

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

September 17-18, 2014

Summary Report

Paul Dioguardi opened the third Secretary's Tribal Advisory Committee (STAC) meeting of 2014, officially the first meeting under the auspices of the new Department of Health and Human Services (HHS) Secretary Sylvia Burwell. Secretary Burwell was in the midst of the confirmation process during the STAC meeting in June. Although STAC members had requested a meeting during the summer, the Secretary's first 100 days in office included a busy schedule of internal meetings and briefings. After becoming familiar with the Department and setting priorities, Secretary Burwell is ready to engage with important partners and stakeholders outside of the Department. The Secretary reviewed the STAC's priorities established for this year to prepare for a robust conversation.

Mr. Dioguardi discussed a few housekeeping items, noting that the next meeting will occur December 4-5, 2014. HHS staff will soon begin the conversation about dates for four quarterly meetings in 2015. Mr. Dioguardi added that STAC Chair Rex Lee Jim could not attend the September STAC meeting so STAC Vice Chair Brian Cladoosby would lead the discussion.

Members Present for Roll Call: Cathy Abramson (Bemidji Area), Ron Allen (Portland Area), Chester Antone (Tucson Area), Tino Batt (Portland Area-Alternate), Dana Buckles (Billings Area-Alternate), Cheryl Frye-Cromwell (Nashville Area), Larry Curley (Navajo Area-Alternate), Marshall Gover (Oklahoma Area), Gary Hayes (Albuquerque Area - Alternate), Ken Lucero (Albuquerque Area), Arlan Melendez (Phoenix Area), Andy Teuber (Alaska Area-Alternate) Roger Trudell (Great Plains Area), and Aaron Payment, William Micklin, Jefferson Keel, Stephen Kutz, Robert McGhee and Brian Cladoosby (National At-Large Members). (Quorum Met)

Action Items

Office of Management and Budget (OMB)

- STAC members should receive a copy of OMB's Tribal Consultation Policy.
- STAC members requested answers to their questions in written form.

Administration for Children and Families (ACF)

- Department should work on the tribal allowance for construction, which is minimal if not insufficient.

- HHS should ask the states if they consulted with the tribes in the development of the 5-Year Child and Family Service Plans required for state funding in relation to Indian Child Welfare consultation and compliance.
- As part of holding states accountable to their 5-year plans, there needs to be a greater focus on data collection to form a baseline that can document evidence and support decisions that are made with respect to states' cooperation and collaboration with tribes.

Center for Consumer Information and Insurance Oversight (CCIIO)

- HHS should increase the level of support to conduct policy development around why tribal members' enrollment in the Affordable Care Act (ACA) is so low after one year.

Intrdepartmental Council on Native American Affairs (ICNAA)

- Update STAC Website.
- Review minutes from other tribal advisory committees below STAC to see if the actions of those groups are consistent with the STAC.

Indian Health Service

- Discuss getting Congress to authorize Indian Health Service (IHS) as a 501(c)(3) nonprofit to seek foundation funding for the Resource and Patient Management System (RPMS) and other issues.
- The IT department of IHS will provide a written response to the statement about RPMS read into the record by Arlan Melendez.

Indian Health Service Discussion

Dr. Yvette Roubideaux, Director, Indian Health Service

After a round of introductions, STAC members moved into a discussion regarding the IHS budget. Budget issues have grown even more complex due to the way the appropriations language is written, said Dr. Roubideaux. IHS received a \$304 million increase that, according to the congressional language, should go toward Purchasing Referred Care, the staffing amount for new construction and to fully fund contract support costs (CSC). The administration is committed to fully funding CSC for 2014, and it is in the President's budget for 2015.

Congress, however, removed the "not to exceed" language for CSC, which meant it removed the overall appropriations cap on CSC. As a result, Congress is in the untenable position of fully funding CSC even if that effort reduces other budget priorities, said Dr. Roubideaux. CSC sits in the services appropriation, so if the amount or need for CSC is greater than what is available, then by law IHS must reduce the rest of the budget in the services appropriation.

In May, IHS reduced the budget by \$10 million. However, the amount has fluctuated due to regular adjustments and changes in indirect rates. What's more, tribes came in to renegotiate CSC, which increased the obligation and need in FY2014 to \$48 million as of August 22. IHS

recently sent a letter to notify Congress of its plan to reprogram funding to cover that increase to fully fund CSC.

IHS hopes that final total will come down as staff finalize negotiations and reconcile amounts. Even so, CSC is variable and costs can change over time. In fact, last week an additional \$5 million to \$6 million was put on the table by a tribe, which sets the total above \$48 million. The number could go up again, and without any limit on CSC in the services appropriation, IHS is under obligation by a Supreme Court decision and Congress' instruction to take that funding out of the rest of the budget.

Typically IHS would have used funding at the end of the year for renovations and provider contracts. Rather than focusing on blaming, Dr. Roubideaux encouraged tribes to understand the problem and concentrate on working with IHS to fix it. IHS wants to support full funding of CSC as well as the rest of the budget with the Direct Service Tribes. No one wants full funding of CSC to come at any expense to the rest of the budget.

Dr. Roubideaux noted that IHS could not have known about the \$48 million sooner because tribes have the right to come in for renegotiation of CSC through the end of the year. So IHS could get additional need through September 30.

To reduce the impact on the rest of the budget, IHS will take the funding out of headquarters first and then take the funding out of the areas. However, funding will most likely have to come out of the service units as well, although IHS will try to minimize that impact.

If the appropriation continues without any limit on CSC within the services appropriation, this problem will occur every year. IHS has posed several recommendations to the Obama Administration, including getting money from Congress for the \$48 million or seeking an anomaly to pay it back. The administration has not made a decision yet. This first continuing resolution (CR) was meant to be a clean CR, said Dr. Roubideaux, so there is minimal chance of getting anything in that. There is still time, however, to get something into the final appropriation for 2015 or a full year continuing resolution.

Moving on to other issues, Dr. Roubideaux noted these points:

- The Tribal Budget Formulation Workgroup and the Tribal Self-Governance Advisory Committee have organized an IHS Budget Summit for October 13-14 in Washington, DC.
- Although the House and the Senate marked up a budget for IHS that was similar to the president's budget, it is likely that a continuing resolution will go through until December 11.
- IHS has completed listening sessions in all 12 IHS areas and plans to focus on better communication and follow-up at headquarters as well as at the area and local levels.
- IHS is now presenting its budget to OMB for 2016. Staff members continue to work on improving consultation, operations, finances and more. Overall IHS continues to seek more funding and make improvements.

Questions and Comments

C: (Ron Allen) The objective of getting 100 percent CSC was not intended to negatively impact the Direct Service Tribes or programs that serve Indian Country. And I don't believe Congress intended it as well. I believe that we need to work closely together -- you, the Secretary, the OMB leadership, in conjunction with Congress -- to identify that this was an unintended problem or consequence of honoring these contractual obligations with Indian Country, and we need to look for a remedy in the appropriation process to remedy potential impact in 2014 as well as 2015 and beyond.

We need to revisit the policy because the way the policy is structured with regard to how we can find certainty of what the CSC obligation is for tribes -- self-governance compacts and 638 contracts. There needs to be a deadline so we have time to sort out what the actual numbers are rather than going up clear to the end of the fiscal year, which actually goes beyond the fiscal year. That kind of uncertainty is unacceptable.

We didn't intend it either. We are just following the rules. So we need to fix that quickly. And I think that our IHS Contract Support Workgroup and leadership can find a solution. That message needs to be articulated clearly back to OMB and to Congress so they know we have recommended solutions. In the long-term we do have solutions that we think can remedy this problem.

The last point I want to make is a comment was made this morning that the Secretary suggested that advanced funding authority is not a solution, and I am not sure if she is well-informed that it actually is part of the solution. It is not the total solution.

A: (Dr. Yvette Roubideaux) I can clarify that last comment. The Secretary met with the tribes in Port Gamble and she can probably --

C: (Brian Cladoosby) I was there and I actually asked that question.

C: (Dr. Yvette Roubideaux) Yes. And I don't think she meant that it wasn't the solution. I think what she meant was that it would be a very difficult solution to get in place, and so -- and were there other ways of getting the outcome you want if it is difficult to get advanced appropriations. That is the message that I have gotten from her -- and I have gotten from a lot of people, even Congress. Advanced appropriations are very hard to get.

And so I think that the Secretary was just genuinely asking. She understands the problem with continuing resolutions and shutdowns is tribes have a lack of cash flow, and it is difficult to plan without getting your full lump sum. And you need better certainty of what your budget is for the 638 programs. We certainly would like better certainty on the direct side.

So she just was plainly asking the question of while we are looking at advanced appropriations and trying to figure out how to make something very hard to do, to move that way, is there anything in the interim that we could do to help. It wasn't her saying that she didn't believe in it necessarily. I think it is more about she wasn't sure it could be done. But you could certainly ask

her that question later. My impression of it was she was trying to figure out is there anything we can do now to help you while we are working on that longer-term solution.

The administration has not had a position on the advanced appropriations yet. Right now we are still reviewing it. But I think she just intended to say is there anything else we might do in the short-term.

C: (Aaron Payment) I am on the Contract Support Cost Workgroup and I do have to say that it is extremely complicated because it is a balancing act between predictability, transparency and also flexibility for tribes to be able to negotiate in their best interest.

And part of the challenge is there is some artificiality going on here with the timelines. And so I think the case is made through this example of the amount that we are going to fall short of \$48 to \$53 million. That is absolutely, to me, the best argument for mandatory funding next year, reconciliations, doing our best estimate at the beginning of the year and then reconciling at the next year.

But then if that is to happen, you need multi-year funding, and you need advanced appropriations. And so if funding for tribal health is a prepaid concept -- you know, we prepaid for this. It is not welfare; otherwise, there would be other health services to the extent that we receive for other groups. Then advanced appropriations should be to me like a no-brainer.

I know there are complications with how do we get it done. So one thing I wanted to say though is with Congress stepping forward, and in some cases probably some members of Congress beating up the administration. Like, how dare the administration not project the budget correctly? And we are here to full fund -- and it is a campaign year so they got contributions out of that.

But to me it is a matter of opportunity. And let's grab that opportunity with members of Congress by having and aligning the president's commitment to this trust obligation that he has stated. And so that means going to Congress with a full request. Not with something less than what we think we need. And I will put it on the table: So the new Secretary is coming from the OMB. And the OMB has always been the area that everything gets bottled up in. So I am wondering -- the current policy with respect to contract support, what role the Secretary had in drafting that up?

But this is her opportunity to step forward and show a commitment. We are really watching this closely because as I have said, this has been the best president we have ever had with respect to Indian Country. And the stated commitment when we have been underfunded doesn't seem to be -- it seems to be incongruent. So how can we get on the same page? How can we work as a team and look to solutions?

Indian Country will continue to stand behind this administration but we need to see some light at the end of the tunnel and a vision for how we can get fully funded, and not only fully funded for CSC but full funding for the obligation in health that we prepaid for.

A: (Dr. Yvette Roubideaux) I think we all have that goal of being fully funded for everything in the budget. It was a big decision for the federal government to say we are going to fully fund CSC in 2014. That occurred because there was a group of tribal leaders who went and met with OMB and made the case in a very good way.

There is a willingness to try to fund as much as possible for the Indian Health Service. Nobody wanted to have a negative impact on the rest of the budget. Congress passed legislation that removed the limit on CSC, and that is what did it. It is not because IHS has somehow miscalculated or somehow not known. It is a functional thing of the appropriations language.

We are lucky we actually do have an increase this year. If we didn't have an increase in the budget, then the contract support cost need above -- the new need would be an additional cut below that. So I know there are people who are saying IHS just didn't budget correctly this year. How could I have known that tribes would now start to want to renegotiate CSC? That was a new thing that happened after July and August.

So I think it is important for us to understand the factual pieces here, that the appropriation is set up in a way that the rest of the budget services account will always be at risk if there are not enough funds for CSC.

You are right: the Secretary understands budget and she understand the difficult choices that are made over at OMB. It can't continue to be the way it is because in subsequent years we could have a decrease and that would be catastrophic. We have just received recommendations from four committees: Self-Governance, Direct Service, Budget Formulation and CSC. We are now compiling that. We just met with the Bureau of Indian Affairs (BIA) to see what they have received from tribes. And we are going to make recommendations to HHS and then OMB and then to Congress.

A: (Brian Cladoosby) I think that is our goal here, to recognize that we have an issue for '14 that needs to be addressed. But how do we make sure this isn't repeated? How do we make sure we put mechanisms in place where we are not doing this song and dance in another year?

C: (Ken Lucero) Forgive me for stating the obvious, but this is unacceptable. It is unacceptable for Direct Service Tribes that we are going to be impacted by this. And I know that Chairman Hayes had brought the message from the meeting that he had with the Albuquerque Area Indian Health Board that that was unacceptable to them as well. And also from the pueblo governors for our Direct Service Tribes, it is also unacceptable.

I just want to go on record stating for the Albuquerque Area that we will also be looking to you and the administration to work with us on remedying this because we do support the Self-Governance Tribes, and in their actions, in terms of trying to get what we all deserve, which is full funding for our contracts and for our services but not at the expense of Direct Service Tribes. So we need to fix this, and it is unacceptable for you to take money out of program moneys.

A: (Dr. Yvette Roubideaux) Thank you, and it is definitely heard. We have got CSC mixed into services, and if there was a way to separate them out then it is sort of -- we would protect the rest of the budget and CSC can go up and down as it needed. From what I understand, that is the reasoning behind the tribes promoting the mandatory separate account, to try to separate out CSC away from services so it doesn't have to impact.

I think a lot has been said about the Indian Health Service, that the reason we never supported full funding of CSC was that we didn't support tribes. And I don't think that really was the reason. I think the reason was they always saw this as a possibility and didn't want this to happen. And so, you know, for the Indian Health Service, it is always budgeting and being put in the difficult situation of managing priorities. And the overall, the "not to exceed" language in the previous years worked to protect the rest of the budget but didn't work because there were never enough funds for CSC.

And so it is like this doesn't work but that didn't work, so we have got to find what does work. We don't want to have this recur in the next years. This is an awful thing. I was heartbroken in May when I had to cut \$10 million. We don't even know what to think about the \$48 million, and we are working as hard as we can to try to minimize it but it is still there.

Q: (Brian Cladoosby) One of the big discussion points this morning was that the Direct Service Tribes would be impacted heavier than the self-governance. In your opinion, is that what you see as happening also? That is what came up this morning. We are going to get into this inter tribal fight between self-governance and Direct Service Tribes as a result of this, and that is the last thing we want to see.

A: (Dr. Yvette Roubideaux) I have been doing everything I can to not be responsible for spurring a fight, so I have been trying to present things very factually but the services budget, only about 5 percent is truly non-tribal shares money. So 95 percent of the services budget is actual tribal shares for Direct Service Tribes. That is funding that is retained in the Indian Health Service on behalf of the Direct Service Tribes.

So if that part -- and I think you said this well yesterday, Aaron. A lot of people say, oh, let's just stick it to IHS and reduce their budget. But the fact is like 95 percent of our budget is actually retained tribal shares for Direct Service Tribes so if there are reductions on the federal side, that does reduce funding for Direct Service Tribes.

This is because of the way the appropriations are set up. CSC is mixed into that. It is like administrative costs are mixed into services. Without any structure or anything in place to separate them, and we have a Supreme Court decision that says we are obligated to pay and we have Congress that says they want us to fully fund, we have legal direction to fully fund CSC, even if it reduces other priorities. So we need something that still supports full funding of CSC but helps protect the Direct Service Tribes' tribal shares.

Q: (Steve Kutz) You are talking about tribes coming now and renegotiating CSC like right up to the deadline. And so what I struggle with here is if the intent is, and the law says fully fund CSC,

why are tribes having to come back to the table to renegotiate something that should be happening and should be predictable?

A: (Dr. Yvette Roubideaux) From what we understand, tribes might not have cared very much about the calculation of CSC when they knew they weren't going to get their full funding. But now that it is a full-funding environment, I think that tribes are being advised, hey, if you look at your calculation, if you do this or that, you might be able to get more CSC.

And we should expect that people are going to do that. They are going to want to get the most funding from their contract. And the reason is sometimes people might have had a rate that has been provisional and they forgot to update the rate with the Indian Health Service. So they want to come back in and renegotiate and say, no, we want to use this updated rate.

There is also, I think, on the IHS side, some thoughts that there is flexibility in how you define direct CSC. So I think some tribes are coming in trying to see if they can renegotiate that and do that differently. And again, that is allowed. You can renegotiate your CSC at any time. And people might be thinking, well, let's go in and see if we can renegotiate it. You can't blame people for that. But there are deadlines for new and expanded. Title I, the deadline is July, and Title V, the deadline is August 17.

But to renegotiate CSC, direct or indirect type costs, that can go clear through the end of the year because there is no actual deadline. So what we have been working with on the CSC Workgroup is can we work on some deadlines earlier in the year, because a lot of this does require planning. It is not unreasonable to think that maybe people would be willing to have a deadline earlier in the year so that we would at least know earlier in the year about the numbers.

Very few renegotiated their CSC prior to this year. So it is a new thing that is occurring. And we have to deal with that reality and try to fit that in. Does that help?

C: (Steve Kutz) Well, it helps only partially. I am saying that the system needs to be predictable. The contract support cost should be predictable for everybody so that you don't have to go in and renegotiate.

A: (Dr. Yvette Roubideaux) We completely agree, and that is what the CSC Workgroup has been working on. But there are lots of variables in the calculation that we now understand can change it over time. We are basically working with what we have and trying to make it more predictable. And I think the CSC Workgroup as well is along the way to doing that with this new CSC estimator tool, with this new matrix of default, pass-throughs and exclusions for the indirect base. There are things they are working on that will make it more consistent.

We have heard recommendations about -- some people have provisional rates for multiple years. And it is unpredictable when the final rate is going to come. So could we have agreements that for this fiscal year this is the rate, and then if it updates later in the year, you will wait until the next year to use it. Then we would have more certainty in the fiscal year.

Some tribes are interested in negotiating a fixed rate for multiple years or a fixed amount or lump sum for multiple years. We had a pilot study on that in the past but it allegedly didn't work out. But we are looking at that again.

Q: (Roger Trudell) This is kind of a three-part question. The statement was made earlier that because we are at this point in the fiscal year, almost at the end of the fiscal year, that this possibility or probability of taking dollars from direct services will not have any impact. I think that is a very untrue statement. This is already impacting the clinics and hospitals in the Great Plains. And will continue to impact not only for the balance of this year but well into next year and maybe the year after.

And the other question was asked earlier about what is that impact dollar-wise on the direct service facilities and tribes? I know you talked about 95 percent of the shares or whatever held, but dollar wise what is that impact on the Direct Service Tribes?

And the reason I ask is because at some point the tribes in our regions or areas are going to ask us, as members who sit here and get a lot of firsthand information, exactly what is that impact going to be?

A: (Dr. Yvette Roubideaux) This late in the year, what we had to do in August when we figured these numbers out is look at available balances and hold them. And so the money that we had available in August that would have been spent in September, now we are holding that money to see what the final amount is.

Money that is spent in September, aside from salaries, is normally for regular operations but would have also been spent on renovations. A lot of times at the end of the year, if there is money left over, they will use that do renovations. A lot of the end of the year contracts for providers and other services are done at the end of the year with money in September.

I had a lawyer come up to me and say, well, you always have a big balance at the end of the year so there is no impact. That used to be the way IHS was but we have improved our financial management. Our balance at the end of the year last year was \$3 million. So we don't have a big slush fund at the end of the year like we used to. So this money would have been spent on something, and right now I am asking our area directors to further define what that was. There is no doubt that there is impact. We will know further as we move forward.

Q: (Roger Trudell) There is going to be some impact on Roger Trudell when he goes to the clinic. And I guess that is what I am trying to determine for us as the Direct Service Tribes. We are getting a lot of, well, if it wasn't mixed in here, it wouldn't have happened. But it has happened. And we need to have, in my opinion, we just need to have more concrete knowledge of what that impact is going to mean to the tribal person who is seeking health assistance.

A: (Dr. Yvette Roubideaux) I think we will have a better idea of that later in the month when we know the final amount. We are reconciling right now, and we are actually encouraging tribes to hurry up their negotiations with us to get them done. So that means the number might go down.

But if more people want to negotiate, it is going to go up again so we don't know where the final number is going to be.

So we don't quite know the exact impact but I already have ideas in each area of what the impact will be based on what the area directors are telling us. And we will be able to share more of that as we know the final number. The impact for each area is different and we actually -- once we know the final amount that we need to reduce the budget by, we will know what share each area has to reduce as well.

The best way to think about it is there will be some services that may have been available that wouldn't be available now or some things that the services budget could have bought that wouldn't be available.

C: (Brian Cladoosby) Our goal here as advisors is to make sure we don't have a repeat of '14 and '15 and '16, make sure that the '15 and '16 budgets have that predicted increase for those two years. But once again I am not sure if we are increasing CSC for '15 and '16 only at the detriment of other line items again. That is a concern.

C: (William Micklin) You mentioned the alternative scenario which was previously that we would have the operations budget, baseline budget, and then tribes would be partially funded for contract support and then litigate for the unpaid portion. The courts found that the administration needed to adhere to the obligation of contracts doctrine.

So here we are with contracts that need to be paid as a matter of law but that -- I think the essence of the problem and a solution in the successive fiscal years other than the one we are struggling with in the near term is that the administration in the president's budget needs to propose a budget request that reflects that requirement for full pay of CSC, and how we determine that will be a determined exercise to provide certainty in that area. But also to maintain the funding for the operational budget.

If not, then we are looking at continued diminishment of the baseline budget as we need to pay into the shortfall in the contract support. And this a devolving level of funding that in no way meets the federal trust responsibility, the obligation of treaties and just the moral obligation of the United States to provide health services when that is really the essence -- the trademark of this administration is the Affordable Care Act to provide health services for people who need health services.

And even the Veterans Administration, when found that military folks were waiting too long for services, there was a rush to fund that to an adequate level. There is a definite moral obligation to make right what we can, and we can do this if the administration will take on that obligation.

And I want to point out that this has impacts far beyond the struggle between contract support and Direct Service Tribes. One of the issues that needs attention is the electronic medical records system, the RPMS that is used by tribes for the Government Performance and Results Act (GPRA) performance and also for programs.

It is integrated into everything: medical, dental, pharmacy, mental health, labs, X-rays, referrals with all the hospitals and specialty care. It is an antiquated system. It continually needs upgrade, and we don't have dollars for it. The CEOs for tribal facilities went to the National Indian Health Board (NIHB) meeting in New Mexico and identified this as a priority challenge.

When a new system is rolled out under RPMS, it is rolled out with the data in test mode instead of in real mode. And it is very frustrating because we are dealing with patients and the quality of life and care. The test mode is inadequate to the urgency of our systems.

As well, there are opportunities and in fact obligations to provide data connections to hospitals for referrals. And that takes money because the requirement to customize, to program RPMS to speak to the IT systems at these hospitals, which are as a matter of rule current and not antiquated like RPMS, it takes a significant amount of money to do that programming. We don't have the money for it. The regions tell us they don't have the money for it. IHS apparently doesn't have the money for it.

These are critical operational health care systems, and we don't have the money to accomplish not only what is within our operational requirements but is in fact an underpinning of the Affordable Care Act that these improvements in IT support reductions of cost.

So RPMS is a critical system, and while we are diminishing our operational baseline budgets in this exercise with contract support, how can we get to the critical issues with RPMS that need attention and in fact funding? It is such a priority that we must not forget this as a current and urgent issue at the time we are trying to solve the contract support issue.

A: (Dr. Yvette Roubideaux) Absolutely. We are still trying to get more money for IT and a lot of times we would use end of year money to address some of those issues. And that is just not possible this year.

The other thing is the administration did propose full funding for 2015 based on what we knew at the time we proposed it. Now that there is a different circumstance, with what we have learned this year, I am certain that there is some thought going into how do we possibly make sure that we have enough for CSC when so many variables in the calculation are moving targets? And we are working with the CSC Workgroup on trying to improve that.

We would like to find a long-term solution so we can fully fund CSC and also support the rest of the budget and all the other priorities. You are absolutely right to bring that up. There are other things that we want to work on. The way Congress set the appropriation up this year creates this situation, so there needs to be congressional action to fix it. And it has to be long-term.

The administration for the next two could put a bunch of money into CSC and make sure we fully fund it. Who knows what is next? Previous administrations have cut the IHS budget. And if we still have no limit on CSC within the services appropriation or no other way to manage that dilemma, a cut to the IHS budget cuts the budget even more for the increase in CSC that year.

So I would encourage everyone to think long-term. We have this appropriations language that in the future, if an administration cuts the budget, the additional CSC need above that will be further cut from the services budget. So we need a long-term solution that can stand the test of time beyond a supportive administration and protect in a nonsupportive administration.

Q: (Marshall Gover) You said that it would be headquarters and then area and then taking money out of service units. Will the service units be hit equally when it comes to that point or will some service units be hit more than others?

A: (Dr. Yvette Roubideaux) We are going to try to make it as fair and as equally distributed as possible.

C: (Marshall Gover) And then I had a question about the Veterans Affairs (VA) Entitlement Act of 2014, about non-Indian veterans being able to be seen at the Indian clinics. And they are having a meeting today in Denver on that. It is kind of bad timing since the CSC's shortfall, and they do allow non-Indians to be seen, particularly Direct Service Tribes. Even though when they get paid, it might be six, seven, eight months down the road.

So we are seeing our doctors and our pharmacists hit, and it is cutting into the Direct Service Tribes even deeper. It seems like the two agencies aren't really talking along those lines, particularly at a time like this.

A: (Dr. Yvette Roubideaux) I hear your concern. There is something that protects us. Right now veterans can come to IHS under the agreements and IHS can get reimbursed. There is also a provision in the Indian Health Care Improvement Act Reauthorization that says that our facilities can see non-beneficiaries as long as they do not negatively impact services.

So it is going to be a local service unit decision about -- the law allows for veterans to be seen at our facilities, but the law also allows for us to say no, we don't have room. So that is a further provision we can provide more information on.

C: (Brian Cladoosby) Most attorneys listen to words very closely, and I have fallen into that habit. But when you use the term limit or manage, that is just another code for caps. I don't think that is what you meant.

A: (Dr. Yvette Roubideaux) I don't know what the word is. If you guys have -- I asked this of some tribal leaders I met with last week. I am trying to be as sensitive as possible about how we are discussing this to not inflame anybody. I just want to present the facts and encourage solutions.

Q: (Chester Antone) I just basically wanted to re-echo Mr. Lucero's comments, and I also want to stress that when we had the teleconference with you at the Tucson Area, we asked that nothing be taken from the hospitals and clinics line item. However, in the most recent mailing you sent out, that is going to be taking the largest cut.

And then I would also like to know when you will finalize the direction that you are giving to the areas offices, and also when we talk about cutting services, especially in the hospitals and clinics line item, does that mean employees will be let go as well?

A: (Dr. Yvette Roubideaux) I don't anticipate any furloughs or layoffs this year because of this. We will let you know when we finalize the direction. This week is focused on reconciling -- get the tribes in and let's get those negotiations done. Make sure we have the right numbers. I think we will know better next week what the amounts will be.

The reason hospitals and clinics have the most amount taken out at this point in the budget is because it is the largest line item in the services that had the largest available balance at this point, or as of August. Those are the dollars we are holding right now looking to the final number.

C: (Chester Antone) Just one more quick comment. I am kind of looking at this in a larger sense. When we say that the priority is Indian Health Service, I think along with that I think the priority is the Affordable Care Act and the reimbursements that are going to come from there or are coming from there. That is why OMB is requesting third-party data to assist in cutting. And also the things like the systems of care that in some way advocate case management to create programs that are self-sustaining. It is a positive but we have to look at it again as how it impacts direct services.

Just a thought there. There are some reimbursement pockets in the ACA but I think also one of the most important things is to maintain the accreditation, and oftentimes third-party billing collections are used for that.

A: (Dr. Yvette Roubideaux) Thank you. You remind me that I should probably let you know about an issue that is current right now in third-party collections since you are meeting with OMB. I met with the Self-Governance Advisory Committee about two months ago and indicated that, you know, when we report third-party collections in our budget justification, we report actuals for the federal side, and we have been carrying over an estimate for the tribal side since the 1990s because tribes have told us they don't want us to update third-party collections because you feel you are sovereign nations. That is your financial business.

For many years, OMB has wanted us to get actual reports of third-party collections for tribes. We have been holding them back, saying, you know, tribes don't want to report this. They don't feel like they should. This year, OMB has said very clearly they want us to work with CMS to report on those numbers. And we continue to drag our feet and stall because we feel like we want you to hear that this request has been made, and we want your feedback on it.

When I presented this at the self-governance meeting, I heard loud and clear that the tribes did not want to share -- the 638 programs did not want to share their third-party collections and wanted to be consulted before that occurred. So IHS' position is this is something that should be consulted on with tribes, and we are dragging our feet as much as we can.

Technically CMS does have the data, and we have been, you know, sort of encouraging all of us to sort of stall so that you all have an opportunity to give comment on it. But I think maybe OMB is thinking they just -- you know, they have been carrying over an estimate since the 1990s. They just want the updated estimate in a factual way. But you probably have reasons why you as tribes don't want to share that information, and we heard a lot of that at the self-governance meeting.

That is an issue I know that is very important to you. Our position is we think further consultation is warranted.

C: (Ken Lucero) I just have a couple suggestions about estimating CSC needs in the future. I think that is something that probably the Contract Support Costs Workgroup and even the Budget Formulation Workgroup need to get a handle on in forecasting what the needs are going to be in the future, maybe even giving and calculating out if there was to be 100 percent contracting.

It is really concerning that you are saying that you didn't have any idea that there was going to be this type of need or that tribes were going to come back and ask to renegotiate given the full funding possibility now because really you should have known that or someone should have known that there was going to be this level of need and this type of impact, and that was going to happen to your budget.

So I am offering I think some solutions to help you be better prepared so you don't have to say that you had no idea because again that is not acceptable.

A: (Dr. Yvette Roubideaux) I guess I shouldn't have said no idea. I said we didn't know the -- what the impact would be. We only found out about the full funding in March when the full appropriation was passed, and then we only submitted our operating plan in May.

And we suspected that there might some increased contracting but there is no way to know until a tribe actually comes in. And that is why the deadlines would help if they were earlier in the year so that we would have some advance notice on it. I wouldn't say we were unaware but two years ago we didn't know the administration would agree to fully fund contract support cost, and we didn't know that the appropriations cap would be removed.

And so because of those two things, not knowing that two years earlier, how were we supposed to know what the amount would be then?

C: (Ken Lucero) I guess just a quick response to that is I think that is why it is helpful that the foresight the tribes had in the budget formulation to actually go out there and say this is what our true need is and this is what our real budget is, that you could have based some of those contract support cost needs off of that.

And so there is -- it is necessary for the Budget Formulation Committee to continue to put in what their real level of need is and what their real expectation for shortfalls in funding is so that we can arrive at a really good number about what the contract support cost needs are.

A: (Dr. Yvette Roubideaux) Absolutely. And I do have to point out that some of those numbers are based on numbers that we give as well. We definitely have to find a way moving forward to better estimate the amounts. But without any deadlines on contracting, there is no way to know because, for example, the Navajo Nation might decide to come in with all six other service units in a year. That is a huge unanticipated need.

If we can work collaborative with tribes and say, if you have a big program and you are going to be coming in, let us know a year in advance. Or let us know that this is coming in. Those things would help us.

I do present the tribal budget formulation recommendations as the first thing when I go meet with OMB. I do present them and let them know: Here is the magnitude of the need. And then we present the budget, the highest budget we possibly can give the constraints that we are under. We try hard to get as much money as possible.

The thing though is that usually in the budget formulation, they give us a high amount that we can propose. I always say the amount is higher and I always propose higher. But we end up -- there is a certain amount of an increase we have to fit everything into. And that is where we get into trouble. And that is just a part of the process.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Pam Hyde, Administrator

SAMHSA has streamlined and consolidated some of its work to provide more effective assistance to tribes. Ms. Hyde gave these updates:

- SAMHSA announced in August the creation of the Office of Tribal Affairs and Policy (OTAP). Under the direction of Mirtha Beadle, OTAP will serve as an entry point of information on tribal services available within SAMHSA. The Office of Indian Alcohol and Substance Abuse is now located within OTAP.
- SAMHSA seeks a new director for the Office of Indian Alcohol and Substance Abuse. Interested candidates should contact Ms. Beadle.
- In 2014, SAMHSA received \$5 million for a new tribal behavioral health grant program called Native Connections. This program seeks to reduce the impact of substance abuse and mental illness on American Indian/Alaska Native (AI/AN) communities through a public health approach. The grant will focus on the tribes with the highest rates of suicide during a 10-year period. SAMHSA will soon announce the 20 tribes that will receive grant awards of up to \$200,000 for five years.

SAMHSA has expanded its technical assistance on workforce-related matters through its National AI/AN Tribal Addiction Technology Transfer Center. Comprehensive and focused technical assistance is also being provided through the SAMHSA Tribal Training and Technical Assistance Center.

- The SAMHSA American Indian/Alaska Native Team (SAIANT), which meets every month, is working on a tribal communications strategy, a streamlined application process for tribes, and data collection issues that have been identified by tribes.

- SAMHSA offers funding opportunities that support integrated home and community-based services and support for children and youth. Tribes can participate in Circles of Care, a three-year discretionary grant program that goes to tribes, tribal organizations, urban Indian programs and tribal colleges.
- In response to concerns raised by tribal leaders, SAMHSA's Regional Administrators are working with the Office of Tribal Governmental Relations (OTGR) within the Department of Veterans Affairs to address issues faced by AI/AN veterans.
- SAMHSA held a policy academy that included four tribes focused on diverting justice-involved youth to community settings.
- OTAP is leading an effort to revamp SAMHSA's project officer training to educate staff on working with tribal governments and assist them in more effectively carrying out their work with tribes. SAMHSA staff will test a new training curriculum in early October. Curriculum modules will cover:
 - the historical and contemporary government-to-government relationship,
 - state and tribal relationships,
 - grants management,
 - high-risk grantee management,
 - data gathering in tribal communities, and
 - cultural considerations.
- As a means of strengthening its work with tribal nations, SAMHSA executives visited tribes in Alaska, Washington, and Montana to learn first-hand about their behavioral health issues and challenges. Among the issues that continue to be raised are the substantial differences between discretionary grant processes and IHS's processes and considerations for awarding funds to tribes. To further the understanding of its Executive Leadership Team, SAMHSA will work with IHS to provide training on IHS funding.
- Ms. Hyde clarified details about the institutions for mental diseases (IMD) exclusion in youth residential treatment centers. SAMHSA does not control this provision but frequently encounters concerns with the exclusion when working with tribes. SAMHSA will work with the Centers for Medicare and Medicaid Services and IHS to address questions and opportunities, and assist tribes.

Questions and Comments

Q: (Ken Lucero) Tribes are eligible to operate certified community behavioral health clinics under a state pilot. What is SAMHSA's role, and what is the benefit of these clinics over traditional Medicaid provider status? How will SAMHSA encourage states to work with the tribes?

A: (Pam Hyde) I think you are referring to the Section 223 pilot. Does that ring a bell?

Q: (Ken Lucero) A Medicaid extender law?

A: (Pam Hyde) It was put into the Medicare bill but it is actually a Medicaid pilot. The pilot is in development now, and states will have to choose whether they want to participate in the pilot. Planning grants will be available for states that want to participate. States will be selected from the grantees to participate in the pilot. There is a multi-step process. Tribes should watch the process and consider what the criteria should be and whether to advocate for their state to be a part of the pilot.

Q: (Ken Lucero) Will tribes have an opportunity to be a part of that development, say, with your office and as you develop the structure and those kinds of things?

A: (Pam Hyde) Yes, we are actually developing a public listening session about this right now. I don't have a date but it will come up quickly. All of this has to be in place for the feds by next September, so we only have a year to get all this in place. So we are already planning public listening sessions for this fall. But you are raising a good point, which is do we need to have a special or separate conversation with tribes about that? We will take that back for consideration.

C: (Brian Cladoosby) For the record, Robert McGhee has yielded his time and his seat to Steven Kutz.

Q: (Steve Kutz) I have two questions. The first question is has Congress -- for the item you have already talked about, has Congress already appropriated the money for that?

A: (Pam Hyde) For the Section 223 pilot? They have already appropriated the money for the planning grants. The actual money for delivery of the services in the certified community behavioral health clinics will actually come out of the regular CMS FMAP [Federal Medical Assistance Percentages], the federal portion. So for tribes, that is 100 percent.

C: (Steve Kutz) So a comment before I ask my next question then is so I do think, for my mind -- because the money is typically funneled through the state I would guess and not directly to tribes. Is that correct?

A: (Pam Hyde) Yes, this is a Medicaid pilot so it would come to the state.

C: (Steve Kutz) Right. So I think some consultation or at least some education for us is going to be paramount for us to understand how to navigate this process through our state processes. And get them to partner with us in the correct way. Understanding the difficulties that we have, and we have a fairly close working relationship, but they don't always understand the discussions that we are having at the national level. And maybe they don't even -- when they amend their state plan, maybe they don't even put it in correctly. Then they say they can't allow it and those types of things too so we need to be sure that is not the case in this matter.

A: (Pam Hyde) Can I just ask you a question? Are you referring now to the Section 223 pilots or to the IMD issue we were talking about?

C: (Steve Kutz) IMD. Well, I want to go back to the IMD. That is my follow-up question. I am talking about the pilot one.

A: (Pam Hyde) Okay. Those are two different issues being discussed, that is why I am trying to make sure I understand your questions.

Q: (Steve Kutz) So my second question, around the IMD issue, my state is Washington, and I suspect many other states, don't understand this issue around the 16 beds restriction. Matter of fact, they are holding, at least in our state, Native programs to 16 beds even with youth. And so if

that is the case, and that is probably happening in other states, how do we start the process? Is it a process that we need to start here? Is it a state-by-state process to make sure that they understand what the regulation is?

I just had a discussion with one of the assistant secretaries of the Department of Social and Health Services (DSHS), at an advisory board that I am on, two weeks ago, telling them I was having some preliminary conversations with you about this, and they don't even understand it as being a possibility.

A: (Pam Hyde) I don't know anything about Washington State but I have to say that I don't disagree with you because when I had a responsibility for Medicaid in New Mexico, I actually had to work with the staff to get them to understand what IMD was and what it wasn't. So I think it is true that sometimes the state Medicaid folks don't understand the nuances of what is or is not covered.

A: (Kitty Marx) What we could do is hold a conference call with the appropriate officials in Washington and with the tribes and just have a technical conference call with our Native American Contact (NAC) and the appropriate people at Medicaid. We could also do additional consultation or an All Tribes Call because I know this is an ongoing issue.

A: (Pam Hyde) And certainly what we will commit to is to have our Regional Administrator for Washington, David Dickinson, be on any call that you want to hold. We have heard enough about this over the years that I really think that CMS and SAMHSA and maybe IHS ought to do a call for anybody who is interested.

If you have specific questions, I would ask you to go ahead and shoot those to Kitty and to Mirtha and let us make sure we have got your actual questions so we can put together something that is useful to you.

C: (Ron Allen) I would like that you recognize my technical advisor here to ask a question about this subject.

Q: (Jim Roberts) Thank you, Ron. Jim Roberts from the Portland Area, advisor to Chairman Allen. The concern that we have about this, because we recognize this is a real opportunity, is that the state in many instances is going to be the grantee and will bypass the tribes directly.

For example, in Washington State, where they have got the regional support systems, the RSNs, that has been historically the problem. And my sense is that the RSNs will become the grantees and there will never be an opportunity, because of the way the state has organized its mental health services delivery system, to become a grantee in that process, and the RSNs will step in and want this opportunity for themselves.

The issue about having CMS step in is that once the demos or the pilots are established, then the interface or the reimbursement system is with CMS, and I think that issue is pretty clear. The reimbursement system will be tied back to the normal reimbursement mechanisms that are already placed in the Medicaid program.

But the key here is to get tribal sites to be eligible to become pilot sites, and the states may not be willing to do that, or the entities that exist in some of the states as Washington have organized themselves. So I like the idea about the All Tribes Call but I think if you are going to do an All Tribes Call, please have SAMHSA participate in the All Tribes Call so you can get the perspectives of the tribes from all the states that might be interested in this.

C: (Pam Hyde) Yes, you are right that each state is a little different in the way they organize, and there is a different set of funding streams that go into each state too that sometimes also get confused. And frankly this demo that we are talking about has nothing to do with IMD. So we have got several things that are all focused on how you want to deliver services and it does get confusing.

This is good input. Let us think about how best to do that with you, and we will get something out there and ask for your participation.

C: (Jim Roberts) I yield back to Chairman Allen.

C: (Larry Curley) One of the things I have a problem with at times is how a lot of these processes make the tribes subservient to the states. We have to have our hands out to states and say, please include us. And it should be a given that tribes be recognized as such.

The Navajo Nation, we are going to have to go to three states: Arizona, New Mexico and Utah with our hand out requesting that we be included. And right now under the Medicaid program under the Affordable Care Act, New Mexico has gone Medicaid expansion, has gone federal right now and going state Market Exchange. Arizona has gone Medicaid expansion and federal Market Exchange. Utah has gone no expansion and they have their own unique little system out there under the Exchange program.

So we are being divided as a nation into three different groups of people. And I think that is one of the major reasons why the Nation has been identified in the Affordable Care Act, Indian Health Care Improvement Act, for the establishment of a Navajo administered Medicaid program.

That feasibility study has been completed, and that feasibility study has concluded that the Nation is capable of running its own Medicaid program. In preparation for the eventuality of the Navajo Nation Medicaid agency, that maybe it is time that we start talking now, preparing for this whole process, and identify, for example, the Navajo Nation as one of those sites without having to ask the state for permission.

Secondly, there is a need for local governments, state governments, to understand that they also have an ongoing responsibility to provide services to tribal members in communities off reservations. The cities and local governments say, they are Navajo people. They are the Navajo Nation government's responsibility. I am sure that probably South Dakota, Rapid City, feels the same way from time to time, and other cities and border towns, who believe it is the tribes' responsibility to provide these kinds of services to Native people.

I think it needs to be made very clear that they have a responsibility, and we are currently dealing with such an issue in the Albuquerque Area for example. I think this is something SAMHSA needs to take a look at. What are the possibilities of creating a border town initiative where both cities, local communities, local governments and tribes can sit down and develop joint projects that meet the needs of Native people who are in these communities dealing with substance abuse and mental health issues?

We do have a lot of our veterans from the Vietnam era who have substance abuse problems, who are in the cities, who are homeless and are having these major issues.

C: (Pam Hyde) Exactly what you said is why SAMHSA proposed and the president proposed for two years to let us develop a program for substance abuse and suicide prevention that would go directly to tribes and not through states. We did not get that through. So we continue to try to advocate as best we can.

I would also be interested, in the urban Indians or the tribal members who are in urban areas issue, I would love to have our regional administrator sit down with you, and maybe we can put together a meeting in that area to try to see if there is some way we can come up with something that makes some sense.

Office of Management and Budget

Julian Harris, Associate Director for Health Programs, Office of Management and Budget, Executive Office of the President

Norris Cochran, Deputy Assistant Secretary for Budget

This session gave STAC members a long-awaited opportunity to hear from OMB and understand the issues that often seem to hinder urgent tribal budget concerns.

Mr. Cochran noted that the current fiscal year ends this month. All eyes will then turn to what is happening in FY2015. There are no discussions of a shutdown. The mandatory sequester remains in place. The discretionary sequester is off the table for 2015. Mr. Cochran expected Congress to pass a continuing resolution (CR) to keep the government funded basically at last year's levels October 1 through December 11.

Mr. Harris reiterated the administration's desire to honor commitments to Indian Country. Tribes have faced numerous challenges during the past six years; indeed, sequestration has been a particularly bad policy that has had a detrimental impact on tribes. Further, the full range of decisions in Washington continue to affect day-to-day services and programs on the ground.

OMB has advocated for higher funding caps for discretionary spending and seeks to work with Congress on that issue in looking toward the upcoming budget. Mr. Harris's remarks also included these points:

- Since 2009 the administration has proposed increases of more than \$3 billion in funding. Mr. Harris's team has focused on how to strengthen funding in the Indian Health Service.
- In fiscal year 2009, the IHS discretionary budget was \$3.3 billion. OMB's proposal in the 2015 budget was for \$4.6 billion. This \$1.3 billion increase reflects the commitment to improving lives in Indian Country.
- OMB has hosted the Tribal Nations Conferences over the past number of years. The 2013 conference included 12 cabinet members and key officials from several federal agencies.
- The White House Council on Native American Affairs has played an invaluable role in helping OMB hear from the tribes about how the federal government can strengthen its partnership and commitments.
- OMB staff members are aware that CSC are a great concern and understand it is a complex, challenging issue. OMB remains committed to working with tribes and with Congress and appreciates input from STAC members.
- IHS has had to redirect \$48 million to pay additional CSC in 2014, so those dollars must come from the 2014 appropriations and has resulted in reductions in services. If Congress honors the 2015 budget, there will be some relief on the services side.

Questions and Comments

C: (Brian Cladoosby) We won a Supreme Court decision that CSC have to be fully funded. You mentioned the \$48 million that we heard could go up to \$53 million on top of the already \$10 million in May that we already had to absorb. So we are approaching \$60 million to \$70 million now.

The victory in the Supreme Court now looks like it is coming at a cost. How do we move forward? How do we make sure we are not sitting here in '15 and '16 and hearing from the concerns of the Direct Service Tribes who feel they are going to be proportionately cut way more above the Self-Governance Tribes.

The concern is that the Self-Governance Tribes and the Direct Services Tribes will be pitted against each other through no fault of our own. We have to come up with some recommendations so we are not in this cycle. The Obama Administration has been by far the greatest administration to work with. All relationships have bumps in the road, we have a bump in the road and we need to work through it.

C: (Ron Allen) To implement the legislation and health care responsibilities of HHS and IHS is a big deal to us and it always comes down to dollars and cents. I don't want to take this context of implementing the Indian Self-Determination Act and that contractual relationship with the tribes as just contractors. We are governments, and there is a longstanding historical, legal and moral obligation to our nations.

None of us had the intention -- I don't believe Congress had the intention to honor contracts at the detriment of other tribal citizens wherever they are and however they receive services. We do need to sit down with you and the HHS and IHS leadership with respect to what the solutions are.

Dr. Roubideaux has been conducting consultation sessions. Many of us who are very engaged in this agenda, we understand indirect and direct contract support, how to calculate it and what the challenges are. The numbers shouldn't alarm anybody. What is alarming is that you can't figure out what the number is until the end and often after the fiscal year is over.

So we have made some suggestions about asking Congress, and we are hoping the administration will be supportive of it, to explore some options that can fix this problem so that we are honoring contracts and we are also doing no harm to the health care of Indian Country. We suggested an anomaly to -- not this current CR but the next CR hopefully that will go out through the rest of the year.

As a footnote, CRs are annoying to Indian Country because there are a lot of things that we can't do because of the nature of CRs, in having only the authority to the date that you are legislated.

We have also suggested long-term that because of this unique contractual obligation, that maybe it should be moved into a mandatory. We know that causes some heartburn, but nevertheless you are looking for solutions and that is one of our solutions. We think we can work with the administration to find policy matters to help find certainty on how you calculate the numbers in a timely way.

We want to urge and encourage you to take a course of action that helps solve this problem so we are not left off the bench when the dust settles in December. Hopefully the next CR will be legislated.

C: (Aaron Payment) I serve on the Contract Support Cost Workgroup, and I have to say it is extremely complicated because it is a matter of having predictability, transparency and flexibility all at the same time. But those are artificial creations because it is how we structure it both congressionally and how the administration interprets that.

I too am very proud of this administration. The hope and change that we looked forward to, we have seen much of that come to fruition. But there is in congruency in the message between the president's lips and the budget and the administration. I am glad that you are here because for the last two years we have been wondering if it is the stopgap or the bottleneck at OMB that just doesn't quite understand the trust responsibility and potentially doesn't fulfill the president's wishes.

The solution really is mandatory funding. It is getting our best estimate at the beginning of the year and potentially with multi-year funding reconciling it in a subsequent year. The timelines by which tribes can renegotiate throughout the year is what complicates this. If we had multi-year funding and it was mandatory funding and it was truly nondiscretionary -- we prepaid for this. We are not asking for welfare. We are holding the federal government to their duty to provide health, education and social welfare.

So it is your job to fight for us. And so when the message gets sent to Congress that we are capping CSC or we are only going to fund it halfheartedly, then there is an incongruity in that message.

The message needs to start with the administration going to Congress and saying, this is what full funding means. It should not be discretionary. We shouldn't have to steal from our services. And self-governance shouldn't have to steal from Direct Service Tribes. We shouldn't have to steal from the administration of IHS because that ends up hurting us as well.

When I became chairperson of my tribe, I challenged our health director to find a way to increase third-party revenue because we just aren't getting what we need to get out of IHS for funding. We will not support that being an offset to the federal government fulfilling its trust obligation. We are helping the federal government fulfill its trust obligation when we go out and find efficient ways to drive third-party revenue so we can provide services for our people.

When we hear that the federal government is going to fully fund contract support, and then we get messages and requests for our third-party revenue, what that alerts me to is that we are going to use that to offset the federal government's obligation. And I can't support that.

C: (Jefferson Keel) I want to make sure that I heard you correctly in you stating that the \$48 million would be replaced?

A: (Julian Harris) No, I was describing the fact that in the '15 budget, that we actually increased our request for the services budget in part to hopefully not have the kinds of challenges that we are having in the current year in the '14 budget, but it is not apples to apples.

C: (Jefferson Keel) The other thing I was going to mention, and Aaron just spoke about it, was the means testing. And that is what it boils down to when you ask about third-party reimbursements, the amounts and how they are applied.

It is a form of means testing. That is what is implied to the tribes, and that is why the tribes are so opposed to that. VA and other agencies do that as a matter of course to determine how much a veteran would have to pay for their health care and those types of things. And that is what the tribes are afraid of when we talk about how to offset those in those numbers, and that is why the hesitancy to provide that data.

But I do appreciate your willingness to come here because we do have people throughout Indian Country who are very highly skilled in how to determine what these calculations ought to be and how to calculate that and how to apply those to future budgets to help the IHS and HHS come up with a way to fulfill that trust responsibility or to meet their obligations.

This administration has done a tremendous job in delivering services to Indian Country and raising the quality of care. In addition to allowing us to raise the quality as much as the level, and access to care. But the legacy of this administration could be to make sure that we don't have the opportunity to serve our citizens and to leave people out of health care or deny access to health care in this coming year.

And that is what is happening with this \$48 million to \$53 million shortfall in the contract support cost. So we can solve this. I know we can resolve it. It is going to require some help. But I appreciate your willingness to come here and meet with us.

C: (Larry Curley) I guess one of the things that we have been concerned about is every once in a while we will see Circular A-133, Circular A whatever. And every one of those circulars define how you calculate costs, how you calculate indirect costs. What is allowable? What isn't allowable?

These are policies and procedures that impact Indian Country. It has an impact on the resources that are available to the nation, and we have never had an opportunity to have a direct conversation as tribes on how you calculate, because we have a different opinion.

And I think that in that regard, one of the questions that I have been asking for years is does OMB have a formal Tribal Consultation Policy? And if it doesn't, why doesn't it when every other federal agency is required to have a Tribal Consultation Policy? And I think that is part of the discussions that we are having, which is that direct government-to-government trust responsibility where we have direct input into the policies and procedures that affect us that you develop at OMB.

C: (Ken Lucero) I would like to yield my seat to Gary Hayes, who is our alternate for the Albuquerque Area.

Q: (Gary Hayes) Since IHS was created in the 1950s, it has never been fully funded. And because of that, my tribe sees the effects of that. When you look at our community, the median age is 42 in the nearest border town. And you look at Ute Mountain, our tribe, it is 27. The national median age is 37.

We are getting younger because many of our people are passing away because of a lack of programs that the government -- many of these programs that we advocate for as tribal leaders was through our treaties and the responsibility of the federal government.

As Dr. Martin Luther King Jr. mentioned, any injustice anywhere is a threat to justice everywhere. And that injustice has been happening in Indian Country for so long.

National life expectancy is on average about 79. For the Ute Mountain Ute tribe, since 1990, it is 52. I am going to go back to median age. The two poorest counties are reservations in Indian Country. When I mentioned about the national median age is 37, look at Pine Ridge, 23. Rosebud, 22. That is a national epidemic. That should be a crisis for the federal government and for those who advocate for First Americans. They should be ashamed of themselves.

Contract support costs, all these discussions we have here, but what is really happening is our communities. That is a direct reflection when you look at the 2010 census of what is happening in our communities.

C: (William Micklin) The discussion on the tribal third-party collections, I just had a question sent to me by some clinic CEOs. There is a 2014 program user population data spreadsheet sent out, and this was collecting data that showed for each tribal facility the Indian registrants, the total registrants, the percent Indian, percent Indian active, non-Indian active, and provided percentages of Indian for total. What is the purpose of this data call-in and the spreadsheet?

A: (Dr. Yvette Roubideaux) I think that is one of the annual data calls that we do to look at user population, and I wonder if maybe that particular spreadsheet hadn't been seen by you all. For the Indian Health Service, every year we have to determine what everybody's user population is. And it goes into those categories. So I think that is something that we have done every year. But if you would like to send that to me to make sure it is the same as previous years, I would like to see that.

C: (William Micklin) You can appreciate the concern of the executives in the field running the tribal facilities. I would associate myself with Chairman Payment's comments. These third-party payments should not be set off for our funding. We use these to operate. Without the third-party collections, we would be in serious trouble.

In fact, we are important providers in our rural communities where there is not access to health care other than our tribal facilities. So we are doing a great service in our rural communities.

C: (Marshall Gover) We have an influx of young veterans coming back. And you notice the VA is getting the money to treat those young veterans. We got all those young veterans coming back from war, and they are being treated and being seen. But yet when we come into the CSC for the American Indian, we are \$53 million short. But the VA is getting the funding to see all the veterans.

And more and more veterans from Vietnam and the older ones from Korea and the very few from the second world war are flying for benefits and receiving them. But yet our contract support is kind of stalled. And last week in Albuquerque it was mentioned by Navajo that they used their code talkers during the second world war to fight for this country. Last November there were 33 other tribes recognized for code talking, that helped this country in time of need.

Those code talkers in my tribe who were honored, they are all gone. But all these code talkers and these tribes who served the United States, helped win a war and came to the aid of their country and spoke a language that my father had his mouth washed out with lye soap at Pawnee government school for using his own language. And then they wanted him to use his language.

But yet our health service is stalled at 56 percent funding. But yet when we are called upon to defend this country, we are the first to go because this is still our land, still our home, even though we get shortchanged.

We come to DC, we have these discussions. But like I said last week, what if our congressmen and representatives, when they went home on a weekend, if they had to be carrying caskets

because their loved ones, members of their families were passing away because they weren't getting the health care that they needed. And each year they got younger and younger.

I come from a tribe that is not big and not small, only 3,600 people. We still have a blood quantum. We used to average about 11 deaths a year. Now it is 36 deaths a year. Half of those are under 36 years of age.

Think if you went home and it seemed like half of your time was burying people. Making sure everything was taken care of for your people, for their funeral arrangements. If they didn't have the means, you were making sure the means were there for them because the means weren't there for their health.

When I see this contract support cost, and being a Direct Service Tribe, that is what I see. That is what I feel because being a tribal leader, I am responsible for those in my tribe. That is why that contract support cost should be fully funded. It has been said many times, all of those treaties. One of these days, maybe those treaties can be honored and we could have some trust responsibility.

C: (Steve Kutz) Third-party revenues balanced equally in the system are disproportionately collected by members in their disproportionate amount of our operating expense. So in the case of my tribe, recognized a little over 10 years ago, I received no direct service dollars. Received purchase and referred health-care cost dollars that now, in the members that we serve, if you average that out, is \$350 per member per year.

So we live and die on the amount of the new AFA that is out there from having no base, and we live and die on our third-party revenues. So to say that there is an even system in Indian Country, in all of the 500 some tribes, is not the case.

And my tribe, in order for us -- because we are scattered, in order for us to pull together operations to serve our people, we also honorably serve all the other members who come to our facilities. And I am proud to say that for almost everybody in this room, we serve your members in our facilities.

But realizing that I don't think the playing field is ever going to be level for all of us, we live in this world where we try to provide services, and the third-party revenues are the only moneys that we have to buy buildings, hire staff, buy equipment and build our programs.

And so this is something that is very difficult for us to talk about. My tribe never signed a treaty. We walked away from the treaties. We were promised reservations by the government. The government did not follow through on its verbal commitments to us and so we suffered for that, and we suffer based on the inequalities of the system to this day.

We have no hospitals to send our people to. We have no specialists unless we contract with those. So the system is not equal. Some people do a better job of bringing in third-party revenues than others. The people who do a good job should not be penalized for those who don't do a good job.

C: (Ken Lucero) I appreciate your willingness to listen to us and to hear the stories. What I ask from you is that you continue to work with IHS and others, work with us to find a way to separate out CSC from direct programs so that we don't have this kind of impact in the future and even for this year. I think that is something that you have the opportunity to do and the ability to do.

C: (Larry Curley) I know there is not enough time for you to answer the questions that we ask. And I would hope that as we move ahead, that the answers are made available to use in written form at some point prior to the self-governance meeting.

C: (Arlan Melendez) For many years, tribes have formulated the budget, and the president's budget usually lined up pretty much with what the tribal formulation ended up being. So I think for many years, when we talk about who cuts down our budget, a lot of the blame in the past has been that OMB looks at it and it is a major reason why the budget ended up being decreased.

And as someone pointed out, all of a sudden the federal government is appropriating money for some war or something like that or rehabilitating a country. And we see a tremendous amount of money being appropriated. So the tribes would say, we are talking about \$48 million so why can't we accomplish that?

The reason you are here is so you have a better understanding of the trust responsibility and the needs of the tribes. We hope that our thinking isn't like it used to be in the past, that OMB is an obstacle. Hopefully you also can stand up for us in this trust responsibility and align a little more with the president's budget and with the tribal formulation of how our needs are really important here.

C: (Cathy Abramson) A lot of us, we tell stories. That is how we explain things. And you will get to know us. I know that OMB likes to hear the bottom line, and so hopefully we will come to some middle ground. Thank you for coming.

C: (Julian Harris) I want to thank all of you. I find stories to be incredibly powerful and an important way for all of us to understand what is really happening.

We recognize that there is additional work to do on the issues that you all highlighted today. And I was really pleased to hear that you all have some proposals to share. I also want to emphasize we are very committed and would not rest on the generous praise that a number of you made of the president of this administration. It is a commitment by the president from his heart. We know we have additional work to do and that is something we are committed to continuing to do.

Administration for Children and Families

Mark Greenberg, Acting Assistant Secretary

ACF presented these updates:

- ACF developed two grant announcements for its Early Head Start/Child Care Partnerships. This opportunity brings the Early Head Start standards, philosophy and quality to more eligible infants and toddlers. The nationwide general grant announcement

has already closed. A separate announcement for AI/ANs will close at the beginning of October. ACF will award in total \$500 million.

- A reauthorization of the Child Care and Development Block Grant is long overdue. Staff now see action for the first time since 1996. The House passed a bill earlier in September. The next step is Senate action, but both worked closely on the process together, which should result in quick action on consistent language. The up to 2 percent set-aside for tribal child care will now become a floor. So it will now be at least 2 percent.
- The Peer Learning and Leadership Network, a technical assistance project within the Office of Child Care, has blossomed during the past six months. Network participants have been working in cohorts on such skills as articulating goals of early childhood programs or doing community projects. Notable results include a public awareness campaign about tribal child care. Posters and information will go out to help tribes promote child care within their communities. The Office of Child Care will seek participants for the next cohort in a few months.
- Four tribes that receive Head Start, child care and home visiting grants were able to participate in a small funding opportunity to promote cross-collaborative work. For more than a year, ACF has been working on this project with the Choctaw Nation of Oklahoma, White Earth Band of Chippewa Indians, San Felipe Pueblo and the Confederated Tribes of Salish and Kootenai. Among other issues, the tribes are looking at shared data and intake systems. ACF seeks STAC input on how to build on that program.
- The Office of Planning, Research and Evaluation in ACF now has a Tribal Early Childhood Research Center that coordinates steering committees from tribal child care, Tribal Head Start and tribal home visiting. Administrators who run those programs within the tribes meet with the center quarterly to offer advice on research activities.

Questions and Comments

C: (Ron Allen) With the regard to the early learning program, we know there are some studies going on. The concern we have is how well we are engaging tribes to make sure we are a part of the studies so that the observations and recommendations that come out are inclusive of the programs in terms of how well they are serving our Indian communities.

With regard to the programs, in terms of helping the youth we are serving, many of our tribes don't have the kinds of facilities to accommodate the kind of environment you would want for quality services and assistance. Is there a way to incorporate facilities, at least to start chipping away at that need?

It is good to have set-asides, but there are 566 Indian nations of all sizes. Often we don't qualify for set-asides in terms of you are too small. The assumption that tribes would just join together, a consortium of tribes, that concept doesn't always work.

Last, we haven't talked about the Indian Child Welfare Act (ICWA). We have raised that with you with regard to what you can do, and we would like to get an update from you on what you have done or what you are proposing to do in terms of ICWA compliance in states and state court systems.

A: (Shannon Rudisil) One thing I want to mention about facilities, because I don't think it is always known, is that under the Child Care and Development Block Grant Act, tribes can use

their money for facilities. States cannot. There is a special provision that allows tribes to use their Child Care and Development Block Grant Act money for construction of facilities.

One of the changes in the new bill is -- it used to say that a tribe could only for construction funds if while you are diverting money, you didn't see a reduction in the amount of services. The new bill language, if it passes, would open that up a bit and say that if a tribe can show that it would increase the amount of services over the long-term. So even if there is a short-term dip, because you are putting money into facilities, as long as you can show either quality or more services would be available in the long-term, you can do that.

A: (Mark Greenberg) Around ICWA, we don't have direct enforcement authority in relation to ICWA. What we can do is when states submit their child and family service plans, the 5-year plans they submit, they need to provide, as part of those plans, an update on the consultations that they have done with tribes, and to describe issues and concerns in relation to ICWA consultation and compliance.

The 5-year plans all had to be submitted by June 30. The Children's Bureau is in the process of doing a review of what came in on that. Staff members are planning to develop a report based upon that review that will summarize information across states on ICWA compliance, highlight best practices and identify areas for improvement.

C: (Ron Allen) That is encouraging but we need monitoring on a more regular basis to track the trends of whether or not they are truly consulting and engaging tribes with regard to the cases.

A: (Mark Greenberg) Tribes as part of their annual submission are also providing information to us about consultations with the states and related concerns. This gives us the opportunity to see if the tribe and the state are saying the same thing.

Q: (Brian Cladoosby) On these 5-year plans that are submitted by the states, are the tribes involved at all in putting these plans together, having an opportunity to review these plans?

C: (Aaron Payment) I will just say we have a really good rapport with our local community action, because I am on the community action board. But even before that we have always had a good collaboration. Probably half of the kids that go to Community Action Head Start are our kids.

So we need a bigger approach because not all of our kids get served through our Tribal Head Start and our early child programs. Our kids are everywhere. And there should be consultation through the states, and it shouldn't be at the discretion of whether the state wants to do it. We don't have a good relationship in Michigan with our state, with our governor's office. So some Indian kids are slipping through the cracks.

Q: (Ken Lucero) I think it is an administrative fix that can happen where there is a requirement that the states consult with tribes on the ICWA regulations and the five year plan in order to receive moneys. It has been done in other administrations with other agencies. And so you can

look at some of your sister agencies to see what that language is for that requirement. So I think it is necessary and it is important for that to get put in place.

But my question is back to your partnership. I guess it is a new partnership. So if we were to combine our Head Start and day care funding, could we use that then to build a facility?

A: (Shannon Rudisil) So we are funding the partnership with Head Start funds. So those are those funds. And I don't know as well the Head Start rules around construction. So I can't speak to that. But I think you could sit down together and look at what is coming in and think about use of child care funds especially if they went up over time.

C: (Ken Lucero) I just took on a new position with my tribe as director of operations. And we have got a pitiful situation that should never happen. We have a facility that is just not adequate for the kids and we don't have enough funding to provide two full-time employees so our child-to-care ratios are not being met.

So I am looking for a way to figure out how do we build a new facility, or do we just revert to going to at-home care providers. Is that partnership competitive?

A: (Shannon Rudisil) It is competitive. So the Early Head Start/Child Care partnerships will be new money. And it is competitive but we don't know how many applications we will have yet. We anticipate, because we have so many Head Start and Child Care grantees already that the word has gotten out.

But either way I think we could talk. We would be happy to talk about ways to think about -- if you have got both coming into your tribe already, how you could maximize the resources to be sure that all the kids have care that you feel good about.

You have to apply to us for construction but for renovations -- like if you have health and safety concerns, such as the kitchen is not up to code, some of those things can be paid for without a separate application to us.

Q: (Ken Lucero) My last question will be about partnering with Bureau of Indian Education (BIE) schools. We have a fairly large Bureau of Indian Education School that was built on the reservation. It has space to accommodate a Head Start and a day care. But how do we go about creating that partnership with them?

A: (Shannon Rudisil) We should just follow up. We would love to work with you on that.

Q: (William Micklin) I had a couple questions. The first one is in response to the state compliance. I think the problem is that the HHS Secretary doesn't have enforcement powers sufficient to compel good behavior on the part of states.

Just a couple weeks ago I was in Juneau with our president signing a mutual cooperation accord with the governor of the state of Alaska. The same day, they moved the venue of our litigation on

child support enforcement to Ketchikan just to make it more expensive for us to have to troop down to Ketchikan to further our litigation.

We win these cases but they are very costly for us to have to go to court every time we are expecting the state to comply with federal statute. So if you don't have the enforcement authority then we need to talk about the authority that you need and work on either a greater exertion of executive authority or some amendment to statute that would be necessary to compel this behavior. And the state of Alaska is one of the worst actors in the 50 states.

I want to go into the child care legislation. I know that there is a question on when you might expect to promulgate regulation, and of those, I will refer to the substantial revision to revise and expand the Child Care Development Fund (CCDF) regulations relating to child care quality, and mechanisms to evaluate the program quality. And that is tied to, in the legislation, taking into account determining payment rates.

These changes present significant burdens on tribes. I think the rate used to be 4 percent. I think it is up to 10 percent in the new law. So this creates a burden on tribes that need to use as much of the resource as possible to fund child care without having to hit these targets for quality that, in our context, doesn't directly contribute to the welfare of the child.

I am wondering what the exercise will be in the regulatory process, if it can be addressed in that, or how you think that can be addressed.

A: (Shannon Rudisil) We don't have a statute yet, but one thing we are cognizant of and that my policy director and I have already started talking about, is the fact that the statute outlines some basic items. And then there is, in the current statute and regulations, a lot of the decisions about how that applies to tribes are regulatory decisions.

And so what I would say is that we are cognizant of that fact, and we haven't fully scoped out yet where we have discretion to decide how things play out for tribes. We are also very aware of the HHS and ACF Tribal Consultation Policies. Those policies will be on our minds as we figure out what the pathway is to get from a statute to an eventual regulation.

Q: (William Micklin) On the 477 program, I understand that there are inspector general investigators who are visiting 477 programs. What is the purpose of those visits?

A: (Moniquin Huggins) I wasn't aware of any visits being conducted but that doesn't mean they aren't being done. Were there specific concerns with tribes?

C: (William Micklin) I would like to yield my time.

C: (April Shaw) The Office of the Inspector General (OIG) came to Temporary Assistance for Needy Families (TANF) and Head Start programs, at least three different programs, two in Alaska and one in Washington State. And that was in the last couple of weeks.

A: (Mark Greenberg) I am just not aware of the specifics around that. We can follow up to see if staff know something more.

C: (April Shaw) I think that Felicia Gaither might have been involved in some of the visits.

A: (Mark Greenberg) We will follow up with Felicia.

C: (April Shaw) I yield my time back.

Q: (William Micklin) On your report on the ACF discussions, were there any additional discussions on new programs under ACF?

A: (Shannon Rudisil) By new programs, do you mean Native Employment Works or actual new programs?

C: (William Micklin) Either.

A: (Shannon Rudisil) Okay. Whether new programs could apply that don't have existing grants? It is open. So it is not simply expansion of existing programs. Programs that did not have grants already can apply for the Early Head Start/Child Care Partnership Grants.

C: (William Micklin) The state is submitting a plan. And in that plan they are required to specify how they include tribes within the execution of the programs for which they are funded. So I really think it is going to take a denial of that plan by HHS, saying they have not met federal statute. That they demonstrate a history of non-compliance with statute in providing for the effective participation of tribes. That is not meeting the plan.

And until there is a consequence to failure to meet the statute and regulations, we will in no way, outside of the courthouse, be able to better the behavior of states that just don't believe it is in their political best interest to cooperate with tribes.

C: (Mark Greenberg) On the issue of authority under ICWA, it is ultimately going to be a choice for Congress as to whether to change the statute. In terms of the things that we can do, we feel like we are trying to do them. But I would also say that if you have other thoughts on things that you feel that we could do within current law that we ought to be looking at, we welcome hearing them.

On the OIG situation, I can think of one instance that I am aware of where I know OIG is interested in visiting a tribe with a 477 project. But apart from that, I am not aware additional specifics but we will go back and ask about it.

C: (Ken Lucero) Gary, I will yield my time to you.

C: (Gary Hayes) I want to go back to ICWA. We are very fortunate we have the Native American Rights Fund (NARF) in Colorado. They brought a couple cases to our attention about some tribal members who were living in the urban area.

But regarding ICWA guidelines, there are four entities that need to be involved: The tribe, the state, BIA and HHS. The state is asking, how do we get this training? We are pointing at BIA. BIA is pointing at the Department of Justice. So we need to be able to somehow get this coordination and collaboration together because the guidelines are 30 years old.

With some push from your side, and working with BIA, maybe we could actually get this thing moving forward and you could come together to update those guidelines. I yield my time back to Ken.

Q: (Chester Antone) Under the Social Security Act you have waiver authority. But the present system has tribes accepting Title IV-E the way they do things and the way they want you to do them. And the waivers can be requested only after you have developed the infrastructure that the state has.

Under that waiver authority, do you have -- is it mainly administrative, and if it is mainly administrative, can you then be able to, at the time of applying for Title IV-E, at the same time ask for waivers?

As far as what the tribe wants to do with their sovereignty, and at the same time being forced to accept the state's mandate, then it doesn't really enhance tribal rights to their children and how they take care of their children. But if you did it at the same time, then you would negotiate why you are trying to ask for a waiver and applying at the same time for the waivers you are asking for.

C: (Mark Greenberg) We can follow up with you.

C: (Ron Allen) I would like to yield to my alternate, Tino Batt.

Q: (Tino Batt) Regarding the child development grant, one issue I always have an issue with is increasing more mandates. Many tribes have to deal with Head Start and its qualifications. From our area, we are losing teachers. We don't even have fluent teachers. We have non-members teaching our youth at Head Start, and that is not appropriate to us.

And we are always continuing to apply for these waivers because we don't have qualified individuals -- who could work at a casino for higher wages rather than working in a Head Start. This issue is the same with child care. I hope there is no more mandate increasing the qualification of a bachelor's because we can't get our own tribal members into those fields.

Another issue is we did get a visit from OIG regarding the 477, and we provided them comments. They didn't tell us they were coming but we had nothing to hide. I yield my time back to Ron Allen.

C: (William Micklin) If we are going to hold the state to the five year plan, then there needs to be data collected, whether it is in ICWA or whether it is in CSC or what have you. There needs to be data collected so we can form a baseline that can document evidence and then support decisions that are made with respect to states' cooperation and collaboration with tribes.

Center for Consumer Information and Insurance Oversight (CCIIO)

Lisa Wilson, Senior Advisor

CCIIO continues to take stock and assess results as the country heads into health insurance open enrollment, which begins November 15. The deadline for plan selection this year is December 15. During the summer, staff members made changes and announcements to help with continuity of care and coverage in the federal Marketplaces. Consumers, including tribal members, should go back and reconsider their coverage for next year as premium subsidies change. State-based Marketplaces should follow similar processes.

Ms. Wilson also highlighted these points:

- Keven Counihan is the new permanent director of CCIIO.
- CCIIO recently announced \$60 million in Navigator grants to give consumers in-person assistance with health coverage options. This should be especially useful for urban Indians, who can walk into a Navigator site and expect culturally competent service. About six tribal entities will serve as Navigators.
- CCIIO has sent out notices regarding data-matching issues. These issues tend to apply to those who had problems documenting their citizenship or immigration requirements. Staff members also have sent out notices regarding annual income. Anyone with an outstanding data-matching issue can still submit documentation.

Questions and Comments

C: (Ron Allen) There are a number of our citizens -- Idaho, Oklahoma, Texas -- we are finding citizens who are falling through the cracks and getting bills. It is not the intent in terms of how it should apply to our citizens.

C: (Lisa Wilson) It is a helpful reminder in just hearing about the real people who are just actually affected. It is alarming, and we will certainly re-up our efforts. We had been working on this internally.

C: (Ron Allen) We want to continue to advocate for electronic verification in collaborating with IHS. And once again delegating the exemption to the IRS. That seems to be something that is dragging on, and we don't know if the problem is here or if the problem is over there or somewhere in between.

At the end of the day we answer to our own tribes and the tribes we represent. The changing of the game for us is when ACA was passed, the benefit was it now allowed us to be able to assist our citizens who live outside our service area. But then we saw the problems with the states that aren't implementing ACA, and we have got the federal Exchange systems, et cetera.

Q: (Steve Kutz) You were talking about the things that are still being worked through the IRS. Have they given you any kind of timelines?

A: (Lisa Wilson) I don't think I can say what the timelines are but they have been great partners and they are working closely with us.

Q: (Steve Kutz) You talked about the open season coming up. Were you generically talking about it because the people in it are going to come up for review?

A: (Lisa Wilson) To put a finer point on it, we really need people to focus on open enrollment. It applies to Indian Country because of some of these changes that are going to be made behind the scenes to the way the premium tax credits are calculated.

Q: (Steve Kutz) Do you have any data on the Marketplace penetration for Indians who are living away from the Navigators on reservation and around ITUs? And if so, what are you doing to try to engage them? You know, maybe it is doing some literature that is more specific with talking about where their opportunities are under the Affordable Care Act versus the normal population material that is out there.

A: (Lisa Wilson) I feel strongly that there is a huge value proposition for people who are living away from facilities where they can receive care for free. The value proposition is very clear for those folks to come in and get a great deal not only on the premium side but also on the cost sharing side.

So absolutely, and we have been thinking and brainstorming internally about ways we can refine our message to folks who are not living close to an IHS facility. If you have ideas on this, I would love for us to brainstorm on ways we can work more closely together and reach out to those folks.

To answer your question about the data, we are going to continue to provide more data on a more granular level. I am not sure we can go to the level you are suggesting, but it certainly something I can take back to our researchers and see what kind of refining they can do.

C: (Steve Kutz) I think there is some reluctance to put into the literature that Indians have a benefit the normal population doesn't because when the other side of the population sees that, they get upset.

However, I would say that it is important when you are reaching out to Indian people who are kind of living out there on their own, they need a bit of a roadmap.

Q: (Ron Allen) A couple of the other areas where we do need support: We need some sort of a system to show how effective we are at the outreach in the enrollment. We don't have necessarily any kind of vehicle right now, and the issue is how CMS/CCIIO can work with the tribes, and maybe IHS, in terms of coming up with a vehicle so we can track how well we are performing.

Right now we have a rough estimate and it needs to be more accurate in terms of how well we are getting all eligibles enrolled.

And the other component of it is a part of the outreach. It is the call centers. And we have already raised with you that we have concerns about these call centers and their knowledge about Indians calling and getting information about what they should do.

One issue is do they speak the language. And No. 2 is if the call centers realize they are talking to an AI/AN, then they might not know the answer but they know of an alternative where they can get the right answer.

If resources are made available, whether it is through IHS or the tribes or the National Indian Health Board (NIHB), that may solve some of that miscommunication.

C: (Larry Curley) I would like to make a motion on two items: One, this morning we had a report from OMB. They gave us all kinds of information. We asked them all kinds of questions. They indicated they would respond.

But to make it more formal, I would like to make a motion that one, OMB provides those answers to those questions that were unanswered. And to share with us that Tribal Consultation Policy that I asked for.

No. 2: That this information that CMS just provided, that they be made available to us and to tribes and to Stacey prior to October 3rd if possible. That would be my motion.

C: (Aaron Payment) I will second that.

C: (Brian Cladoosby) Okay, we have got a motion by Larry Curley. A second by Aaron Payment. Any more discussion to the motion?

(No response)

C: (Brian Cladoosby) The question has been called for. All those in favor, say yes.

(Chorus of yes)

C: (Brian Cladoosby) Opposed, say no.

(No response)

C: (Brian Cladoosby) Any abstentions? Motion carried.

Health Resources and Services Administration (HRSA)

Mary Wakefield, Administrator

HRSA's Tribal Consultation held on September 8 in Albuquerque, NM raised a number of issues, including these:

- Tribes requested better coordination around career development efforts for and with tribal colleges and universities.

- Staff members may pilot a regional conference on workforce issues. A successful pilot could lead to replicated efforts within HRSA's 10 regions across the country. These conferences would help HRSA deploy information and gather feedback.
- As HRSA sends money to nontribal grantees for workforce programs, staff members should encourage those successful grantees, where it makes sense, to work with tribal organizations within a region or a state.
- Similarly, Ms. Wakefield will communicate with HRSA grantees across HRSA's portfolio of programs, encouraging recipients of HRSA funds to reach out to tribal entities, urban Indian communities and so on to build linkages. Regional offices will participate in this process as well.
- HRSA's Bureau of Health Workforce, which oversees scholarship programs, seeks ways to ensure those programs also are open to talented students who may have lower grade point averages.

Questions and Comments

C: (Steve Kutz) It would help if we knew where the funding went to nursing, pharmacy, medical or dental schools where tribes could get some leverage because they are not aggressively trying to recruit eligible AI/AN minorities, even those with good GPAs. We in the states need to do some work but we need to understand where these funds are going, supporting these programs that ought to be responsive to us. So if I came away from here with a list, that would be helpful.

A: (Mary Wakefield) We can accommodate that. Thank you for that suggestion.

C: (Aaron Payment) I appreciate the focus on the non-conventional student. I am a high school dropout. I had 1.5 total credits and a .05 GPA. My sister is a high school dropout. We are both in our dissertation phase right now. We would have been missed.

So when we offer funding intended to train people that look like the people whom they are going to serve, a lot of our people, they don't ever qualify. I don't know what the solution is because you don't want to lower the qualifications necessarily. It might be a matter of targeting scholarships for people who come up through a different avenue.

C: (Mary Wakefield) And if you have ideas about other things that you think we should take into consideration, we would welcome that as well.

Q: (Roger Trudell) Dr. Roubideaux, you may be able to help me out. North Dakota has the Indians into Medicine (INMED) program. Where does the funding come from for that?

A: (Dr. Yvette Roubideaux) So the INMED program in North Dakota is funded through the Indian Health Service through our Health Professions programs.

C: (Roger Trudell) If you took that concept and applied it to some of the other things that are not catching the Indian student -- you are actually taking high school students and prepping them for college, correct?

A: (Dr. Yvette Roubideaux) Yes.

C: (Mary Wakefield) There might be some features that we could pull into some of our training programs too.

C: (Larry Curley) When I see the health care field around Indian Country, it seems to me that we tend to gravitate back to what is Western medicine type: doctors, dentists, pharmacists, nurses.

Some of us -- for example, Navajo -- are thinking about the potential of having our own Medicaid agency. We need health economists. We need actuarials. We need industrial hygienists, compliance officers. More exploration ought to be in those areas of where some tribes are expanding into and looking at other ways of providing health care and redefining the health profession.

C: (Mary Wakefield) We can go back and look at the latitude we might have that perhaps we haven't been using. A lot of the focus of our programs, we don't determine. It is determined by Congress and the statute. So we have to stay in the lane in terms of who we fund, with regard to training. But we will go back and see if there is any latitude.

Intrdepartmental Council on Native American Affairs (ICNAA)

Dr. Yvette Roubideaux, Vice Chair

Paul Dioguardi, Director, Office of Intergovernmental and External Affairs and ICNAA
Executive Director

ICNAA is the workhorse of the STAC, said Dr. Roubideaux. STAC members make recommendations, and the ICNAA is made up of all the Operating Divisions heads and staff who take those recommendations and implement them into policy. During the past several years, ICNAA has accomplished several goals in these three areas:

- **HHS grants data:** This area includes training HHS staff to better understand tribes, and giving tribes opportunities to assist with that training.
 - Staff members are developing a tribal web page that would provide a one-stop shop for tribes to search and apply for grants and get valuable tools.
 - HHS also seeks to recruit and increase the number of grant reviewers who are either tribal members or have tribal experience.
 - The agency also must consider how often to update the grants matrix while assessing continued barriers to eligibility.
- **Consultation policy related to the state section of the policy:** HHS hopes a tribal-state relations workgroup can examine way to mandate tribal consultation by states. Staff also are considering other strategies to improve state-tribal relationships. Further, uniform HHS training materials for states on tribal consultation can create a level playing field of information.
- **Self-Governance Expansion:** The last communication from HHS encouraged tribes to talk to their contacts within ACF, Administration for Community Living (ACL) and SAMHSA to discuss possible ways of moving forward with tribal self-governance in individual Operating Divisions. HHS hasn't cut off discussions on tribal self-governance; instead, staff members are recommending a next step.

Questions and Comments

Q: (Cathy Abramson) When you say states have to consult with the tribes, there are many different meanings to the state as to what consult means. I have been in meetings where the state employees actually have said, we have to deal with you. We need a lot of help with this consultation between the states and the tribes.

As far as grants, funding that goes to states should also be offered -- part of their funding should go to tribes.

A: (Dr. Yvette Roubideaux) We have heard so many stories of frustrations with states not understanding consultation. The work of the state-tribal group now is to determine if there is a way to modify the HHS Consultation Policy to better compel the states to consult with tribes. And also ways to use the grants mechanism, so when states receive grants, making sure there is language in it that says they have to consult with tribes.

Q: (William Micklin) These grants should be more broadly interpreted than narrowly interpreted, and there should be a preference for AI/AN use in understanding the different capacities that are going to take on these grants. There needs to be some thought to an actual preference because we end up competing with professional third-party non-profits.

Finally, I would like to advocate for moving away from the grant-based programs and moving into an annual funding category under a 477-type program where you can allocate these resources according to the need. If we could emphasize the interrelatedness of it without having that narrow boundary focus of the actual program requirement as it is written on the paper, it would go a long way toward relieving the problems that are in play in these communities.

C: (Doug Steiger) Greater flexibility without really clearly defined outcomes is highly dangerous to your funding levels. When you say, substance abuse, then they understand a little better. So having some kind of outcome at the end of the process -- when you say 477, you can say job training, and people get their head around what it is a little more easily. How can you articulate an outcome that you can bring to someone and say, for your money you got X?

Just saying, we need money for this, unless we can show how it is working. To get self-governance, it will help in the long-term to be able to demonstrate results.

C: (Ken Lucero) I yield my seat to Gary Hayes.

C: (Gary Hayes) When the administration says there is \$19 billion out there for Indian Country, a lot of that resource isn't coming into our communities, and we need to be able to find out where it is going. I am trying to get a good matrix that coordinates with the Bureau of Indian Affairs to come together with a good data source. Because if we do the state-tribal relations, they are going to ask that question because they don't know either.

We found out with the state of Colorado that they are like, we don't know what is available either. So this gives the tribes an opportunity, when we are applying for grants, that we know what the criteria is.

Many tribes, we don't have grant writers. And we have also asked for technical assistance on some of these grants. But I think it is a great start as we move down the road with state and tribal relations, identifying those resources.

C: (Aaron Payment) We have to educate Congress and get the funding and provide the best justifications that we can, but when we look at competitive funding, and we have a mix of it -- like SAMHSA, some of it is direct. Some of it goes through states. States don't consult with us. We just had a conference call last week where the state isn't willing to provide -- Michigan again -- the training to demonstrate to the Inter-Tribal Council how to fill out the forms that we need to do.

It is a hostile situation. And I know there is a balancing act between states rights and tribes but don't forget the origin for sovereignty is in the same section of the Constitution as is it for tribes, state sovereignty and tribal sovereignty.

The problems that we face in Indian Country are largely because of U.S-Indian policy toward tribes: boarding schools, forced assimilation, taking away the Indian identity. We have the worst statistics. But that part is good for us because we can write the good justifications.

When we talk about demonstrating the viability of funding, I am all in as long as we don't lose something in the translation and then we end up having to do it as a means test in order to get our funding in the first place.

C: (Mirtha Beadle) With regard to the inventory of federal grant programs, what we would like to do is volunteer to also be a part of that. Under the Tribal Law and Order Act, we are required to develop an inventory of federal programs, so we actually have a draft inventory already that includes grant programs from Justice, from Interior, from HHS. So we would like to be part of that process so we are not reinventing the wheel.

C: (Larry Curley) One of the things that would be helpful as we move ahead is we need to have the most updated information possible as we look at these various programs. And I think if you take a look at the STAC Website, the last time it has been updated is 2011. And I think that is not a good beginning in terms of trying to keep up with the events of today.

Also we have a lot of other advisory committees as well below STAC. There is another advisory committee at another level. I am not sure whether a lot of these recommendations that are happening at that level is consistent to what we are saying to the Secretary here. I think it would be helpful if we also got minutes and actions that are occurring in those advisory committees.

C: (Steve Kutz) Some of us went to the CDC, and we found out the CDC has a nonprofit 501(c)(3), and we found out that the way they got it is Congress authorized them.

And Congress can authorize IHS to have their 501(c)(3). Why might we want to do this? I think there is some concentrated funding for certain things that IHS could go for to benefit all tribes. It is going to take a certain amount of money to go in and fix RPMS. So that is an example of one thing we could go out to foundations, whether it is Microsoft or some others, and do some things on that. Or setting up a medical reserve corps.

I would like to have a nonprofit put on the future workplan to kind of look at that in IHS.

C: (Arlan Melendez) The IT discussion was on the agenda that I received in Nevada. When I got here, the IT discussion on RPMS was taken off the agenda. So I think someone needs to let us know before we come all the way out here that something is going to be stripped off the agenda prior to us arriving here in DC. We could have at least talked about our strategy a little bit.

C: (Dr. Yvette Roubideaux) We did want to discuss that. I think the discussion earlier just got more focused on the CSC issue. If you want to find some time tomorrow, I am happy to discuss that.

C: (Arlan Melendez) If there is an IT division here within Indian Health Service, they should be at the table here telling us what is going on. It would be nice to know who is in charge of IT so that person can give a report and tell us whether the area is underfunded or understaffed. Part of the report would be a status and what can we do about it.

C: (Dr. Yvette Roubideaux) We can consider that for future meetings.

C: (Chester Antone) Regarding Mr. Curley's suggestion, if you go back to CDC's minutes and consultation, you will find that we have attempted to have tribal consultation incorporated into all the grants that come of CDC. Direct funding has been another issue at least for the past six years that I have been there. So we are on the same page I think, at least for CDC.

Following this discussion, STAC members recessed until 9:15 a.m. on Thursday, September 18.

Secretary's Tribal Advisory Committee Meeting

Thursday, September 18

The second day of the Secretary's Tribal Advisory Committee meeting opened with a prayer from Chester Antone and a review of the previous day. Members highlighted a number of points brought to their attention during the first day's session, including:

- Contract support costs,
- RPMS,
- Rules for grants funding,
- Indian Child Welfare Act compliance, and
- Efforts to increase support to address the low Native enrollment in the Affordable Care Act.

Mr. Payment noted that tribes have more work to do in educating others about the federal government's trust responsibility. Something is lost in the translation when tribes are talking about trust obligation in the face of competitive grants they must apply for and outcomes and objectives they must meet to get the federal government to fulfill what it is already obligated to do.

Arlan Melendez read into the record a statement about RPMS on behalf of the Nevada Area. Because the support for RPMS is expected to diminish over time, tribes need to know how IHS plans to address issues with the outdated system. Mr. Melendez covered these points in his statement:

- Tribes depend on the RPMS clinical application to directly support the highest quality patient care available. These applications collect all patient-related information gathered in various patient encounters and keep them in one central data system.
- In addressing issues with RPMS, the Reno-Sparks Indian Colony had to turn to the Information Technology (IT) staff at IHS headquarters, where only one person could provide the necessary lab configuration to fix the problem, and she was already booked out three months working with other tribes across the nation.
- There is significant concern in the validity of accurate data in the RPMS system overall. The Reno-Sparks Tribe has lost providers, both contracted and direct tribal hire, due to the complexity and frustration of the system.
- Billing through the RPMS system creates significant concern due to the lack of training, system problems and inaccurate and sometimes unknown areas within the billing components of the system. The Reno-Sparks Tribal Health Center has lost thousands of dollars in revenue due to system issues within the billing components. The tribe now uses a commercial billing package.

Mr. Cladoosby suggested adding the topic of RPMS to the discussion of 2014 STAC priorities scheduled for 11:15 a.m.

CMS: Center for Medicaid and CHIP Services

Elliot Fishman, Director, Children and Adults Health Programs Group

Kitty Marx, Director, Tribal Affairs Group, CMS

The biggest headline in Mr. Fishman's overview was the implementation of Medicaid eligibility expansion, the implementation of the Marketplaces and the increase in insurance coverage that has gone with both of those parallel expansions. He provided these highlights:

- Although there has been dramatic growth on both the Medicaid side and the Marketplace side nationally, CMS staff members haven't seen similarly dramatic reductions in the number of uninsured Native Americans. Some of that has to do with enrollment where it is available. Yet another factor is which states have expanded Medicaid.
- Of the 350,000 uninsured AI/ANs who fall in the Medicaid category, half of them live in states that have not yet expanded Medicaid.
- A new round of outreach grants are available to support enrollment into Medicaid and the Children's Health Insurance Program (CHIP) in AI/AN communities. That solicitation, which went out in the spring, offers \$4 million in grant funds. These grants serve as the most targeted tool for supporting Medicaid enrollment.
- CMS seeks input on the effectiveness of its Tribal Consultation Policy, which has been in effect since November 2011. Federal staff also want feedback on the state-tribal consultation process.

Questions and Comments

Q: (Brian Cladoosby) What is the federal government going to do as the trustee, in light of the trust obligation and the moral obligation, to make sure there is something available for these Natives in these states?

A: (Elliot Fishman) There are states that have not yet expanded Medicaid that are currently working on proposals to use Medicaid funding to provide coverage that focuses on the tribal population.

C: (Chester Antone) The Arizona Medicaid waiver was submitted to CMS and it includes the uncompensated care cost payments to IHS and 638 facilities. The Inter Tribal Council of Arizona is in support of that, and that is something that we would like to see continue.

C: (Elliot Fishman) That decision is, as you described, in front of us right now.

C: (Steve Kutz) Within our health care system, Medicaid expansion has had a huge positive impact, but statewide I don't know that it has. Despite many Indian people getting signed up for Medicare, they are unable to access -- they are disproportionately affected. In Washington State, the Puget Sound Health Alliance did a report statewide, looking at access to care under Medicaid.

Just because you have Medicaid insurance doesn't mean you are getting health care. Indian people are disproportionately affected and they are not able to access the health care system.

When you are dealing with minority disadvantaged populations -- and these are managed care systems so I don't know where their incentives are to see the people they ought to be seeing. There ought to be some disincentives if people are not getting into care.

Is there any way in your system to address the nonability to get Medicaid expansion to tribal members that are not in states that have gotten Medicaid expansion? And thirdly, some of the states have put adult dental in as part of Medicaid expansion, and that is probably pretty poorly, but access to dental care is a problem in the system. Even within the Indian health care system, there are not enough providers. Outside that system it is a national disgrace, the poor access to dental care for Medicaid people.

A: (Elliot Fishman) On the lack of access to care to people who are enrolled in Medicaid, the conclusion that we are coming to is that having a managed care system can help relative to what Medicaid was in many states before there was managed care.

But that ultimately the way that providers are paid and incentivized, and particularly around taking responsibility for getting an entire population into care, is really critical.

There are a couple of things that Medicaid has going on but they are dependent upon states to take them up.

- Health homes are targeted at people with chronic illnesses. This is potentially 90 percent funded for states, and states can set up as many of them as they want.
- The Innovation Accelerator Program, a new effort rolling out in September, provides technical assistance to states and connects states to one another, specifically with regard to changing the way that the Medicaid delivery system operates.

Further, the Oral Health Initiative in Medicaid has been in place for about three years. Even so, staff members still have a lot to learn about getting people into dental care.

As far as Medicaid access for people not in states where Medicaid has been expanded, there is some basic good news: There has been a continuous flow of states coming into Medicaid expansion. There are now nine states with Republican governors that have implemented Medicaid expansion.

C: (Will Micklin) I understand that currently the state of Arizona, their position is that foster youth aging out of tribal foster care are not eligible for Medicaid just when foster youth aging out of state foster care are eligible for Medicaid. And I understand the state of Alaska has just recently taken that same position. It seems that CMS would need to send a letter to the state of Arizona and the state of Alaska, to state Medicaid directors, to let them know that youth aging out of tribal foster care are eligible for Medicaid the same as if they were aging out of state facilities.

A: (Elliot Fishman) It is a new issue for me. I will say broadly that states have been feeling their way somewhat. What you are describing may reflect that. I need to follow up with you and just touch base with our general counsel.

HHS Federal Member Roundtable Discussion

With a focus on 2014 priorities and questions on the written reports provided by Operating Divisions leaders, STAC members covered these points during the roundtable discussion:

- **RPMS:** The IT department of IHS will provide a written response to the statement read into the record by Arlan Melendez. The Information Systems Advisory Committee, (ISAC) made up of tribal representatives, has made a number of recommendations that IHS seeks to implement. The root of all problems with RPMS is the lack of resources, particularly in this difficult funding climate, said Dr. Roubideaux. Further, tribal shares don't cover all the support needed for technical assistance. The cost for the Veterans Administration to switch to a new system would have been more than \$200 million. The VA has the same architecture that IHS has for RPMS.
- **Elder Care:** Senior assistance programs and the health care of elders are big issues. Diabetes remains a concern in tribal communities. Although the aging population represents about 10 percent of the population, they use 80 percent of the Medicare medical costs that go to tribes, said Mr. Curley. Further, tribal health today requires data entry personnel, computer experts and other professionals to meet the needs of a changing field. Tribes also saw tremendously negative effects on aging services programs during the FY13 sequester. Older Americans Act programs lost more than \$100 million.
- **ACF:** A notice of proposed rule making in relation to the child welfare data system will soon be available. This effort will provide opportunities for weighing in on additional areas that federal staff should think about in regard to data collection. In the area of TANF, federal staff members are waiting to hear from Congress about reauthorization. If funding remains available, ACF will continue to provide TANF symposiums. Staff members also are waiting for a report based on the review of state plans that came in a few months ago. That document will further the understanding of state compliance with ICWA and the nature of consultation.
- **CDC:** The CDC has partnered with the National Association of County & City Health Officials (NACCHO) by providing funding to support health departments engaging in activities to ready themselves for accreditation, which is coordinated by the Public Health Accreditation Board (PHAB).

The CDC has been creating a Tribal Support Data Management System through the Tribal Support Unit (TSU), which will be used to track the work that different CDC/ATSDR programs are doing with tribes. The DMS will also be used to track issues and questions coming from the Tribal Advisory Committee Meeting and Tribal Consultation Session to follow up on those questions and issues with responses from Subject Matter Experts at CDC/ATSDR. Although the system is primarily used internally by CDC/ATSDR, CDC staff informed group they would follow up on the possibility of allowing others to access certain information in the system. .

- **NIH:** Dear Tribal Leader letters were distributed in September 2014, soliciting nominations for committee members for NIH's inaugural Tribal Consultation Advisory Committee (TCAC). The deadline for submitting nomination letters has been extended to **November 28th**. Several important updates regarding the NIH TCAC are now available on the NIH website, including posting of the TCAC charter, at <http://www.nih.gov/about/TCAC-charter.htm> . Access to information regarding NIH's

guidance on the implementation of the HHS Tribal Consultation Policy and other tribal activities can also be found through this website.

NIH's final Genomic Data Sharing (GDS) Policy was released. The GDS Policy takes effect for grant applications with due dates on or after January 25, 2015. The GDS policy promotes the timely sharing of human and non-human genomic data to advance research and speed the translation of that data into knowledge, products, and procedures that improve health while protecting the privacy of research participants. The policy applies to all NIH-funded research projects generating large-scale human or non-human genomic data. More information including the GDS Policy can be found at <http://gds.nih.gov/03policy2.html>

Secretary Sylvia Burwell

On her 100th day in office, new HHS Secretary Sylvia Burwell presided over her first discussion session with STAC members, offering brief opening remarks before listening to reports on such issues as Indian child welfare, the Affordable Care Act and the government-to-government relationship.

From working with Walmart to provide food and education to assisting the Bill and Melinda Gates Foundation in bringing technology to the Navajo region, Secretary Burwell has worked closely with AI/AN communities. Most recently at the OMB, Secretary Burwell made the financial and budget issues of Indian Country a top priority.

In preparing to engage with tribes in the areas of health, education and child well-being, Secretary Burwell noted a brief window of time in which to work. During the next two years, four months and two days, the Secretary plans to focus deeply on delivering results so that she and the STAC can have measurable success in tribal communities.

Questions and Comments

C: (Chester Antone) I wanted to elaborate on my hope that states adopt the Medicaid expansion. And my hope is that as Secretary that you would be able to support tribes that are in those states that have currently expanded to work with tribes, and also to say a few things to the governors of those states that haven't expanded.

And I would just urge that you lend your voice to approving uncompensated care costs because it does help many people.

C: (Steve Kutz) The Indian Child Welfare Act was implemented in 1978 because of the alarming numbers of our children being taken away from their families and placed with non-Indian families. I would like to tell you that since 1978 we have turned things around. But things have not improved as much as we would have liked. We still see the disproportionality.

We are asking you to ensure that states comply with the requirement to consult with tribes around all of the issues in child welfare. They should be demonstrating to the federal government that they are working together on plans to turn this problem around.

When states tell you that they are consulting with us, please make sure that you confirm with us whether that is actually occurring.

C: (Arlan Melendez) The Resource and Patient Management System collects patient-related information; stores and reports patient demographics; manages schedules and more. A properly functioning IT system is essential to providing quality health care to Native people. With your help, now would be the time to assess the RPMS system and initiate a plan of action to address this important issue, both short- and long-term solutions.

C: (Ken Lucero) As Direct Service Tribes, we do support the congressional action and the Supreme Court decision to fully fund contracts. But at the same time, we cannot have it be to the detriment of direct services or for care that is being provided to a tribe like mine, Zia Pueblo. A reduction in services and care will have a significant impact on us, and it is going to have that impact across the country.

C: (Aaron Payment) When we pushed for funding of CSC, and then it was approved by Congress, but then the idea was it was potentially going to come out of our services. That is a problem.

We are here to be part of your team, part of your team to help go and advocate for additional funding. We think we need to have separate and mandatory funding. If we were to have X funding and multi-year funding, then we could do our best estimate one year and reconcile it in the subsequent year. So why would we do this for this program? It is because of the trust responsibility to American Indian tribes. And as a Self-Governance Tribe, we are unified. We are unified in Indian Country to speak out on behalf of the Direct Service Tribes and ask for some other solution for this year and then going forward.

C: (Secretary Burwell) One issue we have resolved: And that is the IRS issue. The IRS will be issuing the guidance. We have worked it through.

A number of issues have been raised, and I will touch on a couple:

- Regarding Medicaid, there is not a week since I have been here that I have probably not met with a governor to try to move that Medicaid expansion ball forward. Voices and examples in communities are important, but it is something that I am deeply focused on.
- Because I am proximate to budget issues, I know we are going to be sailing into a situation in FY16. So hopefully we will get a budget for this year. But '16 is going to be difficult. That is why this planning and working through -- and understanding which of the problems we can make the most progress on, and on which timeframe, is important. We are going to have to work together because the situation will be tight, and the appetite for changing things to mandatory, the appetite for some of the longer-term solutions, is going to be hard.
- What we need to do is think about which of these problems we can try and be creative in, especially the issue of creating some form of predictably for you as you are trying to manage your health care.

- The importance of discretionary funding in our nation, and that gets to the IT issue, having sat at OMB, what gets cut every time is any investment in infrastructure. In tight funding times, that is what gets cut.

C: (Cathy Abramson) I just want to reiterate that any cut to IHS is too much.

C: (William Micklin) We have been impacted by our imprecise ability to really bring to the ground the obligation of that trust responsibility. But there are so many opportunities to exercise that between us. Yes, we will work with you directly on top-level issues like CSC. And we understand that there are issues with Congress, which has provided limits to us.

And yet there is so much opportunity to come to agreement on administrative flexibility that work underneath the budgets and the appropriations.

The 477 implementation speaks directly to administrative flexibility. And it is an opportunity that is ripe for us to come to agreement that is really the exercise of this trust doctrine in providing favorable interpretations through administrative flexibility for performing programs that speak directly to our unique communities. There are opportunities through TANF, child care, Early Head Start -- those are all opportunities where there need not be such a narrow interpretation. There can be a broader interpretation that follows the law and delivers the benefits directly to our communities.

C: (Larry Curley) You have the opportunity on your watch to establish the first tribally managed Medicaid program in the country. It is contained in the Affordable Care Act, which identified the Navajo Nation, the largest land-based Indian tribe in the country, to have a feasibility study done.

That study has been done. The study indicates that the Navajo Nation is capable of administering its own Medicaid program. The law also indicates the Secretary shall provide the necessary resources and assistance when the Navajo Nation requests. Bottom line, Madam Secretary: We will be requesting your assistance on this whole effort. Thank you.

C: (Secretary Burwell) Thank you all. I hope this is the beginning of a number of conversations but not just conversations. I know we need to resolve issues. On the ones we can, let's work to move forward. And on the ones where we can't let's be honest and talk about why we can't and figure out if there are ways to move beyond the barriers.

Whereupon, the STAC meeting adjourned at 4:20 p.m.