you through conference calls to keep everybody abreast.

[A vote was taken and all members were in favor of forming a workgroup to address ACA issues; there were no objections.]

Tribal State Update/Tribal Consultation

During the *Tribal State Update/Tribal Consultation* session, Lillian Sparks, Administration for Native Americans (ANA) Commissioner and ICNAA Chair, acknowledged that Tribal State issues surfaced during the HHS Regional Tribal Consultations. Noting that the Tribal State Workgroup had not met since December 2012, and that the STAC retains Tribal State relations as one of its priorities, Commissioner Sparks indicated that barriers for building better Tribal State relationships are being identified. Among the strategies include utilizing and implementing the HHS Tribal Consultation Policy; utilizing HHS Regional Offices to forge partnerships and relationships to have forums and improve relations; looking at the human service areas of child welfare and foster care; doing education and outreach at the state level; and for CMS-related issues, working with states to work with Tribes on the Marketplaces.

Ms. Ecoffey indicated that additional focus would be given to the issue, stating that the subcommittee would hopefully meet in August 2013, with a plan to provide deliverables and action items to the STAC at its September meeting. After welcoming new STAC members to join the subcommittee, Ms. Ecoffey stated that the HHS Regional Directors are holding follow-up calls to the regional Tribal Consultation sessions. She also noted that the discussion on the HHS Tribal Consultation Policy will occur at the September STAC meeting, per Gloria O'Neill's request.

Judith Monroe, Director, Office for State, Tribal, Local, and Territorial Support, Centers for Disease Control and Prevention (CDC), said the comment period for the CDC Tribal Consultation Policy closed on May 20, 2013. She explained that the policy was previously signed and retracted to allow for vetting across Indian Country. She said CDC received 15

letters from Tribes and/or national or regional organizations; the letters are now under review with the Office of the General Counsel (OGC). She said comments will be shared with Ms. Ecoffey and Mr. Dioguardi.

Isabel Garcia, Acting Director of the National Institute of Dental and Craniofacial Research (NIDCR), National Institutes of Health (NIH), informed the STAC that NIH has considerable efforts going forward, having Tribal point-of-contacts for each center/institute (with almost everyone on board). She said NIH will work to constitute its Tribal Advisory Committee; and she said she was hopeful that the first consultation session will convene in 2014.

Mirtha Beadle, Deputy Administrator, Substance Abuse and Mental Health Services Administration (SAMHSA), stated that SAMHSA is updating its Tribal Consultation Policy and will share the updates with the STAC in the future. She said the SAMHSA Tribal Technical Advisory Committee (TTAC) has been re-energized, touting new members (with only one vacancy for the Phoenix Area and one at-large position open).

Following the updates, Tracy King expressed concern about Indian child welfare and foster care in the Billings Area. He noted disrespectful comments made by BIA Social Services representatives, stating that “BIA is destroying families.” Gary Hayes suggested that the BIA needed to be at the table to talk about issues that arise.

Acting Assistant Secretary for ACF George Sheldon greeted the STAC before opening the session on *Human Service Issues*. He noted that Commissioner Bryan Samuels had worked hard since the STAC’s last meeting to develop a plan to move forward on Indian child welfare issues. Without belaboring the point, he invited his team to provide updates. Commissioner Samuels discussed the plan for holding states accountable with ICWA compliance; Yvette Sanchez, Director, Office of Head Start, ACF, discussed the process for Tribes identified for Designation Renewal System (DRS) competition; Earl Johnson, Director, Office of Family Assistance, ACF, and Felicia Gaither, Director, Tribal Temporary Assistance for Needy Families, ACF, gave an update on Temporary Assistance for Needy Families (TANF) and Tribal TANF. Highlights from their remarks are presented below:

- One Tribe has an approved Title IV-E plan, another is expected to be approved by the end of June, and 4 more will likely have approved plans in the future.
- Letters were sent to states and Tribes reminding states of their obligation to consult with Tribes and comply with ICWA. States were encouraged to consult with Tribes prior to submitting their annual plans and progress reports. Annual reports (due in the fall) will be used to monitor states at a regional level to ensure they do what they report in their annual plan.
- ACF will develop a reporting template for ICWA compliance that can be made public.
- ACF will continue to explore other options to hold states accountable for compliance with ICWA.
- Cohort 2 for the DRS competition was announced in January 2013, and included 29 AI/AN programs.
- Reviews for Cohort 1 are expected in January 2014.

- All Head Start programs, including Tribal programs, will take a 5.27% cut in their grant because of the sequester.
- The ACF Office of Head Start Tribal Consultation will be in Spokane, Washington on June 11, 2013.
- Felicia Gaither was hired as the new Director for the Tribal TANF Division.
- Four letters of intent for new Tribal TANF entities are pending.
- A webinar series to give Tribes technical assistance and guidance have begun; transcripts and presentations will be posted online. The July 31st webinar will focus on the Letter of Intent process.
- A National Tribal TANF Summit will be held on August 12-14, 2013, in Denver, Colorado. Technical assistance/guidance and peer networking opportunities will be provided.

Q: (Robert McGee) First of all, Commissioner Samuels, I would like to thank you for the letter that was sent out. We all know what the concerns are with the ICWA compliance, but I was wondering how can we confirm the states' activities are in compliance when they submit their plans? Are we going to be able to work with Tribes and say this is the plan they've drafted or this is the plan they submitted on how they're going to work with compliance? I understand completely that ACF is not the oversight for ICWA, but I appreciate that you are stepping up and putting it into the plan to see how to address the issues that we have with compliance. And maybe one day we can look at changing legislation so we have an agency that we know will be in charge of compliance. How can we help you to determine that the plans that were submitted and the activities are being done, are being followed?

A: (Bryan Samuels) The first thing to remember is those are all public plans, so any Tribe that believes at any point that something in those plans isn't being done, can refer concerns to us. The second part of it is, our plan would be the annual service plans are very large, they have lots of detail to them. We will extract out of those all of the commitments that are specifically related to ICWA. We will have the regional office staff, on a quarterly basis, confirm with the states that they're actually taking the steps that they have actually submitted the plans in. Anyone who comes across a state that says they are doing something and they're actually not, communicating with the regional office or with us would allow us to intervene and establish that they are or are not doing as they said. In the instance where they're not actually doing what they write in the plan, we do have the authority to require them to enter into a Program Improvement Plan (PIP) which would require them to actually layout additional steps that they would take to meet the obligation. So we are going to push that as far as we can, recognizing that in this instance the PIP wouldn't end with a requirement that they pay a penalty. At this point we don't have the authority to assess a penalty for noncompliance. But today, we have a limited understanding of any of the compliance because states don't provide us with enough standardized information to even judge that. So our plan is to push as far as we can with what we have; and we think the beginning of that is getting a much better handle on the data and the specific progress states are making as a result of implementing their plans.

C: (Robert McGee) To Director Johnson and Felicia, thanks for coming out to the NCAI TANF Task force. Felicia, you did a great job there. You've heard the issues and the task force has submitted the comments that we would like to look at administratively and legislatively. Thank

you for the opportunity to have that conference on August 12-14. I think that you heard their problems and concerns, especially how they wanted to take the opportunity to work with each other “peers to peers” to talk about those model programs, successes, and failures. Thanks for that.

C: (George Sheldon) Commissioner Samuels has put a lot of attention on compliance with ICWA and I think what he is talking about in terms of states being required to inform us of their compliance with their own plan will give us the kind of data and the kind of information which could not only be available to Tribes, but could also be available to BIA and the Justice Department. We are also looking at what additional authority we might request. We are in the process of doing that. Ultimately the Secretary can make a decision as to just how far we want to go. I think this is a huge step forward in terms of giving information on what is happening state by state.

C: (Robert McGee) In 2005, when DOJ did the report on compliance, some data was being collected but it was not being used. I appreciate you guys stepping up trying to get more data, new data so we can use it.

Q: (Ron Allen) [Cheryle Kennedy yielded her seat.] It sounds like we are moving in a very positive direction. You’re lacking legislative authority to try to force some of these states to do the right thing in terms of the processing. It seems to me that when it comes to updating these plans, a part of the plan can be compliance to the ICWA plan. So what is the state’s plan in terms of complying with ICWA? So there may be some criteria we can provide you. There are representatives from the National Indian Child Welfare Association who work these forums very extensively. So now, the question of the day is, what should be in those plans and what kind of data do we need from you? What we hear a lot is, when we get these kids that are going through the system sometimes they don’t take the appropriate measures to identify the child as an Indian. So often these forums have a box, is this an American Indian or Alaskan Native? Sometimes they don’t check that box off, therefore in their minds they don’t have to comply. They don’t have to deal with it; they can process it the way they want to process it. So the question is how do we get them to provide a plan that shows whether or not they are taking the steps or measures necessary to assure if it’s an Indian child. And if it’s an Indian child, then they are required basically to notify the local Tribes or Tribal contacts—particularly if they know where the child is. If they don’t know what Tribe the child is a citizen of, then they can go to the local Tribes and ask for advice in terms of how to deal with this particular case. Then there’s another area where it’s whether or not the state in their plan provides appropriate communication to the court systems in the state. So often what you find is the court systems in these states don’t have a good understanding of what ICWA is and they will defer to the states’ system to advise them with regard to what it is. If it’s education or orientation, most states have orientation updating retreats. So, does the plan provide a requirement or should it include that they communicate with the court system so that the court system is a part of the partnership of complying with ICWA. So there are all these different steps that are essential to make this Act work the way it should work. The second question is whether the Administration will be supportive of advancing amendments to the Act that give you a little more leverage to make sure we’re in compliance. We don’t want to see any “Baby Veronica” cases emerging. [Seat returned to Cheryle Kennedy.]

A: (George Sheldon) There are discussions going on right now about doing exactly that, so I think what the Justice Department and we are looking at is what can we do with the authority we currently have and doing that aggressively. That doesn't mean we are closing the door on ultimately an Administration position. I will assure you those discussions are taking place.

C: (Aaron Payment) For child welfare, in early the 90's we were experiencing the state not following through; Indian children were falling through the cracks. My Tribe called upon me to work on a legislative agenda. This was maybe a half a generation after the enactment of Indian Child Welfare. We knew all the stories of assimilation, e.g., Indian children being placed outside of the home, multiples over any other ethnic population. So it was a continuation of the Assimilation Act. We had a sympathetic ear in the Michigan Supreme Court with Justice Cavanaugh. We facilitated a State Tribal Court Forum. We met with Tribal leaders, judges, social workers, and the state court system and we educated them on Indian child welfare and we facilitated their understanding of it. In tandem we were also trying to pass the Michigan Indian Family Preservation Act, which would have given enforcement to ICWA at the state level. That way those judges that don't volunteer to cooperate (even though it's the federal law) would have had some enforcement at the state level. As a result of the court forum, the Supreme Court created a court rule that required notification; so it gave teeth to it. But even that wasn't an ideal because the Chief Justice is retiring this year. Knowing that, we dusted off our earlier attempt. This last year we did pass a Michigan law, the Michigan Indian Family Preservation Act, which basically mirrors the federal law. I know, depending on your relations in your state, it's not realistic. It took us almost 30 years to get this enacted, so maybe the President could find a way to facilitate these discussions between state courts and Tribal courts. That's what started it. We had a hope that they would be sympathetic and they would work with us and it turned out that way. So maybe there could be some incentives for state courts to do that dialogue. On Head Start, we got a gold letter saying we don't have to compete for 5 years. We have two Head Start sites in the Upper Peninsula. We also have a home-based program. We are real proud of our program, but for the most part our members don't get to go to our own program because there is no program for them. So our kids attend Community Action Head Start programs. I'm also on our Community Action Board for the three counties that serve our population. Regarding the criteria being used to evaluate the Head Start program, there's a "disconnect" in the evaluative criteria. Previously, two observations that were done in instructional, and then you get a score. For the state programs, if you fall below a certain benchmark, those ones have to recomplete. So, two new criteria were added; they were instructional support. One of the observations added was "kids getting on and off the bus." The other one was basically the lunch period. They scored low. So if you look at competitively the previous years, our scores were constant and then there was this huge drop off. So we don't know if we are going to have to re-compete because they're going to norm them first and then this percentile is going to have to re-compete. It looks like it's a summative, not a formative, evaluation process. Summative is punishment; formative is "here's what you need to improve so you can sustain your program." It almost looks like we were put in a real disadvantage and the program might be eliminated. I'm nervous for Head Start programs, that the evaluative criteria that are being handed off to a company might not be exactly what we need. So I'm concerned that there are evaluations being done that are not instructional support for uploading a bus or a lunch activity. Instructional support is in the classroom, it is part of the curriculum process; so I'm concerned about that. We need to make

sure that the companies we are contracting with, if it's not the direction from HHS, need to do a meaningful evaluation, not a punishment evaluation.

A: (Yvette Sanchez) I think you are referring to the Classroom Assessment Scoring System (CLASS) observation that is going on via monitoring. I do want to clarify that CLASS is part of our current Head Start monitoring system. CLASS was developed by the University of Virginia, but the way they developed it was for professional development. We have worked with the developers in order to make some modifications, because when we use it for monitoring we are using it in a different way than they originally intended. When we use CLASS we are looking at instructional support, but we are also looking at the other two domains: classroom organization and emotional support. In one of those three domains we would be looking at the lunch time because the whole purpose of CLASS is to observe the interaction between the adults (the caregivers) and the child. They are looking at the whole day and what does that look like. We have put in place some provisions where we wouldn't use CLASS. So for example, if the teacher in the classroom doesn't speak the same language as the child; if it's a substitute that has been there less than 30 days; or if there are any other extenuating circumstances that the program can say "this isn't my normal day today," then we would take all of that into account.

Q: (Cathy Abramson) We are concerned and we'd like to know if it's been tested with Native populations?

A: (Yvette Sanchez) In terms of how we use it for Head Start monitoring, we have been piloting it since 2008; and we included Tribal programs and Migrant programs. CLASS didn't get fully implemented until 2011, so we spent almost 3 years piloting it with a variety of Head Start programs, including our Tribal programs but also rural, small, and large programs. CLASS only looks at preschools, so we're only looking at our 3 and 4 year-olds in a center-based setting.

C: (Cathy Abramson) I've been sitting on the Policy Counsel for over 15 years for our Head Start program. I am the Board of Director's Liaison there. My grandchildren have been in the Tribes Head Start program, and I have one that will hopefully get into the Community Action one. With the cuts, who knows what's going to happen. But, one thing we are concerned about and want to see is we believe a solution is having proficient reviewers, i.e., Native people that know the culture. We also want grantees that scored below the CLASS threshold to be held harmless until we get culturally competent reviewers. We think teacher qualifications should be waived for those that speak the Native language. In Michigan, you don't have to be a certified teacher to teach language classes. It's important to bring back our language and it's important to us to have this waiver. The Federal Government made the decision to try to assimilate us and take away our language, so we need our Federal Government to help us get it back.

C: (Yvette Sanchez) We agree. All of our regulations, as well as the last reauthorization of Head Start, definitely demonstrates that this is a priority and it's something that the Office of Head Start is very serious about. One of the national centers we have funded focuses on culture and language specifically. They have been producing resources and working with our Tribal training and technical assistance contractor to make sure that we are supporting our Tribal grantees when they want to do any kind of language immersion work. We take it very seriously and if you just let us know what you need, we will absolutely support you in that piece. In terms of the

monitoring piece, I will put out a request for assistance from you all. Based on Tribal consultations, one of the big requests we got was to try to make those teams all include Tribal folks. Since 2012, the majority of our reviewers that have gone out to our Tribal programs have been Tribal individuals. We also understand that every Tribe is different, so one piece that we've instituted is that every team, before they get onsite, has a call or a meeting with the Tribe to talk about cultural aspects of what the team will be seeing when they get there. The piece where I need help is we need more folks to be Tribal reviewers. CLASS requires that an individual gets trained and validated.

Q: (Cheryle Kennedy) Earlier Mr. Sheldon, you made a comment, you made reference that you had a conversation with the Department of Justice; can you elaborate on what the outcomes might be or what are you advocating for?

A: (George Sheldon) At this point it would be difficult to do that in much detail, but DOJ does have civil rights authority for enforcement of the civil rights laws. Given the appropriate kind of data/information, they may be able to utilize that kind of authority. Where that goes, at this point I can't really articulate; but I do think it's a willingness on the part of Justice to look at, whether it's a Tribal American or not, utilization of that authority.

Q: (Cheryle Kennedy) Who is now in charge of that?

A: (George Sheldon) I'll get back to you on that. There are actually 3 different sections engaged at Justice. But let me get to the civil rights section.

C: (Robert McGee) A few of the Tribes have submitted title IV-E plans and they have been rewritten without consultation with the Tribes. We are trying to figure out how to address this issue. I think it was in Region 9 or 10 that this has happened.

A: (Bryan Samuels) If you have specifics, we'd be glad to take a look at it.

Q: (Gary Hayes) Regarding ICWA, if the Supreme Court rules against Tribes, what will happen to ICWA? I know that BIA is leading the way as far as with social service programs for Tribes. But what would happen? Has anyone brought that into discussions with Department of Justice and with BIA? Have there been any discussions or are we just waiting to see what happens?

A: (George Sheldon) I think all of us were pleased to see the DOJ intervene in the case currently in front of the U.S. Supreme Court. I'm as skeptical as to why the courts took that case as I think you are. What the Justice Department tries to do is really narrow the scope of the court's review to try to get whatever the court does to make a determination on the narrow circumstances of this particular case. But clearly they came down on behalf of us, BIA and the Administration, on the side of the father in that case. And I know some may have wanted the Justice Department to come out with all guns blazing, but I think they made the determination to really narrow this case—as opposed to really making this a case about the constitutionality of ICWA itself. We have to be vigilant as this case proceeds. I don't think we are looking at “what if the court throws ICWA out.”

C: (Bryan Samuels) An internal group at ACYF has been looking at others' opinions and the likely outcomes, and trying to anticipate what will likely happen. We are far short of having a specific proposal that would follow any particular "what if" question. We've tried to play this out a little, but we wouldn't claim to have a specific "what if" plan.

C: (Gary Hayes) Many state Attorney Generals, I think it was 18 of them, did an amicus brief on that. It mentioned the track record with this Chief Justice and what the Supreme Court has been doing. Eroding Tribal sovereignty is something that we are very concerned about. There was some discussion about the courts. I know some states are not fortunate enough to have a good relationship with the state. Just a couple of weeks ago, I'm sure you heard about the case in South Dakota, about the state not being at the table when we are discussing ICWA. We had a meeting last week with our Lieutenant Governor and state officials and we brought the issue up about the courts being educated and giving them a "101." That's got to be inclusive as we move forward regarding how we can streamline some of the policies and regulations of ICWA and strengthen it more. The problem I always have is where is BIA in this? They are the department that's supposed to be regulating this and even the state last week asked us that question. They said they don't have a good relationship with BIA because they don't return their calls either. We said, "Well, welcome to Indian Country." Sometimes we don't have that communication, but we're working on it. It's very important to us and I appreciate all that you guys are doing in support of and on behalf us and leading the way having these discussions with BIA and DOJ. Sometimes it takes a law to get the agencies to work together or to cooperate with you.

C: (Tracy King) BIA would probably be against us. I remember I was very young when they removed a lot of families from the state. Child Welfare League of America, BIA and the state partnered and removed a lot of our kids from Fort Belknap. We were one of the hardest hit people. The Catholics too helped to remove a lot of our kids. Nuns stole my cousin and now she has an identity crisis. I was always thankful my parents grounded me and told me who I was. Even though I got in trouble, I was thankful. My mother was a strong Catholic. They beat the hell out of you if you talked your language. They raped our kids. My brother was in a lawsuit against the Catholic Church in 2009. Sometimes you get chastised for speaking out. It doesn't make it easier when the BIA is on the side of everyone else. A lot of the trauma you see with suicide at home is due to abuse. When you have your culture it's easier to deal with a lot of things. It's hard to see the kids in the foster care system go through the abuse. There's a young man in foster care that is in the first grade with my grandson. He calls me grandpa and he calls my daughter mom. He identifies with us. This little man that has been passed around since he was a baby has some identity. We include him in family things, so he knows he's somebody. That's where the BIA and some of the state officials don't care. When we are out of compliance with our 638 contracts, BIA makes us pay our money back. When states are out of compliance they don't have a consequence. That's where I have a problem with them thinking it is okay to wreck lives of kids and families and turn around and say they have a good report. We had two kids in the state system last year that were abused by the boyfriend of their mother. They were enrolled at Fort Belknap. The 3 year-old was hit so hard near his right side that his left eye was bloodshot. The guy killed his sibling. The grandfather tried to get him. I don't like to bring these stories forward, but they are real. We are here to deal with reality. The state fired someone after the death, but they should have fired him before. On a good note, I was wondering why some of the teachers at our Head Start program don't move. It's because they love the kids.

They could go make more money, but the kids are the reason they stay. They get \$5-\$10 less per hour than they could get elsewhere. There should be more pay for our teachers at home. Also, [former STAC member] Roberta Bisbee lost her son about a month ago. He was 8 years old; he was shot. I think we need to send her a card.

Update: Intradepartmental Council on Native American Affairs

For the *Update: Intradepartmental Council on Native American Affairs* session, Commissioner Sparks first had the Grants Eligibility Matrix distributed to the group. She invited Kim Romine and Sue Clain to speak about the document. Ms. Romine indicated that the data set (containing 2010 data) was as complete as possible; saying only final tweaking of the written report that will accompany the matrix was needed. Ms. Clain said input from the STAC and ICNAA would be solicited in terms of how to use the data to meet the original goals of the project, i.e., to identify projects or priorities for additional technical assistance to Tribes on grants for which they are eligible; and to consider revisions to regulations or policies that present barriers to Tribes' eligibility—where the Department has some authority to make some changes. She also said they are looking at how to easily update the document and make it more portable, perhaps via the HHS website and/or use of thumb drives. After walking the group through the matrix, the ladies entertained questions and comments.

C: (Aaron Payment) If the document is in Excel, you can save it as a PDF; that would make it searchable.

C: (Kim Romine) It will be posted on the website in excel and we can also post it as a PDF.

Q: (Robert McGee) What is the rollout plan to let Tribes know the document exists?

A: (Kim Romine) I believe we will issue a Dear Tribal Leader letter and also provide thumb drives.

Q: (Cathy Abramson) Are we going to get an update about making grant announcements more Tribal friendly?

A: (Lillian Sparks) Yes, I'll provide an update on grants accessibility momentarily.

C: (Aaron Payment) This is great and very useful for small Tribes that don't have resources to do this.

Regarding self-governance, Commissioner Sparks said the Tribal Federal Workgroup was finalizing its report on recommendations. Noting that the workgroup had completed its charge, she expressed a desire to keep communication open with Tribes about what they want to see advanced. She said the workgroup's efforts yielded a lot of valuable information in terms of what it means to administer self-governance in the form of grants, and what possible models could be outside of Indian Self-Determination and Education Assistance Act (ISDEAA).

C: (Cathy Abramson) I just want to say that clearly a lot of work has been done and I appreciate your efforts.

Q: (Gary Hayes) OMB put out a proposal, “Proposed Uniform Guidance: Cost Principles, Audit, and Administrative Requirements for federal Awards.” We strongly oppose what they are trying to do. They are asking that Tribal financial documents be open for public inspection. We have some concerns about this. For quite a long time Tribes have been able to successfully manage the federal funds they receive. Congress can learn from Tribes about working within a budget. To interject this requirement for Tribes is a way of trying to politicize our Tribal business activity through unnecessary disclosures to the public. I’m hoping HHS will convey the message that Tribes strongly object to this.

Q: (Cheryle Kennedy) Is the self-governance report going to be shared at the IHS Self-Governance meeting?

A: (Yvette Roubideaux) It certainly can be.

C: (Lillian Sparks) To Cathy Abramson’s question about grants access and the ability to be able to have language that expressly states Tribes are eligible to apply for a grant, and for our grants staff to have a better understanding of working with Tribal communities, we are following up on the 2011 training for the Department’s grants staff. We will repeat with grants management/grants policy staff—having it more of a dialogue between our grants management/grants policy and Tribes to get a better understanding of what the barriers are that existed previously, the barriers that may still exist, and information that may be useful for Tribes to successfully apply for grants and understand the entire granting process. Hope to do this event in late July or in September, but certainly before the end of the fiscal year. Lastly, ICNAA has a new priority area: data sharing. The committee has looked at the HRAC’s recommendations related to Tribes and data, as well as had conversations about how data can help with human service programs and to get a better sense of what Tribes should be receiving. To that end, the three priorities for the Tribal Data Workgroup are: data sharing, data collection, and data warehousing. The grants matrix is a great example of how ICNAA is sharing the data and feedback on its utility will be useful. Additionally, general feedback, specific ideas, and specific needs related to the data priority is encouraged.

Q: (Yvette Roubideaux) This is an opportunity for the STAC to weigh in on some data issues. Data is really critical. You need it for your grants, we need it for outcomes, we need it for Congress. The whole issue of sharing data and how we use data is a big issue in Indian Country. Do we have plans to convene people to talk about it?

A: (Lillian Sparks) We can explore that. Perhaps we could do a webinar to solicit ideas concerning how we should be moving forward. Maybe the first step is to get the STAC to give feedback on this actual plan and then maybe solicit additional recommendations.

Q: (Ken Lucero) How do you want our feedback? Do you want us to talk about it now, or do you want it in writing? How do you want that to start?

A: (Lillian Sparks) If you have ideas, certainly we'll take them now, but folks may need additional time to go back and share with their data gurus or folks that understand some of this a little bit better. I don't know what the typical turn-around is or how we get information back from the STAC.

Q: (Ken Lucero) Working with some foundations and Epidemiology Centers in Albuquerque around youth obesity and diabetes, there's just not a whole lot of information available. When we look at the Albuquerque Area and ask them for information, they say they can't share it. It's complicated because it's not only information from our own Tribes, but we have a large urban population there. So how do we get authorization from all of the Tribes that are represented in Albuquerque to share the data, even if it is aggregated? One of the challenges we have is official Tribal authorization. How do we get these comprehensive data sharing agreements between Tribes and the IHS to release that information for certain areas. Another issue is collecting data from the state and other entities that our Tribal people visit and utilize, e.g., hospital visits. We don't know how to start entering into those agreements. Those are just two things that came to mind.

Q: (Arlan Melendez) There were some Tribes contemplating using something other than RPMS, is that still an issue?

A: (Yvette Roubideaux) That is an issue we are dealing with, with the IHS and the Information Systems Advisory Committee (ISAC) we have been working on the issue of RPMS vs. non-RPMS data. RPMS gets the job done, but it's not very fancy and it's a cheap older version of electronic health records. Some Tribes who manage their own programs are choosing to purchase commercial electronic health records. One of the issues that has come up is how do we make sure that we have that interface where Tribes can share data with IHS and that can go into our warehouse, reports and statistics that relate to that. There are issues around meaningful use, the ability to share data among different systems. The way that RPMS gathers data and calculates it is a little bit different than how the other systems calculate it; and the requirements now that CMS and others are going to have getting that data is very different. We've been talking about how to transition the data from non-RPMS systems to RPMS and to be able to put it in our data warehouse and do those reports. Our self-governance office has given out some grants for that. Some of our GPRA people are working on it. It's a huge issue, especially as we are transitioning with health reform to more electronic data.

C: (Chester Antone) It's a big issue because in some places when you use the data warehouse and IHS data system, it's only specific to what IHS is allowing to go in there; but it won't answer other questions. We're having that specific problem down where I come from on an issue that we have. When we talk about data, it helps to determine work load analysis, e.g., how much work are you actually doing for one Tribe vs. another. And then it ties directly into funds and the division thereof. Data used to determine that is paramount because you're actually putting funds where they should be. California Tribes had an issue about the data under the Indian Health Care Improvement Act (IHCIA). The Epidemiology Centers were to be treated as health authorities, but the state of California doesn't recognize that; so we need to work on that. The other issue is the interface between RPMS and other systems; how do they meet? How does IHS transfer that data and make it compatible with the RPMS system. That is key because many

Tribes are using different systems and IHS has to get the data and be able to make it compliant to RPMS so they can analyze it and have it available. Those are some of the issues that have been discussed over at HRAC. I guess I'm speaking to data as it relates to health delivery rather than grants delivery or grants accessibility; maybe that's two different things. Data in the scene of this 140-page document is really good, particularly if you can search this thing; then it becomes very helpful. The federal agencies will recognize the IHS and state data, but not Tribal numbers. The credibility issue with Tribes also exists and if you're talking self-governance, that's become really key there.

C: (Cheryle Kennedy) Since we're talking about data and where we might go with it, I believe the committee along with all of our partners needs to give some thought to some principles about data. If we're going to be developing data sets and we don't have access to them, it's sitting somewhere. I'm interested in a co-owned or co-access to data that would help us in developing grants and looking at our own health status, making a determination about where to target our own programs.

A: (Yvette Roubideaux) I have heard that vision for many years about what Tribes want to do with data and we haven't gotten there yet. I really think it is worth some further thought about what it is going to take to get there; what's missing in the system? We fund the Epidemiology Centers to do what you're talking about, but there are certain things that prevent them from being able to do that. To know what are the challenges and barriers would be helpful. This issue about state data, we know we need to get that information. The issues around data sharing within IHS, within Epidemiology Centers, and with Tribes and whether that's something that IHS addresses or it's something that has parallels that work with the data sharing related to other agencies is another issue. I think there is a link across HHS, because you need that data to apply for all these grants and you'd like to have that data. It's frustrating to know whatever data you can get, sometimes there's people who say no that's not good enough or no that's not the right data. It would be helpful to figure out what the exact specific priorities of Tribes are, because there are lots of issues around data. There have been a lot of different initiatives that are trying to get at that and I'm not sure why we are still talking about that. It's worth a more global perspective to see why we aren't getting there. What's the key to getting that released? It's actually an HHS priority, this whole issue with access to the data. Do you know about the HHS data paloozas, where they bring in technical staff and tell them what kind of data is available for HHS and then they have a competition about building things like apps for iPhones or computers to release the data? Maybe we need an Indian data palooza.

C: (Paul Dioguardi) We just finished one this week and the purpose is to release as much data as possible and just let it be out there so people can come up with ways to utilize that data in ways that we hadn't thought of or wouldn't have the capacity to do. I'm sure a lot of the applications that have been developed would certainly be useful for your purposes as well. There might be some Indian specific applications. Part of the data palooza is saying, "We need something that helps us do this." Then all the technical people write the application and come out with something at the end. We also have some other innovative contests that we're trying to incentivize outside folks to come up with technology solutions building off of our resources.

C: (Yvette Roubideaux) Brian Sivac (sp) could come to talk to us. Some of the apps they've developed might help Tribes already. Maybe there is something already out there that's helpful.

C: (Aaron Payment) A challenge when you have a limited amount of money is what's the biggest bang for the buck? As a Tribal leader you have to figure out what's the best investment back into the community. We make our decisions based on the elder that comes to the meeting and says what we need. It would be better to have data to substantiate what the need is. We collect data for housing, health, education, substance abuse, social services, and none of them communicate with each other. The data doesn't communicate. In 2002 we created a project and called it our Tribal Census Survey. It's a census, but it's really a survey because it's a reasonable representation of the total population. So, 13 years later we are now going to do another one and do some comparisons. If you can show justifications with a demonstrated methodology, you can correct U.S. Census data when you do applications. Maybe if the data was managed through Tribal organizations, and there was a unique identifier so the data doesn't match up with a Tribal member's name, then data could be collected across the spectrum. There are models. The Center for Education Statistics has been doing data collection on students for 30 years. They manage it by using super users; the name doesn't match up. The super users are authorized to interpret and run reports on the data. So not everyone would have access to the data set, but it would be super users that would be trained and certified. If you're a doctoral student you had to have that certification. Maybe that's the way we do it. Think about what's the best way to collect the data, so we really know what's happening in Indian Country. We develop the instrument and then we work with Tribes to implement these to their Tribal communities and then upload that data so we can then see is what we're doing meaningful, is it having an impact? One of the scary things in education is that statistics are as bad today as they were 20 years ago. The 50% drop-out rate for Natives today, is as they were 20 years ago. So obviously we're not using that data and what all that data can tell us.

Q: (Gary Hayes) Data is very important and we know there are OMB requirements when you are looking at funding sources. We've been dealing with the other side with BIA for 3 years. What we've done just for reporting crimes committed on reservations, they go back to the issue of Tribes are different. BIA does not interact with Tribes' systems. They are two different systems and they don't connect. We've been able to develop a subcommittee that targets some Tribes for a pilot project. They are identifying the criteria; what kind of data or information do you need? But with HHS and IHS it's going to be huge trying to connect Epidemiology Centers, health centers, urban and Tribal centers. Are we going to look at a specific area and ask Tribes to participate and volunteer? Releasing of information and data, that was one of the road blocks we faced, i.e., getting authorization for Tribes to participate. Some Tribes don't want to do it. Once this is created it is for 3 years. We are putting a million dollars into this every year for this process and we still haven't gotten anything out yet, because it's a long process just for this software to connect with BIA and DOJ. Some Tribes provided crime information and when it got to BIA the information just sat in file cabinets. DOJ went and retrieved a lot of this information. If we are serious, maybe we need a committee or to ask for volunteers from the regions. We also need to think about who would fund such an effort. When you look at this 104-page document, what is actually being asked? What kind of data do they want when we are submitting our grants?

A: (Yvette Roubideaux) It's a huge topic. It may be helpful for people to think about it and think about where to narrow the focus. The issue of sharing data between facilities on RPMS is being handled by IHS. Looking at interrelations around data is another area too. I encourage more thought about it. If we have to bring in others to talk to you about it we could. The purpose of this focus is to find a focus.

C: (Chester Antone) The CDC has the National Center for Health Statistics, so they might be included in the conversation.

C: (Larry Curley) A lot of different kind of data sets are out there, as well as research that has been done on Indian Country. The problem is what is out there was determined by universities, not exactly what Tribes are looking for in terms of data. So the data and research is not Tribally developed. Tribes need to move towards developing their own research and data agenda and determining what kind of research they are looking at; making good policy decisions based on good data.

Q: (Cathy Abramson) Can we ask the Secretary to send a letter to the Governors and ask that they recognize our Tribal Epidemiology Centers as public health authorities, granting unrestricted access? They should have access to state data and data sets as other recognized authorities do.

Tribal Prep for Secretary's Meeting

The first day ended with the STAC preparing for its meeting with HHS Secretary Kathleen Sebelius in a closed session.

DAY 2

(June 6, 2013)

The second day of the meeting began with STAC members meeting in a closed session. Once the meeting officially opened, Gary Hayes greeted the participants and reminded them about the importance of Tribal partners understanding the unique relationship that Tribes have with the Federal Government. Reflecting on the previous day's events, he commented that the discussions were meaningful and he thanked everyone for their attendance.

HHS Federal Member Roundtable Discussion

During the *HHS Federal Member Roundtable Discussion* session, the STAC was updated on staff and operating divisions' work on AI/AN issues and initiatives. Presenters and highlights from their presentations are presented below:

1. Kathy Greenlee, Assistant Secretary for Administration for Community Living (ACL)
 - Sequestration cut \$78 million from Aging Services programs.
 - Three of the highest priority programs are: Meals on Wheels; In-Home Support for Seniors; and Tribal (Title VI) Programs.

- ACL can't begin to meet the needs of Tribal elders; notwithstanding the Department has a continued focus on elder abuse.
- Last year ACL got money to start funding demonstration projects: 3 were Tribal projects that are looking at elder abuse in Indian Country.

C: (Aaron Payment) I appreciate you underscoring the populations that are served indirectly. Generally, 40 - 50% of the people we serve through the Community Action Board I sit on are Tribal members, e.g., Head Start, Meals on Wheels. It's a critical piece to filling in the gaps.

Q: (Cheryle Kennedy) For the Title VI Program, what is the impact on Indian Country? Do you know how many meals will be cut?

A: (Kathy Greenlee) That's the hardest question you can ask me. The money has been designed to be matched at the local level. Nationwide, our nutrition dollars draws \$2 to \$3 dollars in match at the state and local level; so it becomes amplified. The most conservative number we've put together for all of our meal programs was \$4 million around the country. The best way to know the impact is to go to the individual programs and ask what it means to them.

C: (Cynthia LaCounte) One Tribe reduced the number of days they provide the meals from 5 to 4 days.

Q: (Ron Allen) [Cheryle Kennedy yielded her seat.] Elders need more than Meals on Wheels. Are you considering doing a best practices workshop where Tribes can talk about options to serve elders? We are an aging society and elders are a big burden to all of our communities. [Seat returned to Cheryle Kennedy.]

A: (Kathy Greenlee) At the end of my report you'll see that we have a national conference two months from now. We bring together people who are running our Title VI programs and provide them with technical assistance and best practices. Part of the complexity of the sequestration is that we need to cut direct services, but we also have to cut technical assistance—which is important and significant, but in a different kind of way. So, this is an ongoing conference that we have. There will be listening sessions. It is August 6-8, 2013. Regarding the ACA, when the IHCA was amended, IHS has more jurisdictions to do long-term care; but they didn't get more money. We have put together a three-way interagency agreement between ACL, CMS, and IHS to talk about what we can do to expand long-term supports and services. We've also been able to come together to provide grantees with technical assistance on long-term care.

Q: (Ron Allen) [Cheryle Kennedy yielded her seat.] Is the report from last year's annual National Title VI Training and Technical Assistance Forum online? [Seat returned to Cheryle Kennedy.]

A: (Cynthia LaCounte) I can send it to you.

C: (Tracy King) A lot of our elders feed their grandchildren, that's tradition. It's sad to see these programs getting cut. When people come to my office for assistance, I can't turn them down; so there is always a hardship. Thanks for your commitment.

C: (Larry Curley) On the Navajo Nation we have a lot of Indian elders and we are finding that the “type” of elders is changing. They are more affluent and more educated than the previous generation. The elders that Title VI was designed for are at the point where they are requiring long-term care, and the long-term care facilities are lacking across Indian Country. As we look towards the future that is something we should think about.

C: (Steve Cadue) I’m concerned about the mental health issue. Dr. Devoine (sp) is a practicing medical doctor that told me that the greatest need in Indian Country is mental health services, preventative and therapeutic. When Native America people are in crisis, we consult with our elders. In terms of suicide, we are asking our elders for their perspective. We believe they are experienced and wise. They know traditional practices and a lot of young people want to incorporate those practices in their mental health solutions. I sometimes think that our elderly in our Tribe are not being heard enough. I want to share with you that as you work, give the elderly a voice and input. They want to contribute.

C: (Kathy Greenlee) Your points demonstrate why HHS has both “health” and “human services” in its title. Our partnership with SAMHSA is critical when we talk about the needs of older people and suicide being such a high risk for them. We don’t get direct funding for mental health services through the Administration on Aging, yet we know about depression. We know it’s not a “normal” part of aging; it’s a disease that can be dealt with. We continue to be an advocate and work with partners at the federal level on mental health issues because the story is bigger than just “health.” I agree with you about the role of elders, I think they are a national treasure and they should tell us how we should support them.

2. Mary Wakefield, Administrator, Health Resources and Services Administration

- HRSA has programs that focus on providing support services (mostly primary health care services to underserved populations); and other programs that are designed to strengthen the health care workforce.
- HRSA developed cultural competency technical assistance for its staff so they can be informed about Tribal sovereignty.
- Regarding child health care, ACA has a provision for home visiting with funding for 5 years (2010-2015). There is a particular set-aside for high risk families. Some of the money is directed specifically to Indian Country. HRSA is deploying this provision in conjunction with ACF. The President has identified that it’s one of three programs that he wants to continue beyond 2015. Ms. Wakefield requested that she return in September to discuss with the STAC how to strengthen the program in Indian Country.
- We are seeing issues with the workforce across the entire program. Maybe we could engage elders in the program.
- The National Health Service Corps (NHSC) program supports primary care providers and general dentists and dental hygienists. It pays for tuition and provides scholarship money in exchange for working in high-need areas. The program received a \$1.5 billion investment from the ACA. Tribal entities are automatically

designated to participate. In June there will be another virtual job fair for clinics to talk about their sites and get matched with scholars and clinicians.

C: (Roger Trudell) Our health board in the Aberdeen Area does Healthy Start; it's an avenue you might want to think about getting into when you talk about high-risk homes.

Q: (Ken Lucero) On your handout there was something about aiding Tribal entities to apply and receive federal funding through our programs. Was that specific to getting clinic grants or what were those funding opportunities? You said there weren't any Tribal entities that got funded.

A: (Mary Wakefield) We created a package of information that helps individuals understand the grants making process across all of our grants. Some of those technical assistance opportunities are specifically targeted to Tribes. They have the unique needs of Tribes in mind. So we have some general information about all of our grants in terms of how to apply effectively, but then we also have a set of specific technical assistance for Tribes on applying for our grants. It would include community health centers or FQHCs. It's general information. We will fund 25 new sites this year. The applications are good for one year.

Q: (Cheryle Kennedy) Regarding the technical assistance and training HRSA has given to Tribes, what have you learned? I'm not sure where you are gathering your input, but Tribes haven't been very successful in accessing these funds. How will you change things so Tribes can be more competitive?

A: (Mary Wakefield) It's why we flagged it in this document for this group's consideration. Maybe in the future we can have deeper discussion about your perspectives on how we can improve the success rates across all of our programs. We now have over 200 reviewers from Indian Country, but that wasn't always the case. We constantly look at how to improve our processes. At the Atlanta region consultation held on February 6, 2013, we learned a fair amount about how to improve our grants process. We get the information from really anywhere we can. We've done live webinar for Tribes on funding opportunities. We flag for Tribes, using every email we have, every one of our funding announcements that they are eligible for. We have tried to support technical assistance for Tribes that focuses on each step in the life cycle of having a grant. We invite input and your ideas.

C: (Cheryle Kennedy) We don't know what gaps your grant readers see. On the email infrastructure that you are setting up, we have the Executive Director of the NIHB in our audience. They have all of the Tribes in their database. I'm sure they would be willing to share information with you. When you see Tribes continually not get the grants they apply for, it's pretty discouraging to keep trying. My suggestion is that HRSA have a dialogue with NIHB, NCAI, and other organizations and Tribes. HRSA has a great responsibility to overcome health disparities and it seems like HRSA funds can help Tribes, but we aren't getting them. Our mental health and suicide rates are deplorable. If we have agencies that have funds that can help out other agencies, let's figure out how to do that so some of these funds can be shared.

C: (Mary Wakefield) We work with NIHB closely and HRSA established a consultation process in recent years and that is another venue for Tribes to give us input. We would love to talk about

what we are seeing, so that we can increase success rates of grants from Tribal applicants. Virtually every one of our programs has been impacted by the sequester. IHS is not the sole source of support for Indian Country; HRSA is all about serving vulnerable populations, wherever they are. We will look for more opportunities; that's why being successful with those grant applications is so important. Some programs, like home visiting, do have set-asides. We know those resources are going to flow, but that's not good enough.

Q: (Ron Allen) [Cheryle Kennedy yielded her seat.] Your update was enlightening and helpful. In terms of making these programs more accessible to Tribal communities, as the Administrator I would say the buck stops at your desk. The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program is something a lot of us are interested in. It says 25 grantees were approved this last year; and it's \$12 million nationwide that the Tribes compete for. Is that correct? [Seat returned to Cheryle Kennedy.]

A: (Mary Wakefield) It's 3% of the total funds. ACF manages that part of it. We can get the exact dollar amount for you by the end of this meeting. In addition to the funds that are directed to the Tribes, Tribes also participate in the non-Tribal set-aside as well.

C: (Ron Allen) [Cheryle Kennedy yielded her seat.] Regarding Tribes' need to access these resources, I'm guessing that your email system goes straight to the Chairs, Governors, and Presidents of the Tribes. Often, they are the wrong people to communicate with. I get them and I pass them on to the appropriate people. Also, about 75% of Tribes are under 1500 people, so I wonder if they can be competitive when evaluated against your criteria. I wonder if you are being sensitive to that issue. All of your programs are important and we have a lot of vulnerable populations in Indian Country. I would like to collaborate with you more so that we can be more competitive in Indian Country. In our community we often want to blend programs, so flexibility of the resources is important for Tribes. [Seat returned to Cheryle Kennedy.]

C: (Mary Wakefield) That's really helpful. We welcome ideas on making sure we have an accurate email list and the right people on the list. We have some non-Tribal applicants that can hire a \$10,000 grant writer; and we know some grant writers who are the same ones running the program and shoveling snow in front of the building. To address this, we are trying to give technical assistance and support to the most vulnerable with regards to the assets they have to even submit exceptional applications. The applications are competitive, so the technical assistance discussion is very important.

C: (Tracy King) On November 27, 1994, I was in Albuquerque at an IHS health conference. There was a session about issues that regard our kids. Subsequent to that, on January 10, 1995, I was part of a group of people to look at issues concerning our kids and families in Washington, D.C. That's where the Circles of Care started. I believe the first round of funding started in 1998. The National Indian Child Welfare Association did a lot of technical assistance. Terry Cross asked me to do some technical assistance. I found out that there were no programs that were culturally-based for Tribes. Each Tribe had its own way of dealing with their issues. I've seen too many kids go from foster care to group homes to lock-up facilities. My concern at the time was mental health and these young people's lives being destroyed by a system that fails. I've never seen a child fail; it's the systems that fail them. I knew we needed something specific

for Tribes. We needed to use our spiritual leaders and our elders for mentoring. Six years ago Jonathan Windy Boy and I were talking about SAMHSA programs, where the states get the money through pass through dollars. At the time a couple of counties, Blaine and Hill, went after grants in the name of Indians. They were Tribally and culturally-based. So you had these non-Indians getting the funds and they were going to show us how to be Indians. In 2008 Jonathan brought this issue to the HHS Budget Formulation meeting with me. I couldn't understand why people who hated Indians were being given money to help us. My point is that sometimes we need our people at the table to "interpret," because I don't want a County Commissioner telling me how to be an Indian. People need to respect the different Indian cultures and understand that our needs are different.

3. Mirtha Beadle, Deputy Administrator, Substance Abuse and Mental Health Services Administration

- SAMHSA has consistently been able to maintain about 100 grants to Tribes and Tribal organizations, at \$69 million.
- The Behavioral Health - Tribal Prevention Grant did not get enough support from Tribal leaders and is not in SAMHSA's budget for 2014.
- SAMHSA is trying to sharpen its work with Tribes, ensuring access to dollars.
- SAMHSA has a Tribal Technical Advisory Committee (TTAC) that advises its Administrator and this year it has the greatest participation ever.
- The SAMHSA AI/AN Team (SAINT), comprised of people from across the agency, looks at how to bring programs together (so they are not in silos) to benefit Tribal communities; as well as to looking at management, improving cultural competency of SAMHSA staff, improving technical assistance to Tribes by having a single technical assistance provider exclusively for Tribes and networking with other technical assistance providers, and improving communications to Tribes. Part of the communications strategy, via Project Evolve, is to collapse over 88 websites into one that includes a specific place for AI/ANs to visit.
- A Tribal Policy Academy was held in Phoenix a couple of weeks ago to look at alternatives to incarceration.
- SAMHSA has a National American Indian/Alaska Native Addiction Technology Transfer Center (ATTC)—this is a first.
- SAMHSA has a new Tribal Technical Assistance Center.

C: (Cheryle Kennedy) Autism rates for children in Oregon are extremely high, so that needs to be addressed. Issues that affect our Indian children often don't come to the forefront, so they struggle in school, they get labeled, and they are isolated. I'm a true advocate for our children and the problems that they face. Schizophrenia and bipolar disorder are also reaching high levels. Indian communities are struggling with how to approach these issues. The schools struggle with how to handle them, then the Justice Department steps in and they get incarcerated. Incarceration is no place for these kids; they need treatment and possibly hospitalization. Interaction with DOJ needs to be paramount. We don't have the tools or the skills to combat the mental health needs in Indian Country. There is no place for children to go to receive the help they need. Alcohol, substance abuse, and mental health issues go untreated and it's dismal. We need funds to combat these problems.

C: (Ron Allen) [Cheryle Kennedy yielded her seat.] For small Tribes, the turnaround time for SAMHSA grants is too short and requirements for “need” are too rigid. The structure is tailored to larger population-based Tribes. Smaller Tribes have a harder time competing. We need these resources. This is really SAMHSA’s turf. Children and adults have problems with prescription and other drugs, alcohol, and mental health issues that accompany them. Please revisit your grant application process, as we need greater access to these resources. [Seat returned to Cheryle Kennedy.]

C: (Mirtha Beadle) We are very concerned about Indian children and we don’t have the funding we would like, but to the extent we can provide support we do. The Behavioral Health - Tribal Prevention Grant would have been great for smaller Tribes, but we didn’t get the support for it. Every Tribe would have been eligible for funds. We may need to talk about how we communicate with Tribal leaders to push forward some of the work that we start. We are also working within the Department to bring resources and people together so we are not duplicating services. Regarding small Tribes, we are doing an analysis now to see what Tribes we are funding and if smaller Tribes are accessing our dollars.

Q: (Ken Lucero) A better coordinating effort with states to meet behavioral health needs is needed. Also, can you clarify what you mean by “lack of Tribal support” for those programs? What exactly do you need us to do or what did you need us to do?

A: (Mirtha Beadle) In terms of the partnership we would have hoped to have with Tribal leaders, we can only go so far. After we get the support of the Secretary and the Administration, we have to rely on Congress to support many of the things we put out. We talked with Tribal leaders at every opportunity and with the STAC about what the program was. There was no collective Tribal leader rally around this program that would have given it greater visibility.

Q: (Ken Lucero) So you are saying that you needed us to go to the Hill?

A: (Mirtha Beadle) We needed Tribal leaders to have conversations with everyone that they could have.

C: (Gary Hayes) Hopefully we can get something from you that we can broadcast about this. Mental health continues to be an important topic throughout Indian Country. Some of our children think it’s honorable to commit suicide, and that’s not what we want.

C: (Chester Antone) On the prevention grant, I mentioned during our caucus that we need to support the effort for those funds. We would like some paperwork from SAMHSA to use so we can garner some type of support from Tribal leadership. In March 2013, during the consultation in D.C., and in later discussions, I talked about fetal alcohol spectrum disorders to see if we can do more on this issue. Fetal alcohol spectrum disorder requires many services for children at a young age. It affects their emotional ability and some may require medication. We don’t have a medical diagnosis for this; and IHS no longer has a line item for this. I wanted to put this issue on the table. It’s important as we talk about Head Start and Early Childhood, as identification

really needs to happen at that level because it will affect their ability and emotional well-being as they age.

C: (Tracy King) Thanks for mentioning alternatives to incarceration. Nobody likes to work with rough kids; but if they can get mental health services and do something productive, that seems to help. They need a pat on their back for their success. A lot of the kids that were locked up are now war veterans. The system failed them. Many of them work for the Tribe on the volunteer fire department. The funds available through SAMHSA and IHS and DOJ really help. Those partnerships really help. We need partnerships for the kids to be successful.

C: (Steve Cadue) The Washington Post said Native Americans have the highest suicide rates per capita in the U.S. Funding is a critical part of all that we do. We need a great push for mental health funding in the U.S. I hope Native American mental health gets priority.

C: (Cathy Abramson) I believe a lot of our people have thought about suicide. I wonder if there is a way we can get that information. We have sweat lodges and more people are attending them. We have a warrior camp that builds character, shares culture/tradition; there is a naming ceremony, language teaching, and more. Young men are finding their purpose in life. All Tribes need help to bring back culture and tradition.

C: (Arlan Melendez) The issue of substance abuse seems to be getting worse and it's a challenge to send them for help. Unless it's mandated by the court, nobody wants to go for help. Another track is to build grassroots unity. Prevention coalitions of years ago ran out of money, but I thought they were great at creating grassroots levels of services.

C: (Pamela Hyde) The Mental Health Conference at the White House on Monday raised awareness about mental health issues. We were pleased with the Tribal Policy Academy that was done. The frustrations you speak about are our frustrations too. We can propose programs, but we can't get Congress to act. I hope we can talk about how to do better going forward, as the issue still remains.

C: (Gary Hayes) We hope to get a letter from you that we can get to the NIHB to get distributed.

4. Lawrence Tabak, Deputy Director, National Institutes of Health; and Dr. Dina Paltoo, Health Science Policy Analyst

- NIH supports biomedical support and training.
- NIH invited 27 students from Tribal communities to come to NIH for a 1-week summer enrichment program (the week of June 23, 2013).
- Funding announcements for the re-competition of the Native American Research Centers for Health (NARCH) programs were released at the end of May and applications are due on August 6, 2013.
- Tribal input is sought on NIH's draft policy for updating the Genome-Wide Association Data Sharing Policy. They are considering broadening the scope of the policy to include other types of genomic data. Once the policy is released, there will

be a 60-day comment period; two public webinars will also be held.
Genetics.ncai.org has information specific to Natives.

C: (Aaron Payment) Seven years ago the Cancer Registry in Michigan wanted to do a study and it was difficult to get my Council to understand its importance. It took us a year to convince our Council to approve it. Webinars to demystify the process would be helpful. It will also be important to note if it's a crime to violate the policy.

Q: (Cheryle Kennedy) There was a study about fetal alcohol syndrome, funded by IHS and done by the University of Washington, which disclosed pictures of children with mothers. Indian Country is concerned about this. How do you know if there has been a breach or not? Where is the bank of samples when someone is swabbed, for example? And could they go back to an individual for additional studies? Are there Natives that participated?

A: (Dr. Paltoo) We don't take samples for blood. We fund researchers, but we get data only. We have them certify what can and can't be done with the data. As far as monitoring, people with access have to submit an annual report on how they use the data. We've had 20 or so data management incidents, but nothing that compromises patient confidentiality.

C: (Lawrence Tabak) We would be happy to have offline conversations.

C: (Gary Hayes) Perhaps we can have a conference call.

Q: (Chester Antone) Can we have a copy of the guidance document?

A: (Lawrence Tabak) We will get the policy to you.

[Gary Hayes indicated that the remainder of the roundtable presentations would occur later in the afternoon. For ease of reading, those presentations are continued below.]

5. Judith Monroe, Director, Office for State, Tribal, Local, and Territorial Support (OSTLTS) from the Centers for Disease Control and Prevention

- CDC continues to look for ways to train its staff to understand the unique relationship with Tribal governments.
- The OSTLTS Tribal Support Unit has announced the availability of funds to strengthen and improve the infrastructure and performance of Tribal public health agencies and Tribal health systems. Up to five federally recognized Tribes will be funded for 5 years (FY 2013-2018). Applications are due by July 15, 2013.
- The CDC/ATSDR TAC Meeting and 10th Biannual Tribal Consultation Session will be held on August 12-13, 2013, in Atlanta, Georgia.
- CDC now has a standardized FOA for the entire agency which clearly identifies Tribes' eligibility.
- CDC's Health Officer Orientation for State, Tribal, Local, and Territorial Health Officials will be held on October 15-17, 2013, in Atlanta, Georgia.

- CDC is partnering with the University of Pittsburg to provide Tribal judges training this summer. Matthew Penn, Director of Public Health Law, is very interested in jurisdictional issues, so Tribes needing technical assistance can go through Delight Satter.

6. Lillian Sparks, Commissioner, Administration for Native Americans

- A report on human trafficking will be coming out in September 2013.
- Acting Assistant Secretary Sheldon's top Tribal priority continues to be Indian child welfare compliance and implementation.
- An Office of Child Care Notice of Proposed Rulemaking (for provisions related to improving health and safety in child care settings, improving the quality of child care, and implementation of family friendly practices) is currently out, with the public comment period ending on August 5, 2013. The Office of Child Care will have a consultation on the proposed rule on July 8, 2013.
- The ACF Tribal Consultation will be held on July 9-10, 2013, in Washington, D.C.
- Attention is being given to the Tribal Early Learning Initiative, where four Tribes that have Child Care, Head Start, and Home Visiting programs are being given supplemental assistance to enhance collaboration between their programs.
- ACF has a partnership with HRSA to do Home Visiting programs, with \$21 million funding the 25 Tribal Home Visiting programs. For FY 2012, \$10.5 million has been provided.
- The Assistant Secretary's Tribal Advisory Committee will convene for the first time at the ACF Tribal Consultation. Appointees will be contacted by the end of the week. There were no nominations from Region 2, 7, and 8, but nominations by Tribes are still welcome.

C: (Tracy King) Human trafficking is a big concern; I hope we can have a MOU with BIA Social Services because this has been an issue for a long time.

C: (Lillian Sparks) The Assistant Secretary has engaged in conversations with the previous leadership at Interior about doing an MOU on child welfare issues. We are looking to engage the new Assistant Secretary on this issue.

Q: (Roger Trudell) On Region 7, what did you need?

A: (Lillian Sparks) We need a nomination.

C: (Roger Trudell) I'll get that to you.

7. Nadine Gracia, Deputy Assistant Secretary for Minority Health and Director, Office of Minority Health

- The mission of the Office is to improve the health of minority populations by developing policies and programs that will help to eliminate health disparities.
- Three strategic priorities are: the ACA; leading the implementation of the HHS Action Plan to Reduce Health Disparities; and the National Partnership for Action to

End Health Disparities—a nationwide community driven approach towards combating health disparities.

- The Office has Regional Minority Health Consultants who can provide information on OMH programs, as well as a Resource Center that supports the Office and the public.
- The next Health Research Advisory Council (HRAC) has its next meeting in July 2013. There are still vacancies for Aberdeen, the Bemidji Area, and Alaska; the Billings nomination is under review.
- A webinar providing technical assistance on grant writing was recently done. Presentation materials and notes are archived and can be made available. Additional webinars are forthcoming.
- The Office announced in April 2013, the release of the National Culturally and Linguistically Appropriate Services (CLAS)—enhanced standards, advocating for culturally and linguistically appropriate services in programs and policies throughout the Department. Training will be made available.
- Tracy Branch is the designated point-of-contact; and the Office also has a newsletter to communicate its opportunities and others aimed at reducing health disparities.

Q: (Ken Lucero) In terms of health literacy, are you expanding the definition to include the new terminology in the ACA, like Marketplaces? The terms are new in Indian Country and across the country, so I would like to you expand the definition of health literacy to include those discussions. Are you working with CCHIO to develop those materials?

A: (Nadine Gracia) Health literacy is important as we think about implementation of the law and certainly with the Marketplaces. One avenue we have is the National Action Plan to Improve Health Literacy, led by one of the offices in the Office of the Assistant Secretary for Health. You are right, this terminology is new for all of us. We are working closely with CMS with regards to issues beyond language access. As you likely know there are language provisions in the ACA that deal with plain language, making sure the materials we put out explain what the factors in the Marketplace really mean.

Q: (Ken Lucero) Do you fund evaluation or is it NIH that does evaluation on the effectiveness of the outreach. We are talking about new materials and outreach. Are we thinking ahead to consider evaluation of the effectiveness of the outreach?

A: (Nadine Gracia) That is a discussion the Federal Coordinating Committee on the Marketplaces has discussed. They are thinking about the types of outreach being done, the best ways to reach communities, as well as the long-term impact. It's not something we would do alone, but it is a concern for all of us.

Q: (Ken Lucero) Do you include Tribes and Tribal organizations in any opportunities that you have to conduct that evaluation?

A: (Nadine Gracia) I would need to defer to CMS on that. Maybe Stacey Ecoffey can follow-up on that.

C: (Gary Hayes) It is important that Tribes understand the process, especially in states that are not cooperating. It's also important that people understand that Tribes have sovereignty. We should be able to be a part of the ACA. Injustice has been going on in Indian Country for decades. Maybe you can get with NIHB to put something in your newsletter about outreach for Tribes and understanding Tribal sovereignty.

As the group prepared for the arrival of Secretary Sebelius, Dr. Roubideaux announced that Geoff Roth is her Senior Advisor and the lead on the ACA, so questions on the topic could be directed to him. She also agreed to hand out IHS' ACA Business Plan Template after the meeting. During this time, Councilwoman Abramson reminded the group that NIHB's Consumer Conference was scheduled for August 26-29, 2013, in Traverse City, Michigan. Finally, Mr. Sheldon commented that ACF has been working on a government-wide Victims Plan for Human Trafficking, including tracking on Tribal land. He said Commissioner Sparks would get the information out to Tribal leaders; and he said Commissioner Samuels would have information on what authority ACF would seek regarding ICWA issues.

Secretary Kathleen Sebelius

Gary Hayes welcomed HHS Secretary Kathleen Sebelius to the STAC meeting. She, in return, recognized and thanked the Chairman for facilitating his first full STAC meeting. She also thanked the returning members for their participation and welcomed the new members into the fold. Noting turnover in the Cabinet with the President's second term, Secretary Sebelius said she will continue to pitch the idea of the STAC as an opportunity to work closely with Tribal leaders. She echoed the STAC's frustration on the budget, noting that the sequestration took \$15.5 billion out of the HHS budget and hit every program. To that end, she said the Administration's number one priority is to get rid of sequestration. On a more positive note, the Secretary expressed excitement about the opportunity to connect people with affordable health care starting on October 1, 2013. For the first time in history, she said hundreds of thousands of Native Americans will have access to affordable coverage. The Secretary assured the STAC that she continues to work with states to encourage them to take up Medicaid expansion; and she acknowledged the concern and problems surrounding the multiple definitions of Indian in the ACA. Regarding the latter, she said technical assistance is being given to Congress with the recommendation that the ACA align its definition with the one used by IHS. In the interim, she said HHS is determining what administrative authorities it may have regarding the issue.

After the Secretary's remarks, Gary Hayes formally introduced the new STAC members: Mr. Melendez, Mr. Payment, Mr. King, and Mr. Cadue; and he invited the STAC members to present the group's priorities.

The following STAC priorities were noted:

- Response is needed from CCHIO when presented with inquiries and requests from Tribal leaders.
- Need for strong advocacy about the Marketplaces and Medicaid expansion to Tribes, while educating them about different plans so they can be informed consumers.

- Tribes need equitable access to resources, e.g., Navigator and Assistor programs, for education, outreach and enrollment—regardless of whether the state is a state-based, partnership, or federally-facilitated Marketplace.
- The STAC has formed an ACA workgroup to address the ACA and related issues such as the hardship exemption, Medicaid expansion, the Call Center, electronic eligibility verifications, and the definition of Indian, among other items.
- Gaining continued support for the Navajo Nation to operate its own Medicaid agency, exercise true self-determination, and establish a laboratory for the development and experience of Indian Tribes across the country.
- Implementation of a waiver to prevent tax penalties that might be there for IHS beneficiaries who have yet to get health insurance.
- Garnering increased Tribal support for SAMHSA’s Behavioral Health - Tribal Prevention Grant that did not get funded.
- Increasing Tribes’ access to data sets held by state governments, as many are not recognizing Tribal Epidemiology Centers as public health authorities.
- Convening stakeholders to have a dialogue on how to get the ICWA passed as state law throughout the country.
- Allowing longer times for Head Start programs to meet standards, as funding reductions will impact programs and necessitate staff reductions.
- Finding ways to address the mental health needs of Indian Country.
- Encouraging collaborations among agencies to help supplement cuts to IHS.

When the STAC was allowed to make additional comments, Councilman Antone resurfaced the issue of wanting consultation with CMS for Arizona Tribes regarding the FFM. Regarding non-IHS 638 facilities on Tribal lands, he said for over a decade the Tribe would do an attestation on certification and licensure of those facilities. When the ACA came about, they were asked to comply on licensure and certification. The problem, he said, is CMS is telling the state to go onto Tribal land to license and certify; and the state is saying it’s not their jurisdiction because of Tribal sovereignty. He said a waiver to continue that process was requested, but they understand that they need to work towards something that is more suitable. He asked at this time that the AHCCCS reimbursements be continued until they can come up with something everyone can agree with. The Secretary admitted that she didn’t know the specifics of what was pending, saying she was told “it’s a Medicaid issue with the state of Arizona.” She said she would have to follow-up on the issue.

Other items identified as important by the STAC members included the following:

- Obtaining an exemption from the sequestration for IHS as the President negotiates the FY 2014 budget.
- Making resources available to Indian Country for its elders.
- Making HHS grants directly available to Tribes.
- Requesting the Secretary’s support on self-governance legislation.
- Making grants more accessible to Tribes and encouraging the use of Tribal set-asides.
- Approaching corporate America to support the ACA and articulating the need for greater economic development in Indian Country.

- Soliciting help with third party payments.
- Having technical assistance on how the health program works.
- Assisting Tribes in the area of electronic health records, as they are caught in the digital divide.

After the STAC members' comments, Gary Hayes thanked the Secretary for her attendance. She acknowledged that some of their issues are recurring, while progress has been made on others. The Secretary said she looked forward to being informed by our team about discussions that took place; and she said she would reach out to her fellow cabinet members and the President to keep Tribal items on their agenda. She noted that she received the working group's recommendations on self-governance a couple of days prior. She agreed to review them and then be prepared to talk about next steps, i.e., anything that can be done that does not require going to Congress. She also agreed to take the messages about mental health and economic development forward. She advised continued conversations with Congress concerning the exemption of IHS from sequestration; and she encouraged dialogue with state governors around Indian child welfare issues, saying it would be great if Michigan's Governor Snyder would be a spokesperson on the issue. She reiterated that she would be happy to work with Tribes, but cautioned that action prior to the Supreme Court's ruling could be premature. She asked that Mr. Dioguardi be given the communiqués that require responses from CCHIO, as well as specifics on states that have turned down Tribes' requests for data. Finally, the Secretary thanked the STAC for its work.

STAC Business, Closing Discussion and Comments

Ms. Ecoffey indicated that the next STAC meeting will be September 17-18, 2013. She asked that anyone interested in joining the Tribal State workgroup email her, as well as those that want to participate on the ACA workgroup.

C: (Ron Allen) [Cheryle Kennedy yielded her seat.] As the ACA workgroup comes up with its recommendations it would be helpful if they are shared with the TTAG. [Seat returned to Cheryle Kennedy.]

Tribal Closing

The meeting closed with Mr. Curley delivering the closing prayer.