

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

June 2 - 3, 2015

Summary Report

The tragedy of suicide in Indian Country took center stage during the opening meeting of the 2015-2016 Secretary's Tribal Advisory Committee (STAC). Secretary Burwell noted acute crisis situations in such Native communities as Pine Ridge and Standing Rock. Seeking a greater level of engagement as an administration, she used her time with STAC members to identify short- and long-term solutions to a critical problem that the Department of Health and Human Services (HHS) must solve quickly and correctly. An overtime settlement involving Indian Health Service (IHS) also attracted great interest from STAC members, and historical trauma remains a hot-button issue. Newly elected chair Cathy Abramson led the meeting.

Members Present for Roll Call: Cathy Abramson (Bemidji Area), Ron Allen (Portland Area), Chester Antone (Tucson Area), Russell Begaye (Navajo Area), Judy (Elaine) Fink (California Area), Leonard Harjo (Oklahoma Area), Gary Hayes (Albuquerque Area), Roger Trudell (Great Plains Area), and Stephen Kutz, Robert McGhee, William Micklin and Aaron Payment (National At-Large Members). (Quorum Met)

Action Items

HHS Budget Updates

- Navajo Nation President Russell Begaye briefly raised the issue of settlement that impacts the Kayenta facilities and asked to meet one-on-one with IHS Acting Director Robert McSwain. Mr. Cochran said a follow-up would occur with President Begaye and Mr. McSwain to address that important topic.
- Mr. Cochran will follow up to see if Adaeze Akamigbo can attend a future STAC meeting.

Indian Health Service Discussion

- A Dear Tribal Leader letter will go out to explain the Joint Venture Program two-step process.

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Welcome and Meeting Logistics

As part of the opening meeting for the 2015-2016 term, STAC members elected Cathy Abramson as chair and Brian Cladoosby as vice chair. Members approved the two-day agenda after adding a discussion on the bylaws to address vacancies for regional representation. Prayer and introductions followed.

In his remarks, Paul Dioguardi confirmed the remaining 2015 meeting dates: **September 15-16 and December 1-2**. HHS staff members seek nominations for the remaining STAC member vacancy for the Phoenix Area to give the board a full slate. Staff also have received positive feedback on the new follow-up process that gives updates on STAC member priorities. Thoughts and ideas on how to improve the reporting process are always welcome. Stacey Ecoffey will send out tentative dates for 2016.

Leonard Harjo noted that the primary delegate seat for the Oklahoma Area is now vacant. Ron Allen moved to amend the language in the STAC rules of order by inserting a new vacancy section. With this change, an alternate member would automatically become the delegate for the remainder of the term in the event of a vacancy in the delegate's seat. Staff will notify the regions and seek nominations for vacant alternate seats.

Aaron Payment seconded the motion. The committee passed the motion unanimously.

Last, Navajo Nation President Russell Begaye briefly raised the issue of settlement that impacts the Kayenta facilities and asked to meet one-on-one with IHS Acting Director Robert McSwain. Mr. Cochran said a follow-up would occur with President Begaye and Mr. McSwain to address that important topic.

HHS Budget Updates

Norris Cochran, Deputy Assistant Secretary for the Budget

For the 2016 budget that is in front of Congress, HHS has succeeded in making funding for the IHS a high priority. From previous discussions, STAC members know that the budget proposes an increase of 10 percent, well above the average for the Department's discretionary budget when taking into account all of the operating divisions. The budget is a testament to the priority that the Secretary and President Obama continue to place in this area to address critical needs in Indian Country, said Mr. Cochran.

Mr. Cochran also highlighted these issues:

- Operating divisions have begun submitting requests for the fiscal year 2017 budget. Secretary Burwell’s final decision will go to the Office of Management and Budget (OMB) in September. The President will submit a budget in February 2016.
- The 2017 budget includes a robust set of proposals, such as putting contract support costs on the mandatory side of the budget.
- The challenge with the discretionary budget: Congress is starting from a different point than the Administration, said Mr. Cochran. The Administration has put forward a budget that calls for setting sequestration aside permanently and bringing up discretionary caps. Congress, however, is operating at a level that is closer to flat with FY 2015.
- The “doc fix” bill, the Medicare Access and Children’s Health Insurance Program (CHIP) Reauthorization Act, has extended a number of important HHS activities, including the Special Diabetes Program through the IHS at \$150 million a year for both 2016 and 2017.
- Adaeze Akamigbo replaces OMB’s Dr. Julian Harris, who has returned to Massachusetts.

Questions and Comments

C: (Ron Allen) There are a number of issues that are on our radar that we have a great concern about. First, contract support costs. The Administration has proposed moving it into mandatory for FY17. A number of us have had conversations with the Hill regarding the proposal. Our concern is that if you move it further down the road, it becomes more political and things don’t get done the way we would like to see them done. So we are interested in what the Secretary’s take is on this initiative.

A: (Norris Cochran) The budget, as you know, put forward a proposal that left room for this to take some time. So we did not take the discretionary dollars out of the IHS in our ’16 request. We proposed that the new mandatory structure begin in FY2017. If we could get it done sooner, of course we would be eager to have it done sooner. What we didn’t want to do was set up a situation by which we delivered sort of a budget that had holes that the appropriators then had to deal with if the authorizers didn’t move quickly enough to create the new structure.

That being said, I think there are three areas that we would want to keep in mind when considering any change to contract support costs, and they help to kind of govern how we put forward the 2016. One is we have a smooth transition. If a change is being made, the new dollars are in place before we lose any old dollars.

Two, it is fully funded. And finally, whatever change we make, it has to work for the long-term. If we end up with a solution that looks different, we are eager to work with you, OMB’s lead, and with Congress. We just want to make sure that it meets those standards.

C: (Ron Allen) On the U.S. Department of Interior (DOI) side, there has been a significant bump in the Tiwahe Family Initiative. Having the resources to address those matters are critically important. There are lots of other priorities but these are important, and we appreciate your making some bold moves.

C: (Norris Cochran) The authorization is in place for that, for the tribal governance of the foster care programs but the technical assistance and the resources are critical, which is why we have the additional \$20 million proposed in FY16.

C: (Aaron Payment) It is a little discouraging to hear of the big difference in what Congress is proposing and what really the Administration -- we are just getting to the threshold of making some breakthroughs with historical trauma. So obviously we are not doing enough to educate members of Congress to understand that. I have to believe if they understood it, they would care enough to fund it. We have got to do more to make sure members of Congress understand this.

I also wanted to hit on Special Diabetes. It has demonstrated its efficacy. The outcomes in that program of measuring biometrics with lifestyle and focusing in on that has the greatest impact of making social change. And so we are on board with that but we are proposing \$150 million over three years. What we have consistently asked for is \$200 million over five years. We have to fight for a one year appropriation, and that doesn't allow for any constancy in planning.

C: (Gary Hayes) Did you receive a copy of a recent National Tribal Budget Formulation Workgroup recommendations for FY2017? I just want to reiterate some of the things we expressed. As you go forward -- I understand you don't know what the baseline is yet because FY16 is still up in the air. But the message we have consistently addressed for a number of years is that unmet need of \$29 billion in Indian Country.

The funding for these services is being eaten up by medical inflation, population growth, infrastructure, and all these other things that have been put off. So it is difficult as you look at the disparities in Indian Country. Reading from this report, life expectancy in Indian Country is even lower than Haiti. That message needs to come out to emphasize the injustices. As the OPDIVS go through this budget process, they should be given a copy of this report.

I appreciate that the National Indian Health Board (NIHB) was able to put this report together; however, there is a lack of funding to distribute copies to you all, the STAC members here, because of the budget. So I am pushing for increases in that support for the NIHB, to support the message from Indian Country. As tribal leaders, we need copies of this also. This would be imperative as we talk about moving forward because we know there is going to be a challenge.

For FY17, the budget formulation workgroup came up with a 22 percent increase. Is that going to be realistic? We always shoot higher because we know we are not going to get that but we still need to pound that message. It is evident we are underfunded by the stats I mentioned here. We also think it is important to have OMB here to really look at the actual message, and hearing it from tribal leaders is just as important.

That message on the Interior side is being heard by OMB. This administration has been supportive, and now we don't know what is going to happen after this administration. It is important to emphasize how this process, what we have been going through, will continue on to this next administration.

C: (Norris Cochran) I am going to take two assignments from the points you raised: One is how important it is to communicate continually the sense of urgency. I will follow up with that ask. I will follow up with Adaeze and her deputy to see if she can come to a future meeting in the same way Dr. Harris did. And to your point about transition, to start bringing some of the career staff into those conversations as well.

And regarding the document, we can scan it and get it to the budget offices of our operating divisions to make sure they are aware as well.

C: (Ron Allen) Just to add to Gary's request, a lot of time these responsibilities to communicate and justify to the Administration these health care needs falls on IHS. This is HHS wide. IHS does make a contribution to NIHB, and we certainly advocate that they would step even more. With regard to a report like this, it is not just putting the report together, it is putting together the justification for it.

So when we say we need \$29 billion, not \$5 billion, we want to be able to show that here are the reasons why. That task cuts across HHS, and everyone should be stepping up to assist us in communicating and putting together the data that really shows what that need is in Indian Country.

Q: (Stephen Kutz) I understand that you are looking at budgetary issues around a letter that was sent out. And our understanding from an earlier discussion is that could be \$20 or \$60 million, and we want to understand what that affects. Is it direct service tribes?

A: (Norris Cochran) The underlying case, it is a settlement, so it went to arbitration. It is specific to direct service tribes only. It is a settlement for overtime that was not properly recorded and therefore not paid. So the total settlement -- it has literally taken years from the time of the case first being filed to going through what ultimately ended through arbitration in a settlement to figure out the correct amount that both parties would agree to but the fundamental concept is this was work that was performed but not fully paid.

And so the plaintiff is the union, who is represented by a law firm. IHS/HHS is not unique in having one of these. Other departments have gone through these types of settlement proposals under the Fair Labor Standards Act. For the IHS settlement, it is a total of \$80 million, \$20 million of that legally has to be covered out of current fiscal year dollars.

Then for the bulk of it, it is the actual overtime. We have been working to align basically where those hours, where those employees are within the direct service areas by area. And looking at balances that, had time been recorded properly back years ago, those dollars or other dollars would have been spent on that time. They were not. That is how we have a settlement. And so those balances would be used to cover that portion of the cost, that \$60 million.

Q: (Stephen Kutz) So I am guessing these are the non-exempt employees who are federal employees, who are not uniformed. Is that correct -- that it affects?

A: (Norris Cochran) Yes, so there are two fundamental issues. One is that some employees were either classified as exempt and should not have been, or they were classified as non-exempt and should have been classified as exempt but then weren't being sort of reimbursed in a way that was consistent with that.

Q: (Stephen Kutz) So you said there are some direct implications to the 2015 budget. Where are the implications to the out year budgets?

A: (Norris Cochran) So there are two allocations of funding: the current year dollars that legally we have to use current year appropriation. That is the \$20 million. IHS is meeting that new obligation because of a delay in the opening of a facility by using dollars that were for new health care staffing.

The '16 budget assumed that facility would be up and running so in that manner there is no change or implication for the '16 budget because it is a onetime '15 payment that is effectively made possible by a '15 delay. In '16, then, it is built into our base. So that is for the \$20 million.

For the balances, there are -- this would not be repeated. There is clearly an opportunity cost but it wouldn't be repeated. The \$60 million was the final settlement number. The \$60 million, that is out of prior year balances. It is the \$20 million that is out of current year. So none of the total, none of the \$80 million would come out of '16 or '17 or future years.

C: (Russell Begaye) The issue that we have is the lack of consultation or the non-consultation, I should say, that took place. It was a unilateral decision made without our input. So we don't want this to be a precedent as we move down to other years, which the Department makes these types of decisions without consultation. And also as we look at other funds, that those other funds not be impacted, and that too really -- even though the judgment funds were not utilized, that those other resources be considered before drawing money from appropriated funds.

Q: (Stephen Kutz) So I am assuming also some of these things are attorney fees, huge amounts. Is there a reason that HHS has not gone to ask for a supplemental appropriation to cover these costs?

A: (Norris Cochran) Ultimately a decision was made that, that wasn't the direction that was going to be taken or that would be successful for the \$20 million. Legally the \$60 million has to come from prior year balances because it is again charged to what is a valid prior year obligation. For the \$20 million, the decision was made to move forward through the reprogramming as opposed to asking for supplemental for that amount in '15.

In terms of the lack of consultation, you are right. This is not how we like to operate. This one was very difficult from the sense that it was negotiation between the counsel's office and the plaintiff, whereby I would say we had little room to maneuver and have proper discussion.

C: (Russell Begaye) I understand that the settlement amount is around \$83 million. So it is not just impacting Navajo. And also we have the opening of the facilities, the Kayenta facilities, this

fall as I understand. And we just want assurance that the opening will not be impacted, that we will not diminish services and also that the entire facilities be opened. So our concern is that as these dollars have been taken away, that it will not diminish the opening of the facility this fall.

C: (Norris Cochran) Right, and that is a critical point I am glad you raised. The amount coming from this budget line, this allocation, is informed not just by what was needed to conclude the settlement but by the sort of separate and independent delay of the opening of that facility. So the programmatic judgment in IHS is there will not be an impact.

Q: (Stephen Kutz) Then I guess a follow up question: \$60 million out of prior year, I fail to understand where the \$60 million can come from out of prior year because I would assume that IHS or HHS doesn't have \$60 million sitting in the bank somewhere for a rainy day fund from prior year authorization. So where is the impact of that \$60 million going to be in the budget?

A: (Norris Cochran) So the settlement dates back to 2005, so it is 2005, 6, 7, 8, 9. Then beginning in 2010, because -- for annual appropriations, you have 5 years after the year of obligation to actually draw down dollars before they are canceled so the IHS was able to effectively use \$9 million from the appropriations that otherwise wouldn't legally be available from 2010, 11, 12, 13 and 14. So that \$9 million doesn't have an impact from the sense that it couldn't otherwise have been used. We go back and say that the amount that we thought was going to be needed is higher.

That is specific to 2010 through 2014 because 2009 back to 2005 are beyond that five year window. The remaining amount then, roughly \$50 million has to be drawn from balances from each of those years.

C: (Stephen Kutz) So I think that there are impacts then to everybody because if there are funds in the IHS system that IHS could have legitimately drawn down, balances, to take care of existing obligations -- for example, we know the Resource and Patient Management System (RPMS) and all of those things are severely underfunded. This has to have an impact if you pull money out of the system that IHS can draw down in the different areas and nationally. So I would urge that you go for a special appropriation so we don't harm the system.

C: (Norris Cochran) It is confined to the direct service areas but that is not a trivial list. That is a number of areas and so it does have an impact obviously in terms of opportunity costs. There would be other uses for those dollars, where the balances exist, to buy equipment or make other improvements. We don't have a lot of legal flexibility in the sense that as it is structured, those are obligations that -- for which prior year funds are available and so we are in an unfortunate position of having to use those.

C: (Gary Hayes) Tribes, when we talk about direct service, it comes back to the question of where that \$80 million is going to come from and we know where it is coming from. It is coming from the tribes who are not here at the table. Who are not represented. Even though we say we

want to move contract support costs forward, this is something that -- as you talked about special appropriation, there is nothing. There are no earmarks. There is nothing like that anymore.

That is the decision that it is going to come down to. Where do you want to cut? How are you going to pay for this? And that is going to come back to the tribes. The only avenue is direct service programs. That is the bottom line. There are tribes that cannot afford to be self-governance. There are tribes that -- their budget is 90 percent grants. They don't have the resources. They are relying on direct service, and you are killing them.

C: (Roger Trudell) I come from a direct service area, where a number of tribes still get direct service. I guess you have to come from that area where service is inadequate to start with, and that is definitely the Great Plains Area. We have the highest rates on everything. When you hear millions of dollars are coming from prior year funding, you know, why wasn't that money put forth to meet some of those unmet needs in the Great Plains Area or other areas?

We have people who have probably died because IHS has not brought those dollars down to provide care. And yet you have money that is sitting there available to pay some overpaid people already that work in the system.

C: (Aaron Payment) What would be helpful is the provision for the five year ability to reconcile after the -- that has a valuable purpose. What I don't understand, and I think would be helpful for us to understand, is as the agency projects out their relative risk going forward because what I believe you are probably doing is you are setting aside on the potential liability the reconciliation of your budget so that you have that to be able to close those out when the risk comes at a different time. So I understand that part.

But the part that I think would probably be helpful is ongoing to report that so it doesn't come as a surprise, because it is a surprise right now to people.

Q: (Stephen Kutz) So my understanding is that around \$50 million is going to come from IHS third-party revenue collections, and so that also disturbs me a little bit. So I don't know if third-party revenue at the federal sites is going to a central budget and are not -- because I would want to understand why, when you get significant third-party revenues, those are not programmed into expanding the services and paying down the waiting times, the equipment issues and things that happen in all these federal facilities.

Because all of our people, they don't just come to our own facilities, they live in these other areas and get their services at direct service sites and so I don't understand why even \$50 million out of third-party revenue is sitting there able to be captured back and pay for this. Why is it not programmed back into services?

A: (Norris Cochran) The third-party collections are no-year. They don't expire. They are collected in a given year and IHS can track how much was brought in, in a given year. But those balances are allowed to be carried forward.

They are used on an ongoing basis for a number of critical investments. I think a lot of it does sometimes end up being what you might consider more one time improvements to facilities or procurement of more expensive equipment or upgrades to things like your electronic health records.

As they are brought in, they are also obligated, spent down, but there are balances, and again the time period is 2005 through 2009 for these types of collections, and while much of those collections that came in over that period by various areas have been obligated, there are still sufficient amounts by area to meet this cost and so a lot of those decisions -- and the Indian Health Care Improvement Act (IHCIA) changed the character of these types of collections in terms of how they are aligned by area. There is flexibility, more flexibility, in these prior years but we are at least starting with the data that we do have, which is how many employees in each area -- that is our best guess for where the dollars would be drawn.

C: (Liz Fowler) I want to clarify there is a specific reason why the \$60 million, the greatest portion of the settlement, is being paid from funds that are at the service unit level. As Norris explained, he explained the differences between 2010 going forward and then the 2009 to 2005 time period.

But we are required -- this is considered back pay, and the payments are required to be charged to the year where the overtime was earned. So what we are trying to do is in the end, when we do the final reconciliation, all of the claimants who are paid, we have to make sure that the payment is charged back to the service -- most of them are service unit employees -- is charged back to the service unit where they worked, where they earned the overtime during those years.

And so the funds that are available at that level are the third-party collections. I think the other major point that I wanted to stress is that this rolls out of an employee grievance process, and so that is a primary reason why the information was not able to be shared until this point, until we actually reached the settlement point. And it was an administrative decision but it was a determination on the basis of actual experience and arbitrating a certain number of cases. And then the projection going forward of what we would have ended up paying had we just continued in arbitration until we reached the end point of all of the claimants.

Indian Health Service Issue Discussion

Robert McSwain, Acting Director, Indian Health Service

Continuing the settlement discussion, Mr. McSwain noted that staff have worked on this issue for a number of years. Through arbitration, IHS realized the issue involved about 22,000 claimants, most of whom are at the service units and who are health care providers or those who support health care providers. Paying each claimant would have cost hundreds of millions of dollars, said Mr. McSwain. The Navajo Nation also will get the full amount of staffing for its facility in 2016.

Mr. McSwain also made these points:

- On May 13, IHS held its first joint meeting of the Tribal Self-Governance Advisory Committee (TSGAC) and the Direct Service Tribes Advisory Committee (DSTAC).
- IHS continues to move on contract support claims. The staff is on track to finish all offers by the end of the year. The Contract Support Cost (CSC) Workgroup will meet in July or August.
- Mr. McSwain sent out a letter to the tribes requesting the top five facility needs for an upcoming Federal Appropriations Advisory Board (FAAB) report. Mr. McSwain will encourage FAAB to take a fresh look at the need for staff housing in Indian Country.
- A Dear Tribal Leader letter will go out to explain the Joint Venture Program two-step process.
- Regarding the Resource and Patient Management System (RPMS), ICD-10 is on track for Meaningful Use II. Staff members are preparing for Meaningful Use III. Starting with Billings, IHS will conduct an area-to-area review of IT services from the RPMS standpoint.
- Mr. McSwain thanked the tribes for participating in the Ebola deployment, which sent 40 officers to western Africa.

Questions and Comments

C: (Stephen Kutz) I have overtime issues as a direct service tribe. I also know that time and a half is expensive time. I struggle to get my system to authorize additional staff so I don't have to pay time and a half. Hopefully also you are looking at that and using some of this money to staff up some of these facilities so they don't get into that situation.

C: (Robert McSwain) We are trying to operate a health care system under federal regulations and pay regulations. And we need to pay attention to both to make it work.

Q: (Russell Begaye) Mr. McSwain, thank you for the opportunity to meet initially. In that meeting, we requested a list of places where funds were coming from, and we have not received it yet so we are looking forward to that. And also the impacted facilities: Are they being asked to identify funds that will be applied to the settlement?

A: (Robert McSwain) We are going to certainly drill down. What we want to know is No. 1 -- obviously we have only estimated -- the union did not give us their full number of claimants. That is another part of the whole process. We only identified the amounts by service unit by who we knew were bargaining union employees in those service units. And so we estimated what their amount would be for the settlement. The other part of it is they will then begin, as of August 14, they will begin to provide us detail on who they are paying so we will get a chance to know who the claimants really are.

We intend to circle back and reconcile where the estimated amounts were taken and to ensure that the only amounts we are taking are the amounts that correspond with the claimant

individuals. Anything that is unused will return to the IHS after five years. Most likely employees will not see a payment until January 2016.

C: (Ron Allen) The biggest issue we would raise is the responsibility of the agency and the federal government to communicate up front with the tribes in a respectful government-to-government relationship. We would hope this is a lesson learned that we can't go down that trail and come up with excuses.

No. 2, because this is a federal obligation, I am questioning why a supplemental budget request is not made. These are federal employees and federal obligations. And for the federal government to say, well, find it out of Indian Country to pay this legal obligation doesn't sit well with us.

C: (Robert McSwain) Our first look was whether the judgment fund would be available. Unfortunately it was a mediation and not a contract dispute so we weren't able to get to the judgment fund.

I apologize because we didn't know we were going to be this fast. We were looking at another arbitration. We were beginning to schedule the next arbitration and then we said, why can't we just settle this? Perhaps at that time we should have notified tribal leadership. The problem was it was such a tension between would they or would they not. I wish I could have said there was more transparency on it but there were so many moving parts. And the Department took a particular interest in this because of its size.

C: (Leonard Harjo) As stated, this impacts primarily direct service tribes. In our area, we have a fairly even mix between tribes and facilities and direct service facilities, and we actually have in Seminole Nation one of the direct service facilities. And my concern is that in the direct service system there is evidently several years of money sitting there, whether it is federal appropriation or third-party collections, that are not being used or reprogrammed to meet the needs of the people in the facility.

I think that is something we are going to have to pursue a little bit more directly with you in the future. So we urge you not to leave that kind of funding on the table if it is there.

C: (Robert McSwain) The other part of it, in the response, was that at this point, we knew where the money was. We just didn't know what the purpose was going to be. Now we are going to circle back, and we are going to ask each of the service units, what was your plan for that money? And what is the impact of pulling this share from you?

As you know, collections, particularly Medicare and Medicaid collections, by law now are actually returned to the service unit that generated them but the purpose of the use of it under law is to attain and maintain accreditation. That is pretty broad, and they can do a lot of things with that. Staffing is one of them, and accumulating the resources to do some repairs on the facility.

I expect that when we circle back now that we have moved this decision out, is to go back to the service units and say, okay, you had \$3 million, and we just took \$400,000 from you. What is the impact? Why were you holding it? And the whole idea is to be able to circle back to all of you and indicate to you what the impact of this particular payment is and actually is going to be.

C: (Aaron Payment) I come from a perspective -- we have been self-governance since the early '90s. We were one of the pilot projects. And so my orientation is completely self-governance, and I know there are other tribes that the circumstances of rural nation and the size of the population and their resources dictate them being direct service tribes.

So third-party revenue has a maximum ability to cover things like constructions, facilities and all of those things. So I think we need to be careful as we move in this discussion because we don't want Congress to yank that money back and then to reprioritize according to Congress' priorities.

I also see, from the perspective of the direct service tribes, a level of paternalism in the fact that the regions are making a judgment and a decision about what to do with those third-party revenues and any excess revenues that they are carrying on their balance sheet through the end-year funding. So I like allowing the flexibility but I think they should have to report some kind of a plan for that. And the tribes they are serving should be the strongest voice in weighing what that plan looks like.

Within the confines of being a direct service tribe, the federal government could contract with that tribe and fund the tribe. The tribe could employ the team members and lease those team members back to IHS. That way we would be exempt from the Fair Labor Standards Act. That might sound like sacrilege to a federal agency but tribes operate very well under conditions -- in fact, we have a legislation we are pushing through Congress to exempt casinos from the National Labor Relations Board.

And so I think the issue is not that you want to be exempt from the Federal Labor Standards Act (FLSA) but that the local on-the-ground people should be making those judgments, and I think that we manage it better.

C: (Robert McSwain) That is an interesting proposition. I guess I see that as what we refer to as a reverse intergovernmental personnel act assignment. We don't do many of those where we actually have the employee coming back to the IHS.

C: (Cathy Abramson) You are talking about possibly taking money from tribes that they didn't use but my concern would be that at a lot of us have a hard time recruiting physicians and health professionals. And maybe the overtime for employees wouldn't be so much if we didn't have that issue. We certainly don't need money taken away from our direct services.

C: (Robert McSwain) We would like to think what is happening, if you can just think through it completely, is that we are only paying the overtime and call-back time, et cetera, for the

employees who actually work for you. And so it is not like we have taken the money and we are paying somebody else. It is an important thing to remember.

Q: (Stephen Kutz) You mentioned that the funds we are talking about are Medicare and Medicaid third-party revenues or collections. And you didn't mention private insurance. And so one of the things we may need to work on is -- my understanding is IHS cannot go after all of the claims that self-governance and 638 tribes can. And if that is the case, that is something we may need to work on because you ought to have the ability to bill everything possible to bring in all the revenues you can.

C: (Robert McSwain) The amounts we are looking at are all collections in those years, so those collections include private insurance.

Q: (Stephen Kutz) Is there anything that you can't bill?

A: (Robert McSwain) Our current billing sources are private insurance, Medicaid, Medicare and the U.S. Department of Veterans Affairs (VA).

Q: (Stephen Kutz) So then I guess the only other revenue stream that you don't have access to is Medicaid claiming then, Medicaid administrative match.

A: (Robert McSwain) Right, we don't get the Medicaid match.

C: (Ron Allen) On contract support costs, we need to fix the policy and the process where we resolve the issue of -- there are many tribes that do not have current, updated indirect cost rates. We want to move that agenda forward. On RPMS, we need updates on where we are with that process.

C: (Stephen Kutz) Our health care providers in states where Medicare has been made legal are struggling with the interaction of our patients using marijuana legally in our state and other states, and how that interacts with the treatment regime. Even though we are not writing any prescriptions for them or anything like that, nevertheless they are using it both medicinally and recreationally, and it is impacting our ability to understand how we can accommodate that. We need some effort focused nationally to help us address that issue.

Q: (Ron Allen) The effort to get a more accurate accounting of all the third-party collections that the tribes are gathering, I am not sure where that whole effort is coming from. We see it as not federal money. These are moneys that we are recovering with regard to our operations.

A: (Robert McSwain) I think it is generated by the fact that we show collections in our congressional justification, and we just do a wild guess on what is over on the tribal side. I think that is where the inquiry is coming from: What is the true number of collections on the tribal side? And we have not pressed it at all.

C: (Ron Allen) Why is it in the budget in the first place, and should it be in the budget? I am wondering whether the Administration should be advocating that, that is money we have no

control over. It has nothing to do with us and the services we provide. Tribes are working hard at accessing those third-party collections so we can make our clinics and hospitals more effective.

C: (Robert McSwain) I think we can have some further discussion because the law is very clear that all program income is for the tribes' use to further its programs.

Centers for Medicare and Medicaid Services (CMS)

Kevin Counihan, Deputy Administrator, Center for Consumer Information and Insurance Oversight (CCIIO), CMS

Jim Golden, Director, Division of Managed Care Plans

Nicole Kaufman, Technical Director, Managed Care Policy, Division of Managed Care Plans

Kitty Marx, Director, Tribal Affairs Group, CMS

The CMS team has worked closely with STAC member Ron Allen on these three areas:

- **Data and information:** Staff members have had a variety of discussions on the kinds of information to get, how to share it and how to make the information actionable. CMS must continue to pursue the area of definitions used to populate data cells.
- **Call Centers:** There is a perception that tribal members aren't getting appropriate responses when they contact the call centers about enrolling for health care. A separate call center for tribes, however, would not be cost-effective, said Mr. Counihan. Additional training and dedicated supervisors could improve wait times and the accuracy of the information given. Thirteen call centers are available during the open enrollment period.
- **Qualified Health Plan (OHP) contracting:** Staff have identified some inconsistencies with respect to how the QHPs enroll Indian providers and how CMS is meeting its essential community provider standards. The Department has launched a study to investigate and update information about QHP enrollment. In addition, Navigators and assisters will receive an updated toolkit in July to help them enroll people more effectively.

The CMS presentation also included these highlights:

- Medicaid recently released a major regulation that modernizes Medicaid managed care and the CHIP. This is the first time that CMS has updated the Medicaid managed care regulations since 2002.
- The proposed regulation would set standards for managed care plans and the level of access to Indian health care providers. CMS seeks comment on these three areas:
 - Whether the provisions set forth are consistent with the protections in Section 5006 of the American Recovery and Reinvestment Act (ARRA) to ensure timely access of Indian enrollees to Indian health care providers.

- How to better coordinate care when an Indian enrollee has seen an Indian health care provider who is out of network and then requires a referral for specialty services to a provider who is covered in network.
- How to better understand the barriers that Indian health care providers have to contracting with managed care plans as network providers, and they types of helpful technical assistance that CMS could offer to help forge those relationships.
- The comment period will remain open until July 27. An All Tribes Call will take place June 25th to reach out on Indian health issues and inform tribal members about the regulation.

Questions and Comments

C: (Ron Allen) The goal is to set things in place during the last two years of this administration so things work for the tribes with regard to CCIIO responsibilities.

The Tribal Technical Advisory Group (TTAG) supported the idea of maintaining someone in the regional call centers who has expertise in Indian Country in the particular regions for which they are responsible.

C: (Stephen Kutz) As a modification of your thought process, when a call comes in, it should go to a boots-on-the-ground person who knows the answer. If you had a few people in the call center to cover all shifts, so that when an Indian call came in it went to them, and when an Indian call didn't come in, other calls went to them. But someone would always be there who knew regional Indian issues.

C: (Kevin Counihan) That is the right idea. What we were trying to talk through was how you could scale that based on either high-peak volume, like we get during open enrollment, and also off-peak when calls slow down, typically during the summer. Your point is spot-on. We are trying to figure out the best way to operationalize that.

C: (Ron Allen) With respect to the tribal providers, that they are being recognized and used, our issues are, No. 1, making sure that they are recognizing us. Many do but don't actually use the tribal providers. So we wanted you to assist us in tracking, you know, are they offering our providers an agreement that recognizes the tribal provider?

No. 2, are they actually using it? We are hearing that the Nevada tribes, for example, are having a poor experience in terms of actually using the tribal providers.

C: (Kevin Counihan) You are right. I don't think I fully understood it. I got the first part, which was to make sure that we and the states have contracts with the providers. I don't think I fully appreciated the second piece of that, which was also to track use. We are going to initiate a Webinar with issuers and also with the states to talk about the importance of including providers in their QHP networks and give examples of that.

Q: (Will Micklin) I believe that there is a CMS response that we were looking for on advanced payment tax credits and issues with tribal members not being appropriately qualified for Advanced Premium Tax Credits (APTCs) as required by the regulations. Do we have anything on that? It is the issue for people who are between 100 percent and 400 percent of the Federal Poverty Level (FPL).

A: (Kitty Marx) What we found out, even before the last STAC meeting, is that there is a lot of confusion with QHPs and I think even with some people within CMS as to the zero-cost sharing plan variations and the limited cost-sharing plan variations that are available to tribal members. The zero cost-sharing is based on a specific provision in 1402 that says tribal members that are below 300 percent FPL can sign up for zero cost-sharing plans, which means they still have to pay premiums but they can qualify for the APTCs that can reduce the amount of the premiums.

But the zero cost-sharing means that there are no co-payments, co-insurance or deductibles when they receive services from their Indian health care provider or their QHP. What we found though is -- this was a question that was raised at the last STAC -- is that the advanced premium tax credits by regulation and in 1402, another section of 1402, says that the APTCs are only available between 100 and 400 of FPL.

So what we are seeing in states that have not expanded Medicaid, such as Texas, Oklahoma, South Dakota and Alaska, the zero cost-sharing plan variation is not available to tribal members below 100 percent who can't sign up for Medicaid. Medicaid expansion goes up to 133 percent of FPL. So these are individuals below 100 percent. They cannot qualify for APTCs so they can't enroll in the zero cost-sharing plan. The Office of General Counsel (OGC) can't find a way to get around that unless we do regulations or even a statutory fix. That whole issue of below 100 percent FPL goes away when the states expand Medicaid.

Tribal members who have a FPL of 300 percent and above can enroll in a limited cost-sharing plan regardless of what their income is. Limited cost-sharing means that you are not charged any co-payments, co-insurance, when you receive services from the Indian health care providers but if you receive services through a QHP, you will need a referral through the purchased referred care program. Below 100 percent will require either a regulatory fix or a statutory fix.

Q: (William Micklin) Is there any discussion of administrative measures that would address this issue?

A: (Kitty Marx) Based on discussions so far with the OGC, they have indicated there is no administrative policy flexibility. We just need to work on states deciding to expand Medicaid.

Q: (Chester Antone) I want to ask that you disapprove the Arizona Medicaid waiver that has the exemptions on eligibility because that will do a lot of harm to the remote areas as far as gaining or justifying search for employment, and gaining employment, which requires -- is required. And if that isn't done, then we have one year where you are not eligible for Medicaid. And then after that, if you still don't get employment you are not eligible for a five year period.

And then after that, you are not eligible for your lifetime. I would ask CMS to not approve that portion because it will be detrimental to many tribes in Arizona because of the remoteness.

Tohono O’odham Nation also will be forwarding a resolution supporting the Native American Caucus at the state legislature. I believe they sent a letter to Secretary Burwell already.

I also wanted to see if it is your understanding, as far as the Burwell vs King, is the IHCIA severable from that should it not turn out well?

A: (Kevin Counihan) We believe the Secretary of HHS has been pretty eloquent on the issue of the case. We think we are on the right side of that issue.

C: (Chester Antone) Our understanding is it is severable from the Affordable Care Act (ACA). As we know, it passed along with that legislation. That is why we are asking if that is severable if the Supreme Court decision should fall in the favor of the other side.

C: (Kitty Marx) It is the Arizona State Bill S1092 that the state legislature passed that would impose a work requirement as a contingency of receiving Medicaid. The state would need to submit 1115 waiver to implement that, and we have not seen that waiver yet but to the best of my knowledge, CMS Medicaid has not approved a state that has proposed a work requirement as a contingency for receiving Medicaid.

C: (Chester Antone) I also just wanted to comment on your discussion on the call centers. What happens in Arizona currently, at least with members of our nation is that there are people on a list within hospitals who, when an elderly person comes in or doesn’t speak English, there are people on that list that the hospital calls to translate to the patient. So that may be something to think about.

C: (Yvette Roubideaux) I just want to ask Geoff Roth this question about King vs Burwell and the IHCIA, I think it is important to clarify that. King vs Burwell is about whether the federal Marketplaces versus the states would exist. And the IHCIA is a whole separate provision in the ACA so in order for that to be impacted it would have to be specifically repealed.

This thing with King vs Burwell is just about whether the government should pay to help subsidize the cost-sharing in the federal Marketplace, I believe. And so people have talked about, oh, the whole ACA is going to go away if King vs Burwell doesn’t come around. And that is sort of wishful thinking by the opponents of Obamacare. The ACA is still here. It is just that the funding available to support the federal Marketplaces would not be available. I believe that is the issue.

I think the IHCIA is not impacted by the King vs Burwell decision. But what would impact the IHCIA is if Congress took legislative type impact that voided it out.

C: (Geoff Roth) I think that is right. The court case is about the federal Marketplace premium subsidies. In the past, when things have happened before with the Supreme Court, advocates for

Indian health had prepared a separate version of the same bill to introduce. I think things along those same lines have been prepared or are being prepared in case that does happen but we are trying not to get into that kind of speculation.

C: (Stephen Kutz) When states send in waivers that have poison pills in there for Indian people -- and it is not only Arizona sometimes where that happens -- why don't you send them back saying we will allow that to be in there if you exempt Indian people in that provision? They are not going to want the public to see that a waiver is in there that gave Indian people special privileges that the rest of the population didn't get, but you can still put it in there anyway and tell them that.

And the other thing, it may in fact be hype because we know that we still have a lot of antagonists against the ACA but as I was getting ready to come to the meeting this morning, on the news they were talking about potential doubling of the premiums for the next round of insurance products.

And so I don't know whether there is some oversight on the government's side on what they can charge for those insurance plans that are being put into the Marketplace. And so maybe those are scare tactics that are being put out leading up to whatever is going on.

C: (Kevin Counihan) I had not heard that story. We have not seen that type of dramatic change you are talking about. We are still at the first step in a process to get to the right numbers.

C: (Ron Allen) I would like to take privilege to recognize Jim Roberts to ask a question.

Q: (Jim Roberts) Jim Roberts, technical advisor for the Portland Area. I want to come back on this issue related to the cost-sharing variation for those individuals who might be above 400 percent and less than 100 percent.

You mentioned that the statute is explicit in that but I want to call to CCIIO's attention that in your regulation at 155350 that deals with special eligibility standards for Indians, that it describes kind of the process that you laid out but there is some additional language there that gives CCIIO the authority to perhaps extend cost-sharing protections to those individual who might be less than 100 percent.

And in the guidance that was issued by CCIIO some time back, you describe a process where individuals who are between 100 and 300 percent, and then 300 and 400 percent, but then it almost seems like that CMS has created kind of this third kind of category of cost-sharing variation for those individuals who are above 400 percent but less than 100 percent of federal poverty level.

But in the section that I cited, it talks about that there is additional authority for CCIIO to extend the cost-sharing without requiring the applicant to request an eligibility determination for insurance affordability programs in accordance with 1553B, which of course is just the

application process itself. It doesn't talk about anything really kind of substantive that would affect this interpretation of this regulation.

To me that at least implies that there might be some latitude to interpret this in a way that would be beneficial for Indian people to get cost-sharing below 100 percent. Have you looked at this portion of the regulation.

A: (Kevin Counihan) I have not. I would like to go back after this and take a look at that with some folks.

C: (Jim Roberts) We are going to have an additional meeting with CCIIO tomorrow afternoon so perhaps we can have this discussion. I yield back the chair.

C: (Stephen Kutz) I heard the term "sufficient Indian providers" in the system. And we believe that every tribal entity or IHS entity that wants to contract with them, they ought to be required to contract with them and not be able to say we have sufficient Indian providers in our network.

In Washington State, tribes can be fairly close to each other geographically. And that does not mean that they all utilize multiple systems, although some of them do. And so "sufficient Indian providers," using that term sends the wrong message.

Secondly, in your regulations, is this addressing the move to also place mental health and chemical dependency into the managed care plans in the state where there are early adopters? And in our state we have one, and I am it.

So does that address what happens under the circumstances when that goes into place or are you leaving it up to the states to wrestle with that internally in their rules because for the first time, Indian people are exempt from managed care on the mental health system but the state plan was managed care for mental health, and we were exempt. And chemical dependency has not been in a managed care plan. Now that is going into a managed care plan.

And at least in my part of the state, all of them are going to be bidding on that, and the other thing they are going to be bidding on is any open coupons will be a separate pool that the managed care plans are bidding on to manage separately from the other managed care plan.

So there are these things that are happening internally, so do your regulations address any of those issues?

A: (Nicole Kaufman) So in terms of whether or not the Indian population would be mandatorily or voluntarily under a managed care program is subject to the type of authority the state is seeking to use and the results of tribal consultation through that public comment process.

So we do not alter the existing arrangements for how the state would work with tribes to figure out the best fit and what they would ultimately have, how they would decide to design their program.

C: (Jim Golden) When a state uses multiple managed care plans, they might have one plan for physical health. They have another plan even for long-term services and supports. And certainly with some of the expansion population, thinking about chemical dependency, substance use treatment and mental health, some states use multiple plans for that. Other states use one.

It is the clear expectation that there does need to be coordination between those plans, and there has to be an exchange of information across those. As well as with fee for service.

So if any portion of an individual's health care is in managed care of any type, and their other part is either in another portion of managed care or fee for service, there are clear requirements that those organizations must coordinate across the areas, and that is much stronger than it is without regulation.

A: (Stephen Kutz) So currently our state is planning on putting them under one managed care. They are not planning on splitting all of the silos out to different managed care plans. They are planning on putting them under one for payment purposes.

The state is really trying to work with us to try to figure out how to make this work but my assumption is at some point in time we are going to have to put in a waiver. At that point in time, if there are any of the provisions in there that we disagree with, you will probably be hearing from us. I was just wondering whether you had addressed mental health and chemical dependency as well as physical health, or just the overarching thing covers it all.

A: (Nicole Kaufman) One of the big changes we have made is to recognize that Medicaid managed care is not limited to acute care services. It involves behavioral health, substance use disorder services as well as long-term services and supports. So in a number of areas you will see a broadening of requirements to be more inclusive and be very clear that we are in a much broader program here.

C: (Jim Golden) Two things I would highly encourage: one, I understand your point on sufficiency. I would highly encourage you to submit that in a written comment. In the regulation, it also tries to strengthen network adequacy by identifying a number of issues that need to be considered around what is an adequate network. And some of them include geography -- which even though people might be very close, as you were pointing out, that might still be a geography that is different in certain ways. The other is ensuring there is cultural competency and language competency.

To the degree that you feel the network adequacy criteria to be evaluated don't adequately meet Indians' needs, I think we would like to hear about that in written comment.

C: (Ron Allen) I would like to take the privilege to defer to Jim Roberts for a question.

Q: (Jim Roberts) There are some things in the rule I really like but one of things that is concerning is the ability for CMS to what I call mission creep with the ARRA protections in kind of reducing the effectiveness of ARRA.

That is where CMS may waive the autoenrollment requirements associated with 1915(b) and 1115 demonstration waivers. What was the rationale for perhaps giving that flexibility for CMS, and I think as time goes on, and we will provide comment to this fact, there are a number of reasons that contracts don't materialize between tribal programs and managed care entities.

In a lot of instances, when we are autoenrolled into these things, we kind of lock out our folks from sometimes culturally competent care, timely access to care and different types of issues.

A: (Nicole Kaufman) I think you are referring to the background section. Remember we discussed the different types of authorities. So the background section is just a restatement of the existing authorities that are at the state's option when they are designing a managed care program.

So under 1932(a), which is a state plan option, in statute, it means are exempt from managed care. In 1915(b), in that authority, there is the authority for the state to mandatorily enroll that population into managed care. The savings is for 1115, so I encourage you to send a comment. But there the background was just laying out the general state of affairs and the authorities that are out there for designing the program. So there is no change proposed.

C: (Jim Roberts) So there really wasn't an intent to perhaps waive that requirement that is included the ARRA.

C: (Nicole Kaufman) Maybe I am not understanding the explicit requirement that you are referring to.

Q: (Jim Roberts) In ARRA, correct me if I am wrong, I thought there was an exemption from autoenrollment of managed care.

A: (Nicole Kaufman) For 1932(a) programs.

C: (Jim Roberts) So that is the distinction. Thank you for the clarification.

C: (Jim Golden) Both authorities that are mentioned in the background section, 1915(b) and the 1115, those are waivers, and those do have to go through an entire process that includes tribal consultation, public comment. And then those actually do have to be approved. So it is not a state option straight away.

Q: (Jim Roberts) Might there be an interest in doing that just for the duals that are discussed in the background section by CMS? Or would the exemption from autoassignment be across all waiver programs?

A: (Nicole Kaufman) I think again in the background section it was just intended to lay out the existing landscape without proposing any changes. But if that is not clear, feel free to submit a comment.

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

Q: (Gary Hayes) On these proposed rules, are you working with IHS also? I bring that up because some of us are direct service tribes, and for Colorado, Colorado expanded Medicare but we don't get any feedback on -- as was mentioned about data -- on how that process is working with our community because many of us are saying we don't really fully understand that. So we don't see many of our tribal members enroll.

So I think our tribe would be a good way of gauging how IHS is implementing an Exchange program in Colorado because we got a grant from the state to do a Navigator but during the meantime our clinic is supposed to be enrolling or signing people up for Medicaid/Medicare. And we always are hounding them: Tell us what the stat is. What are you guys doing?

We even have a close circuit TV where they can go on television and tell our tribal members what they need to do. And I guess I am just trying to -- as you are looking at proposals, are you guys getting any feedback from IHS?

A: (Nicole Kaufman) So IHS was part of the clearance process. And they were involved in several layers of review, so any comments that they submitted, to the extent they did so, they were taken under consideration during the clearance process.

Q: (Gary Hayes) So are we able to see those?

A: (Jim Golden) As I said, we had some high principles that we were trying to figure out how to incorporate into the reg. We had drafts of that. It goes through a wide array of groups. It goes to the general counsel to make sure that it is legal. And as it goes through different parts of the agency, they tend to focus on their specific pieces.

I think the part that you are most interested in is we anticipate getting a lot of comments on this regulation on kind of everything because I think it is about 650 pages in the original piece. And so we will get a variety of comments on those, and when those all of those comments are public.

And then as we start to work through those, we will consult with a wide array of places inside of HHS, and certainly IHS would be a place we would consult with.

C: (Kitty Marx) I would just like to remind everybody: Under another provision of Section 5006 of ARRA, there is a state requirement to consult with tribes but also Indian health programs within their states, which includes IHS, the tribal and ITUs. If states are proposing changes through the 1115 waiver, the state plan process to managed care, they will need to obtain the input from those ITU programs in their states.

C: (Geoff Roth) On the IHS side of that, we did provide comments during the clearance process in the Department, and while those aren't public, we do participate with tribes in a lot of different ways. So we will all be working on the same issues.

C: (Gary Hayes) I am glad you mentioned that but at the ground level, working directly with our clinical director, I think that is an issue I will have to discuss with Mr. McSwain because of all

the states, Colorado is very open. In fact, it is appointing tribes to move forward and find Navigators but it just seems like there is a disconnect with the correspondence with IHS and the state. IHS may be participating at the 30,000 feet level, but down at our level it is not working.

C: (Kitty Marx) I want to let you know that in your packet is the Dear Tribal Leader letter that went out this past week notifying tribal leaders that the proposed rule is out. And also the save the date notice for the all tribes call.

C: (Stephen Kutz) So in our state and hopefully other states we put together a small group of tribal members to put together and support the Indian Navigators who are out there working with our Indian patients. Encouraging the states to pass through some dollars to ensure those systems happen in each of the states is very important.

The state constantly turns to tribes to understand what are the implications, and it isn't that we have this static pool of trained Indian people, people who really know what is going on. It is just like any other process: You have people coming and going. So there is a constant training of new Indian Navigators.

In order to have that happen, you need a small corps, I believe in every state, that works with the Indian population to make sure that they are fully understanding all of the issues that are going on as it relates to each state. And encouraging states in written form and as part of the contract to pass through some of the dollars to make sure that infrastructure is put in place. They never pass through enough money to tribal members in the states where they do get it. And I am sure that there are some states where they don't even bother passing any money through.

C: (Kitty Marx) Liz just distributed a fact sheet that we just published on the Medicaid estate recovery rules and the protections for Indian property. Another protection under Section 5006 of ARRA is that certain Indian property is exempted from this Medicaid estate recovery lien.

Administration for Community Living

Kathy Greenlee, Administrator, Administration for Community Living

Updates from the ACA included these highlights:

- The White House Conference on Aging will take place July 13 in Washington, DC.
- A listening session for the Title VI Older Americans Act programs funded by ACA will take place August 11 during a conference.
- A number of funding opportunities are available for tribes, including funding for chronic disease self-management programs and evidence-based falls prevention. Tribes are eligible for all discretionary grant programs.
- Ms. Greenlee will be out of town for the September STAC member. Erin Bishop, the ACA commissioner on disabilities, will give a presentation to the STAC during that meeting on the work occurring in Indian Country with regard to people with disabilities of all ages.

Questions and Comments

Q: (Chester Antone) When you say to support long-term care in Indian Country, what exactly does that mean?

A: (Kathy Greenlee) It can mean a variety of settings. The setting that is probably most well-known would be a nursing home setting. There are some tribes that have built nursing homes, and so what are the mechanisms to be able to staff them and pay for the cost of care?

Universally we focus on providing services in someone's home so they don't have to go to a nursing home. The reason why this is a three way conversation between CMS and us and IHS is that it usually involves a combination of long-term care services so people can provide in-home supports and ongoing health care services. It is often provided at a state level through a Medicaid waiver program.

What becomes a real problem, especially in rural areas, is the lack of a provider base. It is both how do we pay for the services and how do we have enough resources and providers who will actually go into someone's home and provide care -- everything from a few hours a day to around the clock so an elder can continue to stay in their home. Who will pay for those costs and deliver those services?

Q: (Chester Antone) So the focus is for those with nursing home settings to staff and pay for the cost of care?

A: (Kathy Greenlee) For people who need that level of care, how can they get that care at home? And if the need it or a tribe decides to build a nursing home, how does that become possible financially, and where does the care come from?

C: (Chester Antone) I am asking that question because as you know, we have a nursing home. However, reimbursements will not make it work. It has to be supplemented. That is why I was asking about that support what it entails because that is what our experience has been.

We do get reimbursements from Medicare and Medicaid, private insurance but that doesn't cover the cost of operation and staffing. Last year we had a report that focused on building nursing homes facilities but the question of operations and staffing and everything it entails was not discussed in that setting.

The aging in place is something that we know is better because our elders tell us so. If you are completely incapacitated, then the nursing home is the second option. But even aging in place through use of medical equipment or aides trained to do wound care or therapy. So wherever the discussion is, we need to look at the care that is to be provided.

C: (Kathy Greenlee) I think you have a handle on the problems and the issues. There aren't additional funding streams for either setting, for a nursing home setting as a building or for community-based services. Medicaid would be the only option for community-based care

depending on how that was set up in the state and what people were eligible for. This is a universal problem in this country, paying for long-term care.

These are the kinds of issues that we have been working on to provide at least technical assistance to tribes so that if there are options that we know of that you can pursue, that we at least can provide that information.

C: (Chester Antone) One of the options would be to work with a local college to provide certification classes for care. That way you can claim reimbursements.

C: (Kathy Greenlee) It is important to keep IHS in the conversation because there are services that older adults need that will help them remain independent, medical services that IHS can provide.

C: (Cathy Abramson) What is needed is respite care for the people who are taking care of their elders so I am hoping that is out there and part of the conversation.

Q: (Ron Allen) In my small community, we have a clinic, and we dedicate one of our doctors to go out and visit the elders to see how they are doing with diabetes, Alzheimer's or Parkinson's disease or other issues. The issue is can we recover through Medicaid or Medicare so there is a way for us to cover those costs? What is the federal government doing to help that cause with regard to the new implementation of ACA and Medicaid expansion?

A: (Kathy Greenlee) You have done a nice job of laying out the issues, and I don't have the answers. You are describing that as how do we get reimbursements, and that often ties back to what is the elder person eligible for? And that is where we get into I don't know in terms of IHS services and the other services and the reimbursement. That is why we have got to have the three-way conversation.

C: (Geoff Roth) We can bill Medicare like a traditional provider, and we deal with direct service, and tribes are able to as well when elders come to the clinic. Your question is about the preventive services, the in-home services, those other services.

C: (Robert McGhee) One of the things we are having trouble with -- like we provide a respite program. We actually built an assisted living facility. However, a lot of tribal members did not want to leave their homes, even though the facility is located right within the reservation, so we started providing respite care. We are trying to figure out how we can turn this facility into a nursing home facility.

The problem you run into is the reimbursement issue, and how can we get around that because now we have this amazing facility -- and we actually have a lot of tribal members with relatives in nursing homes throughout the state of Alabama who would like to move them home but it is hard to get a certificate of need from the state because other nursing homes throughout the state are not filled. However, we know that we could probably fill ours by moving our tribal members

back home and placing them into the facility. But it is the Medicare reimbursement issue that they are trying to deal with right now.

C: (Kathy Greenlee) I think each of you is adding another complex layer. The certificate of need is state-by-state decision. So you still have the fundamental problems of making the economics work but the certificate of need creates a different barrier.

The only source of payment for a nursing home from Medicare is for someone who has come, spent three days in a hospital, has moved to a nursing home for rehab. It is what we do now instead of keeping people in the hospital for rehab.

The greatest funder is Medicaid for long-term services but if you are highly dependent upon Medicaid in a nursing home, the reimbursement rates are small enough that it can make it difficult to run the nursing home.

Q: (Robert McGhee) Who is the best person to ask those specific, detailed questions?

A: (Kathy Greenlee) CMS Medicaid.

C: (Leonard Harjo) We have been looking at developing and operating a tribal nursing home for a number of years. And the issue we have Oklahoma is we can't get a certificate of need. One of the things that encouraged me about the IHCA, under the most recent rendition, is that long-term care is an authorized IHS service.

If we were to contract with IHS to provide this service, would we be able to add this facility or this service and bill Medicare/Medicaid directly as we would any other medical service? I am told we can do it but we haven't been able to pursue it far enough to be able to determine how we would do that.

Q: (Jim Roberts) Jim Roberts, Technical Advisor, Portland Area. We are having the same issue in Washington State and the states that we have in Oregon, Idaho and the Portland Area as well. The reason why the states are involved in issuing certificates of need and kind of controlling how many patient beds are in a state in the Medicaid program is because there is a non-federal share of the services that the state has to deal with. So they have got this fiscal impact that they have got to be cognizant of and appropriate for.

With the Indian health system it is a little different, recognizing the fact that most services that would be delivered in our facilities would be would be 100 percent pass through to the states. There are also some provisions in Section 408 of the Indian Health Care Improvement Act that stipulate that the state can't impose any certification, licensing and other types of requirements as a condition of participation in reimbursement in the Medicaid program.

Perhaps if we could sit down with the state and convince that these are likely budget neutral types of services that they would be providing, and also looking to see if Section 408 would

provide some relief, perhaps there might be an avenue there we might be able to pursue. I yield back the floor.

National Institutes of Health

Lawrence Tabak, Deputy Director, National Institutes of Health

Dr. Tabak provided these updates:

- The roster for the Tribal Consultation Advisory Committee (TCAC) still includes one primary delegate vacancy in the Albuquerque Area, vacancies for alternate delegates for the Aberdeen, Albuquerque, Billings and Phoenix Areas and openings for three national at-large member alternate positions. The first in-person meeting will occur September 29-30 at NIH.
- A new American Indian/Alaska Native Health Research Website will provide information on all NIH American Indian/Alaska Native focused projects and funding opportunity announcements. The National Congress of American Indians (NCAI) and the NIHB can link to these sites.
- Twelve American Indians/Alaska Natives will participate in summer research programs on the campus. In addition, six will participate in a post-baccalaureate program. Other opportunities for Native youth are available as well. Tribal leaders should contact Dr. Tabak for more information.
- NIH seeks feedback on additional dimensions to consider in the area of research on historical trauma. The campus also wants to draw more people into doing this type of research.

Questions and Comments

C: (Aaron Payment) With a high school dropout rate of more than 50 percent in tribal communities, sometimes by the time we get to that point we are not so young. I hope the summer research opportunities are not limited to young people.

C: (Lawrence Tabak) One of our newest programs is for people in community college, which has become the surrogate entry point for people of all ages.

C: (Aaron Payment) At the Health Research Advisory Council (HRAC), we have identified historical trauma as a priority. So there are two key researchers on historical trauma from Indian Country: Yellow Horse Brave Heart and Theda New Breast. Among 14 to 24 year-olds, we have the highest rate of suicide among any racial ethnic population. We have issues with gun violence and very high rates of sexual molestation. That is all tied in together with survivors of historical trauma.

C: (Stephen Kutz) Recent studies have shown that trauma can influence genetic change in people. So even if you don't have that trauma enforced on you, it still gets passed on. That might

explain why we have some of these terrible things like diabetes and some of the other things that are passed on.

Whether there would be some opportunities to do some research in that area, I don't know. But if you looked at some of the studies that you have on file, what are some of the unanswered questions? What are some of the areas of opportunity for future research that might have been pointed out in there that need broader research? And then solicit that type of research with some funds attached.

C: (Aaron Payment) One of the things we have brought up at this table is the need to actually commission a study. I think a collaboration, especially under the rubric of STAC and HHS, is valuable because the impacts find themselves under Head Start, health, the Centers for Disease Control (CDC) and the Administration for Children and Families (ACF), all of these because it is in the environmental factors, and it does change the makeup. People who suffer repeated trauma then basically develop an adaptation for fight or flight. So when you have that in the DNA, whatever conditions you are facing -- and underclass, lack of jobs -- the outcome is conflict.

C: (Roger Trudell) I think you need to involve more people at the local level, whether they have got degrees or not or they are trained researchers or not. You have got to involve people who care. We have got qualified people in Indian Country who don't have degrees but they have come through the very types of things we are talking about. They have turned themselves around. Those are the people we need to pull in for research, to find out what changed it for them.

C: (Robert McGhee) One of the needs out there in Indian Country is how do we come up with trauma informed programs because we have so much narrow funding that we have to deal with. How can we start gathering all this funding from the National Institutes of Health, the Substance Abuse and Mental Health Services Administration (SAMHSA) and CDC and put it together to create programs at the tribal level? There are plenty of people who know the problem but how do you get the dollars down and get people aware that this issue exists?

Kaiser and CDC came together and did a study on adult trauma in the white community. We need to figure out the best way we can take programs and provide funding to get these programs to come together to implement some very good ones in Indian Country. A couple of tribes out there are trying to create different types of programs. It also would be helpful to get those individuals together and maybe start having some presentations done from a group perspective.

In 2010 or 2012 there was an interagency task force on the effects of domestic violence on women. Maybe that is the approach we need to take, creating an interagency task force to address the issue and then how we can get the funding to come together.

C: (Mirtha Beadle) There are a number of things in play right now from SAMHSA.

- SAMHSA put out a white paper last year on implementing trauma informed programs, an extensive effort with a lot of folks who contributed to it.

- As part of that process, multiple conversations are beginning to occur regarding how communities implement trauma-informed services. There will be a meeting on addressing historical trauma in a trauma-informed way. Further, specific SAMHSA grants allow tribes to address historical trauma as part of their work.
- You have heard from NIH, CDC and SAMHSA. There are other parts of government, including the Department of Justice (DOJ), working on this. It may not be called trauma-informed care but it essentially does address this issue. So we need to address what is out there and how we bring these issues together in a way that allows tribes to determine how they want to implement it.
- As part of the national Tribal Behavioral Health Agenda, tribal leaders want to identify and discuss historical trauma as one of the foundational issues for addressing behavioral health more holistically. They have asked us to bring together multiple federal departments to talk about how we can leverage current work to address some of these issues in Indian communities.

C: (Chester Antone) When grants come out, it is usually from the agency, what they expect, but it is never from the perspective of what the tribes expect from that grant and what they feel is beneficial to them. So that is where this behavioral agenda comes from, in the hope that when we begin discussion, that we will have things that are common with all tribes. A kick-off discussion is going to happen in Arizona to get this going. Through that we can realize what our environment is. From our environment come our illnesses and our cures.

We also will add an extra day to our Tribal Advisory Committee (TAC) meeting with CDC in August to discuss the same issues with Dr. Ursula Bauer, who is going to talk about changing the grants and what should be in those grants for tribes to measure success in their way and define their own well-being.

C: (Judy Fink) I appreciate that studies have looked at the effects of trauma on grandparents, parents and the children. My mom, who is going to be 89 years old, she was brought up by my great-grandmother. She can probably speak about the times that she learned from her grandmother and she can speak about what she knows.

My children were in school in the 70s, and they experienced discrimination just in how they were treated as Indian children versus the non-Indian children. So this trauma has followed all of the generations. Those are the people who need to talk about these issues. A lot of this links into behavioral health, and it has caused mental issues.

C: (Gary Hayes) When you look at the continuation of hopelessness or suicides or what is going on in communities, it goes back to the funding issue, the lack of funding: lack of adequate housing, health facilities, schools, roads, telecommunications. All these different programs that tribes provide are inadequate. Because of gaming, some tribes have been prosperous but there are many tribes who don't have that opportunity and that can't supplement the lack of funding to support these programs in their communities.

All these different factors of lack of funding are something that hopefully will tie and correlate together the inadequacy and the failure of the federal government to provide funding in these areas. There has got to be a message here that we can come together and articulate the responsibility, the lack of responsibility, the federal government has had.

C: (Aaron Payment) What I would like to see is something to get initiated. We need to do something bold across agencies that recognizes this issue, and we need to initiate some kind of comprehensive study to get to -- at least to kick off some study of historical trauma. One way you do that in education is through a colloquium. Maybe we need a cross-disciplinary colloquium that would have cross-agency support and pull this together and do proceedings from it. Then it has a stamp of legitimacy from the agencies on it.

So then no matter who is the next president, that person is going to have to either passively or actively reject this report if we do some kind of a report through the balance of this term.

C: (Leonard Harjo) On the concept of historical trauma, there are so many levels to address: community, family. Most of our systems, particularly in terms of behavioral health, focus on the symptom, not the cause. One of the things I am wondering is to what extent trauma-based assessment has, and treating folks from the point of view of trauma, made it into the training of our providers? One of the most fundamental ways we need to address this is at the provider level when they are working with someone who does come in.

C: (Robert McGhee) I like the idea of a study but right now the longer it takes to do a study -- we already know the problem exists. How do we get the services and the individuals trained in these areas, trained to recognize and address this issue? What models are being implemented? If tribal nations have successful programs, how can we share those with others? And teach them that this is an issue?

Not all tribes know that this is an issue. We may need to figure out a way to do more to get information about historical trauma to the tribes -- what those programs are and how to train the individuals who are out delivering that service, to give them this new approach in treating these issues.

C: (Stephen Kutz) HRAC has been working for years to pull together a central database where all the research done in Indian Country resides. We also talk about trauma but our Indian people have a lot of strengths. The Native American Youth and Family Center in the Portland Area has started using a strength-based assessment tool. When you talk to people over and over about their problems, you reinforce those problems. So partly you want to talk about their strengths and what they can build on.

Money being put into assessment tools and things that work for Indian people, that needs to be someplace where researchers can take a look at it. We can look at turning thing around. We should get the organizations together and start looking at addressing this together. This is the

most engaged topic for the STAC every time we bring it up. We as Indian people believe this needs to be addressed and resources need to be put here.

C: (Mirtha Beadle) I just want to mention a few quick things.

- In terms of data collection, through what is called the Tribal Law and Order Act, there is an interagency committee that includes IHS, the Bureau of Indian Affairs (BIA), the Bureau of Indian Education (BIE) and the DOJ. We have started looking at the data on tribal communities. We are all trying to bring our data around American Indian/Alaska Native issues. We will come back to you to talk about that.
- As part of the Behavioral Health Agenda, we are trying to look at what we know about historical trauma. One of our folks has already done a literature search, and we are working with NIH. I have got two stacks on my desk just on the writings on historical/intergenerational trauma. There is a lot of information to cull together so we can talk to tribal leaders who have asked for help in doing something differently in Indian communities around these issues.
- SAMHSA continues to discuss and examine issues around creating and evaluating programs in Indian Country.

HHS Actions on Opioid Abuse

Andrea Palm, Senior Counselor to the Secretary

Secretary Burwell has identified opioid abuse as a critical issue in light of rising deaths from drug overdoses and increases in heroin use. Ms. Palm noted a 39 percent increase in heroin deaths between 2012 and 2013. An initiative across the Department seeks to identify the most evidence-based interventions to reduce overdoses, overdose related deaths and drug dependence. The budget that went to the Hill during the past budget cycle included \$99 million for activities in this initiative. Staff continue to work toward outcome-based measures in these three priority areas:

- Prescribing practices, striking a balance between legitimate pain management and dangerous overprescribing.
- Increasing access to Naloxone, an overdose reversal drug.
- Increasing access to and the use of Medication-Assisted Treatment (MAT), the most effective form of treatment for opioid use disorders.

Questions and Comments

C: (Aaron Payment) One of the things my community is doing is we are not prescribing certain prescriptions because of the danger of them. We have a controlled substance policy under our tribal health program. These efforts stave off the flow of these medicines that make their way into the community. This is a cross-disciplinary problem with law enforcement, substance abuse, health and behavioral health.

C: (Stephen Kutz) What I would like to see is a national conference or a series of regional conferences where we can pull our practitioners together and look at using the tools we have in trying to reverse the trends in our communities. One of the things I am seeing is people are getting prescriptions for suboxone and they are not put into a treatment counseling program. All of this should be coordinated.

C: (Will Micklin) This issue has many layers. One is overprescription of narcotics, opioids, to the elderly. My parents, grandparents and great-grandparents had no exposure to these drugs. When they are being treated for cancer, arthritis or dementia, there is a habit of doctors to just prescribe massive doses of oxycontin or heroin-type products as painkillers.

Methamphetamines are prevalent even in the most rural communities. We are also getting synthetic drugs that you can order online. One of symptoms of the new synthetics is violence, and we don't have a way to deal with these users within cultural/societal norms.

We need effective programs based on the local conditions because every community is different. We need to be able to change programs as drugs change if we are going to be effective. The program should be some type of 477 program where we have control over the allocation of the funds. We are still using the funds for the purpose and intent of the program but we are shifting it around to be most effective.

Q: (Andrea Palm) Is it your sense that the illegal drugs are more of a problem than the prescription drugs?

A: (Will Micklin) Well, it is both, it is just different segments of the population.

Q: (Leonard Harjo) There is evidence that tends to support medical marijuana as a pain management tool. There was a question raised earlier about how can the federal government facilitate issues of prescribing/not prescribing in the Indian health system? The federal government's position is it is a controlled substance drug. We are not going to do anything with it. But most of the opioids are on the controlled substance list as well, but we still prescribe them.

There are people who swear by medical marijuana as pain management, and it has kept them off of opioids. They still function reasonably well. One of the only alternatives you have is to try to find other avenues for pain management. The other issue is that Indian health doesn't embrace other nontraditional methods of pain management. Chiropractic care is one of the simpler ones.

To the extent that the issues are deriving from pain management, and our facilities are trying to help people live better lives, are there some things we can do differently other than the standard opioid-based drugs?

C: (Will Micklin) We really need the Secretary's help in looking at the HHS policy on these issues. We have issues with the DOJ memoranda that have developed since 2008 or 2009. The most recent has been portrayed in the media to give carte blanche authority of tribes to do whatever they want with marijuana. That is far from the truth. We have concerns with the

Controlled Substances Act and the severe criminal penalties under that act, and we need an expression of clear policy from HHS, particularly in the medical marijuana area.

Generation Indigenous

Lillian Sparks Robinson, Chair, Intradepartmental Council on Native American Affairs (ICNAA)

Stacey Ecoffey, Principal Advisor for Tribal Affairs, Office of Intergovernmental and External Affairs

Several successful Native youth activities have taken place leading up to the Generation Indigenous event that will occur at the White House on July 9. As a co-sponsor for that event, HHS has been involved in the planning, and Secretary Burwell will participate. HHS staff also seek feedback from STAC members on broader ways to identify and promote internships and jobs for youth. The Department also wants to connect youth input and priorities with ongoing STAC initiatives.

Questions and Comments

C: (Leonard Harjo) If you have youth events in our regions -- usually the youth want to report to somebody. If you invite the delegates to be part of those activities, then we could bring those issues here.

C: (Aaron Payment) Our youth council is working on a viral video that will address some of the health or physical challenges of youth. The video will include vignettes on drug abuse and resiliency skills to highlight that youth aren't invulnerable. The video also encourages them to bring information about the ACA back to their parents. We also are sending three of our youth out to the conference in July.

C: (Geoff Roth) At IHS, we are focusing on these three efforts:

- We have asked all of our area directors to roll out a Pathways project to look at hiring student interns over the summer, and these internships can also happen year round as students have breaks, whether they are in high school or college. We are trying to have paid internship opportunities in our direct service units.
- The second component is a youth engagement steering committee type approach at the local service unit level. These steering committees build on resources that already exist in tribal communities and focus on the most appropriate way to reach and tailor services for youth. If we are funded by Congress with that money that the President has put into the budget, it will also be an opportunity to discuss how to get the most out of those resources. We will eventually see area level steering committees and potentially a national level committee if the General Counsel signs off on that.
- The third prong is a continuation of the Let's Move in Indian Country Initiative, which includes healthy activities as well as visual storytelling projects.

C: (Mirtha Beadle) SAMHSA has multiple efforts as well, including these:

- We are trying to bring about 30 youth together to give them tools and training around behavioral health, helping them become ambassadors in their communities.
- We plan to launch a Tribal College and University Initiative that will bring together folks from across all the tribal colleges and universities to work with them on behavioral health issues.
- Check Yourself, a project for tribal communities, will give individuals way to monitor themselves and their friends around behavioral health concerns to address issues early.
- SAMHSA will launch a music contest to bring out the best of Native youth.

Whereupon, the meeting adjourned at 5:34 p.m., to resume at 9:00 a.m. on Wednesday, June 3.

Secretary's Tribal Advisory Committee Meeting

Wednesday, June 3

Administration for Children and Families (ACF)

P.L. 102-477 Implementation

Felicia Gaither provided an update on Public Law 102-477 and the Tribal Temporary Assistance for Needy Families (TANF) program. Among the highlights:

- A federal partner meeting with the BIA took place two weeks ago to discuss new reporting forms and plans for ensuring that all tribes affected by changed forms are trained and understand fully how the transition process will occur.
- HHS staff will draft the audit supplement guidance and share it with the Tribal 477 Workgroup.
- Staff continue to work with tribes that already have approved TANF plans to help them incorporate those plans into their 477 programs.
- A Tribal TANF meeting will take place in Washington, DC, August 31. The meeting will include roundtable discussions between both states and tribes. In response to a question from Councilman Antone, Ms. Gaither noted that Tribal TANF has additional flexibilities that state TANF programs don't have. Staff also expect to announce Tribal TANF grant recipients by the time the meeting occurs.

Tribal leaders responded with continued requests for expanding the 477 programs for greater flexibility. Mark Greenberg, acting director of ACF, noted that staff continue to work through legal and policy issues.

Indian Child Welfare Act Implementation

Joo Yeun Chang, Associate Commissioner for the Children's Bureau, discussed data collection, child and family service plans, cross-agency efforts and other issues related to strengthening the Indian Child Welfare Act (ICWA). Primary highlights included these points:

- An upcoming report will include state-by-state fact sheets that spell out:
 - what states have told the Children's Bureau about their consultation practices;
 - the policies states have in place to ensure ICWA compliance;
 - how states measure ICWA compliance, and;
 - any challenges states have shared regarding ICWA implementation.
- The report will include feedback from tribes within that state as well as discrepancies HHS staff have identified regarding state ICWA compliance. The report should be available in mid-August.
- The Children's Bureau is reviewing applications for direct Title IV-E planning grants. Staff will make announcements by the end of the fiscal year.
- Heather Zenone has come on board as the senior tribal advisor working to coordinate activities across agencies, states and tribes.

Tribes reported that negative attitudes and ICWA non-compliance continue to occur within the states. Councilman Kutz said the upcoming report should provide a pathway of enforcement and consequences for the states that aren't making progress.

Ms. Chang said staff will use the report to identify communication failures between states and tribes, highlight what works well and identify what the federal government expects from states. Further, tribes, states and the federal staff in the regional offices can use the report to ensure compliance on a state-by-state level. Chairman Trudell reminded HHS staff about developing policies for tribal children who aren't enrolled in any tribe.

Office of Head Start

Bianca Enriquez, the new Head Start Director, provided a status report on Tribal Head Start statistics, funding, monitoring, training/technical assistance and other issues. Tribal consultations will occur this summer in Sacramento, California; Tulsa, Oklahoma; and Billings, Montana. Staff also have proposed consultations in Alaska and Mississippi in October. Linda Smith encouraged tribes to comment on the revised Head Start standards that will be available in two weeks.

Tribal members asked questions about prospective, proactive approaches to compliance and improvement. Head Start also should offer more creative, flexible solutions to tribes that don't quite meet the numbers needed to have a program. Funding cuts for underenrollment also present a major challenge. In his remarks, Principal Chief Harjo encouraged staff to provide governance guidance tailored to tribal settings.

Chairman Trudell added that pre-kindergarten classes in the public school system are drawing potential students away from Head Start program available on smaller tribes. That reflects a conflict between two government agencies. One potential solution has been for Head Start to put more funding in Early Head Start to reach more infants and toddlers. Other Head Starts have adjusted their hours to meet community needs.

Secretary Sylvia Burwell

Focusing the discussion on suicides in Native communities, Secretary Burwell asked tribal leaders to share thoughts on causes and solutions to this troubling issue. STAC members highlighted the following points:

Short-term fixes:

- Publish available tribal/local resources in obvious, continuous ways so family members know whom to call if they notice a problem.
- Understand the impact of alcohol and substance abuse, mental health issues and high unemployment on tribal communities and the lack of faith-based programs such as traditional healing practices.
- Establish a workgroup to review existing approaches and develop a comprehensive approach based on community culture. Generation Indigenous should tie into this effort.
- Using the CDC approach, attack the issue of suicide as an epidemic and go into communities with a team of counselors and other professionals to build skills, interventions and coordination at the community level.
- Train tribal staff/community residents to identify problems and be available to avert crises.
- Talk to youth and families that have been directly affected by suicide to identify true causes.
- Use the EpiCenters to develop behavioral risk assessments for high school students.
- Develop culturally sensitive approaches based on expert information.
- Create public service announcements to educate the general public about suicide in Indian Country and increase support for funding.
- Tackle cyberbullying.
- Provide safe, confidential places to talk.
- Focus on the strengths of Native communities.
- Teach youth how to overcome disappointment and the fear of failure.
- Give youth a sense of hope and resilience.

Long-term solutions:

- Get federal support for the Tribal Behavioral Health Agenda to help Native communities develop their own definitions of well-being.

- Address the funding increases needed to provide adequate housing, schools, justice, law enforcement, behavioral-health professionals and more in Indian communities. Provide greater flexibility so tribes can use the funds in effective, culturally appropriate ways.
- Tackle such issues as child abuse, child neglect and trauma in the childhood home.
- Coordinate the behavioral health systems with primary care to more quickly identify and address mental-health and substance-abuse issues. Connect mental health counselors with the school system -- even within Head Start -- to identify and get children into services early.
- Help tribes get the matching funds needed to secure grants that can address these emergencies.
- Strengthen ICWA and conduct extensive research on historical trauma in Indian Country.
- Restore a sense of spirituality, identity and culture, along with the use of Native language, back into the family structure and Native communities.

At the end of this session, STAC members agreed to submit a letter to the Secretary to highlight the other topics they didn't have time to discuss. Tribal leaders also can submit additional comments and solutions for preventing suicides in Indian Country.

HHS Federal Member Roundtable Discussion

Generation Indigenous as well as historical/current/community trauma continue to be major focus areas for **SAMHSA**. Discussion about the National Tribal Behavioral Health Agenda is ongoing as well. This initiative will cover these five elements:

- Historical/intergenerational trauma
- National awareness/visibility of behavioral health issues
- Ways to integrate behavioral health into other health care issues
- Prevention and recovery support
- Behavioral-health services and systems improvement

Administrator **Pam Hyde** also provided these updates:

- For 2016, SAMHSA has proposed a budget of \$30 million. Administrator Hyde requested the tribes' support in getting those dollars into Indian Country.
- A request for applications is available for tribes that wish to serve as Certified Community Behavioral Health Centers and receive additional funding.

As Native communities continue to deal with substance abuse, tribal leaders requested more focus on preventive rather than curative activities.

Increasing access to quality health care services tops the priority list for the **Health Resources and Services Administration (HRSA)**. During the next 12 to 18 months, Acting Administrator **Jim Macrae** also wants to tackle these issues:

- Strengthen the health care workforce
- Promote a team-based approach to care
- Build healthy communities
- Improve health equity
- Strengthen internal operations

Mr. Macrae also provided several supplemental items, including details on the AIDS Education and Training Centers, a full list of all the agencies that receive funds from HRSA and a list of programs to which tribal entities have applied. Further, Mr. Macrae supplied a sample of a successful tribal application. In other news, two new funding opportunities are available for tribes.

In their response, tribal leaders noted that the Code of Federal Regulations (CFR) that calls for privacy for chemical-dependency patients restricts coordinated care. Further, restrictions to the National Health Service Corps create difficulties for tribes that have trouble attracting medical staff to rural areas.

Reporting for the **Centers for Disease Control and Prevention (CDC)**, **Judith Monroe** addressed these points:

- August 4-5 are the dates for the CDC/Agency for Toxic Substances and Disease Registry (ATSDR) TAC meeting and the 13th Bi-Annual Consultation.
- Trainings will occur this summer and fall inside CDC to help staff work well with tribal governments.
- CDC seeks more tribal applicants for its Public Health Associate Program. From 2013-2014, CDC had six placements. A new class that will begin October 2105 has had a substantial increase in applicants from Indian Country.
- As part of Generation Indigenous, the agency also has geared three websites toward tribal youth:
 - It's Your Game: Keep it Real, focusing on HIV and STDs as well as teen pregnancy prevention;
 - The Native Diabetes Wellness Program;
 - Native STAND, Students Together Against Negative Decisions.
- The Native specimens work continues.
- Last year, CDC funded tribes with an increase of \$6 million in grants. Two funding announcements have a June application deadline.

In response to a question from tribal leaders, the CDC's **Carmen Clelland** reported that the agency will get involved with behavioral health initiatives by inviting a traditional healer to the TAC meeting in August.

J. Nadine Gracia, Deputy Assistant Secretary for Minority Health, highlighted these points in her presentation to the STAC:

- Karen DeSalvo is the acting assistant secretary for health in the Office of the Assistant Secretary for Health (OASH).
- Dr. Gracia provided details on workshops available through the Higher Education Technical Assistance Project, an initiative designed to help minority-serving colleges and universities strengthen skills in coalition building, financial management, evaluation and resource development. The August 26-28 workshop at the University of Denver will place special emphasis on tribal colleges and universities.
- OASH developed a flier/infographic to give tribal members clearer information on accessing the ACA. STAC members offered comments and suggestions to improve the flier's clarity.

The meeting ended with final remarks from Dr. Yvette Roubideaux, who is leaving IHS, as well as words of gratitude for Dr. Roubideaux from STAC members. Whereupon, the meeting ended at 1:42 p.m.