

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

September 15-16, 2015

Summary Report

As the Obama Administration winds down, members of the Secretary's Tribal Advisory Committee (STAC) want to pursue decisions that will strengthen Indian Country long after the President leaves office. During the fall meeting, members called for the creation of an Indian Desk at the Office of Management and Budget (OMB) and pushed for more flexible funding. Federal and tribal partners also want to tap into the energy and excitement of Generation Indigenous to spark long-term change in education, economics and behavioral health. The Indian Health Service (IHS) overtime settlements remain a topic of interest, and concerns about the HHS-operated tribal hospital at Winnebago highlight ongoing issues of access and adequate care.

Members Present for Roll Call: Cathy Abramson (Bemidji Area), Chester Antone (Tucson Area), Tino Batt (Alternate, Portland Area), Russell Begaye (Navajo Area), Cheryl Frye-Cromwell (Nashville Area), Leonard Harjo (Oklahoma City Area), Gary Hayes (Albuquerque Area), Arlan Melendez (Phoenix Area), Andy Teuber (Alternate, Alaska), Roger Trudell (Great Plains Area), and Robert McGhee, William Micklin and Aaron Payment (National At-Large Members).
(Quorum Met)

Action Items

HHS Budget Updates

- During an upcoming meeting with the Office of Management and Budget (OMB), Mr. Cochran will reiterate STAC members' request for an Indian Desk at OMB.

Indian Health Service Discussion

- Mr. McSwain will mandate a standard format for the monthly reports that go from the IHS facilities to tribal leaders.
- Mr. McSwain also will find out the status of Medicare-like rate regulations.

Administration for Children and Families

- In response to a question from Gloria O'Neill, Maria Cancian will provide an update on the general waiver for tribes for match requirements across the Department.
- Ms. Cancian also will share any available details on why ACF couldn't include Head Start and the Low Income Home Energy Assistance Program (LIHEAP) in the 477 expansion.

Administration for Community Living (ACL)

- In response to Tino Batt's request, Cynthia LaCounte will provide a summary report on the states that are working with tribal communities as directed by ACL.
 - Ms. LaCounte also will give Stacey Ecoffey a list compiled through CMS' Long-Term Services and Supports Project regarding nursing homes and long-term care facilities. Ms. Ecoffey can disperse the list to the STAC.
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Secretary's Tribal Advisory Committee Meeting

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Welcome and Meeting Logistics

Emily Barson met with the STAC as the new director of Intergovernmental and External Affairs (IEA) following the departure of Paul Dioguardi. Ms. Barson served as deputy director for the past four years and has worked closely with both Mr. Dioguardi and Stacey Ecoffey on tribal issues. Ms. Barson has been familiar with the STAC since its founding and has seen it develop as a critical piece of the Department's tribal work. Following Ms. Barson's remarks, the board approved the agenda for the September meeting.

STAC member terms will not be up for renewal until February 2016. Members approved these meeting dates for next year:

- March 1-2, 2016
- June 7-8, 2016
- September 13-14, 2016
- December 6-7, 2016

HHS Budget Updates

Norris Cochran, Deputy Assistant Secretary for the Budget

Adaeze Akamigbo, Office of Management and Budget

The budget process remains a bit of an unknown for 2016, said Mr. Cochran. The Administration has presented Congress with a robust set of proposals, asking for an increase of roughly 10 percent for the Indian Health Service (IHS) in particular. That increase is well above the average for HHS overall in the discretionary budget.

There is talk of Congress not continuing funding for annual appropriations bills in October. A government shutdown did not appear likely as of September 16. Appropriations staff are working on a continuing resolution that would keep the government operating between October 1 and early December.

With a keen understanding of policy and health services research, Ms. Akamigbo serves as the policy official over health activities for the Office of Management and Budget (OMB). HHS staff work with Ms. Akamigbo on both discretionary funding for the Indian Health Service and most of the operating divisions, as well as Medicaid and Medicare.

Providing quality health care and maintaining access remain top priorities for the Administration. Since the President took office, he has worked to increase overall funding that heads out to Indian Country, said Ms. Akamigbo, and continues to reach out to tribes to strengthen government-to-government relationships. Specific accomplishments include:

- OMB has developed strong budgets for IHS during the past six years. Congress has usually supported these requests, not often at the full funding level OMB has put in, but there has been decent support for IHS activities.
- The Affordable Care Act has permanently reauthorized the Indian Health Care Improvement Act, which serves as the foundation for preserving access and maintaining health care services for American Indian/Alaska Native populations.
- Tribes can offer insurance to their employees through the Federal Employees Health Benefits Program offered through the Office of Personnel Management.
- IHS has some tribal organizations that now have the ability to get reimbursed through the Veterans Administration (VA) for care given to American Indian/Alaska Native patients who are in the VA system.
- The Generation Indigenous initiative that focuses on improving the lives of Native youth through new investments and increased engagement. Key focus areas include education, juvenile justice, housing and health.
- The fiscal year 2016 budget continues the President's effort to strengthen Indian Country with significant proposed investments especially focused on Native youth. Multiple agencies now work together to better communicate and develop specific programs.

Regarding appropriations for IHS, Ms. Akamigbo noted that sequestration was never supposed to happen. Drastic budget cut proposals should have motivated everyone to come to the table and reduce the deficit. Instead, the sequester has occurred and hurts Indian Country specifically.

Although the Administration has been able to avoid two years' of sequester caps, for the 2016 appropriations, Congress has chosen to offer a 2016 budget framework that would lock in sequestration levels. Indeed, Congress has decided to act on total nondefense discretionary levels that are much lower than the President's budget, cutting nearly \$35 billion.

The FY16 budget requested \$5.1 billion for IHS. Both the House and Senate bills would cut that amount by more than \$300 million, said Ms. Akamigbo. The budget also requested a total of \$32.2 billion in Interior and related agency appropriations. The House's alternative reduced that number by \$3 billion while the Senate's bill reduced the amount by more than \$2 billion.

In addition, contract support costs (CSC) have been a priority for tribes. OMB has worked closely with HHS and IHS to propose full funding during the past two years. Congress has responded favorably to those two requests. OMB wants to continue to work with Congress and

tribes to develop a more permanent fix for contract support costs, such as the mandatory proposal included in the President's fiscal year 2016 budget.

Questions and Comments

Q: (Aaron Payment) When sequestration hits, it hits discretionary. We believe our funding should be nondiscretionary because treaties are not discretionary. Cathy uses the term prepaid treaty rights. We prepaid for everything that we get.

Contract support costs should be fully funded not only because it is a trust responsibility but also because it is a legal obligation. I am looking for any kind of insight about where we might be in terms of getting full funding for contract support costs. What is happening in Congress, and what do we need to do?

A: (Norris Cochran) The appropriators have been living with this responsibility for a number of years. They have seen the court case and the budgetary growth, and so they are on board for wanting to encourage a permanent solution.

In the meantime, they have been helpful in fully funding at least the request through their bills, and we want to continue to see that. The Administration's proposal effectively says, we want to take it out of the appropriators' jurisdiction and put it into the authorizers' jurisdiction. That can be an awkward request. Sometimes when you say we want to take something away from this committee, you can face opposition.

The good news is we really didn't. The fact that the appropriators have had time to understand the pressures that you are under, it has led to good discussions in our hearings for the Indian Health Service, where they are on board with coming up with a long-term solution, even if it means they are no longer the ones in charge of that number.

That leaves getting support from the actual authorizing committees. We have been thinking about that with our legislative colleagues to try to socialize the idea with those committees.

C: (Chester Antone) In Arizona, the governor has proposed that we eliminate non-emergency medical transportation. And I believe he is lumping tribal transportation services with independent services that transport patients as long as you are AHCCCS-eligible, which is Arizona Medicaid. Tribal transportation services have been receiving reimbursements for a long time. So to me that is not the problem. The problem lies in the newly created transportation system that Arizona has put together, which includes independent contracts.

So where the independent transportation companies can get a contract or an agreement with AHCCCS to transport AHCCCS-eligible patients, now that doesn't seem right to lump two different systems together. And I know that it is under the guise of trying to prevent fraud, but when you look at the history of tribal transportation, it is not there. So a relatively new phenomenon has created uncertainty for tribes in Arizona.

The other thing I want to suggest to you is that another part of this is the 1115 waiver. EMTs are also part of the new waiver that the governor is going to submit to CMS. But the eligibility caps under AHCCCS are five years for able-bodied folks to obtain work. To be able to look for work doesn't work for Indian Country because you have a poor economy and high unemployment rates.

And it is not like you can jump on a bus and go to look for a job because there is no transportation. So I would like for you to take a look at that. It is supposed to be access to health care but this isn't access.

C: (Will Micklin) A couple of quick points:

- Sequester: I wish to emphasize how much sequester and rescission have adversely affected tribes. For us, we have absorbed a 28 percent overall reduction in Indian child welfare budgets. Our overall reductions for all of our tribal family and youth services, which includes foster care, child support enforcement, the Indian Child Welfare Act (ICWA) and other programs is an 18 percent reduction. So we are well below our funding before FY13 in FY15.
- And with the prospect for a continuing resolution imposing the budget control act limits for going forward until I don't know when, it is a serious issue for us.
- ICWA: ICWA is under significant attack. And our ability to perform, to protect our children, to adequately implement the intent of the act is threatened by our funding levels.
- TANF: The 15 percent administrative cap on the ability to recover indirect -- or apply your indirect rate for Temporary Assistance for Needy Families (TANF) is a significant obstacle.
- Community Services Block Grant (CSBG): There is a 5 percent cap on CSBG.

These cause us to dip into our own pockets. We don't have oil and gas, gaming or economic development resources. We dip into our trust fund, which is our savings from our settlement act of 1958. These caps should be raised, and if they were raised we would be in a much better position to perform for these programs.

Finally, the distribution of funds by competitive grants, that is a big issue for us. Those grants include prohibitions on applying indirect rates to recover on those programs. And, in fact, the new guidelines say that you can't even apply your existing resources or pay your staff that you have with the grant money. You have to contract outside. That is an inefficient use of resources. We favor moving away from competitive grants and putting these into formula allocations.

We think these are administrative issues that the Administration has the executive authority to change.

C: (Gary Hayes) As of the latest census in our community in Colorado, we are finding that we are getting younger because we are dying earlier. Our females, the average age since 1990 is 54. And the average for our males is 50. The national rate is close to 78 or 79.

You look at the FY16 and budgets beyond that and even with the 2017, you look at the actual need in Indian Country for our facilities and for the quality of health care, the need is about \$29 billion. So when we talk about a 10 percent increase, and we should be grateful as we are always told, we still feel that is a slap in our face because our communities -- every day someone young is passing away.

As you go back and discuss and deliberate how money is split, the huge impact of any type of cuts to our services -- or even the 10 percent when we asked for 22 percent in FY17. We still get half of that, and that is not able to keep up with inflation or medical costs in our communities.

C: (Roger Trudell) A 10 percent increase is actually probably meaningless. It doesn't allow you to get quality people you need to help extend lives. We don't have the continuum of the same medical people addressing our people. You learn who the people are, and then they are gone.

The grants may help for a while or whatever, but if the grant requires a match, we are not going to get it because we don't have the matches. There is no way to sustain what you have learned or developed with the grant because those types of moneys are not there to sustain things that are initiated.

Maybe the country feels it no longer has an obligation to us because the treaties are old. They are not as old as the Constitution of this country so they should still have some meaning.

In the Great Plains Area, we lose ground in the disparities between race and health every day. Our facilities are run down. The new facilities you have, you can't staff them. You can't sustain anything. I guess that is the biggest problem we have in Indian Country.

C: (Russell Begaye) We should not be in the category of discretionary funding due to the treaties that we signed -- several treaties, the last one in 1868. And the trust responsibility that the U.S. government assumed, that we should be funded not based on that but also on the needs of our nation.

We need to start looking at more specialized facilities such as cancer treatment centers. We don't have any of that on our nation. And also mental in-patient facilities. That is a big need for us mainly with our returning veterans.

The suicide rate -- the recent spillage that we have encountered, last week we had three suicides in a community that heavily depends on the river. So we need those in-patient centers on the nation, especially in the area of mental health.

We have had decades of pollution of our land, our water. We will now and probably for another three, four or five generations, we will be dealing with the effects on the health of our people because we will be consuming the produce, the livestock that we depend on that drink from the river. Just the amount of cancer that is the second cause of death on our nation. So those types of things we encounter on a regular basis. And I want to put those things on the table as something that needs to be considered now.

Q: (Brian Cladoosby) Where are you guys at with creating an Indian Desk in OMB?

A: (Adaeze Akamigbo) Steven is actually the OMB examiner working exclusively on Indian Health Service. The branch chief has worked on Indian Health Service before he became a branch chief. My deputy Tom was an IHS examiner as well. And there are others who have probably touched on that account. But we have three folks with significant experience on the IHS account.

C: (Brian Cladoosby) Yes, I think we have been advocating for that for a number of years, that we have a person in OMB who just deals exclusively with Native issues. But I am glad we have a team that is working on that.

One issue that we brought up a year ago with Secretary Sebelius was the need to get advanced funding for tribes. When it comes to continuing resolutions and a dysfunctional Congress not being able to pass their budgets on time, we don't need to continue to tell you this but we will: We are the poorest of the poor in the United States.

Some tribal communities are living under third-world conditions. If you go into some of the communities throughout the lower 48 and Alaska, and you talk to those individuals and ask them, what is your access? How is your access to health care here in Indian Country? It is a serious issue still for a tribal member to get adequate access.

We have got situations where doctors and dentists and people with the ability to provide the services are just not relocating out into Indian Country.

With the issue of advanced funding, we need to work as a team. We need to be going to the halls of Congress and meeting with our senators and congressmen. The VA was able to get advanced funding but it took years. I will continue to push. It is a treaty right, not a line item.

The sad joke in Indian Country is don't get a serious illness after June or July because we are on Priority 1. That is unconscionable for any tribe in the nation to have to be under Priority 1. That shouldn't be happening in the 21st century. And so that is an issue that we need to look at and address: How are we going to deal with Priority 1?

These diseases don't need to get to catastrophic care because tribal members aren't getting in to be diagnosed and taken care of early on. They wait until it gets to the last end stages, and it is costing us hundreds of thousands of dollars to care for these tribal members.

Q: (Cathy Abramson) I would like to know how various agencies, departments within HHS, are working together so there is no duplication of services. It would be nice to get a report to see the progress and what everyone is doing.

A: (Norris Cochran) We have a few mechanisms to do so. One is these meetings. We learn things, and as you see on today's agenda, we have folks from our operating divisions who come to these meetings. They hear the discussion and have an opportunity both at the STAC as well as

at our budget formulation sessions in the spring to hear about areas of need and cross-cutting interests.

That then helps inform their budget formulation process as well as having programmatic discussions about how various operating divisions can coordinate.

C: (Ellen Murray) This year we made a special effort to coordinate our efforts. We want collaboration and coordination. We don't have all the answers so we have made a special effort in this budget process to bring together all of our agencies and Indian Health Service to make sure we are not duplicating efforts but also that we are putting our dollars where they will have the most impact.

C: (Aaron Payment) I want to elaborate on the Indian Desk concept. What we are looking for is an elevated understanding and commitment to Indian Country based on an understanding of our unique responsibility and treaty obligation.

So that is still our ask. In the absence of that, what I would suggest is that a team might be just as good if the team is acclimated and oriented to the legal basis for the issues we face.

The reason that we ask for an Indian Desk is not just because we think an Indian should be in that position but because we think somebody with the right orientation will be able to be our safeguard and gatekeeper who can forever remind everything that happens in OMB that the job is just not to balance the budget.

To balance the budget on the backs of American Indians, and the treaty obligation -- we didn't create the budget crisis. The big issue is contract support costs. That had a legal basis and a Supreme Court case. But also the trust obligation. And when the Administration collectively didn't understand that was shortchanging us, that threatened the legacy of President Obama.

What we need then is if the Indian Desk isn't going to be as we asked for it, there is an orientation that could be provided. The National Congress of American Indians (NCAI) does an Indian 101. So if we could facilitate that understanding of that legal obligation --.

Another big issue is historical trauma. We believe that is the explanation for us having the worst of the worst statistics. Our 13-year-old children have the highest rate of suicide out of any racial/ethnic population. If we don't get the Indian Desk, I think an interim measure would be to have us participate in providing the right orientation so people know that they are not just balancing a budget. They are upholding a treaty obligation consistent with the President's commitment.

C: (Adaeze Akamigbo) I completely agree in terms of how OMB staff or examiners work. It is important that you go, see, touch, feel, hear what people experience. And if you have the IHS account, you have to go to Indian Country. And you can't just visit one. You have to visit a bunch. They are all different.

Steven has done that. I am next. I think mine will be happening next year. Your point is absolutely well-taken. It is more than an orientation or a course. You kind of have to go and spend some time.

C: (Tino Batt) Tribes are not in agreement with whether it is census or self-attest. And I think that is the biggest concern. We always express the need in Indian Country, but to back up that information with data, that is the hard part.

Many tribes don't agree with the census. This is what you get based on your actual need. But in fact, it is not. The need is greater than that. Those numbers are not really affecting the needs of Indian Country because they are not accurate. All these programs require data, and that is hard for the tribes to aggregate all this information.

Our Indian people are not just stuck in one area. They are in different areas, different service units. And we are trying to address all their needs wherever they are.

C: (Roger Trudell) I would like to talk about funds for the Methamphetamine Suicide Prevention Initiative (MSPI). We are totally dissatisfied with how they distribute the funds. Number one, there are not enough funds to make an impact. Number two, each tribe used to get some but now they are competitive. If you don't have a grant writer, you are not going to get any of those funds. We all need them but we have to compete with each other.

And in the Great Plains, I know there are people out there, when they are throwing dirt in their face -- when they are burying them -- they are going to be saying, there is no way direct service tribes or direct service facilities should be paying for the overtime of people who probably can't even prove they had overtime. That needs to come from somewhere else. It can't come from direct funds out of Indian Health Service.

Somebody needs to look around and find money to pay that somewhere else. If there is money in the Great Plains to pay that, that money should be going to improve the health care of the people as opposed to paying some overtime to people somewhere.

C: (Will Micklin) We have talked briefly about the potential for a government shutdown. There is a potential or perhaps a probability we will be operating on a continuing resolution all the way through the next general election. So we need an emphasis on doing those things that have real impact in our communities.

I mentioned executive action on TANF, child support enforcement, CSBG, on the Substance Abuse and Mental Health Services Administration (SAMHSA), on other issues.

Another one is the Head Start performance standards. The tribes' request for waivers to full-day, full-year and prioritization requirements. It is a contest between the view that we need to improve quality in the program that is running up against the practical issues in Indian Country, where full-day may not make sense in remote, rural villages. Where full-year is not a practical issue.

And the prioritization of the quality standards, like certification of teachers, pushes our people and our elders out of Head Start, where they should be teaching our children the cultural values that they traditionally teach in our communities.

These all come down to policy decisions. These are not numbers on a budget spreadsheet but these have tremendous importance.

C: (Leonard Harjo) Mentioning an Indian Desk is an attempt on our part to request the ability to actually institutionalize all the gains we have made at OMB. If that is not possible, we would request that the team, or whatever options you can come up with, maintain that. Access to OMB and the budget process is critical to our being able to sustain the activities that we have accomplished.

Q: (Brian Cladoosby) I would be surprised if we don't have a government shutdown. What is the plan for engaging coordination between IHS and the tribes?

A: (Norris Cochran) The Administration really wants to avoid a shutdown to begin with because it is not the right solution to what is an important policy discussion. We do remember because it wasn't that long ago, the last shutdown of two years ago. We have been recalling the various issues that came up when this last happened, and we will continue to do. If there is not a CR in place or coming together for final passage, I would suspect that planning effort and associated communications will begin to accelerate.

Thank you for engaging Aadaeze. We have a meeting later this week at OMB on the Generation Indigenous planning effort. She heard your ask directly about the Indian Desk. I will reiterate it at that OMB meeting.

Indian Health Service Issue Discussion

Robert McSwain, Indian Health Service

Mr. McSwain briefly shared the Department's plans for a government shutdown. An All Tribes Call will occur should a shutdown become imminent. IHS would provide other instructions at that time. Mr. McSwain also now has, in writing from HHS Secretary Burwell, all the authorities the director of Indian Health Service would have.

Mr. McSwain also gave these updates:

- 12 area listening sessions and 4 national meeting listening sessions have taken place. These sessions gave details on the transition from Dr. Roubideaux to Mr. McSwain.
- Top priorities for the Department at this time include:
 - Looking at ways to improve Indian Health Service -- ensuring that American Indians/Alaska Natives have their options for health care coverage under the Affordable Care Act.

- Improving the quality and access to care -- the initiative on hospital consortia falls under this priority. IHS must look at the 28 hospitals it operates and ensure consistent, quality care in accordance with current standards.
- The Department has seen positive results in the states that have expanded to the 138 percent of poverty. In one state, collections are up and programs are operating at Level 4 rather than Priority 1. Priority 2 is prevention while 3 is primary and secondary referral. 4 is elective surgery. Many tribal communities have never gone past Priority 1.
- Alaska and South Dakota are in conversations about expanding Medicaid.
- IHS is moving quickly and urgently across the contract support costs claims. As of September 11, 1,370 claims were analyzed. IHS has extended 1,373 settlement offers to tribes. In total, \$721 million in claims were accepted or finalized. IHS will have all offers out by the end of the year.
- The CSC workgroup met at the end of August for two days in Phoenix, and has developed a tool to better calculate CSC. Seats are available on the workgroup. The next workgroup meeting will take place November 4-5. Meeting dates in March also are tentatively on the schedule. This is the second year of full funding for CSC, so the numbers must be correct for reconciliations. Some IHS areas are conducting trainings.
- Suicide prevention: IHS and SAMHSA have been working together on this issue, particularly in light of the crisis on the Oglala Sioux Tribe that began in December 2014 and continues to occur. Through listening sessions that took place around the country this year, federal staff members have learned that the Oglala Sioux Tribe isn't the only one experiencing tragedies. The issue has sparked a great deal of coordination among such federal agencies as IHS, SAMHSA, the Administration of Children and Families (ACF), the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA).
- The MSPI program has moved out this year with a grant program.
- IHS is working on integrating behavioral health with primary care so patients don't have to go to a separate building to get this additional care.
- The number of grants available this year for diabetes has increased now that IHS has combined the Healthy Heart Program into the Community-Directed Diabetes Program.
- Regarding Meaningful Use payments to the second quarter of 2015, more than \$143 million was received as a result of the adoption and meaningful use of the Resource and Patient Management System (RPMS) electronic health record by IHS tribal and urban hospitals and providers.
- Mr. McSwain encourages tribes to get their data sharing agreements in place.
- The next meeting of the Federal Appropriations Advisory Board will take place in Phoenix. Meetings are open.

Questions and Answers

C: (Roger Trudell) Regarding South Dakota's expansion, there are no funds in the area to -- the health board had a contract to assist with that, with the ACA, but there are no funds to recontract with the health board, to assist the tribes in the process. Maybe somewhere in Indian Health Service there might be a few dollars left around to help South Dakota in that process.

And I will give up my seat for the Winnebago Tribe so they can come forward and express their thoughts on what they are going through.

Q: (Robert McSwain) On the question of outreach and education, Senior Advisor Mr. Roth -- you want to reply to that?

A: (Geoff Roth) We will work on getting outreach and education money out. It can also be used for Medicaid enrollment. The Alaska Area will be doing that as well.

C: (Vince Bass) I have some notes here I would like to read.

The Indian Health Service operates a federally owned, federally staffed hospital on our reservation. This is a 13-bed facility with an emergency room, pharmacy labs and radiology. It is a primary hospital serving the members of the Winnebago and Omaha Tribes as well as other Indians in our surrounding geographic area.

In 2011 the HHS Centers for Medicare and Medicaid Services began to point out deficiencies at this facility. After that study, a few things got better but most did not. In 2014, the facility was subject to five CMS survey reports, which in July of 2014 concluded that the deficiencies at our IHS-operated facility had become so serious that they caused actual harm and were likely to cause harm to persons seeking treatment.

Within the past four years, five deaths have occurred as a result of untrained staff and mismanagement. All of these events led CMS to notify IHS that the Winnebago Hospital would lose its Medicare/Medicaid certification if all deficiencies were not corrected by July 15, 2015.

As you have probably seen in the press, these deficiencies were not corrected, and our IHS hospital became the first HHS-operated hospital to lose Medicare/Medicaid certification on July 23rd.

We believe these events at Winnebago mandate procedural changes in the Department. More specifically:

- Each time the CMS issued a new report, the IHS insisted to the tribe that the deficiencies documented had been or were being corrected.
- The tribe never received copies of these CMS reports from CMS because the hospital was operated by the federal government.
- The types of deficiencies referenced in the CMS report suggest that the IHS was hiring untrained, unqualified staff at Winnebago.

- When this actual loss of CMS certification happened, people at IHS central office and HHS central office seemed genuinely surprised.
- Since IHS has never lost CMS certification before, they are working now to figure out the process for reinstating Medicaid/Medicare third-party billing capability. There are no procedures for this.
- Finally only last week we learned that federal accreditation reviews do not include a review of tribal emergency rooms. Why were we never told this?

Mr. McSwain has assigned Mr. Richard Grinnell to oversee the next IHS corrective action plan at Winnebago, and while we appreciate these efforts, we are baffled as to why this did not occur two years ago. We are also pleased that IHS has replaced the CEO and a number of senior managers at the Winnebago hospital but ask again, what took so long?

At this time we are seeking from IHS and HHS continued direct communication to the tribes and participation in the process, including hiring of permanent administrators. We are seeking assurances that the corrective actions will be permanent and timely. And we are seeking additional funding to ensure no loss of services and to pay for the additional support for contractors needed to carry out corrective actions.

C: (Robert McSwain) I kind of lived through this from the very beginning when we were facing the actual notice of termination. You mentioned that there are several hospitals -- and I talked with our senior staff. We are going to want to have a conversation with all the tribal leadership in the Great Plains Area because we want to look at all seven hospitals that are equally at risk.

A part of that has to do with the fact that, an observation I am making, is the fact that the average daily patient load is so low that the staff can't maintain their skills. How do we address that when you are running three patients a day? That is hardly a patient load for a facility.

This is not just Winnebago, but several in the Great Plains Area. We need to have a conversation about how we can either adjust that or have a conversation about what that means. For the other tribal leaders around the table, we have to have that conversation in your areas as well.

Are we keeping these facilities open and running the risk of untrained personnel, or even trained personnel who have not been challenged with their professional skills in some time -- as we found out with the surprise. And I will say that CMS was in there last year, and last year we wound up, through firings or terminations or people leaving, we dropped 29 positions last year. We are trying to recover to get those positions in place.

That is a challenge we have in Indian Country. We ran up against that in Pine Ridge when we didn't have housing. And we had to move temporary housing in just to get some providers on staff.

I am not satisfied with the Winnebago corrective action plan. It is my intention, as soon as that corrective action plan is completed to my satisfaction, then I will then sit down with the CMS administrator, and we can start talking about restoring the ability to bill Medicaid and Medicare.

We are keeping an eye on the other six hospitals in the Great Plains Area. We need to talk about how do we go forward with these facilities, knowing the staffing that we have?

C: (Arlan Melendez) There are a lot of tribes that want to build a hospital on a reservation. There are a lot of factors. The trend seems to be that tribes are compacting hospitals or taking them over from the direct service that the Indian Health Service provided for all these hospitals.

We had a couple in Nevada, and in that situation, the hospital -- my understanding now is it is operating as a regular clinic but the funding level that they get is the same. If a tribe compacted for a hospital and for some reason you decided to just convert it to an outpatient facility --

C: (Robert McSwain) We generally will convert them to a health center, and sometimes we refer to them as an alternative health center, which means there are five to six beds.

C: (Arlan Melendez) I think it would be worthwhile to do a study so we can see the condition of hospitals in general throughout the United States -- the ones operated by the Indian Health Service, the ones where the tribes have basically taken them over. It would be interesting to know where the trend is going, and that tells us where the appropriations should go.

C: (Robert McSwain) Those are the conversations I want to have. Our facilities are staffed at such a point, even our hospitals, if you were to all take a reflection on our hospitals, we may have three patients but we are buying care outside. Even if we had the hospital capacity, we are still purchasing complex care in the private sector, our PRC dollars.

When you think about how many facilities we have built, all the hospitals are being replaced with health centers. We would rather provide more services in that health center, and that goes to the point that, well, they are still getting the budget. They have increased the amount of capacity in that health center, and then they can actually buy their in-patient care.

C: (Leonard Harjo) You probably do need to look at the classification of hospitals. There are options you need to look at.

But one of the things I would recommend to prevent issues of that nature in the future, I would like you to overhaul your required reports that those facilities are expected to give us. We don't get standard reports of any kind from our service unit.

The other thing I wanted to comment on, we got a letter from our area office indicating our share of the \$50 million. The local service unit contributed \$5.7 million in Medicare/Medicaid to the employee issue. We asked our service unit director, do we have any overtime issues? No, we are a clinic. We don't have any.

Why are we putting in that large of an amount? Our contribution was right at half of the area's expected contribution to the settlement, and over 10 percent of the national. How were we determined to put in that kind of money when we had no overtime? And how is it that we had that much money available? That should have been going out into the services our people need.

You say you will get it back in five years. Maybe. Who's going to honor that commitment that we get it back in five years? And what about the people who go without in that time period? We are loaning you almost \$6 million. We are not going to get any interest on that. We are operating on good faith with the Indian Health Service that we are going to get it back. That is a long time to deny people funding.

(Robert McSwain) Let me address what is on your minds. First of all, the reports: I have been getting copies of reports, and I drew the same observation. There is no standard format. We need to get your thoughts about what you want to see in a report. We will mandate that report out to all the CEOs to be able to do that on a monthly basis. That is one area we will definitely work on as a follow-up.

The settlement, this is a settlement with the union and it is for the years in which they allege that their particular overtime was not paid, and that is from the year 2005-2014.

That is the level of settlement, and this is based upon one major arbitration finding that Indian Health Service had with the unions. And it was determined that the average settlement was a little over \$40,000 per person.

That was our settlement. We then looked back in the accounts for those years, back to 2010, because the appropriation is good for five years, and then we actually used \$10 million of expired appropriation that we were able to use for purposes of paying the settlement claim.

I know it is distasteful but we didn't take your current year nor did we take any of your current year funds. We did take money -- we did use some of the staffing money for Kayenta that was not used for this year. So we used that \$20 million for purposes of the settlement.

Q: (Roger Trudell) Somebody needs to explain what is an expired fund. They had to be from somewhere. Was it because the service units didn't provide the level of care they should have been providing? Were they stashing money for another reason?

It is just not acceptable to me that we talk about expired funds. There should never be expired funds. Those should have been used to treat people. If we have enough money to pay off federal employees, why don't we ever have enough money to treat tribal people?

A: (Mr. McSwain) The rules under the Fair Labor Standards Act are that if an employee works more than 8 hours a day or 40 hours a week, they are entitled to overtime. And if they are nonexempt, which are all of the union employees, they are entitled to be paid overtime.

They have alleged that they worked overtime, and we didn't pay them. We have no evidence to say with some certainty that they did not work overtime. So if an employee has, in arbitration, for example, said they worked overtime -- and I draw the example that when the waiting room is full of patients toward the end of the day, if the employee is not going to be paid overtime, they would have just left, and those patients would have been left in there. But no, those employees actually provided care beyond their tour of duty.

In doing so, we -- we managers -- should have immediately calculated what they owe that employee for working those two or three hours beyond the eight. And they did not. And we have no evidence to prove that they did, and certainly no evidence to prove that they didn't.

C: (Roger Trudell) So if I were working in a clinic, I wouldn't even have to prove that I worked overtime? I could just file a claim and you guys would pay me? But if I am in that same clinic as a tribal person, trying to see a doctor or somebody, and they are not there, they just get up and leave at whatever time they leave -- and that is the more practical. They don't care who is sitting in that lobby. When it is time to go, they are going.

I will never understand how a federal employee can belong to a union. They are paid by the taxpayers. They are not paid by private industry or anybody else. The whole thing is senseless to me why tribal people have such inadequate service but yet the people who are supposed to treat them can get all kinds of stuff.

C: (Mr. McSwain) The Fair Labor Relations Act actually authorizes employees to collectively bargain. And we have four different unions in the Indian Health Service. We abide by the provisions, and they all have provisions for overtime.

Q: (Cheryl-Frye Cromwell) The status on the Medicare-like rate regulation: Can you give a brief update on where that is? And on the standardized reporting from our service units, I would recommend we have a discussion around the list of questions that we could put forth so they could answer them in a report.

A: (Mr. McSwain) On Medicare-like rates, it is in this building someplace. It has been bounced back and forth, and there have been little tweaks to it. We have finished it, and I believe we have answered all of their questions. It is really close. We will find out.

C: (Will Micklin) So Chairman Begaye had two questions that he wanted to pose so I would ask his representative to ask those for him.

Q: (Carolyn Drouin) -- Going back to the employee union settlement, on August 17, I contacted the direct services office requesting information that they asked that I put in an email format because we needed to distribute this back to Navajo. I believe it was raised again in Flagstaff about the information we are looking to get, and we have not gotten that information.

We want to get:

- a breakdown of all the service units within the Navajo Area that had claims, overtime claims against them
- a breakdown by facility that shows the amount of the settlement that was each attributed to each service unit or facility
- a breakdown by each facility that shows how much of the third-party billing dollars they were sitting on so we can see what is going to be remaining from that.

And our last request regarded -- IHS told President Begaye you had contacted each of the units to find out what they were planning on doing with that money. And we would like to know what the unit's response was on that.

About a month ago we found out the Oglala had filed a lawsuit against IHS because they were planning on using that money to bring their facility up to standards for CMS because I think they are facing possibly the same thing that Winnebago has gone through. So we would like to know what our facilities were planning on doing with that money.

And a letter that was sent as a follow-up to an in-person conversation you had with the president and vice president out in Flagstaff, it is regarding the Gold King mine spill and the contaminants in the water. President Begaye had to leave because there are going to be three hearings on the Hill this week about the Gold King mine spill with the EPA.

A real concern with the Navajo Nation is that there are hundreds of these mines up in Colorado. This has really impacted the nation. Our main crops, agriculture, all are located along the San Juan River.

The okay for irrigating has been given but there hasn't been enough testing with the water to even use it for livestock. The letter that was sent was to ask IHS to help the nation right now, and also help prepare in the future with regard to drilling and construction/infrastructure for clean, safe drinking water along the San Juan.

We have heard that this is going to impact the nation for decades potentially. But we also have to prepare because they are saying there are hundreds up there.

C: (Mr. McSwain) You said you had an email you sent to us? We will track it down. And on the other piece, we talked at the direct service tribes. I think there were 12 wells he would like to see drilled. We need to do well testing because people were afraid to use the wells that are along the San Juan. And there was a water treatment facility at Shiprock he wanted to restore.

C: (Arlan Melendez) Regarding the workgroup on the contract support costs, one of the things we had asked there was for the pilot project to be either approved by yourself so it wouldn't be put off. I think we are kind of looking for an answer by the next contract support costs workgroup meeting.

C: (Mr. McSwain) Admiral Pattea and I have talked about the pilot. We think it is a great idea to begin moving in that direction. We just need the pilot to be defined. If they can define the pilot, then we will move ahead with it.

C: (Gary Hayes) Several years ago, Mescalero, the Apache Tribe, had over 20 youth suicides. They put together a program. It is called the Mescalero Systems Care for Youth Group. They presented to us, and the issue is trying to get that message and what they are doing to be able to help the youth because it is actually run by youth. And they did present to the health board.

They were also invited to the Gen-I conference and UNITY. What they are asking is if there are any grants or any way that they can be able to provide the videos that they have. They actually have a person go to different areas to present their program because, as you mentioned, one of the concerns they had was not listening to old fogies like us, but really again to have it driven by the youth.

During our consultation, we have asked, at that table, that SAMHSA be there at the regional level when we have these consultation meetings. And I think that would be helpful, especially when you talk about grants available and issues put out by SAMHSA. I think it is not getting to our local level. I think it would be beneficial to have them there throughout Indian Country when you have meetings with HHS. They should be at the table also to address this epidemic.

Centers for Medicare and Medicaid Services (CMS)

Timothy Hill, Deputy Center Director, CMCS

Mr. Hill highlighted emerging policy proposals that have come from South Dakota and Alaska regarding 100 percent Federal Medical Assistance Percentages (FMAP) for services provided by IHS and tribal facilities.

Alaska expanded Medicaid effective September 1. State leaders have asked for two changes: To get 100 percent FMAP for emergency and nonemergency medical transport, which, as in many rural areas but particularly in Alaska, is a big issue. The state also asked CMS to expand the 100 percent to referrals made by an IHS or a tribal facility to those who receive services outside of the facility. HHS is looking into revising its guidance on this issue.

South Dakota's leaders continue to discuss expansion. As part of its proposal, the state has made three requests:

- Extending FMAP 100 percent to telehealth services provided at a tribal facility.
- Expanding and providing 100 percent FMAP for expansion of specialty services, such as diabetic care, through collaborative arrangements with non-IHS facilities provided by non-IHS providers.
- Expanding the use of community health representatives to help Medicaid eligible American Indians/Alaska Natives access primary care services through facilities.

HHS is considering these requests. Any responses to state proposals will have implications for the tribes, so CMS staff want input from Indian Country. Tribes should submit comments as soon as possible.

Other high-level discussion topics included:

- The Medicaid managed care rule: CMS received a significant amount of comments from the tribal community regarding rules published this spring. Staff continue to examine the guidance as they seek to get the rule finalized.
- Staff members also are in the process of updating the tribal consultation policy.

Questions and Answers

C: (Tino Batt) We are asking for authorization for the urban contract. Many of our tribal members were relocated and some of them are still in these urban areas. We are asking that it be part of the 100 authorization and the state officials be more cooperative in negotiating the plan.

I am glad to hear about moving forward with 100 percent FMAP. Tribes feel that the extension of 100 percent in urban health organizations will further support efforts addressing many of the health issues.

Q: (Timothy Hill) Do we have a proposal in place on the urban issue?

A: (Tino Batt) That is my question. Kitty?

C: (Kitty Marx) Yes, we have received one letter from the Seattle Indian Health Board requesting that. And on the All Tribes Call that we held on September 11, this issue came up as well.

Q: (Tino Batt) How soon do you think we can get a response?

A: (Timothy Hill) The Secretary and others have given this particular policy and its implications a high priority. I would anticipate having something out sooner than we otherwise might have.

Q: (Tino Batt) I know we have been working with the northwest, especially with the state of Idaho, regarding the waivers with behavioral health. We have issues with the contractors. They are being referred through IHS but yet our individuals going through the system are being deferred because they have to re-take the intake process.

We are working on it internally. I know we have a call that we are working on but we want to put that in as well. If we are trying to prevent issues with suicide and we are trying to get our youth through the process, and then having a delay in services, that affects the individuals.

C: (Timothy Hill): I know you have submitted comments as part of the waiver process. We will keep working through them.

C: (Roger Trudell) We are in support of the expansion in South Dakota. We just want to make sure the details are beneficial to the tribes.

C: (Timothy Hill) I have to tell you, I don't know that I am prepared to go through the details of the expansion statewide other than to say -- to describe what they have asked for with respect to the tribal FMAP changes. I am sure we have a write-up. I can get it to you quickly to describe what they are proposing.

C: (Chester Antone) As you go through your yearlong review of the Arizona governor's 1115 waiver request, we have a resolution that we forwarded. You should have it in your office.

We are asking CMS to reject eligibility cap. We are also asking CMS to look closely at the reimbursement issue on nonemergency medical transports because Governor Ducey is proposing to eliminate that for a year. Unfortunately, that is going to really hit transportation services, and I want to point out a difference.

The tribal health transportation services, at least in Arizona, have been reimbursed for many years without anything major going on. But when the nonemergency medical transports under the Medicaid expansion -- they lumped the tribes in with the independent transportation. Independents are the ones who contract with AHCCCS and provide transportation to eligible persons for Medicaid.

So there are two different transportation services available. The state has never had an issue with us. But the issues came when you had many of the independents because one of the ways independent drivers can get additional funds is to go further. So from one end of the reservation, there is a clinic midway that people want to go to. But they take them further, so you get more reimbursement.

Q: (Timothy Hill) And that doesn't have anything to do with the waiver request. That is just the way they have currently organized the NEMP under the expansion?

A: (Chester Antone) They are terminating for a year the NEMPs. But what they have done is they didn't exempt tribes. And yet tribes have been doing it for years.

Affordable Care Act (ACA) Outreach Discussion

Stacey Ecoffey, Principal Advisor to Tribal Affairs, IEA

Kitty Marx, Director, Tribal Affairs Group, CMS

Geoff Roth, Senior Advisor, Indian Health Service

In preparation for open enrollment, HHS staff decided to get STAC members' suggestions for outreach and education. Session presenters also raised these points:

IHS continues to fund its National Indian Health Outreach and Education Initiative, a partnership of the National Indian Health Board (NIHB), the National Congress of American Indians (NCAI), the Self-Governance Tribal Advisory Committee and the National Council of Urban Indian Health. These organizations have done hundreds of individual tribal trainings with consumers and leaders.

Training will focus on non-Indian Navigators to give them more information about specific American Indian/Alaska Native provisions.

Open enrollment will occur November 1 to January 31.

CMS conducts trainings and webinars on various topics as they arise. The agency also has partnered with the VA to talk about the reimbursement rates and the agreements that are

available to tribes. Fact sheets and outreach documents also are available to spell out rules and protections for Indians. Drop-in radio and newspaper ads and public service announcements help get the word out about coverage.

A new campaign, Native Art for Health, uses social media to reach tribal communities in urban areas not served by an IHS hospital or tribal/urban Indian clinic. The campaign, which has already been in Philadelphia and Atlanta, will now head to Houston, San Antonio, Fayetteville, Kansas City and other locations.

CMS scheduled a tribal listening consultation for September 21.

Questions and Answers

Q: (Arlan Melendez) One of the big issues has to do with the respective states where Medicaid is -- you know, the insurance Exchanges. In the state of Nevada, it was a challenge working with them. Unless it is a federal Exchange, how do you see getting help where they maybe have a lot of issues with respective states?

A: (Kitty Marx) From a CMS point of view, the State-based Marketplaces have a lot of discretion. They really have taken over responsibility of their Marketplace so the ability of the federal government to influence a State-based Marketplace is limited. They have received money and resources for outreach. But I know if there is a particular issue, I can certainly take it back to my partners at the Center for Consumer Information and Insurance Oversight (CCIIO).

Q: (Arlan Melendez) Is there an adequate number of Navigators?

A: (Kitty Marx) CCIIO just recently awarded grant funding for our CCIIO program. There are two Navigators per state. There were five American Indian/Alaska Native selected. Great Plains, for North Dakota and South Dakota. Forest Potawatomi in Michigan. And the Urban Center in Salt Lake for Utah. Of the hundred Navigator grantees, there were only five selected for this grant award funding. It is a three-year funding source. From CCIIO, or from CMS, that is all the Navigator funding that we will have available.

Q: (Arlan Melendez) So is that something where even if it wasn't funded by this specific -- you are saying you are funding those, or who is? If there is a need for more, would you put in place a similar program funded just out of IHS or what?

A: (Stacey Ecoffey) I think NIHOE was doing some of this education. And we always beg, borrow and steal our different resources and try to replicate them in different areas. And so I think what we did last year, the Great Plains Navigator did a good job with a lot of their outreach and being creative with how they went out into the communities.

Taking some of those best practices from the Navigators we have had the last two years will help us do better in regions that don't have Navigators. But that is part of the nice thing about NIHOE and your regional health orgs along with the national orgs. We are able to share those education

pieces and get people to where we need if we need to do more education and outreach in certain areas.

C: (Geoff Roth) We are looking at expanding some of the purpose of the funding that we have been providing to the regions. And that is out of a request from the areas. We had primarily tried to focus just on the Marketplace enrollments, but the areas have been saying, hey we would like to focus on Marketplace and Medicaid.

So we are looking at allowing the regions to -- while we are not able to really expand the amount of funding that we are going to provide, allow them to focus on enrollment and insurance in general, Medicaid or Marketplace.

C: (Kitty Marx) Through our particular funding in our division, we were able to supplement the NIHOE training through a cooperative agreement that we have with NIHB so that when NIHOE does go out to talk about the Marketplace, they will have additional funds to use to talk about Medicaid.

Q: (Roger Trudell) When you encounter attitudes about it is a treaty responsibility, how are we relating that you are going to be better off doing this as opposed to waiting for somebody to fund a treaty? Are we addressing that?

I am going to ask if Jerilyn, our technical advisor, could have the floor for a few minutes.

C: (Jerilyn Church) In respect to ACA, the first year we had funds to do outreach and education and we focused on the community at large, providing education on the ACA itself and the provisions.

The second year we focused on tribal leadership. But with the potential for South Dakota expanding, one thing we really need in our region is just basic education to community members on what insurance is. Because we are predominantly direct service, a lot of our tribal members have never had insurance.

Another area where there is a need for education and communication is with insurance providers. They must understand some of the differences and some of the provisions under ACA and the Indian Health Care Improvement Act in order for them to be able to manage insurance in tribal facilities.

In terms of our Navigator grant, one of the things that I see as still a weakness is we provided training to IHS staff but what we have run into are some challenges around their availability to actually do the enrollment. Some service units are better than others but there are still some service units that are not doing enrollment to the level that I think they could be.

The comment that we hear frequently is that they don't have time or they don't have the capacity. That they need additional staff, because it does take a long while to enroll in the Marketplace.

We also need additional support from IHS with reporting. We do a separate report to CMS on our enrollment activities. For our Navigators in the service units who are IHS employees, we don't always get those reports.

C: (Gary Hayes) When it comes to Navigator grants, we are fortunate. In the state of Colorado, the state is putting money aside regardless of whether they get a grant. Whatever they get from CMS, they are including tribes to be part of the funding.

When you only have two tribes in Colorado, that is easy to do. But when you are talking about other areas where other states have a different number, I can see where the problems may arise of every tribe wanting a Navigator.

The conversations you should be having with your tribes is to be able to set up areas where you can be more effective in at least having a process of having a Navigator in areas where many of your tribal citizens can have access because transportation costs come into play.

Other topics of discussion:

- Outreach: The problem we are having -- it was just mentioned about the IHS clinic -- is they send their employees to the Navigator training, but the outreach, someone needs to get them actually doing the outreach. They want our people to come to them. They need to be more proactive to get the enrollment up. I have talked to our regional director about this. This has been going on for a while and I don't see any improvement.
- NIHB materials: When I was at the direct service conference, the National Indian Health Board passed this packet out.

(Holding up packet)

I think this would be great to give to all the IHS or tribal clinics. This is a good resource. I want to thank NIHB for putting this together, but we need more effort in how we can get that distributed out.

- Referrals: I also think there needs to be an effort where the IHS clinics are able to work with the area to see what is available, the specialties, so they can refer them instead of our tribal members going all the way to Phoenix. Because of expansion, some of the medical facilities are saying we have a waiting list because they don't have enough providers or medical professionals in the area. That is why they are saying we don't accept Medicaid or Medicare. That may be something a lot of the tribes in rural areas may experience.
- Trust responsibility: The issue that was brought up about trust responsibility -- why do tribal members have to pay? We are finding out that through the Marketplace, some tribal members would only have to pay \$1 a month to get insurance. Some are refusing it because this takes away from the trust responsibility.

With the third-party billing, why can't IHS pay for that \$1 a month somehow for tribal members? Why don't we research and see if there is a possibility of doing that?

Q: (Cheryl Frye-Cromwell) This is for a request for administrative relief from employer mandate tax penalties for tribal member employees who are exempt from the individual mandate. I just want to mention a few concerns that we have:

- Our tribal governments employ a significant number of tribal members who are otherwise exempt from the individual mandate. For many tribes, particularly those with few resources, up to 75 percent of their workforce is made up of tribal member employees.
- The IRS has interrupted the employer mandate to apply to all full-time tribal employees even though tribal member employees are statutorily exempt from the individual mandate.
- This interpretation requires tribes to either offer and pay for insurance coverage for their tribal member employees or pay a significant tax penalty to the IRS.
- Either way, the tribes are being required to pay for health care for their tribal member employees simply because they work for the tribe. Requiring tribes to pay for health care coverage for their members is inconsistent with the federal trust responsibility to provide health coverage to American Indians and Alaska Natives at no cost to them, and inconsistent with congressional intent to meet that trust responsibility by exempting them from the individual mandate.
- Tribes have consistently offered coverage to their non-Native employees for many years and will continue to do so but tribes are concerned that the current IRS interpretation will require tribes to spend a significant portion of their IHS appropriation to either pay for coverage or pay a penalty for their tribal members.

Would it be possible to have a joint discussion with IRS and CMS officials to resolve this issue?

C: (Aaron Payment) What I have requested are a series of consultation sessions because this is a very complex issue. There are many different permutations of the impact of this, and I think we should have an exemption, and we should have that joint committee with IHS and HHS to find out the different permutations in Indian Country.

C: (Stacey Ecoffey) You have raised this with the Secretary, and it is on her radar. She has talked about this and the issues that it raises. Part of our limitation is that it does fall under the IRS.

C: (Jefferson Keel) We simply can't get to a point where all the federal agencies agree on a particular process. If it is an HHS initiative, then HHS ought to be the one who resolves it with the IRS. It should not be tribes having to come and ask for meetings and consultations with the IRS to resolve these issues. It is a federal undertaking.

So we shouldn't have to come every meeting and ask for a consultation on something. Let's get it resolved. And if that has to do with the Secretary talking to the IRS, then that is what needs to be done. My recommendation is that we simply put a letter together to the Secretary. Our advice is that she sit down with whoever and get it resolved. This is not going away. A year from now we will be talking about some other issue unless we get them to resolve it.

Q: (Gary Trudell) Would he consider expanding that, this letter, to the IRS and the President as well?

A: (Jefferson Keel) We can send it to the President too. I think you should send it to the White House. I think all of them ought to be involved.

C: (Aaron Payment) In preparation for our meeting last week, we reviewed -- the Federal Register published the IRS's consultation requirement. And it is pretty consistent with President Obama's -- the spirit of consultation but obviously it didn't happen. Maybe one of the things Secretary Burwell could ask the IRS is, how did your tribal consultation go? This is a model for how it should happen, created under Secretary Sebelius. I did ask that the materials we shared last week circulate to Stacey. And it has got some succinct examples.

C: (Will Micklin) I was on the IRS advisory committee for tax-exempt government entities. Tino Batt was on that as well. So we did publish a report on the IRS consultation plan. Essentially they don't have one. They don't have an effective one. They certainly don't have one that is compliant with the President's executive order requesting all federal departments and agencies to put forward a plan so I would endorse Lt. Governor Keel's suggestion.

Administration for Children and Families (ACF)

Maria Cancian, Deputy Assistant Secretary for Policy

Linda Smith, Deputy Assistant Secretary, Early Childhood Education

Nisha Patel, Director, Office of Family Assistance

Felicia Gaither, Director, Division of Tribal TANF Management, Office of Family Assistance

Rafael Lopez, Commissioner, Administration on Children, Youth and Families

Ms. Cancian began her remarks by announcing these leadership changes:

- Joo Yeun Chang left ACF although she will continue to work on children's issues.
- Rafael Lopez is the new ACF Commissioner for Children Youth and Families. In that role, Mr. Lopez oversees both the Children's Bureau and the Family Youth Services Bureau.
- ACF now has an Office in Trafficking In Persons (OTIP) led by Katherine Chon, a senior advisor in trafficking.

ACF staff also highlighted these issues:

- Ms. Cancian announced there is a legal basis to expand 477 to include CSBG. ACF will move forward with that expansion. There is no legal basis to include Head Start or the Low Income Home Energy Assistance Program (LIHEAP) in 477.

- Ms. Smith reported on one of the goals of the redrafting of the Head Start performance standards: Rather than tell people exactly how to do the job, tell them what the goal is, and what HHS is trying to do with Head Start.
- Ms. Smith also released a report on the Tribal Early Learning Initiative project, a collaborative effort across Head Start, home visiting and child care. Staff members have announced the next six sites for the projects ACF wants to do around this collaboration.
- ACF provided details on its Early EdU, an alliance with the University of Washington for Head Start and early childhood teaching. The program offers a core curriculum for a bachelor's degree in early childhood, which will help bring high-quality teachers into Head Start. Courses are available online or in a written format. The courses were paid for with Head Start dollars so there is no charge for the vast majority of the materials.
- Ms. Smith alerted the STAC to a joint technical assistance center, the Early Childhood Mental Health Consultation Center, in conjunction with SAMHSA. Two tribal specialists will come on board, and consultations will be available. HHS will formally announce the collaboration in a few weeks.
- Federal staff will begin developing strategies to help Early Head Start/Head Start teachers work with children who were born drug-addicted.
- The Office of Family Assistance will be announcing new grants for Tribal TANF Child Welfare Coordination, Healthy Marriage, Responsible Fatherhood and Health Profession Opportunity Grants by the end of September.
- Felicia Gaither will be leaving TANF for a new position at Housing and Urban Development (HUD).
- Staff will implement the new OMB-approved 477 forms as of October 1. The first training on implementation has already taken place. The office will continue to draft compliance supplement language for the audit process.
- In fiscal year 2016 HHS will provide a \$900,000 set-aside for awards to tribes and tribal organizations to evaluate teen pregnancy prevention models.
- A new round of funding for the Tribal Personal Responsibility and Education Program (PREP) will be available. A \$3.25 million funding announcement will be published in April of 2016.
- Tribal Title IV-E announcements for fiscal year 2016 will be available shortly. Five tribes will be announced.
- The Indian Child Welfare Act (ICWA) data elements and the Children's Bureau report remain in process.
- A new technical assistance structure will respond to issues and concerns raised during multiple STAC meetings. ICWA will be among the issues specifically addressed.
- Staffs also are developing a model tool for State ICWA self-assessment.

Questions and Answers

C: (Gloria O'Neill) Regarding CBSG and 477, thank you. I know it is halfway but I so appreciate your looking at the issues after the years of our conversation and meeting us halfway

with CSBG. We won't give up. We will continue to be relentless. We would love to understand the legal position as it relates to LIHEAP and Head Start, but thank you for listening.

C: (Will Micklin) I want to thank you for the ACF Tribal Consultation that took place yesterday. We are submitting written comments to the consultation, and if there is a summary of those comments or those are individually available, I think it would be helpful to distribute those to the STAC members before the next meeting.

I want to recast a couple comments:

- Thank you for the determination on the request for 477 expansion. I think it is important that we are making progress toward decisions.
- TANF program: Both TANF and CSBG have an administrative cap on recovery for indirect – 5 percent for CSBG and 15 percent for TANF. That is an extreme burden for self-governance tribes. There needs to be support for removing those caps.
- For the Indian Child Welfare Act, the highlight I will pull out is on the Adoption and Foster Care Automated Reporting System (AFCARS). Joo Chang did a lot of work in that. There will be a change to those data fields to make them more helpful for us. I just hope that the transition to Mr. Lopez doesn't impede that progress.
- Data: That other data become available to us for other issues, like state compliance with ICWA regulations. There is a report that is pending to us.
- The APPLA, Another Plan Permanent Living Arrangement, lends itself to tribal definitions for kinship that are unique and integral to tribal communities, so I think that is a solution for the APPLA issue. You need to work with tribes in customizing these definitions.
- Head Start: The National Indian Head Start Directors' Association put together some comments on the issues of Head Start performance standards, including the full-day/full-year and performance requirements. It really goes to the question of moving to quality. But in that move to quality it can inflict some unintended consequences on Tribal Head Start programs. I am hoping we can really work with this organization, work with these comments and provide some flexibility in the interpretation of the program standards.

C: (Aaron Payment) The proposed rule, QRIS, that states that we should participate in state and local Quality Rating Improvement Systems is kind of an abrogation of sovereignty because it is having us go through an interpretation that is not adaptive to us. Wherever possible, we want to be consulted with, participate in, in a sovereignty way, to develop that because we strongly believe in quality for our most precious commodity. We need to participate in developing that training from the inception and not have us fit into one size fits all.

C: (Robert McGhee) Years ago, it was a boarding school epidemic, and we pretty much were told this will never happen again. Well, it is happening. Our Indian children are being adopted out. And I think it is time we find out what is going on and get that Notice of Proposed Rulemaking out. Let's get it finalized by the Administration, if we could, by October, if that could be published.

And also the other report. We need to know what is going on. So if we could get that other report released too.

Q: (Gloria O'Neill) I have three questions:

- As we have engaged in the strategic conversation around, and implementation of a general waiver for tribes for match requirements across the Department, I would like to know the timeline to implement such a waiver. And if ACF staff is going to move forward on this issue.
- We have requested a grants matrix that shows tribes and tribal organizations across the United States that have received competitive awards. I would really like STAC to receive that report as soon as possible.
- When are you going to make your grant awards this year? Is it going to be at the end of the year, September 30?

A: (Lillian Sparks Robinson) So I will start with the grants matrix. We will work with the IEA to make sure that the STAC receives that prior to the next STAC, the most updated version.

With regard to the awarding of the grants, I can tell you for ANA that other than our language awards, which we typically award by the end of August, all the rest of our awards are done by the end of September.

A: (Maria Cancian) On the match waiver, I don't have news to report but I will commit to there being an update at the next STAC. It has been a topic of conversation but I don't have a resolution to report.

C: (Akilah Kinnison) I represent the National Indian Head Start Directors Association. We have been welcoming of the streamlining of the comments and the focus on outcomes. I want to draw your attention to a few things.

- The focus on goals, which is that in some places, especially with the full-day/full-year requirements, and the requirements to prioritize younger children if there is state pre-K available, our goals are not necessarily aligned. Some of our communities don't want their children in full-day care. Full-year requirements impose cultural barriers.
- The requirement to prioritize younger children if there is state pre-K available. State pre-K is just not an adequate substitute for Indian Head Start.

We have asked for blanket exemptions for tribal programs for the full-day, full-year requirements and the prioritization of younger children.

C: (Linda Smith) I think the goal is whatever lines up with the school year of the local community, and they do vary. We are trying to balance all these things.

National Institute of Health (NIH)

Dr. Francis Collins, Director, National Institutes of Health

Dr. Collins gave details on the Precision Medicine Initiative that the President announced in January. This effort includes two parts:

- A focus on cancer using a targeted approach that will match cancers at a molecular level with possible treatment.
- A long-term, ambitious effort that would derive information about all diseases as well as health by enrolling a million or more people as partners in this research effort. In March, NIH formed a workgroup to develop a vision and design for the project.

Other updates included:

- NIH recently held its first listening session at the National Indian Health Board conference.
- The NIH has established its Tribal Consultation Advisory Committee (TCAC) to help institutes leaders hear directly from tribal communities. The committee has 17 representatives. After the first meeting in late September, the group will come together twice a year.

Questions and Answers

C: (Will Micklin) There has been a lot of conversation among our tribal citizens in southeast Alaska. We have very high incidents of cancers. And there is great concern that these are somehow environmentally caused type of cancers. There is now a conversation going around about how we could find out, how we can lend ourselves to a medical study that would tie together the outcomes to the environment and see if there is a link.

Because of these illnesses, there is a need for remedial pain treatment. We have a problem with our elders not having much of a history with opioids for pain treatments. We have seen some very bad reactions to the most heavily dosed opioids, from Oxycontin to even Codeine. So alternatives to that would be useful.

C: (Dr. Francis Collins) With regard to the cancer, these are always challenging to sort out. Is there a cluster? And if so, what might be the cause? This is the sort of thing the CDC is generally set up to do, go and do an analysis.

I appreciate your comments about the problems with opioids. This is a national crisis. And we desperately need alternatives for those who need pain control, and NIH is working hard to develop some of those.

Q: (Aaron Payment) Any thoughts on the way you are going to do the stratification when you do the study, and certainly oversampling? Oversampling is critically important when you study Native people.

A: (Dr. Francis Collins) A million sounds like a lot of people, but if you are starting to try to identify differences between subgroups, the subgroups can start to get small as you get more precise about which ones they are.

What we are trying to do here will be most beneficial if we think of individuals as the main unit that we are trying to study. We are really trying to get away from perhaps the tendency to lump people together based on ethnicity or other factors, and understand what is happening with the individual.

When it comes to subgroups, where we may learn the most, it won't be about genetics. It will be about environment. It will be about socioeconomic and other opportunities. It will be about things like diet and exposure to toxins and smoking. I think those will be a stronger correlate than anything that happens to lie in someone's DNA.

Q: (Chester Antone) Would the primary provider be the one to recommend a person -- let's say under the Indian Health Service -- to take part in this study?

A: (Dr. Francis Collins) We would really like to empower participants themselves to take on that role. NIH is the largest research hospital in the world, and many of those individuals are, in fact, referred by their physicians, who know that this clinical center is there, although some people do self-refer to NIH's Clinical Center.

Q: (Chester Antone) Do you have any idea what percent of Native Americans would make up that one million?

A: (Dr. Francis Collins) I have no idea. That is partly why I wanted to come and speak with you. I don't know what the interest will be. I know there is a history here. Many Native Americans are not likely to see this as necessarily something that is entirely in their best interest given the things that have happened in the past. What do you think the likely receptivity would be?

Q: (Chester Antone) We have a large number of cancer patients, and that is why we have the CDC comprehensive grant, which involves tracking and navigation of the systems. Where do our patients go when they come to IHS? Were they referred?

The other thing was the samples from an individual. Do those individuals have the opportunity to say what will happen to those after the study?

A: (Dr. Francis Collins) So the way it is arranged is there will be a consent process, and basically we will outline in general terms the kind of studies that will be done on the blood samples. But you can't anticipate necessarily what might happen further down. The individual will have the opportunity to decide at any point to withdraw and take the sample back. But they won't be able to take back data that has been already generated from that sample and that is already being used by researchers.

C: (Arlan Melendez) I heard somebody say they really don't want to find a cure for cancer because there is big drug industry that probably wouldn't want to find a cure anyway. That is in the mind of a lot of people.

C: (Dr. Francis Collins) I have heard those things as well. I appreciate your putting them out on the table. The whole effort to try to find a cure for cancer, if it is going to be successful, has to involve both the public and the private sector. The public sector, in the U.S., it is primarily the NIH. The process has to identify what makes a cell grow when it is not supposed to?

We have made phenomenal progress on that question the last 20 years. The challenge is to take a basic understanding and translate that into treatments that are safe and effective. We do need to work hand-in-hand with biotech companies, with drug companies. I have never met anybody who works in cancer research -- whether they are in an academic institution, university or big drug company -- who wants to do anything other than to cure this terrible disease. People don't go into this field of medical research without having a passion for wanting to help people.

Q: (Gary Hayes) We have a community in Utah called White Mesa. It is about 12 miles south of the only processing mill in the nation that takes uranium and puts it into yellowcake. We have tribal members who have passed away, and then currently -- because of cancer -- and we also have a family, three sisters, who have been diagnosed with cancer who live in that community. If I can go back and talk to some of the community members who have been diagnosed or are currently being treated, and those who are interested in this analysis, would you be open to that?

A: (Dr. Francis Collins) Absolutely. We are certainly trying to do everything we can to make research possibilities happen. This Precision Medicine Initiative is actually going to be rather a small proportion, less than one percent, of NIH's research portfolio. When it comes to investigations about particular types of cancer, the National Cancer Institute will be supporting a wide range of studies that are different than what is occurring with the Precision Medicine Initiative. If you don't know about something called clinicaltrials.gov, this would be a good resource for tribes to know about.

Centers for Disease Control and Prevention (CDC)

Carmen Clelland, Associate Director, Tribal Support Unit

The CDC seeks to respond to tribal requests, understanding tribal sovereignty and self-determination as well as the consultation process. The agency uses these strategies to accomplish that goal:

- The Tribal Advisory Committee (TAC) includes 12 members of the IHS areas as well as four at-large members. Cathy Abramson, Chester Antone and Jefferson Keel serve on the TAC. The TAC wants to develop a strategic plan to guide what members' seek in improving public health.
- The Office for State, Tribal, Local, and Territorial Support (OSTLTS), which serves as an engagement office, looks to support health officers as well as other entities such as

tribes to ensure there is an infrastructure for public health, and that infrastructure receives support from grants or funding opportunities.

- The Tribal Support Unit, within OSTLTS, acts as the primary link between CDC and the Agency for Toxic Substances and Disease Registry and tribal governments. Two new analysts have come on board to ensure the unit addresses policy issues, information resources and outreach efforts.
- CDC continues to increase its visibility in Indian Country to provide greater impact and perspective to the unit as well as center and institute directors.
- During a recent consultation, tribal leaders identified access to and transparency about the CDC budget as a top priority.

Whereupon, the meeting adjourned at 4:41 p.m., to resume at 10:00 a.m. on Wednesday, September 16.

Secretary's Tribal Advisory Committee Meeting

Wednesday, September 16

HHS Federal Roundtable

Substance Abuse and Mental Health Services Administration (SAMHSA)

Kana Enomoto, Acting Administrator

Ms. Enomoto greeted STAC members as the new Acting Administrator of SAMHSA following the departure of Administrator Pam Hyde, who left in August after six years in leadership. Ms. Enomoto led a discussion on historical trauma during the March STAC meeting.

Ms. Enomoto provided these updates:

- Building on the legacy of Administrator Hyde, SAMHSA continues to pursue the Tribal Behavioral Health Agenda. Staff work actively with partners at NIHB and other national organizations. SAMHSA has a framework for developing a blueprint based on input from tribal leaders and members as well as federal partners. The agenda will focus on five foundational pillars:
 - Historical and intergenerational trauma and lateral violence
 - National awareness and visibility
 - A socioecological approach
 - Enhanced prevention and recovery support, and
 - Improved behavioral health services and systems.
- The agenda also will include four cross-cutting themes:
 - Youth
 - Culture
 - Identity, and
 - Individual self-sufficiency.

- SAMHSA will present the priorities and actions where consensus exists and complete the HHS clearance process to get to the 2015 White House Tribal Nations Conference.
- The Tribal Technical Advisory Committee has primary delegate vacancies in Phoenix and Billings, as well as several alternate delegate vacancies.
- SAMHSA has formed a data workgroup for the Office of Indian Alcohol and Substance Abuse. The workgroup has identified data sets in CDC, CMS, IHS and SAMHSA. Participants also have reached out to NIH and Tribal Epidemiology Centers for additional collaboration. The Center for Behavioral Health Statistics and Quality leads the workgroup.
- SAMHSA also serves as the lead of the Interdepartmental Indian Alcohol and Substance Abuse Coordinating Committee.
- Staff members are developing a framework for a more standard response to national behavioral health crises. This year SAMHSA has responded to major tribal behavioral health situations, unrest in Baltimore and the HIV/AIDS/prescription drug abuse problem in Scott County, Indiana.

Questions and Answers

C: (Will Micklin) In Alaska, although suicide rates among Alaska Natives decreased slightly between 2008 to 2010, hospitalization rates due to suicide attempts rose significantly. We have found that we can be more responsive with locally designed programs and less burdensome regulatory requirements.

Q: (Roger Trudell) Some of the lay people -- traditional concepts of grandmother intervention -- have some success but those people have no status. Is there a way things could be expanded to allow them status? Their time is valuable too.

A: (Kana Enomoto) We have made some changes to our National Registry of Evidence-Based Practices and Programs, and in that we are expanding our learning center to be inclusive of indigenous/traditional practices, which don't necessarily have a typical research base but that do have more practice-based evidence. Those kinds of practices can get inclusion as fundable services in SAMHSA programs.

Health Resources and Services Administration (HRSA)

Jim Macrae, Acting Administrator

HRSA seeks to address health access issues with these two strategies:

- Establish as many new sites as possible in terms of the programs that HRSA supports, attempting to reach all parts of the country.
- Improve the quality of care that is provided. This area includes:
 - delivery system reform in terms of the models of care
 - the use of patient center medical homes
 - the use of data and information to drive quality improvement

- the reduction of health disparities

HRSA also continues to focus on these issues:

- Health workforce: Staff want to see increases on the supply side and from the distribution side, with a focus on primary care and underserved communities.
- Increase the awareness of HRSA programs.
- Offer assistance with completing grants and implementing awards.

Last, Mr. Macrae announced these updates:

- HRSA scheduled a tribal consultation as part of the NIHB conference.
- During the summer HRSA announced the second round of new Access Point Awards to establish new community health centers and support satellites (or new service delivery sites) for existing health centers. 10 applications came in from organizations that focus on serving American Indians/Alaska Natives. Of those, 8 were successful. HRSA awarded a total of \$6 million.
- Out of 29 organizations that currently focus on American Indians/Alaska Natives, 28 received awards that recognize health centers that have improved quality of care, perform well in terms of clinical outcomes or made the transition from reporting paper data to electronic information. The Department awarded a total of \$1.3 million.
- HRSA recently made an announcement around expanded services, an opportunity for health centers at existing sites, to add more primary medical capacity, oral health services, behavioral health services, vision, pharmacy and more. Of those awards, 29 went to organizations focused on American Indians/Alaska Natives. HRSA awarded a total of \$7.5 million.
- Staff announced a construction opportunity, and one tribal entity received about \$1 million to support expanded construction renovations.
- HRSA seeks advice on how to boost awareness about the National Health Service Corps.

Office of Minority Health

J. Nadine Gracia, Deputy Assistant Secretary for Minority Health

Dr. Gracia highlighted these points during her presentation to the STAC:

- In June, Dr. Gracia attended the Health Equity Conference on the Wind River Reservation in Wyoming. The conference included discussions on the Affordable Care Act and integrated health care as well as a youth presentation.
- The Health Research Advisory Council (HRAC) also met in June. Members elected Aaron Payment and Stephen Kutz as co-chairs. Navajo President Russell Begaye is a new member. The group also approved its charter and identified these priorities for fiscal year 2016.
 - Establish an HHS-wide policy for research
 - Develop a Native health care research database or clearinghouse

- Publish an IRB point of contact list in the Federal Register annually
- Build local capacity to inform practice
- Promote IRB best practices throughout Indian Country
- Address social determinants of health
- Examine historical trauma and adverse childhood experiences
- Understand culture's role in prevention and wellness, and
- Ensure federal funding opportunity announcements reflect more culturally based research questions
- Dr. Gracia acknowledged departing HRAC member Chester Antone. The HRAC still has vacancies.
- The Higher Education Technical Assistant Project helps colleges and universities become more competitive for funding opportunities to build capacity. An August workshop at the University of Denver focused on tribal colleges and universities.

Office for American Indian, Alaska Native and Native Hawaiian Programs, Administration for Community Living

Cynthia LaCounte, Director

Meeting with the STAC in the absence of Assistant Secretary Kathy Greenlee, Ms. LaCounte highlighted these activities:

- The office is providing grants training and developing a list of barriers to the ACL grants process.
- Following the retirement of Meg Graves, Ms. LaCounte hopes to introduce a new deputy to the STAC in December.
- ACL plans to develop a networking collaboration among the 11 tribal nursing homes. The group will meet October 14 in Arizona the evening before the conference on Alzheimer's in Indian Country. The conference will run October 15-16.
- Responding to the need for long-term services support, staff continues to work with CMS and the Indian Health Service to find ways to keep elders in their communities. Vacant Bureau of Indian Affairs (BIA) facilities can become senior centers or long-term care facilities. Ms. LaCounte is working to help a BIA facility on Navajo get ready for seniors.
- In addition to offering grants for the prevention of elder abuse, staff members are working with ACL to develop national guidelines around adult protective services.
- As part of the Office on Diversity, Ms. LaCounte's work has expanded to the Lesbian, Gay, Bisexual Transgender (LGBT) community. That change will require expanding the elder abuse focus to those subgroups.
- ACL will enforce more monitoring of states to determine if they are actually working with Native communities. Staff members are reviewing state plans and will enforce how states work with tribes.

- The office funded Medicare Beneficiary Outreach and Assistance programs. The 99 tribes that applied received awards between \$3,000 and \$5,000. Ms. LaCounte will also be able to fund falls prevention opportunities.
- The office is developing two guides to help tribes and states work together more effectively.
- Traumatic brain injury programs will move to the disability division on October 1. The division also houses the Christopher and Dana Reeves Foundation, a \$6.5 million resource center that wants to work with tribes.
- Ms. LaCounte recommended scheduling a STAC presentation that will highlight the disabilities programs available to tribes and expand ACL's knowledge of the needs in Indian Country.

Questions and Answers

Q: (Tino Batt) You mentioned the states and the three-year plans. Is it possible for the STAC to get a report, a summary report, of which states are in compliance and if they are working with their respective tribes? The same thing we are asking from ACF and the Children's Bureau.

A: (Cynthia LaCounte) Yes.

Q: (Cheryl Frye-Cromwell) What is the process going to be for obtaining those falls prevention funds?

A: (Cynthia LaCounte) I have a meeting Friday to talk about how we are going to disperse those funds.

Q: (Cathy Abramson) When it comes to elder/tribal nursing homes, within a lot of tribes, the elders prefer to stay home as long as they can. Do you have information on what is out there? Was there any research done with the emphasis on nursing homes versus getting help in the home?

A: (Cynthia LaCounte) We have compiled a list like that through CMS' Long-Term Services and Supports Project. I will make sure that list gets to Stacey so it can get out to all of you.

Secretary Sylvia Burwell

Secretary Burwell thanked the STAC members for their service as well as their patience in allowing her to focus the June 2015 discussion on the topic of suicide. The Secretary also acknowledged the regional directors who came to observe this portion of the STAC meeting while they were in town. The Secretary briefly touched on Medicaid expansion in Alaska and open enrollment for the Affordable Care Act before turning the session over to tribal leaders.

C: (Gloria O'Neill) With the historic visit of President Obama to Alaska, and with the 15 months you have left in office, what kinds of strategic conversations have you had since his return as it relates to moving the needle and having impact in the Native community as a whole? And what would you like to get accomplished?

Q: (Secretary Burwell) The Administration has overall made a commitment across the board in our areas, whether that is the overall funding levels that we continue to propose -- but I think it is more than about the money. It is about seeking to have long-term change in these specific places:

- Gen-I and the focus on young people as an important part of the long-term solution and change in economics, health care, educational status and the issues surrounding historical trauma. I think we are focused on youth as a means by which we go at each of those issues.
- IHS and engagement directly in health care but also funding. And SAMHSA is, together with IHS, the lead on some of our mental health issues.
- Tribal suicide in the young people.

My goal is to make as much progress as we can together on as many of those issues as we can.

C: (Gary Hayes) There is an issue of collaboration between the departments. What affects our communities is not just specifically within HHS. It goes with the Departments of Justice, Education and Labor. It is important that we be able to come together, and the White House Council was established that tribal leaders be part of that. I am hoping that you will be able to, in your next meeting with the Secretary of the Interior, that we will be able move forward as far as how tribal leaders can participate.

When you talk about ICWA or the issue of marijuana, the issue of 477, employer mandate issues with IRS pass-through dollars with the states -- those are just some of the topics that are impacting Indian Country. We need to get everybody at the table.

C: (Secretary Burwell) I heard three things:

- coordination
- some departments don't play -- or maybe they are just not as active as others, and
- sustainability of engagement after this administration leaves.

The path to solving those problems you articulated -- I don't know that additional presence at the meetings will resolve those issues. I believe we ought to have good interaction.

Maybe we need to start bringing the other departments to this engagement. With regard to the other issues, on the issue of sustainability after our departure, the best way for us to have that sustainability is that the tracks have been laid for career teams at the departments to work together.

I agree with you that is not working, and it is one of the things I have talked with Secretary Jewell about that I believe we need to do a better job of. As we are thinking about sustainability over the next 16 months, we need to think through how we maximize a White House presence but also make sure that the issue you are raising is starting to work at a level that it doesn't matter who is in the White House, that this will happen.

I've started some conversations with Secretary Jewell, and I think we need to just think about the right way to get that participation level of some of our other departments to a different level.

C: (Chester Antone) I am pretty sure you are aware of the Arizona 1115 request. We have a resolution opposing the 5-year eligibility cap for able-bodied persons simply because we have a high unemployment rate. We don't have much economic development in remote areas. Along with that is the proposed elimination of the nonemergency medical transports. Even if it is a year, it is still going to impact us. We have used reimbursements from AHCCCS, which is Arizona Medicaid, for a number of years. I believe they are trying to get away from Medicare/Medicaid fraud. But in so doing, they have lumped independent contractors with tribal health transportation systems. I would ask that you consider those and not approve those elements within the 1115 waiver.

In a letter dated to you, we ask that we address oral health care and ask Indian Health Service to develop tribal oral health profiles. When we have that data, we are able to chart our course as far as addressing the oral health issue.

For the Tribal Behavioral Health Agenda, we need to get something into the White House Tribal Nations Conference because all the players are there. If it gets support from the Administration, then the sustainability question is doable.

Q: (Secretary Burwell) When we get to the White House meeting, that is the point in which you hope this is finalized. It is not another input session.

A: (Chester Antone) What I want is for the Administration to support this and move it forward.

C: (Tino Batt) One of the issues is the IRS mandate. Many of our tribal governments and businesses, they do offer employment to tribal members and hire tribal members.

So when we have an increase of 80 to 90 percent of tribal employees, yet we get penalized for not offering health coverage even though those individuals are exempt from the mandate.

I am aware there is legislation moving forward but we ask that these tribal members be allowed to receive any of these subsidies and tax exemptions because they are being prohibited. The only way that tribal members can get these subsidies or tax credits is if the tribe decides not to provide health coverage for all employees.

We are asking if you would take lead with working with CCIIO and getting with the IRS Commissioner John Koskinen so we can address these issues.

C: (Brian Cladoosby) We have co-sponsors to the Tribal Employment and Jobs Protection Act. It is S1771, being introduced by Senator Steve Daines from Montana and HR3080, which is being introduced by Representative Kristi Noem of South Dakota. And that would exempt tribal employers from employer mandate under the Affordable Care Act.

Last week a number of tribal leaders were invited to the White House to talk about this issue. Aaron Payment was there representing the majority of us. We need support on this.

Q: (Secretary Burwell) Who hosted the event at the White House just so we can track it down?

A: (Brian Cladoosby) I am not sure. Tribal governments are currently counted as large employers for application of this rule. We need that fixed.

C: (Secretary Burwell) We will follow up because certainly if the White House is engaged, that is a positive, important thing. We will find out who has the lead at the White House. The engagement of the White House with Treasury is obviously a much more important and powerful thing.

Because a case was brought, and the determination of the court was that we don't have administrative authority, that the ways there will be changes that could fix this are going to be statutory.

Q: (Brian Cladoosby) What about the legislation that was introduced?

A: (Secretary Burwell) So I think there are two things: one, what the legislation exactly and specifically says. It sounds like we have started that conversation since you had the meeting. And then the question of the legislation in the broader context of ACA issues.

Q: (Roger Trudell) I want to talk about the Winnebago IHS facility at Winnebago, Nebraska, that serves not only the Winnebago Tribe and Omaha Tribe but also a lot of members of other tribes. The CMS -- the hospital did lose that. I don't know exactly how that will affect the treatment and services to people but I know it can't be good.

We want to ensure that somehow -- if we can implement something for the future so another IHS or tribal facility can avoid this. I know Mr. McSwain has some ideas, and there was a lot of discussion on it yesterday.

A: (Secretary Burwell) This is obviously a challenging one because it is two different parts of HHS: IHS and CMS. And one of the things is making sure the facilities that we fund through CMS are safe in providing services. So that is what we are trying to get to. Bob and I have had a chance to talk about how did we get here, what are the ways that we try to not get here again and what are the constraints that the communities that we are working in are facing.

We all need to think about what is the right way to get care that we need provided and paid for. We are open to trying to be creative about that. But we will need tribal input on thinking through how we can get there.

C: (Will Micklin) I want to go over a couple issues:

- Lifting administrative caps and allowing tribes and tribal organizations to use their recognized indirect cost rate is fair to tribal communities and increases program efficacy.

- I refer specifically to the Community Services Block Grant program, the CSBG, which is a 5 percent indirect capped rate. The TANF program is a 15 percent indirect capped rate. For grants, I will refer specifically to suicide prevention programs that are primarily funded through grants. Match requirements are inconsistent with the crisis Indian Country is experiencing in this important issue.
- ICWA: So tribes are keenly interested in enhanced data collection on issues pertaining to effective implementation of ICWA, including collection of data elements related to key ICWA requirements.
- Our request is for the continued consultation with tribes on the development of ICWA related data measures for inclusion in the Adoption and Foster Care Automated Reporting System (AFCARS).
- Head Start: We urge you to revise the proposed rule so that it is compatible with the distinct needs of Indian Head Start programs and to adopt Indian-specific exemptions where appropriate.
- Indian Head Start programs should be able to locally develop their own culturally appropriate curriculum.
- Administrative flexibility should permit locally designed certification programs in order to certify teachers for the Indian Head Start programs.
- Tribal certification for tribal elders as teachers should be available as a way to translate our culture into the Head Start classroom.

C: (Cheryl Frye-Cromwell) My comments will be on the on 477 implementation. The STAC members had requested a decision on whether the Community Services Block Grant and the Low Income Home Energy Assistance Program (LIHEAP) and Head Start could be included in the 477 demonstration projects.

Yesterday Rafael Lopez gave us an update that the Community Services Block Grant was allowable to be put into the plan. However the LIHEAP and Head Start were not. We would like to hear the legal analysis on why those two programs were not considered to be added into the implementation of the 477.

C: (Secretary Burwell) Lillian, do you want to address --

A: (Lillian Sparks Robinson) So we were very happy to be able to announce that CSBG can be part of the expansion for 477. As Maria Cancian indicated yesterday, certainly we will see what we can share with regard to the legal basis for why LIHEAP and Head Start are not considered to be able to be part of this expansion.

C: (Arlan Melendez) I wanted to talk about contract support costs. I am member of the workgroup. We just had a meeting in Phoenix last month. Among the outcomes:

- Tribes would like to initiate a pilot project that would allow the agency to determine the best way to reconcile tribal contract support costs on a contract-by-contact basis. Tribes

would like to establish agreements on the front rather than reconciling and requiring tribes to pay back money.

- Also consider implementing the tribal contract support cost pilot project that fixes tribal contract support costs for three to five years and to aid in the stability of tribal contract support costs requirements and the ability of the IHS to accurately project contract support costs requirements in a timely manner.
- And then the other thing was that the changes to the policy -- as you know, to revise the IHS contract support costs policy to reflect an environment of full contract support costs funding as required by the Supreme Court decision.
- Another thing that came out of the Phoenix meeting was the return to an era of cooperation and transparency, where the agency willfully shares an annual contract support cost funding report.

C: (Robert McSwain) The pilot project that you want to do, and I think it is a great idea, we are just working out the details. Then we can settle into actually doing a full revision of a policy that reflects the current requirements of 100 percent full funding.

Gary Hayes, a member of the STAC since its inception, will not be running for tribal office again and will not return to the STAC. Mr. Antone acknowledged Mr. Hayes in the closing tribal prayer.

Whereupon, the meeting adjourned at 1:43 p.m.