

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

June 4-5, 2014

Summary Report

The Secretary's Tribal Advisory Committee (STAC) met June 4-5, 2014, at the Hubert H. Humphrey Building in Washington, DC. With the arrival of a new Department of Health and Human Services (HHS) Secretary, STAC members seek to shape and establish tribal policy for the next two years and beyond. The meeting provided an opportunity for the STAC to converse in-person, hear updates, and engage in discussion on the HHS budget, Intradepartmental Council on Native American Affairs (ICNAA), Indian Health Service (IHS), Administration for Children and Families (ACF), Affordable Care Act (ACA), human service issues, the Office of Intergovernmental and External Affairs (IEA), participation in the regulations process, the Administration for Native Americans (ANA), and the Centers for Medicare & Medicaid Services (CMS). Throughout the meeting, the STAC was afforded numerous opportunities to engage with HHS leadership, program staff, and agency officials.

Members Present for Roll Call: Cathy Abramson (Bemidji Area), Ron Allen (Portland Area), L. Jace Killsback (Billings Area), Eileen Fink (California Area), Cheryl Frye-Cromwell (Nashville Area), Rex Lee Jim (Navajo Area), Chester Antone (Tucson Area), Gary Hayes (Albuquerque Area), Arlan Melendez (Phoenix Area), and Aaron Payment, Jefferson Keel, William Micklin, Stephen Kutz, and Brian Cladoosby (National At-Large Members). (Quorum Met)
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Action Items

- STAC members have created a committee to develop a document that addresses members' needs and priorities for different categories within HHS. The committee will draft this document by June 13. William Micklin is the chair. Other members include:
 - Aaron Payment
 - Ron Allen
 - Jefferson Keel
 - Chester Antone
 - Gloria O'Neill
 - Ken Lucero
- Members tentatively set June 9 at 2:00 p.m. for the first conference call. Discussions also will take place at the National Congress of American Indians (NCAI) Mid-Year Session in June. The technical groups from NCAI and the National Indian Health Board will work together to assist this committee in creating the draft document.
- Members should submit comments to this document by June 20.
- STAC members hope to have a meeting with the incoming secretary in July. Rather than a meeting with the full STAC, a group of no more than seven members will meet with the secretary. Members want to put recommendations on the table and check off those items as the STAC accomplishes results.

- Paul Dioguardi and Stacey Ecoffey will inform the workgroup when the secretary can meet in July.
- In preparation for this meeting, STAC members request financial support to help pay for the travel, if possible.
- During the week of June 9 a conference call will take place to discuss the report that explores the feasibility of a Medicaid agency for Navajo Nation.
- Schedule a meeting for STAC workgroup members to begin reviewing and updating the charter. Workgroup members are Ron Allen, William Micklin, Stephen Kutz, Cheryl Frye-Cromwell and Ken Lucero.
- Reconvene the state-tribal relations workgroup.
- Make the new secretary aware that reconvening the self-governance workgroup is a tribally driven priority.
- Recommend to the new secretary that Head Start and Child Care Development Funds (CCDF) should be part of the expansion of self-governance within HHS.
- In light of the new partnership with Early Head Start and child care, schedule training to educate tribes on how to blend and braid federal funds, and what that really means.
- In the briefing to the new secretary, highlight the areas where tribes need greater flexibility, interpretation and waivers in terms of formulas, cost recovery and other issues to more effectively administer programs and service delivery.
- Allow more time for Tribal Caucus during the September STAC meeting.
- Establish a STAC workgroup to engage with Mark Greenberg on the issue of states' requirements and obligations with regard to the Indian Child Welfare Act (ICWA), child care, foster care and child protection matters. This issue requires extensive discussion.
- Dr. Yvette Roubideaux will meet with the Substance Abuse and Mental Health Services Administration (SAMHSA) to discuss IHS rates for in-patient facilities for mental health/chemical dependency for youth and adults.
- Mary Wakefield will determine if staff in community health centers need additional training on providing outreach to tribes. Ms. Wakefield also remains open to conversations about oral health care grants.
- Dr. Roubideaux will check on the status of upgrading the Resource and Patient Management System (RPMS).
- Dr. Roubideaux also will circulate a link to a January 2013 summary report on interdepartmental agency efforts to address environmental contamination on the Navajo Nation from uranium.

Welcome and Meeting Logistics

After the Tribal Caucus, Paul Dioguardi, director of Intergovernmental and External Affairs, opened the meeting at 9:30 a.m. After the opening prayer, members addressed the election of the chair. Lieutenant Governor Keel noted that STAC members elected Vice President Rex Lee Jim as chair and President Brian Cladoosby as the co-chair during the Tribal Caucus. For the formal STAC record, Lieutenant Governor Keel nominated Rex Lee Jim as the chair and President Brian Cladoosby as the co-chair. Councilman Antone seconded the motion. Members passed the motion unanimously.

Throughout this document, questions, answers and comments are denoted by “Q,” “A,” and “C,” respectively.

Other announcements:

The confirmed dates for the remaining STAC meetings are:

- September 17 and 18
- December 4 and 5

Sylvia Mathews Burwell, the director of the Office of Management and Budget, is the nominee for the new secretary of HHS and was in the midst of Senate confirmation. A confirmation vote was expected on Thursday afternoon. Secretary Sebelius would appear at the STAC still in her capacity as secretary of HHS.

The new secretary will be in place and up to speed on the work of the STAC in time for the September meeting. Prior to confirmation, staff cannot predict or commit to how Ms. Burwell will interact with the STAC. The committee, however, was established formally with a charter and bylaws so it is part of the way the Department does business at the secretarial level and is not dependent on changing personnel.

C: (Ron Allen) I have had discussions with Stacey on the existing charter, so I would like to recommend that we establish a work group to review the existing charter. There are some issues that I have concerns about, and other tribal leaders do as well. Stacey said that she has some recommendations as well from your office. So I think it is time to update that charter, not just for this administration but for subsequent administrations to carry this initiative forward. I would like to volunteer to be on that work group.

CMS: Center for Medicare and CHIP Services

Cindy Mann, Director

Kitty Marx, Director, Tribal Affairs Group

Cindy Mann brought good news to share during her STAC presentation. First Ms. Mann met with Chairman Jim to hand him personally the long-awaited report to Congress that explores the feasibility of establishing a Medicaid agency for the Navajo Nation. As required by statute, the report went to members of Congress the evening of June 3. The report is also available on Medicaid.gov. These are the highlights of the report:

- Congress required the study as part of the Indian Health Care Improvement Act.
- The report says it could be feasible for the Navajo Nation to operate as a Medicaid agency.
- The report highlights tasks, opportunities and challenges the Navajo Nation might face if it were deemed a state by Congress for purposes of operating the Medicaid program.
- This is a feasibility report. It is not within CMS or HHS authority to make this happen. This change would require a change in law.

- The feasibility would be influenced by such factors as availability of professional and management staff, availability of policy operational experts, contracting, outreach and education, and more.
- The report breaks down the start-up costs and the annual operating costs. The costs are estimates and subject to further work. The contractor came up with a five-year start-up cost of \$134 million to \$243 million. The report gives an estimate of annual operating costs, which would be somewhere between \$360 million and \$526 million. The portion borne by the federal government versus nonfederal sources is still to be determined.

In other CMS news, the Marketplace enrolled more than 8 million people between October 1 and April 1. Through April 1, an additional 5 million people enrolled in the Medicaid/CHIP program. Medicaid/CHIP enrollment is not tied to open enrollment. Further, 26 states plus the District of Columbia have decided to expand. The last state that decided to expand was New Hampshire.

There is no deadline for a state to come in and expand Medicaid, and states continue to debate this issue. STAC members should continue to promote the value of providing Medicaid coverage to Indian Country. By current data, there are about 350,000 eligible, uninsured American Indians and Alaska Natives (AI/ANs) whose income falls within that Medicaid eligibility level if every state were to expand. About half of them live in states that have expanded and about half live in the states that haven't expanded.

A second solicitation for \$4 million in grant funding is now available specifically for outreach work to AI/ANs. The request for proposal (RFP) is available on Medicaid.gov. The grants will focus on increasing enrollment of eligible AI/AN children and their parents. Eligible entities include:

- Indian Health Service providers
- Tribes
- Tribal health care programs, and
- Urban Indian organizations.

The proposals are due June 30. The awards will be available at the beginning of September.

Ms. Mann also announced a new initiative on Improving Delivery Systems that will roll out during the summer. CMS wants to consult with STAC members on the new initiative and think about how to make sure that resources such as technical assistance support and peer-to-peer learning can involve those who have focused on providing good care in Indian Country.

In addition to the available Medicaid grants, states can claim federal dollars from Medicaid for administrative supports, giving grants out to tribes and other organizations to do outreach in enrollment.

Questions and Answers

C: (Ron Allen) I would raise two issues. The first one is the need for CCIIO in order to provide a strong, effective data matrix system so that we have the kind of data to show the performance,

so we know how successful we are. Our intuition is that we have got a long ways to go. And without the data, we can't make the argument about additional resources that could be provided to the tribes to help collaborate CMS and CCIIO to make that work.

There are a number of other issues out there that require support. So on the one hand IHS has a role because direct service is to the citizens out there, and they are the vehicle that tribes collaborate with. But a great deal of us, through self-governance and 638 contracting, administer those functions. Those citizens, whether they are living in what we call our service area or outside the service area, turn to us. So the resources we have available in order to make this system work, and we want it to work, it needs to be out there, and that database is critical.

A: (Cindy Mann) I couldn't agree with you more. I don't know how successful we have been, how unsuccessful we have been, where we target our resources where we can see that success has worked without good data and drill-down data. So we are working on refining what we have available both generally to the Marketplace and then also with Medicaid and CHIP we have a new data system going into effect hopefully this summer with states. It is not going to be overnight but it will provide, once it is in place, real-time, real data and drill-down, obviously, with the kinds the information that is needed to do it.

We agree it is a high-priority issue. There are obviously some systems issues that we are still working through to make sure we can get the data that everybody needs.

Q: (Brian Cladoosby) Once again my concern is for those tribes in the states that did not embrace Obamacare. And I just wonder about the CMS technical assistance for uncompensated care waivers to states and tribes that did not expand.

A: (Cindy Mann) Sure. I know we have had a workgroup with our TTAG looking at what some of the financing options are and budget neutrality options are in terms of how we do waivers. Right now we don't have any state proposals before us but we are open for talking to states as well as obviously continuing to do consultation with tribes about that.

Q: (William Micklin) In the past tribes have brought up the subject of expanded Medicaid being delivered through tribes. And if that discussion is to move forward, it needs to be the subject of some analysis. And I was wondering if there is any concerted effort to look at that as a possibility for tribes who are in states that have not accepted --.

A: (Cindy Mann) Well, I think this feasibility study from the Navajo Nation does exactly that. So, yes, that is what that study looks at. The kinds of issues that are raised are ones that could be applicable to other tribes.

Q: (Chester Antone) I just wanted to let you know that at least in the Tucson Area, at least the Tohono O'odham Nation has enrolled. I believe the last report referred to the Exchange because most of our folks are eligible for Medicaid, which is good. The other thing that I want you to know is that at least seven of IHS facilities have increased service levels, meaning cardiology, dental, podiatry and orthopedics, which brings me back to the original question of last time.

One of the four categories that aren't included in the state waiver, or the state Medicaid, they have not included any optional benefits except for insulin pumps. So Arizona is still supporting the waiver, and I just wanted you to know that because I believe you will probably be receiving a survey from AHCCCS, Arizona Medicaid, on the questions they posed to the Indian Health Service facilities.

And so at least 46.16 percent is the average percentage that Medicaid payments bring in. So it is a real help but if the state does not include certain things, then waiver covers those.

A: (Cindy Mann) That is right. And we renewed the waiver so we are continuing to provide support for those services.

C: (Ron Allen) The electronic verification process is still a high priority for us in terms of verifying who is an Indian. So we want to continue to underscore the importance of establishing that system.

The other thing that comes to mind is the QHP piece, requiring QHPs to provide clear options with regard to what their options are for tribal citizens as they enter into those -- the different options they provide. And I think a lot of our citizens, when they look at getting health coverage with these different QHPs, they kind of go, I am not sure what this means to me.

We have got to dumb down, for lack of a better word, in a way to help keep it simple but still require them to make it clear. It is not always as easy as one would think, whether it is the state plans or whether it is the fed system.

C: (Cathy Abramson) We are asking CMS and the IRS to establish a hardship exemption for persons eligible for health services from Indian health care providers. And allow persons eligible for services from our Indian health care provider to apply for hardship exemption through an Exchange and through IRS tax-filing process.

CMS didn't grant the ability of an applicant to secure the exemption through the federal tax-filing process, and HHS needs to delegate that authority to IRS.

A: (Cindy Mann) So I will put that on Lisa's list to respond to since her shop addresses the exemptions, the hardship exemptions.

C: (L. Jace Killsback) I just wanted to announce that we are trying to get Medicaid expansion on the ballot in Montana. We have groups that are doing the work there on the ground in Indian Country. The other thing, you mentioned the grant for Indian Country at Medicaid.gov. Is there a link on Medicaid.gov? I just looked it up.

A: (Kitty Marx) It is insurekidsnow.gov. It should be through both. Insurekidsnow.gov, and it is right on the page, and it will take you to the funding announcement. It is on Medicaid as well but it may be harder to find through Medicaid.gov since it is a bigger website.

C: (Cindy Mann) I had heard a little bit about the Montana ballot. Let us know if there is information, analysis -- my sense is people have what they need on that but numbers, dollars,

anything that you think will provide some facts into the debate that you think we might have that you still need, please let us know.

CMS: Center for Consumer Information and Insurance Oversight (CCIIO)

Lisa Wilson, Senior Advisor

Nancy Goetschius, Senior Advisor

During the past few weeks, CMS has focused on preparing for the next open enrollment period, which starts in November for the 2015 plans, said Ms. Wilson. To that end, CMS has addressed these tasks:

- Finalizing its Market Standards for 2015 and Beyond regulations. This provided more meat on the bones for some of the policies CMS needed to establish before open enrollment.
- Working on the operation and technology side, realizing how painful it can be if the technology doesn't work. CMS has taken in account feedback from tribes, issuers, consumer advocates and others. Time is the biggest issues right now as staff seeks to do things on the technology side that are possible.

As it improves its information technology operations to ensure a positive customer experience, CMS has put focused attention on these five work areas:

- Payments and premiums stabilization: CMS is still completing a great deal of back-end work with the issuer community.
- Closing out 2014 open enrollment: This includes reconciling data to enrollment baseline, adjudicating appeals and dealing with inconsistencies.
- Looking forward to 2015 open enrollment: Staff must address eligibility redeterminations and renewals. This issue will require lots of conversation during the summer.
- Enhanced consumer experience: Looking at ways to streamline the application.
- Easing enrollment in the Small Business Health Options Program (SHOP): This program will be more automated online accessible. CCIIO hopes to talk more about this program in Indian Country.

Questions and Answers

Q: (Stephen Kutz) In this in between time, it sounds like you are gearing up for November for the normal population. This is a good time to focus on Indian people and try and raise the numbers of people that gain access to these programs. One of the asks that we have had in the past is to look at integrating with the Indian Health Service database to create an Indian verification data market to conduct real-time electronic verifications. Have you looked into that? Have you made any progress?

A: (Lisa Wilson) I think the progress is slow but I have been working with our data verifications team. We all understand the importance of it and they certainly understand the ask and have

worked with Geoff Roth and other people, Dr. Roubideaux and other folks, to continue to scope that. I think it is going to be a heavy lift for this year.

Q: (Stephen Kutz) With all of this then, understanding that you have had all of these challenges in the system, where is this in your priorities for the upcoming year?

A: (Lisa Wilson) I can tell you that we have had some meetings again with our verifications team and discussions with IHS. You know, I can go back and talk to that team again about the exact status. I apologize, I should have gotten an update before I walked in the room but I can go back and talk to them again.

Q: (Stephen Kutz) I think also, I didn't know if it was coming from you or not, but you were -- we had a note in here from follow-up action items from our February meeting that you were going to provide an update on the IRS support of exemptions.

A: (Lisa Wilson) We have definitely had some conversations with the IRS and expressed the point of view that it would be very helpful if the IRS could work on that. The one thing I would say is that for members of federally recognized tribes, they already have an option to work through the IRS for an exemptions process. So this is for people who are eligible for IHS services, and that is what the conversations thus far have been about.

So recognizing that is a very important population, and anything that we can do to grease the skids for them and make an easier process is a great thing, but certainly we have had those conversations with the IRS and continue to press forward on that.

C: (Stephen Kutz) So partly that goes back then to something that was mentioned earlier, which is really getting that nailed on what an Indian -- the definition of what an Indian is. And we had conversations with the secretary at our February meeting about that because we believe that she has some authorities within the Department to do some things that she hasn't done.

A: (Lisa Wilson) I think that we are all on the same page that certainly a streamlined version of it would be very helpful. And we have been looking to our friends up on the Hill to help us through that legislative kind of issue.

C: (Yvette Roubideaux) We have heard sort of a renewed call from tribes to want HHS to reconsider their position about not being able to change the definition of Indian administratively. So I think that there was a pretty thorough review that had been done that said they didn't think it could be done primarily because Congress in this circumstance put the exact definition in the law. And the interpretation of Congress intends what it says.

There is also a lot of negativity about the Administration changing things that are explicitly stated in the law through administrative actions, and I think that is just a broader issue. That you may have heard in the news one of the committee chairs counted up the number of times they thought that HHS had actually changed policy that was different from what was in the law. And we get the message from Congress that they want it to be implemented based on how they wrote it.

I think maybe it is different in this case because there are a lot of people talking in Indian Country about how this was an inadvertent mistake. I think it would be extremely helpful if there were some way that the Administration could feel like it was okay to do something administratively because I think the problem is that for everything else in the Affordable Care Act, there has really been a lot of pressure from Congress about not wanting the Administration to veer off from what was in the law. And so this unfortunately is hooked into all of that.

But we hear loud and clear that tribes want to have a re-look at that. I have raised the issue at higher levels. The climate now is different than it was three years ago. I have raised it internally and will continue to discuss it.

Q: (William Micklin) My understanding is that only about 100 Alaska Natives signed up on the health Exchange during the open enrollment period. We have 29,000 tribal citizens. We had a concerted program to encourage folks to sign up. The Alaska Native in the state are about 20 percent of the population. So this is an extraordinarily bad outcome, and my understanding is that the process was very slow for enrollment and it required a lot of work for an extended period. Only federally recognized tribes appeared on the drop-down list. And many Alaska Natives were not able to sign up based on regions or other status.

So you are talking about the 2015 enrollment period. What actions would be taken to provide an easier process for Alaska Natives to enroll?

A: (Lisa Wilson) That question actually ties back to one of Steve's comments about, I think at least, about what are we doing all summer, all fall. Because it is not for American Indians/Alaska Natives. It is not just what starts in open enrollment. It is what is going on now. And we have had conversations with folk up there about summertime in Alaska is a time when there is a lot more movement and we can really get people motivated.

We have been working very closely with a particular Navigator and have a good relationship there. But there is a concerted effort, and Stacey and other people in the Department have been helping us kind of lead this charge to talk about the opportunities for American Indians/Alaska Natives all year round.

The good thing is I think we are actually in a good place going forward. We are thinking kind of globally about ways to streamline the application for people who have sort of easier financial and family situations. My goal would be for us to be working together throughout the summer and the fall as we go into open enrollment.

C: (Brian Cladoosby) If we were to be open and honest about where we are today, and if we were to grade ourselves about how good of a job we have done in enrolling American Indians/Alaska Natives, a D- would probably be generous. We probably have the lowest enrollment of any segment of society. That is something we need to work on. It has to be top priority to make sure that we get more than 100 Alaskan Natives signed up under the Affordable Care Act.

Tribal leaders have been asking for electronic verification of IHS beneficiaries. That has to be a top priority. We have been recommending the use of an IHS service maintained database to

create an Indian verification data mart. That is very important because the way it is set up now, it is costing us money. It is costing us delays. Tribal members, I think they are being discouraged. As tribal leaders, we need to continue to repeat this message to anybody who will listen that we need to get this electronic verification in place sooner than later.

Another issue, our elders. Once again we need to work together on this issue. Our tribal elders, we need to increase that number also. Including the urbans. And once again it is a team effort.

C: (Stacey Ecoffey) Good morning, everybody. I know I am not on the agenda but I think it was a good place to step in. We had a full two days of talking about issues that Navigators were facing on the ground. Some of those things I think were very solvable.

Some of the issues that we were seeing on the ground were things like how can we make our materials more regionally focused, having people that look like them. Having people who are in their area. We talked a lot about media and press and things that were in their areas and some of the issues that they were going up against.

And some of the things they talked about were in states where people were opposed to the Affordable Care Act, they didn't have enough face time with tribal leaders or other people advocating to get Indian Country enrolled.

One of things we have faced at HHS is not having an Indian person or success story to talk about. Jace has agreed to tell his story and so we are going to do a video with Jace. We are going to do a story about Jace and hopefully get that out.

We want to come back to the STAC and ask you guys if you guys can do some articles in your local papers in the tribal newspapers in your regions because that was something that people on the ground asked for assistance with.

C: (L. Jace Killsback) Yes, I did sign up for Obamacare back in February. I helped some elders look at it and sign up. One of them only had to pay \$14 a month. And she got scared. She still hasn't gone through with it. I tell them, \$14 per month, and you are going to be covered. No more five-hour waits at IHS. She said, I have had IHS my whole life. It is that fear. I think it is cultural, back at home. It is the fear of the unknown.

Every week we have a sign-up. And I sit there for probably two hours trying to get tribal employees because our tribal government doesn't offer them health insurance. I have been on the council for 10 years. I have been using IHS. So I signed up. And even I was a little worried. But when I saw that tax deduction, and I saw what I would have to pay to have health insurance, I couldn't believe how simple it was.

I think we did it wrong by promoting the Affordable Care Act before we educated our people about what health insurance is and what it means. My people have no clue what it means.

C: (Ron Allen) I feel that tribes are doing the best we can with the resources we have available. We have said numerous times in the TTAG environment that we think that CMS and CCIIO need to step up and recognize that if you are going to be effective in the 566 Indian Nations, with

the complexities of the large tribes like Navajo or even small tribes, that you need to help us have the resources to get the job done.

We need you to make a commitment. We need you to make the QHPs provide in their plans the right for tribes to do sponsorships. We don't want us to be an example used by the negative folks out there with regard to criticizing the ACA. We are your friends but right now we are not getting the love back.

C: (Stephen Kutz) It isn't just Indian Navigators, people working in our clinics, people working in our reservations, that have the responsibility to enroll Indians. It is the 330 clinics that have gotten the money, that turn over the calls and send them to us. We are getting calls from outside our areas. They are not getting help in the areas where they live. There ought to be a big push just across this nation to take care of all of our people in the cities and the places where the tribes aren't.

To go ahead and do some specific outreach to try to get our Indian people and Alaska Natives into the services. Lastly, I heard some things that make me sad. The thing that makes me sad is to hear that now I have this card and I can drive five hours to go get some care with some white people who don't really care about our Native people.

So I think the Indian health care system needs to do some analysis and figure out -- if we can get successful in working with all of our eligible people to get enrolled in all of these programs, how can we put the money back into the system to provide better health care, to provide urgent care, to provide lower wait times so that they don't have to feel like they have to go. It is a sad thing to hear, now I have an opportunity to go somewhere else.

We ought to get together and figure out -- this is a possibility of some new revenues coming in to help make a little bit of difference but I don't even know if there are conversations saying this is what we could do in these communities.

A: (Yvette Roubideaux) I will answer in my section.

C: (William Micklin) Two things: One is, this is important. But at the end of the day, this is a subsidy. These are not healthy folks making a large income. So that they need to go somewhere else is probably a calculation that probably this administration and this Congress needs to decide. Is this appropriate for a subsidy in another system instead of fully funding the IHS for the trust obligation to provide these services?

C: (L. Jace Killsback) Why doesn't the ACA give all Indians health care for free? That would handle our shortfalls in IHS. We would recover our tribal members, and in return our service units, whether contracted or direct service, would receive revenue. I think that is something that tribal leaders in my region are going for.

Indian Health Service Issue Discussion

Dr. Yvette Roubideaux, Acting Director

Dr. Roubideaux shared these highlights in her presentation:

- The senior leadership team has changed in response to a call for more responsiveness, communication and follow-up. These changes also will ensure that Dr. Roubideaux can get out to Indian Country more frequently and spend more time in meetings with a stronger management team in the background ready to implement the actions that tribes request.
- Robert McSwain has moved up to deputy director. Liz Fowler is deputy director for management operations. Carol Lincoln is in a new chief of staff position to assist with operations.
- The good news for the IHS budget is the full funding for contract support costs (CSC) in 2014 and 2015. IHS has distributed all the 2014 money for CSC. Staff are still reconciling a few payments. The CSC workgroup is assisting with pre-award estimates, recommendations on distribution and recommendations on a long-term solution to CSC appropriations.
- IHS has a lot of momentum this year on settling claims. 333 offers are on the tables of May 2014. Of the 1,200 claims pending, 900 now are in analysis due to a commitment of more resources and staff to this process. Secretary Sebelius gets a lot of the credit for the acceleration of the settlements. The goal is to get offers on the table for all pending claims by the end of the year.
- IHS is now at work on the 2016 budget. Tribes want a budget summit in mid-October to discuss the future of the IHS budget. Budget priorities include:
 - Advanced appropriations
 - Exemption from sequestration
 - The Special Diabetes Program for Indians
 - Medicare-like rates for non-hospital, physician services
 - IHS/VA, evaluation and coordination of care regarding the MOU
 - The Reimbursement Agreement with the VA -- all federal sites are billing and collecting
 - Facilities – a new call for applications will be available this summer for the Joint Venture Construction Program.
- Implementation of Agency priorities continues. In terms of strengthening Tribal partnerships, IHS is conducting listening sessions in all IHS Areas during June, July and August.
- In terms of the Affordable Care Act, IHS would prefer that patients who gain access to health coverage continue to receive services at IHS. IHS has encouraged tribes to do local business planning. All federal sites had to complete business planning templates that include business planning toward three goals with the ACA:
 - User population should be the same or increase
 - Collections should be the same or increase

- Quality of care should be the same or increase
- Dr. Roubideaux agreed that many IHS beneficiaries do not understand insurance. One solution could be videotaping STAC members explaining the ACA and putting the video online.
- The National Indian Health Outreach and Education (NIHOE) is up for renewal. STAC members should share ideas about how to best spend that money getting the message out about the ACA. IHS and tribal leaders need basic, practical ways to discuss the benefits of purchase or obtaining insurance coverage. Tribal leaders also are pushing Medicaid expansion in the states that have not expanded.
- Nine out of thirteen IHS hospitals are now nationally designated as Baby-Friendly to promote breastfeeding to reduce childhood obesity.
- Tribes need to make a final push to help meet all the GPRA measures for the 2013 national dashboard.

Questions and Answers

Q: (William Micklin) On the budget, we talked to other administration officials, we talked about contract support full pay and programs that need budget increases or are recovering from either a sequester or budget decreases. And the response we get back has been pretty consistent. They say be careful what you ask for. If you are asking for IHS, it will come out of BIA or BIE. If we are asking for BIA, it will come out of BIE or IHS. There is the finite amount of money that is ever going to go for Indian programs.

I understand that viewpoint but we certainly don't agree with it. It is somewhat concerning that is maybe the Administration's viewpoint. My question is focused on solutions to that. One area in contract support costs is -- and the initiative that this need be, since it is the contractual obligation, it needs to be mandatory funding.

We have heard that the Administration is cool on that because they just don't think they can win that battle in Congress. I think there needs to be some analysis, as you said, about what is the actual concept behind health care insurance. So in picking up our discussion today, for the health care Exchanges, and with ACA effectively for those who need the care the most can afford it the least, which is the predominant situation for our tribal citizens, there is a subsidy to support those in need.

So really if we are talking about that, which is really what IHS is. It is providing expenditures to support our needs that are necessitated by the trust obligation in federal/Indian policy. So if there are transfers for ACA for that purpose, should that not be effective through the organization that is -- its mission and purpose is for the support of tribal/Indian health?

And in its separation, it seems to be diminishing both the moneys available, which as I mentioned, there is this view that there is only so much and no more. And it also seems to be undermining the message as well, that if you want real health care you go to the white people's health care.

I think it is a real dilemma as we try to inform and influence our folks to take advantage of the health care Exchange and enrollment that is available for them because there is a benefit to it, a real benefit to it, in getting services that they would not otherwise have under IHS and contract care. I am not sure where to go with this other than it kind of begins at policy formulation, begins at the president's budget. And it begins in the message that is decided at the top level in the Administration about what direction they are going to go in and what they are going to support.

We have clearly asked as tribal leaders that we want the services that we feel are mandated, and if it is delivered in a fashion that is not understandable, is difficult to communicate and is segmented into different areas, then the benefit is much diluted. What is the belief in the Administration regarding the folks who make those decisions and set that policy? Because what we hear is that the funds that we can allocate from appropriations for whatever is viewed to be an Indian trust obligation is a finite amount.

If that is the case, what are the solutions to bringing in additional dollars? We are talking about mandated budgeting for contract support, and we are talking about bringing ACA dollars into IHS.

A: (Yvette Roubideaux) What I like hearing is that we are now starting to have this conversation in Indian Country about what is it going to take to get what we really need. Believe me, I have done everything I can within the Administration to get us as much as possible. The lessons over the last six years have been that the Indian Health Service runs in the context of HHS in the context of the Administration, including the White House and OMB, in the context of Congress holding the purse strings.

And I think that is what Lynn Malerba and Carolyn Crowder with the Budget Formulation Workgroup are settling on, that they want to have a budget summit to talk about what are some different strategies that maybe Indian Country can take on the budget.

We are a piece of this big pie where there is lots of other politics. And part of it is how do we get into those politics or how do we separate ourselves out of it? We do better thinking together, and we do better trying to think about what are the creative ways to move this forward.

C: (William Micklin) Congress is certainly one huge factor in this discussion but also it is at the 602 and the 302 budget category level where there is an opportunity for the Administration to reallocate funds at the Department level. We don't think they have exercised that authority to the extent that is available. As well, it is in the willingness of the president in his budget to propose the budget levels that we feel are necessary.

C: (Brian Cladoosby) I am a firm believer in repetition so once again I am going to keep pushing for an Indian verification data mart, going to keep pushing the electronic verification of IHS beneficiaries, going to keep pushing HHS to designate IRS for hardship exemption. I am not sure where you are at in that loop of discussions.

From what I was told in February, that is one thing IHS is ready and willing to do for us, we just need a letter from the secretary. It would be nice if Secretary Sebelius on her way out the door

could just send a letter off to the IRS saying that she gives the IRS the authority to issue a hardship exemption for tribes.

We need to continue an ACA data metrics in order to evaluate the AI/AN outreach and enrollment. Advance appropriations for IHS, I think we need to continue to work on that. I know that would make your life simpler if we had that in place, and once again that is going to be a team effort with us here at the table and the new secretary.

We talk about two years, but if we can get these things in place now, it will have long-lasting impacts well beyond the two years that we still have. The expansion of Medicare-like rates for IHS contract health services is very important. And as you have been hearing over and over, ensure that the CSC remains fully funded.

One other thing, we talked about the definition of Indian and that is something that Congress has to deal with. But we all know in this room that the Obama Administration has amended the ACA in the last couple years but he has gotten in trouble for it. And maybe he is a little gun shy now to keep doing that.

But if we could work with the Administration or with Congress to work on that definition, make that a priority for the next couple of years, I think would be a great goal.

A: (Yvette Roubideaux) We are ready -- our data mart is ready for the link. The challenges are so much else. And when Lisa says there is so much else that CMS and CCIIO have to do. You know we keep encouraging that we are very important and should be moved up the list. It is just that they have got so much to do. CCIIO is like drinking from a fire hose right now trying to get ready for open enrollment in the fall.

The IRS thing -- the IRS seems amenable to this. But you can't encourage too much so I would continue to keep it on the list. The repetition is good.

C: (Brian Cladoosby) Excuse me, doctor. Once again, we heard in February that the IRS is just waiting for a letter. I don't know if that is true.

C: (Geoff Roth) Yes, they are not that far along. They were waiting for responses from HHS and IHS specifically about the feasibility of it, what the capabilities were and how we could do it or not. We have done that, we have sat down with the IRS and CCIIO and had initial meetings. We are waiting to hear back from them on their ability to actually do it.

C: (Yvette Roubideaux) The message on advanced appropriations has to be crystal clear, precise. Everybody going to Congress has to be talking about the same thing because actually there are different ways it can be done. We actually went and talked to Congress and they had it wrong.

What I think the tribes are asking for is you want the funds available but they are scored in the year that you use them. Really what we are talking about is you are using the funds in the year that you use them, it is just that you have the authority a year in advance so you don't end up

having to be impacted by continuing resolution or shutdown. If people misunderstand, that is one more reason not to do it.

Second, it is helpful for tribes to explain why it is important. IHS can still operate on an obligation, but in a continuing resolution for tribes you are not getting the full-year funding, and that hurts your planning. In a shutdown, IHS can't disperse cash to you, so your cash flow is a problem. That is helpful for Congress, that you just want access to funds.

C: (Brian Cladoosby) I think it would be important the we get a commitment on a timeline on working on advanced appropriations. We want the Department to support I believe it is S1570 and HR3229, I think those are the two bills.

C: (Arlan Melendez) One important thing we have always advocated for contract health service and I don't want it to seem that contract health services start to diminish because of insurance. Indian Country in general still depends on contract health service, especially the tribes that don't have facilities within their state. So it also seems as though as we start to push people toward insurance, that there is going to be this diminishment of contract health service. So I want to make sure that we stand firm with that.

Also with tribes that have become self-governance, like my tribe where we have taken over contract health services, there are still outstanding bills that are the responsibility of the Indian Health Service, where we have the service units that have a consortium of tribes that have bills.

And as the tribes become self-governance, those outstanding bills that are still going to be attributed to individual patients, we want to make sure that even though we manage contract health service now as self-governance, we want to make sure that those bills are paid by the Indian Health Service that were in the pool, that these individual patients don't have their credit ruined.

C: (Dr. Yvette Roubideaux) I want to reassure you contract health is a top budget priority. We are always going for the biggest increase we can because that crosses all lines of tribes.

Q: (Stephen Kutz) So who are the people that you kind of hear from who say this okay?

A: (Dr. Yvette Roubideaux) Maybe we can talk offline a little about that. We are providing technical assistance now to the Senate Finance Committee, who is very interested in changing the definition in legislation. So I think they are the one committee who has the most interest in it. This is issue of whether it should be done administratively or legislatively, you know I raise that because I think that is one of the big stumbling blocks.

The things that are barriers, I wonder if we can break them down.

C: (Brian Cladoosby) Thank you, doctor. You have our to-do list and we will remind you about that to-do list.

HHS Budget Updates

Norris Cochran, Deputy Assistant Secretary for Budget

Senate 1570 is the advanced appropriations legislation, and conversations continue with the Office of Management and Budget about tribes' interest in this topic. It isn't a cure-all, but staff understands its importance. OMB owns that budget process.

In terms of the appropriations process, the president's budget request for IHS is about a \$200 million increase in regular budget authority. There is also the Option and Growth and Security initiative, which is an increase of \$200 million.

Mr. Cochran noted the 302B allocations, simply the totals for the Interior Subcommittee Appropriations Bill. The Interior appropriations bill funds the Department of Interior and the Indian Health Service. Most of the HHS dollars are through the Labor, Health and Human Services, and Education bill. The Interior subcommittee funds directly the IHS activities that are in that bill.

The House and Senate have put out their allocations for the appropriations process for the year. The total for that subcommittee in 2014 was \$30.058 billion. The House wants to put together an appropriations bill that is a little bit above that at \$30.22 billion. The Senate will work toward putting together an appropriations bill that is a little below that at \$29.45 billion. How that will get translated into the budget for the Indian Health Service won't be known until the appropriators do their mark-ups.

The House is looking at late June/early July for the Interior bill. Both appropriations chairs -- Chairman Rogers in the House and Chairman Mikulski in the Senate -- worked well together for the FY2014 bill, and neither wants to have extended continuing resolutions or a shutdown.

For the 2016 process, meetings are always well-timed for the Office of the Secretary to be thinking about formulating the budget. A budget process occurs during the summer, and the new HHS Secretary will be familiar with the budget due to her work as OMB Director. However, the new secretary will have the benefit now of getting more into a greater level of detail and working on the summer process for 2016. In September, staff will engage with the Office of Management and Budget.

The president put forth a budget request, and then on top, in the case of IHS, there is another \$200 million focused more on facilities' needs. But there was a proposal where the president is articulating a vision to revisit the total spending levels that those appropriators use on an annual basis. The Administration is already seeking to communicate that come 2016, officials need to think about those budgetary caps on the discretionary side in a way that takes into an account all the pressures on the annual budget.

Questions and Answers

Q: (Ron Allen) Often when we come in here, we talk about ACA and IHS budget matters but we also are equally concerned about Head Start and long-term care programs, SAMHSA, LIHEAP,

et cetera. What is your read on where the Administration is and where we are in terms of what kind adjustments we are looking at in those critical areas that serve Indian Country?

A: (Norris Cochran) I will start with the Administration for Children and Families -- LIHEAP is a difficult area in terms of the annual president's budget as you know. Many of the budgets have brought the number down to kind of a pre-spike, so the appropriation had been relatively level and then it came back up. And then it came up kind of precipitously, and the president's budget has proposed floating it down, not because it is not a priority but just trying to make the totals work.

From your perspective, the good news is the appropriators have not agreed to that. They have continued to fund at a high level. In terms of areas where we have been proposing increases, we do have the Early Learning Initiative within the Administration for Children and Families, and we fared pretty well in the '14 process. A lot of new dollars are for the Early Head Start and child care partnerships, and we are getting close to being able to announce that funding announcement.

That appropriation was designed to allow the grants to not all be made just in this fiscal year but as late as next March. Because it is such a new program, we are eager, ACF especially, to have that announcement out to get the applications in. That remains a priority in the 2015 process.

In the House, for the bill that funds ACF and a lot of other HHS activities, staff have shared that they are looking maybe late June for the HHS bill mark-up in the House. At this stage we have no idea where they are headed in terms of the various funding levels.

Within SAMHSA we had a targeted program that we had proposed through the Prevention Fund for a number of years. We have continued to try to push for that.

We also have initiatives both in suicide prevention and in what the Administration has called the Now Is the Time initiative around mental health and behavioral health and violence prevention.

Q: (Ron Allen) The only other thing I was concerned about was the programs that are targeted at long-term care. That has become a serious concern for us to be able to serve our elders. You don't have any money in there to help us with our elders, the actual elder assistance programs. What is your read on where that program is heading?

A: (Norris Cochran) That area is a priority for the Administration and it is being supported through different mechanisms.

One, the most obvious, is that the Administration on Aging is combined with disability programs within ACF into the Administration for Community Living. Kathy Greenlee, the administrator of that organization, has really been pushing both those traditional support for caregivers as well as elder justice. She has been trying to build support for both through the appropriations process and through her interagency planning with the Department of Justice and others.

In addition to that, the Centers for Medicare and Medicaid Services have continued to look at both where they have some dollars and then where they have some demonstration authorities,

ways to work with Medicaid and others systems that we have to provide support there. We are hopeful we will get traction on the ACL initiatives. The dollar streams are pretty small. It is important and it is something we still want to push. Until we can figure out all we can do on the larger funding streams --.

C: (Ron Allen) I see where it has really flat-lined and we have been advocating for a decent bump if you will. Where the president and first lady have raised the priority of healthy lifestyle, the good news is our society is living longer. The challenge with regard to living longer means greater responsibility to provide quality health care in living assistance.

It is a matter of looking to not just resources but even looking to opportunities to enhance best practices and opportunities to address that need -- everything from assisted living facilities and programs to home care.

C: (William Micklin) There are a number of priorities that tribes have identified in various programs. In the Office of Family Assistance, for example, in TANF, benefit determinations, the maximum benefit is \$923. It was \$923 in 1996. The census reported that costs in our region have gone up 20 percent between the 2000-2010 censuses. Our incomes have dropped and expenses have increased. That maximum benefit buys a whole heck of a lot less, so program assistance is becoming less and less efficient.

We have asked for things for grants in specific areas to become part of program funding, like SAMHSA, to become part of community health rather than a grant program. We have a significant suicide issue in Alaska. So, for example, that would be an impact on budget formulation.

We have programs where we have identified as a priority where we would like waivers of shares in percentage if not in completely for priority programs. I could go through a long list of -- like Title IV-E waivers or child welfare systems, other examples.

These all, if they are to be seriously considered, would need to be part of a budget analysis. So while we identify these as priority actions, they can't be accomplished unless there is an analysis on the impact to the budget. And therefore what the president's proposed budget would need to be if the Administration were to accept the priorities that tribal leaders have identified.

If our advice to the secretary and to the Administration is ever to be achieved, there needs to be, for these areas, the appropriate budget analysis. If those are not already under way, how could we get those under way, and need we put a priority on those areas where we would want analysis?

A: (Norris Cochran) I don't have a specific solution that would cover all cases. What I would say is process wise, our operating divisions -- you mentioned activities within both ACF and SAMHSA. Annually we go through a budget formulation process that kicks off about in April. Then the Office of the Secretary engages beginning around June. OMB engages beginning around September. That culminates typically in February.

Limitations on making changes -- in some cases, like TANF, which you described, can be top-down limitations. So we have had difficulty finding a legislative path to reforming TANF and extending funding. In other cases, if you are talking about a way a grant is run, some of our authorizations are very specific.

In terms of analysis, in some cases we do have very good evaluations of program design and program effectiveness. We have had some programs under this administration, like in the teen pregnancy area, where from the very beginning we had a set-aside within the totals to do an evaluation to inform what was most effective.

And so that meant fewer services for that program, which is a tradeoff, but long term it will mean that we will know more about what is most effective.

Most programs, the program is on the service delivery, and the ability to get good studies, evaluation or research is constrained.

Where do we have data? Sometimes it is administrative data from the hard work that you may do in filing your annual grant reports, for example. There are instances where we have administrative data that we can try to use as a proxy for evaluating what is working or where a change could be made.

Often it is a barrier in terms of being able to do more costly analysis. But that shouldn't be the only thing we strive for. Even just starting again with making sure that the program directors, the operating division heads or office, that we know program design barriers you are seeing that are problematic.

C: (William Micklin) It is important that effect of the sequester or taking program funds to pay for contract support be made up, and the only way it can be made up is through the president's budget asking for it. The decision makers can't make that decision unless they have the data, the analysis of what that would be. If they adopted that position, what would they need to ask for?

C: (Brian Cladoosby) I know you have heard these numbers but I think it is worth repeating and putting into the record. For 2016, the National Tribal Budget Formulation Work Group recommended a request for a 17.8 percent increase, for a total tribal budget recommendation of \$5.4 billion

Highlights include:

- \$166 million for full funding of current services
- \$199 million for binding fiscal obligations
- \$449 million for program expansion increases
- Restore the cuts and shortfalls in the '13 to '15 sequestration
- Advocate that tribes and tribal programs be permanently exempted in the future from sequestration
- Provide an additional \$300 million to implement the provisions authorized in the Indian Health Care Improvement Act

C: (Eileen Fink) Congress directed HHS and DOI to consult with the tribes for long-term strategies to correct the problems with CSC funding and yet that is not resolved. Full funding for CSC must not come with a penalty, namely a reduction in program funding or effective permanent sequestration of Indian program funds. The result would have the same devastating effect on our service delivery as the failure to fully fund CSC.

Yet Congress in a joint explanatory statement accompanying the 2014 consolidated appropriations act noted that “Since contract support costs fall under discretionary spending, they have the potential to impact all other programs funded under the Interior, and environmental appropriations bill, including other equally important tribal programs.

Moreover, without any permanent measure to ensure full funding, payment of CSC remains subject to agency discretion from year to year even though tribes are legally entitled to full payment.

Noting these ongoing conflicts of law, Congress directed agencies to consult with tribes on a permanent solution.

CSC should be appropriated as a mandatory entitlement. Congress recognized that the current fundamental mismatch between the mandatory nature of CSC and the current appropriations approach leaves both the House and the Senate committees on appropriations in a position of appropriating discretionary funds for the payment of any legally obligated contract support costs.

So then the obvious solution then is to bring the appropriations process in line with the statutory requirements to recognize CSC for what it is, a mandatory entitlement, and not a discretionary program. Thank you.

C: (Norris Cochran) Thank you. That is very much an area we have obviously been focused on. And this is an odd situation where due to action of the court, you have effectively an entitlement that is still covered in a discretionary appropriations bill.

We have the '14 appropriation where we caught up. The president's budget for '15 is out there. We still are continuing to talk about what is the best long-term solution for this given that we have a mismatch between the budgetary mechanism and the budgetary reality.

C: (Yvette Roubideaux) We just sent our work plan to Congress to consult on a long-term solution.

C: (Stephen Kutz) When we looked at the mandatory payments of contract support costs, and we put the money to take up for the sequestration and rescission, that left, if my memory was correct, less than 1 percent of a true increase to the budget for the health care services, which does not keep up with inflation let alone medical inflation.

C: (Norris Cochran) That is an excellent point because under the Administration we have been proposing budgets and except for the years we had a CR, we have by and large gotten the president's budget request. So it hasn't been at the pace any of us wanted to see but we were

making some progress, and then the sequester was really awful in that not only did it halt any forward progress but we actually took a very substantial step down.

We are, in the '14 appropriation and the '15 budget, trying to not only make up for the sequester but also trying to get back on a path of continuing to grow the IHS investment, both contract support costs and all the various service lines.

C: (Ron Allen) Regarding the CSC obligation and our request to get it moved into mandatory, it is a matter of taking a realistic bite and we are asking the Administration to be supportive recognizing that against the political backdrop, that mandatory is under a lot of scrutiny.

We also understand that IHS money is competing with BIA money and the Department of the Interior, not in the HHS budget, which is a different budget that may have more flexibility if the secretary had a little more discretion.

At least if we could get it into mandatory, it would remove the competition from services that actually serve the community versus these contractual obligations.

And touching on Steve's point that we have requested, when it comes back to the Budget Control Act, which is going to come back at us in '16, is the desire that our program should be exempt. And there are a number of programs that were exempt.

Q: (Gary Hayes) You mentioned about the president's initiative on opportunity and growth and hoping for \$200 million for facilities for IHS. When you look at the proposals and look at the need for Indian Country, it is \$28 billion. Are there other resources where HHS could support in helping offset some of the cost that is occurring or the need that is throughout Indian Country? Is that the only initiative, in that Opportunity and Growth Initiative?

A: It is in the 2015 process so we have the annual president's budget that has the \$200 million increase for Indian Health Service budget authority overall, and then this Opportunity and Growth Initiative was at a different process. The Administration used it not as a full detailed shadow budget process but more as a way of flagging that at our current caps under the Budget Control Act.

Q: (Gary Hayes) When we had a meeting with BIA, that OMB would say \$19 billion for Indian Country. And you really look at the two agencies that really impact Indian Country is BIA and IHS. And that is less than \$7 billion.

So I think that maybe this is a discussion beyond us, but I think as tribal leaders we need to be mindful of what they are saying. And we look in our communities and we don't see that. We just need to have more transparency and accountability.

C: (Dr. Yvette Roubideaux) The tribes have heard the White House say there is \$19 billion in Indian programs. And I don't know if that has ever been released or has OMB ever broke that out?

A: (Norris Cochran) We will ask them. Did they give you a detailed kind of -- this is transportation and so on and so on or was it --.

C: (Gary Hayes) I am hoping that they will provide. That is what we are asking. Where is that going and what are the restrictions?

A: (Norris Cochran) We will push for that as well.

C: (Rex Lee Jim) One of the things we are interested in is not only the \$19 billion but I would like to see a budget analysis of if we get any increases that benefits Indian Country within HHS. We want to know where that money is coming from, the negative impact on sister agencies. We would like to ask for that type of analysis as well.

C: (Jefferson Keel) In summary, when we talk about the CSC, the payments are supposed to be made out of the judgment fund, the question is the judgment fund needs to be replenished. So tribes are concerned that the judgment funds or the funds that are going to be paid, contract support costs will come out of the allocation for IHS. So that is a concern.

A: (Norris Cochran) The judgment fund is a strange animal budgetary. It is open ended from a budgetary perspective, so it is governed not by an annual appropriation but by the case by case legal determinations.

Agencies do by statute have a responsibility to reimburse that but only when they have legal appropriations to do so.

Because you mentioned OMB, I should have said this at the start. I know we have invited OMB. Julian Harris, Dr. Harris, he is the policy official at OMB that is over Indian Health Service, so OMB has a director, a deputy director, and then they have four leads on the budget side. We have invited him to these sessions before. Each time there has been a problem with his calendar but we haven't let the fall off our to-do list.

C: (Brian Cladoosby) We would want that the Administration not take the judgment replenishment out of Indian appropriations.

C: (Norris Cochran) Our budget policy has been to put every resource into future costs. And that is where we have been and where we want to be.

Update: Intradepartmental Council on Native American Affairs (ICNAA)

Lillian Sparks Robinson, Chair

Dr. Yvette Roubideaux, Vice Chair

The STAC and the ICNAA work closely on numerous priorities. For the term of this administration the ICNAA has focused on these goals:

Data Sharing

For 2014, the data workgroup has three focus areas:

- To undertake an inventory of all the data elements that Native American grantees across program offices that serve Native Americans are asked for both in applying for grants and for ongoing data reports. Efforts will begin with the ACF.
- The development across the Department of a coordinated data plan informed by Native American stakeholder needs as well the priority and needs of HHS. The data plan will include strategies for the collection of data, data analysis, the sharing of data and the ongoing maintenance of all of the data assets.
- The exploration of how the HHS Tribal Consultation Policy can perhaps be revised to facilitate and support Native American access to state and local data assets as well as to expand the mutual benefits of cross jurisdiction data sharing for the well-being of Native American children, families and communities.

Staff has completed the migration of all the required data elements for applications for funding as well as the ongoing data reports into one consolidated document. Program offices are verifying the accuracy of the data collection included in that document and identifying mechanisms through which grantees are required to report the data.

The coordinated data plan and the review of the tribal consultation policy are in the beginning stages. In July, the data workgroup will ramp up a framework for these two projects.

The first project, the data inventory, may be the first-ever complete inventory of required data elements and will give a sense of not only the duplication across program offices but will enable the development of strategy that will eventually become a single data portal. Grantees will be able to report through a more streamlined mechanism that will in turn enable HHS to conduct data analysis and generate reports back to grantees. Multiple offices may be able to use the information as well.

Grants/Report Training

Staff members have worked on increasing and improving access to grants throughout the Department during the past few years, including working on the grants eligibility matrix and conducting training. The grants matrix is now available online under the Office of Intergovernmental and External Affairs.

This work of this group has expanded to these five areas:

- Increase the number of trainings and improve accessibility. This will include webinars and trainings in the regions.
- Develop a web portal specifically for tribal grants access. It will hold all the tools that we have developed over the past years on accessing grants, and it will also hold information on upcoming trainings throughout HHS, information for previously held webinars and trainings and information on peer review panel opportunities.

- Hear from OPDIVS on what their best practices are at recruiting and retaining Native American reviewers. Also, look at which OPDIVS provide feedback to unsuccessful applicants.
- Make sure staff are updating and maintaining data for the eligibility matrix.
- Take a look at which agencies provide technical assistance, what their best practices are, and how to improve them. Also expand that effort throughout the Department.

Training will also be available internally to ensure that staff are aware of issues and best practices so that when they are designing their training and outreach, they are aware of how best to make sure that there is equal access to these opportunities.

Q: (Cathy Abramson) If we have issues with the Department, we can tell that department too but is it good also to let you know too when it comes to grant reviews?

A: (Liz Carr) You can send that to me.

Tribal Consultation/State Relations Section

The new section added to the HHS Tribal Consultation Policy during the last iteration includes much to consider. As a result, staff will focus on these goals:

- Focus on looking at something that will result in a resource similar to the research matrix on grants.
- Survey the agencies in HHS on who has legal authority to require tribal consultation for their relevant program areas.
- If those areas don't have legal authority, staff will determine if there is a policy in place that strongly encourages consultation.
- Examine best practices as well as training materials to assist states in consulting with tribes.
- Determine guidance materials and hopefully come up with some best practices and standards for consultation to share with states.
- Look at the opportunity to decide if it is a policy or if it is legislated, determine if consultation could be a term of award to a state.

C: (Ron Allen) I guess I have a couple of concerns regarding consultation requirements with the states. One of them that we have raised in this forum in the past is the state obligation to implement the Indian Child Welfare Act in terms of the spirit and intent of the act itself. Many of the states do not. So they receive all these different resources with regard to child care and responsibilities and their respective communities in each state but we have asked in the past that you take into consideration that as a requirement, not just in consultation with the tribes, not just a requirement of consulting with the tribes regarding all these matters, but that you will, to the best of your ability, implement or honor and respect existing federal law.

And that has been a big problem for many of the tribes in most of the states if not all of them. Part of the issue under consultation has been:

- Resources that are intended for the tribes go through the states, so we want to double-check that they are not carving out too much for the state before it even gets to the tribes.
- Concern over the Indian Child Welfare implementation. Those requirements should be added to it. It is a part of the consultation or respect of the tribal government's authority as that act was intended.

A: (Lillian Sparks Robinson) The STAC actually had a state-tribal relations workgroup that worked hand in hand with a number of folks from our ACF offices, from ACL, from SAMHSA, CMS and from our regions. And one of the areas that we identified that we would look at through the state-tribal relations workgroup of the STAC would be the Indian Child Welfare Act.

I think what we are looking to do is looking at the tribal consultation policy and aligning it with what the priorities of the workgroup are including ICWA. On top of that, we do have a new associate commissioner who has been able to visit the STAC and actually has taken tribal issues to a much higher level. She has been having monthly conference calls with the National Indian Child Welfare Association to figure out how we might be able to do a better job of implementing ICWA and educating the states.

And we have also developed a much stronger partnership with the Bureau of Indian Affairs under that leadership with regard to the revamping they are doing of the guidelines and guidance that they are giving to states.

C: (Rex Lee Jim) One of the things we need to do is reconvene the state-tribal relations workgroup.

And I want to tell you a story. There is a Navajo mother who gave birth in a non-IHS facility and took the baby home. By then the non-Navajo father kicked the mother out. So the child didn't get a chance to be registered with the Navajo Nation. And now the mother wants help, but the Navajo Division of Social Services can't do anything and we can't really work with ICWA.

A: (Lillian Sparks Robinson) We will follow up with you with that particular issue.

Q: (Gary Hayes) In Colorado we have been asking that question and giving them training. A lot of the judges in District Court are asking for the training to offer an understanding of ICWA. BIA's policies and regulation are really outdated. It talks about providing services only to tribal members, and we have a lot of children who are not able to be enrolled in the tribe. But we still need to provide that protection for them.

So what is the progress? Dealing with BIA is a cumbersome process.

A: (Lillian Sparks Robinson) BIA actually has been having consultation with regard to updating the guidance. There was a consultation that was held in March during the NCAI Executive Session, and I know they had another consultation that was held in Florida in April during the National Indian Child Welfare Association meeting.

They are now convening internal workgroups with other federal partners including HHS and Justice to look at the recommendations and provide and updated guidance.

Self-Governance

The update for the Self-Governance Tribal Federal Workgroup is not much different than the update that was provided last time. The workgroup has concluded their activities. A report was issued late last year or middle of last year. Points of contact include Linda Smith, deputy assistant secretary for early childhood and the liaison for the Department on early childhood issues.

The outcome is different than what the actual Self-Governance Tribal Federal Workgroup proposed in terms of looking at the programs altogether, said Commissioner Sparks Robinson. Each agency has been charged by the ICNAA to take a look at the priorities and to be open to having these conversations and begin talking about the issue internally.

ACF has had several conversations among leadership about how to advance self-governance. ACF would like to hear from the STAC directly on how to thoughtfully move forward in a way that works within the existing grants model but also works for the tribes.

C: (Ron Allen) I am really disappointed in this report. It has been six years. Self-governance has been active, engaged and successful for 25 years. It is disappointing that this administration, which has been supportive of empowering tribal governments, can't find a way to launch and advance an initiative to make self-governance work within the framework of HHS and all the non-IHS programs throughout this department that serve our communities.

The notion that there are different pieces of legislation that say you can't, tells me you are looking for reasons why you can't. The way is available. I don't think you guys are doing enough to recommend to the secretary this really needs to happen.

A: (Lillian Sparks Robinson) I will take your concerns back. I think we have differing views with regard to how the conversations went with the Self-Governance Tribal Federal Workgroup. Certainly we weren't looking for impediments. We were looking for models to make this work but there was not an agreement with the tribal and federal side with regard to how to advice this.

C: (William Micklin) The problems we had with OMB on the implementation of Appeal 102-477, one of the by-products of that was just reaffirming the success of that program that allowed us to integrate federal programs into our delivery system without the stove-piping of the program requirements and restrictions on reallocations of funding.

That was part of, I think, our thinking on contracting/compacting the programs under the non-IHS operating divisions in HHS. It is a great emphasis for us as Central Council and also as part of the self-governance tribes to find a way to collaborate with HHS to revise the HHS programs to facilitate program integration because it would vastly improve the delivery of services to our tribal communities.

We know this, we practice it through 477 and we can see the ways where it would be a great improvement. One of the considerations is that some of those programs are delivered through the grant process. I think that is just a consideration for our plan for revising these programs.

Perhaps some can remain grants but I think others need to become programs so we can integrate these into our delivery of services.

C: (Lillian Sparks Robinson) Thank you for offering that suggestion of the 477 model. I think that was raised at the time the Self-Governance Tribal Federal Workgroup was meeting but it wasn't something that was further explored. So we are very interested at ACF in taking an additional look at how 477 might work for programs outside of the ones that they are currently operating under, which include our Tribal TANF, our new programs and our Child Care.

We know that it works for those and we are definitely interested in exploring and having conversations about how we might be able to push it even further.

Q: (Ron Allen) I am not quite clear from Lillian's report. Are we reconvening that workgroup to try to find a solution? I couldn't remember what our proposal was and I am looking at it now. We did put a proposal on the table, and it is consistent with what we did with the Department of the Interior way back in 1988. I am not sure we got a formal response why not or what you would do to modify it.

It does provide the opportunity for a demonstration project and how to identify any legal and logistical/regulatory barriers and the pros and cons to both the Department and the tribes. We want to move this thing forward. Are we reconvening?

A: (Lillian Sparks Robinson) I believe the request to reconvene the workgroup was sent up to the secretary, and I believe the response was sent that the workgroup would not reconvene.

C: (Ron Allen) I would like to have that as priority with the secretary, Mr. Chairman. I want the Secretary to know that this is an initiative of the tribes, it is a priority of the tribes.

C: (Rex Lee Jim) Thank you. We will add that to one of our to-do lists, to reconvene. The workgroup made the recommendation that this is tribally driven.

Human Services Issues Discussion

Linda Smith, Deputy Assistant Secretary for Early Childhood Development, ACF

Shannon Rudisill, Director, Office of Child Care, ACF

Ann Linehan, Acting Director, Office of Head Start, ACF

Moushumi Beltangady, Senior Advisor, Office of the Deputy Assistant Secretary for Early Childhood Development, Home Visiting

Capt. Bob Bialas, Regional Program Manager for Region XI, Office of Head Start

This presentation gave an update on the early childhood issues the Department continues to address, the relationship to tribal efforts and the tribal efforts connected to Child Care, Head Start and the Tribal Home Visitation Program. Ms. Smith's opening remarks included:

- Details on a meeting with the office of research to address future tribal research needs and ways to build more capacity in the tribal community and tribal colleges to do their own research.
- Interest and support in Congress around early childhood issues following recent Senate hearings. Testimony from the White Earth Reservation resulted in changes in the Senate bill that passed out of the Senate, which would change the child care amount from a ceiling to a floor.
- The need to include tribal issues within presidential initiatives. The My Brother's Keeper Initiative, for example, should address needs and issues confronting Native American children and youth.
- Ongoing efforts to clarify confusing regulations and break down stovepipes between offices and departments.

Ms. Rudisill noted that the Office of Child Care has 260 Tribal CCDF grantees. Because of the large number of consortia, the office actually reaches 520 federally recognized tribes. A 2 percent set-aside works out to about \$100 million. The recent Senate bill would change that from a ceiling to a floor. In addition:

- New regulations proposed in May 2013 will strengthen the child care program, recognizing that children in child care frequently live in poverty but don't get the same links to health and other services as the children in Head Start.
- 29 tribes submitted comments to the proposed regulation. Staff members are incorporating those comments and completing final steps on the proposed regulation.
- The proposal calls for comprehensive background checks and health/safety standards, consumer education and continuity of care strategies that allow services to continue during a period of a job search when a parent loses a job.
- Tribes are no longer exempt from immunization requirements.
- Trainings focused on health and safety best practices took place in April and May in San Francisco; Norman, Oklahoma; and Kansas City.

Ms. Linehan noted that this year's budget allocated \$500 million for Early Head Start/Child Care Partnerships. This uses Early Head Start funding and expands Early Head Start services by partnering with child care programs in tribal communities, bringing those child care programs up to the same standards. Money is set aside for tribes, but urban Indian organizations can consider the non-tribal money as well.

Ms. Beltangady gave these highlights:

- The Tribal Home Visiting Program awards grants to tribes, tribal organizations and urban Indian organizations to plan for, implement and evaluate home visiting programs for expectant parents and parents and primary caregivers of AI/AN children from birth to kindergarten entry.
- Since 2010, ACF, in collaboration with the Health Resources and Services Administration (HRSA) Maternal Child Health Bureau, has awarded 25 grants under the Tribal Home Visiting Program to entities in 14 states.
- Grantees' programs send home visitors who are trained in early childhood education and maternal and child health to work directly with expecting parents and families with

young children to promote maternal and child health, school readiness and family sufficiency and to prevent child abuse/neglect, domestic violence and crime.

- The program also seeks to improve coordination and collaboration among tribal early childhood programs and support stronger early childhood systems in the communities.
- During the last reporting period, which ended September 2013, tribal home visiting grantees provided over 5,600 home visits to nearly 650 families. As of April 2014, grantees were serving an average monthly caseload of nearly 1,000 families.
- HRSA and ACF have been promoting state and tribal collaboration and letters have gone out to state grantees as well as tribal leaders on this topic. A webinar for state and tribal home visiting grantees took place in March to promote partnership. A webinar for state grantees in August will focus on working with urban Indian populations.
- On April 1, the president signed the Protecting Access to Medicare Act, which included a provision extending authority for the home-visiting program until March 31, 2015. This also provided \$400 million in FY15 funds for Maternal, Infant, Early Childhood Home Visiting (MIECHV) and this includes \$12 million in tribal MIECHV funds in 2015.
- Interest remains high for the home-visiting program. More than 100 entities have applied for funds and only 24 could receive awards.
- The White Earth Nation joined the Tribal Early Learning Initiative in 2012. Since then, tribal members have completed a great deal of work to build a stronger early childhood system and build a strong system across the entire tribe for all families involved in any service. Using funds from home visiting as well as from the Tribal Early Learning Initiative (TELI), they invested in a data system that allows them to do case management across all families that enter any point in the tribe. And in the most recent State of the Nation Address, the tribal chair said all tribal programs would participate in this data system.

Questions and Answers

C: (Brian Cladoosby) I would really love to see Head Start and CCDF as part of the expansion of self-governance within HHS. I am not sure how soon we could start working on that, who the players would be, but I think that is something we would like to see recommended to the secretary.

Also, will the Tribal Early Learning/Head Start have lowered numbers for eligibility threshold for direct grantee status for tribal grantee eligibilities?

A: (Ann Linehan) We fund some very small tribes with very, very small -- we have some tribes where we fund 15 children. So I don't think that is a barrier, and I think this opportunity actually may -- for tribes where we are only serving may 15 eligible Early Head Start, we may find through the collaboration of child care that you could have a couple infant/toddler settings. So I don't think for us that is a barrier, but if it is a perceived barrier, that is important for us to know.

C: (Brian Cladoosby) We will do a follow-up with you on that.

Q: (Stephen Kutz) We are just starting a CCDF program, but I have a couple of technical questions. One of them has to do with the CCDF program. When you say to conduct an unannounced visit when parents submit a complaint, I am assuming if somebody is using a voucher in a state certified program, certified by the state, the state would do that unannounced

visit. That tribes are not going into state certified programs off reservation to do unannounced visits. Is that correct?

A: (Shannon Rudisill) So I think we got some comment on that issue actually and I think we are going to be clear about that in the rule but I think there -- in your question I think that you are implying that you don't see a role --.

C: (Stephen Kutz) We don't have jurisdiction. So that would be my concern, that we were going into a place where the state ought to be going.

C: (Shannon Rudisill) And then we just need some referral program, right? So if the complaint came in to you, you could refer it to the appropriate people.

Q: (Stephen Kutz) The next one I had was on your home visiting program. You said home visiting program serving birth to kindergarten. You mean from pre-natal to kindergarten, right?

A: (Moushumi Beltangady) So, yes. It serves pregnant women, expectant fathers and then parents with children birth to kindergarten.

Q: (Ron Allen) To follow up on Brian's comments, when you talk about breaking down the silos, you should focus on not just within the agencies but crossing agencies as well. We have found we have problems even getting to first base on a grant proposal because of the numbers. I find it interesting that you say you have funded a tribe with 15 children, because that is probably the kind of category that we are in, 15-20 children.

Yet one of the challenges is how your regulations for accessing these grants apply. So again going back to Brian's point, this is what self-governance is all about. If I have got a grant over here for \$10,000, a grant here for \$2,000, a grant here for \$5,000, I can take those moneys and put them together and make them work. And there are tribes that do it. It isn't the way you designed it. It is how it fits our community.

That is why we advocate concepts like self-governance. For really small tribes, this really works because if we can get the resources, they are often small pieces of change, but together we make something happen that serves our children or the families. When can something be implemented in a way that allows us to get the job done?

A: (Linda Smith) In the case of Head Start and Early Head Start, we haven't had new money so we haven't really had competitions for new grants within the Head Start community for quite a while. So the new partnership money allows us that opportunity to expand.

Exactly to your point is what we have been trying to do with the four projects that we have been funding for the last couple years and trying to figure some of this out. I would be interested in tribes who want to do more around the idea of the child care and Head Start, in hearing from you.

Q: (Ron Allen) 477 program are designed to do just that as well. 477 has the same philosophical and administrative approach. But we find resistance in terms of being able to weave these programs into the 477 programs. Why?

A: (Lillian Sparks Robinson) It is concerning that you find resistance about us doing that because we have actually proposed that a number of times and have gotten a lukewarm reception but certainly I think we are interested in exploring how we can use 477 as a model to incorporate some of these programs or something that looks like 477.

C: (Linda Smith) One of the things that we hear from early childhood providers is they are concerned about it. Our tribal grantees, whether they are Child Care or Head Start, get concerned because they are not sure what is going to happen to their control over their programs.

C: (Ron Allen) That is exactly right.

C: (Linda Smith) And so I want to say it is kind of a mixed thing going on here. And something we all need to have some conversations about.

C: (Ron Allen) We urge you to explore this seriously in the very near future. We need to develop trust and confidence. Nobody cares about our children and our families more than we do. The program people have to let go and let us take care of our people. We are not opposed to accountability but we are opposed to excessive paternalism, bureaucratic oversight.

C: (Linda Smith) What we really want to do, in part, in hearing from you is really how can we -- you help us set the stage for this to happen. We can do certain things that are within our control. When you hear of issues out there, if you could let us know so that we can begin to break down these false perceptions and stovepipes that are there unnecessarily.

C: (Shannon Rudisill) Thinking that you have to come up with a center might be a perceived barrier for you, and that might not be the program model that makes the most sense in your community. Doing a network of home-based child care, family child care homes, that has a family service worker that goes around and visits, and trainers who go around and visit, might be a better fit.

C: (Jefferson Keel) The fact of the matter is when we talked about self-governance earlier in our discussions, I am not sure why it broke down, but one of those was the fact that we are already doing some of these things with child care, Head Start, with our veterans programs, with our senior nutrition program. Tribes have already proven that they can operate these programs more efficiently because they are closer and it requires less oversight.

Tribes accept the fiscal responsibility for the funding and all the operation of those things. But the problems we run into are these bureaucratic delays. Tribes are operating these Head Start and child care facilities, and I think maybe part of the problem that we, and the perceived barriers that you mention, is that when the grant proposals or grant requirements are printed and posted, there are number of things that are requirements, that are stated in those grant documents. And one of the things is you can't mix-match federal dollars regardless of where they come from. And these have long been ingrained in tribal accounting procedures. So there are tribes that may not be familiar with updated accounting policies.

C: (Linda Smith) One thing I can suggest we do sooner rather than later is we have done some training, especially with the new partnership opportunity that we have, to educate people on how

to blend and braid funds and what that really means. There are lots of ways to make this work that I think we need to help with.

C: (Ann Linehan) I think the particular language also in the legislation give us a lot more flexibility than we have ever had before, and we will exercise that flexibility to the nth degree.

C: (Linda Smith) She is talking about the partnership language, not the language on the whole bill, but still we do have a lot of flexibility there, and I think there is a lot that can be done.

C: (William Micklin) We have 17-18 villages in southeast Alaska, and the numbers can fluctuate according to the population. If we get down too low, it is hard to bear the cost of the facility in an area. So as a standalone, it is prohibitive. But if we can assume those costs across our entire population, it is much easier for us to do that.

So that is where I think numbers come in, not as a hard number or hard cap or limitation on how many you need but it is really spreading the cost of overhead across the available grant, and if you can't combine that with other programs it can be a problem.

The real issues that are killing us are the statutory caps on the indirect cost rate recoveries. That has caused us to take TANF and Head Start out of our indirect cost rate proposal because the caps, I think it is 15 percent and 25 percent respectively, are set against what was a 30 percent rate, and now because of the decreases to our rate pool, by the effect of sequestration and then by program decreases, it has gone up in the 40-something percent.

We have to bear the cost of that shortfall, that inability to fully recover, and we are not a gaming tribe. So it is a huge problem, and we don't like the formula dictating to us what services we deliver to our tribal citizens. Their needs aren't measured by the formula.

By providing greater administrative flexibility and by allowing us to function as a 477 program to operate as a cohesive community, we can diminish the effect of formulas that are at present dictating to us what amount and type of services we can deliver to our communities.

Hopefully we can work in the briefing to the new secretary, use that as a performance measurement, so we can set out clearly where we need this type of flexibility, where it is we need interpretations or waivers, and where it would be most beneficial and a more effective administration of these programs and delivery of services so we don't keep listing this as a concern of the STAC.

C: (Shannon Rudisill) CCDF is so flexible that it is quite possible that there are opportunities to blend and keep Head Start sites going despite fluctuating numbers. There is also potential to look at ways to blend and cost allocate because a tribe could go up to 85 percent of tribal median income with CCDF.

C: (William Micklin) We have done some of that, but it is something that we would like to see as better defined within Indian Country so more folks are doing it. What we would be more comfortable with is seeing this in policy.

C: (Ann Linehan) We also within government can commit to working with our fiscal colleagues much more closely because we need to make these decisions together. Talking with our grants folks, we could do better collaboration.

C: (William Micklin) Part of the certainty we are looking for is certainty in the 12-month plan. With sequestration, we had to furlough our Head Start folks for quite a while, and it was very disruptive to our families. And we are looking at continuing resolutions into the future. Without a plan, we are again subject to a lot of these problems.

Office of the Assistant Secretary for Health

J. Nadine Gracia, Deputy Assistant Secretary for Minority Health (OASH)

As the Director of the Office of Minority Health, Dr. Gracia updated STAC members on these health priorities:

- Strategic goals include creating better systems of prevention, eliminating health disparities and achieving health equity, and making the national health agenda healthy people come alive for all Americans.
- Staff meet these goals through such efforts as awareness, policies, partnerships, data collection and research. The office also awards grants and cooperative agreements to support demonstration projects toward addressing health disparities. Grant recipients include the Menominee Nation and the Inter Tribal Council of Arizona.
- The OMH Resource Center (OMHRC) serves as a public resource to, among other things, provide support in grant writing workshops.
- OMHRC initiatives include Native Generations, designed to address high rates of infant mortality and prevent infant deaths among AI/ANs.
- The Circle of Life effort offers an online HIV/AIDS prevention and intervention curricula designed for AI/AN youth.
- The AI/AN Health Research Advisory Council (HRAC) advises HHS on AI/AN health research priorities. Areas of interest include tribal epidemiology centers (EpiCenters) in relationship with state health departments and public health authorities. A databases/clearinghouse for Native research is a key issue.
- Staff used tribal feedback from the NCAI to develop an infographic to help AI/ANs know their health coverage options.
- In light of sensitivity issues regarding call center operators responding to tribal members, Ms. Gracia highlighted her office's National Standards for Culturally and Linguistically Appropriate Standards in Health and Human Care. The standards are available at www.thinkculturalhealth.hhs.gov.

Questions and Answers

Q: (Gary Hayes) On your Partnership to Increase Coverage in Communities Initiative, it is not for those who participated as Navigators. For those who participate as Navigators, is it just for FY14 or will it continue for FY15?

A: (Nadine Gracia) It is always subject to the availability of funds but it would continue for a second year. Those who are currently funded as Navigators are not eligible for the grants, but we know that Navigators have also partnered with other entities that then may become eligible for the actual grant opportunity.

Q: (Gary Hayes) Regarding the EpiCenters, we have an issue with the state treating them as a source, and what we are trying to do in Albuquerque is we have to get a resolution from each tribe to be able to access data. And I think it is important that we are moving in that direction. I just want to ask whether the other 11 EpiCenters, are they facing the same issues?

A: (Stephen Kutz) The Health Research Advisory Council requested Secretary Sebelius to issue a letter to all of the states that were withholding or charging exorbitant rates for accessing our information. So if this is an ongoing problem, maybe your area wasn't identified as one of those areas and didn't receive a letter.

So we ought to try to make that connection internally and see if -- so is it New Mexico?

C: (Gary Hayes) Albuquerque.

C: (Stephen Kutz) Albuquerque -- whether they were identified as one of those areas that were refusing to treat us as an equal partner.

C: (Nadine Gracia) If it is Albuquerque, one of the reasons we may not have known that from the HRAC is because that seat is vacant. It would be good to have that voice on the HRAC to say that is still an issue.

Whereupon the meeting recessed at 5:00 p.m. with plans to resume on Thursday, June 5, at 9:15 a.m.

Secretary's Tribal Advisory Committee Meeting

Thursday, June 5, 2014

Vice President Rex Lee Jim called the second day of the STAC meeting to order at 9:30 a.m. Following the invocation from Chester Antone, Vice President Jim noted these highlights from the Tribal Caucus that met prior to the general body meeting:

- STAC members have created a committee to develop a document that addresses members' needs and priorities for different categories within HHS. The committee will draft this document by June 13. William Micklin is the chair. Other members include:
 - Aaron Payment
 - Ron Allen
 - Jefferson Keel
 - Chester Antone
 - Gloria O'Neill
 - Ken Lucero

- Conference calls will occur during the week of June 23. Discussions also will take place at the NCAI Mid-Year Session in June. The technical groups from the NCAI and the NIHB will work together to assist this committee in creating the draft document.
- Members should submit comments to this document by June 20.
- STAC members hope to have a meeting with the incoming secretary in July. Rather than a meeting with the full STAC, a group of no more than seven members would meet with the secretary. Members want to put recommendations on the table and check off those items as the STAC accomplishes results. In preparation for this meeting, STAC members request financial support to help pay for the travel, if possible.
- Members requested more time for Tribal Caucus during the September STAC meeting.

HHS Federal Member Roundtable Discussion

Tribal Budget Priorities/STAC Program and Policy Discussion

This portion of the meeting gave STAC members and federal partners an opportunity to discuss tribal recommendations for the FY16 budget. Members also could address priorities for 2014. Chairman Allen opened the conversation with compliments to the national Indian leadership who engage in HHS programs and receive STAC members' recommendations.

Even so, Indian Country always needs more funds, said Chairman Allen. Tribes of all sizes -- whether a large nation such as Navajo or a small tribe on the West Coast or up in Alaska -- struggle to succeed with limited funds, confusing or conflicting policies, and burdensome oversight.

STAC members raised these concerning issues:

- The Budget Control Act and sequestration impacts on various program, and how sequestration affects tribal programs.
- On the IHS side, contract support costs remain a big-ticket item, and full funding must continue.
- Vice President Micklin noted that while the federal government achieved full pay to contract support costs, the full pay is discretionary funding and came from the transfer of dollars from other programs. The Administration should seek supplemental funding to restore moneys to those programs that lost funds due to the full pay of contract support costs. The Administration also should backfill sequester reductions to restore tribes to their funding base.
- Tribes continue to raise concerns that they never receive funds that go through the states.
- OMB has said \$19 billion is available to Indian Country. Once those numbers are broken down, is it really \$19 billion? STAC members can see where IHS and BIA dollars go. Within other programs, the picture seems more murky. This is the challenge of the Administration, whether it can, through its own authority, provide resources directly to tribes or advance an initiative to ask Congress to give that authority to HHS so those resources can go directly to tribes.
- The federal government must find a new pool of funding to address the needs of tribal members who don't live near their reservations. In some cases, the vast majority of tribal members don't benefit from IHS at all. Councilman Kutz's tribal facilities serve more

members of other tribes -- but the tribe receives contract health dollars for tribal members only.

- Millions of dollars are going to the states to implement health care reform, but there are no provisions, except in small ways, to provide money for tribes to implement reform with tribal members as well as other AI/ANs served, Councilman Kutz added.
- Chairman Payment requested a statement of commitment for full funding of contract support costs.
- Tribes need more assistance in getting states to participate in meaningful consultation.
- Medicaid expansion is based on a means test, but the IHS obligation to tribes for health, as well as education and social welfare, has been prepaid with millions of acres of land.
- The development of public health infrastructure -- basic water systems and certified operators to run these systems for safe drinking water -- remains an essential need. Councilman Antone noted that IHS has developed water systems through the sanitation deficiencies systems. The tribes then take on the responsibility of operating the systems. Many of these systems require certifications under the Rural Facilities Program, which is not in the 2015 budget. That funding should be reconsidered. Further, the development of public health infrastructure, related to economic development, should be a key issue.
- In addition, the Affordable Care Act and the Indian Health Care Improvement Act play a big role in shaping Indian health policy. Access to care, however, can cut into tribally provided contracted transportation, said Councilman Antone.
- Facilities remain a priority. Is money available for small, rural tribes? Where do they operate their health facilities? Are funds going to tribes and states fairly? Chairman Melendez requested a booklet that could report the facilities conditions of every tribe, including those in Alaska.
- Tribes in southeast Alaska need funding to bring the remains of loved ones back from the Alaska Native Medical Center in Anchorage. Family members look to tribal councils to donate that funding, and councils don't have it, said Vice President Micklin.
- Tribes want to see greater effort in addressing the statutory caps on indirect cost recovery for such programs as child care, TANF and community service block grants.
- TANF benefits remain capped at \$923 maximum for a family of four. Average rents in southeast Alaska have increased to about \$1,500. Tribes request a federal floor on TANF benefits, with benefits indexed to inflation.
- States need additional federal oversight to ensure they are complying with the Indian Child Welfare Act (ICWA). Further, tribes have expressed concern about states' privatizing foster care. HHS should ensure states train agency personnel and private partners to apply the minimum federal standards established by ICWA.
- Title IV-E needs realistic, fair modifications to the match requirement, and tribes should have full access to funding available to states.
- HHS should combine the Title IV-E waivers with the Title IV-E applications to give tribes more flexibility in developing child welfare systems.
- STAC members continue to call for advanced funding. Two doctors and two pharmacists left during sequestration because they saw the insecurity of funding, said Chairman Payment.
- Tribes should work with an OMB liaison to enhance communication back and forth.

Questions and Comments

Updates from SAMHSA

Adding to the conversation, Ms. Beadle provided details on a \$5 million tribal behavioral health grant to support substance abuse and suicide and promote mental health among AI/AN youth.

For the first time, SAMHSA also has included tribes as an eligible entity in the Partnership for Success program. Previously only states were available. However, only half the tribes who are eligible applied.

Ms. Beadle also reported:

- Tribes will have an opportunity to talk with SAMHSA leadership over the next several weeks. The principal deputy administrator and team, including policy director Mary Fleming, will visit several Alaskan villages between the 8th and 11th of June.
- A senior leadership trip to Lummi Nation will take place June 12 and 13. Administrator Hyde will join the trip on June 16 and 17 and the trip will be to Montana, to Rocky Boy, and to Fort Belknap.
- A Healthy Transitions mental health grant is currently available with applications due June 13. Dear Tribal Leader letters have also gone out from Administrator Hyde.
- Regarding policy issues, Administrator Hyde sent a Dear Tribal Leader letter regarding SAMHSA's Tribal Consultation Policy. Tribal leaders should submit comments by August 29.
- A second issue that has come up in STAC is alternatives to incarceration. Last year SAMHSA conducted an Adult Tribal Policy Academy for the first time to look for alternatives for AI/ANs. SAMHSA received a subsequent request to look at the juvenile population. This week there was a Tribal Policy Academy on juvenile justice in Albuquerque to find options other than detention for young Natives. A blog from the meeting is available.
- Administrator Hyde also sent a letter to tribal leaders about a listening session at the NCAI conference. Last, the SAMHSA Tribal Technical Advisory Committee needs a representative from the Phoenix Area.

Updates from the Administration for Children and Families

Mark Greenberg responded to Tribal concerns with these comments:

- For us around budget choices, at least in recent years, our situation has generally been that each year we are needing to come forward with proposals that are essentially at the same funding level as we were the prior year or lower.
- STAC members providing comments should identify areas of highest priority should additional funding become available.
- In areas that involve issues about ensuring states are meeting responsibilities, ACF can take action whether or not there are changes in funding.
- ACF has increased its engagement around child welfare issues in recent month, adding an associate commissioner for the Children's Bureau. Staff welcomes further discussions.

Q: (Ron Allen) Can I recommend we establish a small working group of the STAC leadership to engage with Mark and your new team because those programs are really important to us and we have asked for you to consider some requirements for the states in terms of their obligations with regard to ICWA and child care, foster care, child protection matters. We need to discuss this more extensively.

A: (Mark Greenberg) I am happy to commit right now to working with a STAC working group on these issues.

Update from the Administration for Community Living

C: (Cynthia La Counte) Grants are open that are due July 8 to fund five \$100,000 two-year fall prevention projects. We are looking for applications from tribes. It coordinates with Title VI but it does not have to be the Title VI program that applies.

Thank you for your conversation about forward funding. We are looking at that at ACL or AOA. I am also pleased with your discussion around state responsibilities, because states do have a huge responsibility in the aging world.

Yes, you did receive fewer dollars from us with this newest grant cycle. We cut Title VI programs 5.7 percent through sequestration, then we had -- this was a year for new grant cycle, and we funded 8 new tribes, which meant that we reduced many of your programs between 9 and 12 percent.

Our first full-blown consultation will occur August 19 here in Washington, DC, at the Washington Court Hotel. Dr. Roubideaux will be participating in that along with the assistant secretary, Kathy Greenlee.

Update from HRSA

C: (Mary Wakefield) HRSA is in dialogue with the American Indian Higher Education Consortium to better identify the barriers between tribal colleges and their ability to compete for funds from various training programs. Some tribal colleges receive funding but not many.

Second, there is a set-aside of funding that goes to tribes through the Home Visiting Program. Funding is also available that goes directly to states. These 10 states currently receiving funds are moving some of the state-funded resources to tribes:

- Arizona
- California
- Maine
- Montana
- North Carolina
- North Dakota
- Oregon
- South Dakota
- Utah

- Washington, and
- Wisconsin.

Some of the states are putting resources into one tribal location. Others are putting funds into multiple tribal locations.

Update from NIH

C: (Isabel Garcia) NIH has drafted the charter for its first Tribal Advisory Committee and will solicit nominations during the summer. The inaugural meeting will take place this year. NIH also plans to reissue a funding opportunity announcement called Interventions for Health Promotion and Disease Prevention in Native American Populations.

NIH also hosted several STAC members during a visit to the campus. The visit prompted meaningful discussions on how to increase the number of AI/AN researchers in the workforce. Five Native scholars who work at NIH shared their research and the path that led them to their current positions. Please continue that dialogue with us and let us know if there are young people in your communities who would like to participate in NIH programs.

NIH also needs more Native American reviewers who can be part of the grant applications process. The campus offers a number of programs to train new reviewers.

C: (Cathy Abramson) I wanted to address Isabel and say that NIHB wrote a letter November 7, 2013, to Dr. Collins in regard to NIH research funding in review for AI/AN populations. There were inappropriate and derogatory remarks from grant reviewers regarding Natives. We never got a written answer to this letter.

C: (Isabel Garcia) I am almost 100 percent sure it was provided. I know it was e-mailed. I will check to see whether a hard copy accompanied that.

C: (Aaron Payment) I appreciate there is a call for more Native people to do the reviewing, but this is a critical moment to draft up and to develop that cultural sensitivity training.

C: (Stephen Kutz) Only a few of us from the STAC went to NIH. You would have been proud to meet the Native researchers and hear their stories. They inspire you to go back and figure out how you can work with your tribe and work with all of the other tribes in your area to have more of them.

Having Native researchers in NIH is going to go a lot toward changing the culture that we just talked about around that letter.

330 Clinics and Oral Health Care

C: (Ron Allen) The 330 clinics that receive a lot of ACA money with regard to outreach and enrollment, we are having problems with most of them in regard to assisting the tribes with enrollment and with regard to exemptions. They are turning our citizens to IHS. That is wrong.

We need to take corrective measures so these clinics understand it is their job to assist citizens who are not close to tribal or IHS facilities.

And as far as Section 5304, with regard to alternative options for oral health care, we are not clear who is in charge. We know it is going on up in Alaska, but we want to open up that program more in the lower 48 states. What is being done to move that opportunity forward in our communities?

A: (Mary Wakefield) In regard to your first point, I take a look periodically at the summaries we get from our community health centers across the country in terms of problems with outreach and enrollment. This has not shown up on those reports. I am pleased that you raised this issue. I will go back and find out if we need some additional training for individuals in those community health centers.

Oral health care grants are available, and we can have more conversation about the types of competitive grant funding streams. Further, more dental hygienists and pediatric dentists are receiving funding through the National Health Service Corps. Many of those dentists now work in tribal communities.

C: (Ron Allen) This requires a little more discussion. We know where some of the political pushbacks are coming from.

A: (Mary Wakefield) We are trying to be creative as we can be. We have invested in training for oral health for other traditional providers, including primary care physicians and nurse practitioners. We have developed curricula for those disciplines. We are trying to use every available lever because there is a big gap in access to oral health care services.

Q: (Stephen Kutz) You said Congress had said who you can't fund. I was wondering what type of dental provider you can't provide for. Also, preventive care with dental hygienists, children are covered but adults are not.

A: (Mary Wakefield) I think, on your second issue that is a reimbursement issue, a payment issue, that is Affordable Care Act so it is a CMS issue. And I will have to get you the general programmatic area where we had received some reported language that told us what we couldn't do with one of our statutory programs.

I assumed Chairman Allen was talking about our oral health training grants because that is the only place we have funding available other than the National Health Service Corps. Do you have more descriptive information? Do you have a title of 5304, what the program actually is?

A: (Brian Cladoosby) I might need to call on my technical people to step into this conversation.

(Vice Chair Cladoosby yielded his seat to Jim Roberts)

C: (Jim Roberts) Section 5304 is a section in the ACA that authorizes 15 dental/oral health demonstration projects to be carried out under the authority of the secretary. It is confusing

when you read the act. When you try to look at who the agency of jurisdiction is for carrying out this authority, it appears it would be HRSA. But it could be CDC as well.

But this is the authority to carry out 15 demonstrations, and it is supposed to be carried out within two years of an enactment and sunsets after 7 years of the bill. So the question is whether Congress has appropriated funding for this and whether these 15 demos would be carried out and under whose authority?

A: (Mary Wakefield) We will check with our oral health care expert back at HRSA right now. I think that is one of our grants programs.

C: (Brian Cladoosby) Alaska is probably the model program for DHATs, as you know. And we have been trying to get the expansion in Washington. We need some support from IHS if possible. A letter or something just to talk about the savings that this would create and the access our members would enjoy. And of course the dental association of Washington, our strongest opposition for various reasons -- turf and issues like that. But maybe you could just speak to that?

A: (Dr. Yvette Roubideaux) Yes, we received a request from the STAC about two meetings ago because there was some fictitious letter going around saying IHS didn't support it. So we sent a letter to the American Dental Association and told them if anybody that they are affiliated with is using such a letter that they should cease and desist basically. And we provided a position paper that I published on my director's blog.

C: (Brian Cladoosby) I might need help from my technical people, but I believe in the ACA, under the DHAT program, that the state has to approve it before we can -- Jim, you want to jump in again?

(Vice Chair Cladoosby yielded his seat to Jim Roberts)

C: (Jim Roberts) Thank you, chairman. It is actually the Indian Health Care Improvement Act, and it is a nationalization provision dealing with the Certified Health Aid Program in Alaska. But there is a nationalization provision that applies to the Dental Health Aid Therapy program, and the statute indicates that the program cannot be expanded into another state unless a mid-level provider authorization and state statute exists. That is the clause we are talking about.

C: (Mary Wakefield) This might a little off topic, but we have a created a web-based job center, so National Health Service Corps clinicians, who have to repay their loans, go there to look for openings or vacancies. So right now 641 IHS and tribal clinics and urban Indian health clinics have been approved as service corps sites. If you are not listed on that site, it is a missed opportunity.

C: (Stephen Kutz) A position paper is good but I think a letter recommending that DHATs be eligible to be deployed to the lower 48 at IHS and tribal facilities and maybe even the urban Indian centers would be very helpful. Some of the dentists teaching in the Washington dental schools are the ones directly advocating within the state to keep the DHATs in Alaska and not deploy them down here.

Resource and Patient Management System (RPMS)

C: (Stacy Dixon) Stacy Dixon, the alternate for California. My delegate, Eileen Fink, had to step out. An important aspect of providing health care to Indian people is a functional data and health record system that is usable across providers, across platforms and between agencies.

In 1984, the IHS debuted its medical records and data collection system, the Resource and Patient Management System (RPMS). In 2005, IHS implemented the electronic health record component of RPMS. A number of tribes and tribal organizations have experienced great difficulty in working with the RPMS system due to problems with third-party billing.

We request the Administration support a comprehensive study of the RPMS system to determine:

- Its effectiveness in managing patient data and records
- Its usability by tribal health-care providers by including ISDEAA contractors

Its interoperability with commercial systems, systems in use by non-Indian health care providers

- The degree of adoptions among IHS facilities, tribes, tribal contractors, and urban Indian organizations providing health care
- Any persistent or unsolved problems with the system and its cost-effectiveness compared to other records management solutions

Q: (Arlan Melendez) Regarding RPMS, contemplating a change to an alternative system, the cost is about a half million dollars. What is the long-range plan for information systems from the Indian Health Service?

A: (Dr. Yvette Roubideaux) Originally it was adopted by the VA. The VA and IHS continue to have conversations about do we continue going down this road. One part is related to cost -- it would take hundreds of millions of dollars to change the whole system. If I only get a \$200 million increase each year in the budget, how can I possibly afford to change to a new system?

We are working to try to make sure we can do everything to make this system work for people. We just piloted successfully the ability to transmit information from commercial off-the-shelf systems that tribes have to our data mart, which is a big step I know a lot of tribes wanted.

This is a huge issue. Every medical journal I get has issues on it. We have been discussing this with the Information Systems Advisory Committee (ISAC). I am happy to talk about this more. We don't have enough money to purchase a new system, and it would take us years to get that implemented, and I am not convinced that the other systems -- how we would be able to support those is also an issue.

C: (Stephen Kutz) I had two medical students from Albert Einstein School of Medicine in New York City that spent three weeks with me about two months ago. They had never seen RPMS, but within three days they had my system figured out more than my doctors who had been working with it for two years.

Generally I don't know how we can afford to provide multiple systems. I know that our system does not talk to the systems that our local hospitals use. I think that the system has been underfunded and has not kept up. Using RPMS, we were the first facility in the state, both Indian and private, who went on e-prescribe.

Even the tribes that go with these other types of electronic medical records, they will still need some kind of support to interface their information back to RPMS. Whatever system we use, we need to adequately support.

C: (Ron Allen) Dr. Roubideaux's point is well-taken with regard to the cost of a system that is needed to upgrade into the 21st century. I know they keep trying to upgrade it but it seems like it is patching. I would encourage IHS to collaborate with the tribes in at least identifying what would it take to upgrade the system.

C: (Dr. Yvette Roubideaux) I think ISAC was working on that. I will go back and check on the status.

Uranium Exposure/Environmental Contamination

C: (Rex Lee Jim) One of the issues on the Navajo Nation was uranium exposure, if anybody could speak to that. We also have issues with contaminated water so we need drinking water there as well.

C: (Dr. Yvette Roubideaux) I will let the other operating divisions know that there is a lot of work going on, interdepartmental agency efforts with EPA and HHS and many other agencies working on identifying the imminent risks related to contaminated structures, water supplies, mills, dumps and mines with the highest levels of radiation.

So far more than \$100 million has gone to address the highest risks. A summary report was published in January 2013. We will send around the link so people can see that.

C: (Gary Hayes) If you can add the White Mesa Mill in Utah. That facility was opened in the '80s. It was only supposed to operate for 15 years. From our analysis -- we hired an outside source to come in -- we have information that it is leaking. We have been working with the state for the past 5 years. EPA is aware of it but the big issue is the state.

C: (Ron Allen) I want to make sure we keep on our radar a remedy for the 477 challenges that we have. It is still troublesome for the tribes. We still run up against excessive oversight and accounting requirements that makes the program more difficult. We believe a legislative remedy is necessary but we also appreciate any administrative steps that can help. I expect that to be on our list of issues that we raise with the new secretary.

Additional Comments

C: (Stephen Kutz) We struggle in our state to provide in-patient services for mental health/chemical dependency for youth and adults because we are constrained by how many people we can put in a facility. For short stays, you can only have 16 beds, at a cost of \$1,300 to

\$1,500 per day. We don't have an IHS rate for something that is not a hospital. Some of these in-patient youth chemical treatment facilities are failing as a result.

We are working with states to come up solutions but we need tools in the toolbox. I would like for SAMHSA get together with IHS to address that issue.

C: (Mirtha Beadle) Dr. Roubideaux and I will commit to meeting on that issue.

C: (Yvette Roubideaux) Some of you have raised issues about the distribution of IHS funds and the financial strains at the local level. I would welcome having additional discussion with the STAC on the IHS budget in preparation for the fall budget summit.

C: (L. Jace Killsback) Tribes should advocate for our off-reservation members via the urban funding. Too often that leadership is not included in these discussions.

C: (Gary Hayes) The STAC is a collective body of tribal leaders, and that voice needs to be heard. When Congress asks for testimony STAC should be included or the packet we do on an annual basis can go to our congressional leaders. We can talk all we want, but the bottom line is Congress. We need to tackle both House and Senate to move this forward.

Remarks from Secretary Kathleen Sebelius

Following well wishes from STAC members, Secretary Sebelius offered thanks and closing comments on the final day in her official role at HHS. The meeting brought the secretary full circle as she recalled meeting with tribal leaders during a budget consultation on her first day at HHS.

The efforts of STAC members and HHS federal partners won the attention of colleagues across the president's Cabinet. Secretary Sebelius also will discuss the importance of the STAC during a meeting with her successor. The STAC's work will go forward, said the secretary, noting the efforts of Paul Dioguardi, Stacey Ecoffey, Lillian Sparks, Dr. Yvette Roubideaux, Mary Wakefield, Nadine Gracia and Lawrence Tabak. Senior leaders will continue to view the STAC's work as a priority that all top-level staff concentrates on all the time.

STAC Business Closing Discussion and Comments

Chair Rex Lee Jim recapped plans for a meeting with the incoming HHS Secretary in July. STAC members also covered these areas prior to closing the meeting:

- Ron Allen reminded the group about forming a workgroup to review and update the STAC charter. Workgroup members will include Ron Allen, William Micklin, Stephen Kutz, Cheryl Frye-Cromwell and Ken Lucero.
- Workgroup members creating the document of STAC priorities for the new secretary tentatively set June 9 at 2:00 p.m. as the date/time for the first conference call.
- Paul Dioguardi and Stacey Ecoffey will inform the workgroup when the secretary can meet in July.

In his final remarks, Mr. Dioguardi thanked STAC members for their sendoff for the secretary. Addressing the STAC was the secretary's final meeting in her role at HHS, which shows the commitment that the secretary and staff have to this process.

The Senate confirmed secretary designate Burwell. The swearing in was set to occur on Monday, June 9. Staff will then brief the secretary on taking the STAC conversation forward. The meeting that STAC members wish to have in July should give everyone a chance to weigh in and comply with all bylaws and requirements.

After the closing blessing by Gary Hayes, the meeting adjourned at 2:20 p.m.