

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

**November 14-15, 2013**

***Summary Report***

The Secretary's Tribal Advisory Committee (STAC) Meeting was held on November 14-15, 2013, at the Hubert H. Humphrey Building in Washington, DC. The meeting provided an opportunity for the STAC to converse in-person, hear updates and engage in discussion on the Department of Health and Human Services (HHS) budget, the Intradepartmental Council on Native American Affairs (ICNAA), Indian Health Service (IHS), Substance Abuse and Mental Health Services Administration (SAMHSA), the Affordable Care Act (ACA), and staff and operating divisions' work on Native issues and initiatives. The STAC also prepared for a discussion on its priorities with HHS Secretary Kathleen Sebelius, met with the Secretary, and addressed its business items. Throughout the meeting, the STAC was afforded numerous opportunities to engage with HHS leadership, program staff, and agency officials. The meeting was facilitated by Ken Lucero.

Members Present for Roll Call: Ken Lucero (National At-Large Member), Aaron Payment (National At-Large Member), Roger Trudell (Aberdeen Area), Rex Lee Jim (Navajo Area), Marshall Gover (Oklahoma Area - Alternate), Arlan Melendez (Phoenix Area), Cheryle Kennedy (Portland Area), and Chester Antone (Tucson Area). (Quorum Met)
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**Action Items:**

1. Pamela Hyde and Cynthia LaCounte agreed to look into avenues of volunteerism as a means to assist veterans with mental health issues.
2. Stacey Ecoffey agreed to add Arlan Melendez to the Tribal State Workgroup.
3. Stacey Ecoffey agreed to send a letter out concerning the rescheduled date of the Grants Matrix Training and coordinate a webinar to accommodate people unable to attend the session.
4. Arlan Melendez was instructed to provide Paul Dioguardi with specific information on enrollment issues in Nevada pertaining to descendants so he can pass it on to Cindy Mann.
5. Yvette Roubideaux will send a letter out to tribes soliciting input on Medicare-like rates.
6. Kathleen Sebelius agreed to put Rex Lee Jim in contact with Sally Howard regarding his concerns about the FDA's Food Safety Modernization Act regulations.
7. Kathleen Sebelius agreed to talk with the Office of Management and Budget (OMB) regarding the possibility of having an Associate Director for Native Programs in the OMB and a Tribal Advisory Committee.
8. Cindy Mann agreed to get more information on the status of the Navajo Nation Feasibility Study.

9. Arlan Melendez asked Cindy Mann to follow-up on the Navigator program in Nevada, as Tribal Health Directors are reporting challenges with implementation.
10. Mandy Cohen agreed to work with Geoff Roth to ensure tribes' State Benefits Coordinators are provided with updated information and details on available Assistor trainings.
11. Yvette Roubideaux agreed to include tribes' State Benefits Coordinators on IHS weekly calls for business office staff.
12. Geoff Roth agreed to provide information at the next STAC meeting on IHS facilities that have met the requirement to have at least one person complete the Certified Application Processor training.
13. Lawrence Tabak requested names of potential American Indian/Alaska Native (AI/AN) peer reviewers for research projects.
14. Yvette Roubideaux agreed to work with the Administration for Community Living (ACL) regarding how to educate AI/AN communities on why health care providers ask about elder abuse.
15. Cynthia LaCounte agreed to plan a webinar around explaining why health care providers ask the elder abuse question for tie-in with Title VI programs.
16. Yvette Roubideaux agreed to share comments with the workgroup that is focusing on outreach and education related to prescription drug abuse and IHS area directors about the need to educate Native communities on polices concerning pain management.
17. Lawrence Tabak agreed to follow-up with Chester Antone regarding the status of the National Institutes of Health (NIH) guidance document.
18. Mary Wakefield agreed to work with Cheryl Kennedy to ensure her tribes' service area is being accurately designated.
19. Yvette Roubideaux agreed to speak with Cindy Mann about the availability of Medicaid data and what can be shared with tribes.
20. Mark Greenberg agreed to follow-up with Rex Jim Lee regarding his request for technical assistance for the Navajo Nations Head Start program.
21. Lawrence Tabak invited Rex Lee Jim to contact him about specific interests the Navajo Nation has regarding infrastructure building for the purpose of research capacity.
22. Cynthia LaCounte agreed to speak with the National Indigenous Elder Justice Initiative and have Jackie Gray contact Rex Lee Jim or Larry Curly to do some capacity building with the Navajo Nation around elder abuse protection.
23. As SAMHSA is part of a department-wide group that deals with behavioral health and coordination, Mirtha Beadle suggested that the STAC be updated on the recommendations of the subgroup that is looking at prescription drug issues once those recommendations are finalized so a discussion can be had regarding how to address them in Native communities.
24. Yvette Roubideaux agreed to check on the progress of the IHS and U.S. Department of Veterans Affairs (VA) sharing behavioral health information, e.g., trainings on Post-traumatic Stress Disorder (PTSD).
25. Yvette Roubideaux agreed to check with her behavioral health staff to see if they are working with the five PTSD centers throughout the U.S., as Marshall Gover suggested that the VA work with IHS on providing training to them.
26. Yvette Roubideaux agreed to check with her behavioral health program staff to see if they are aware of the 3-week PTSD courses offered in the Black Hills. Mary Wakefield

- asked to be updated on this topic, wanting National Health Service Corps (NHSC) clinicians to have an opportunity to take part in the training.
27. Mary Wakefield agreed to work with IHS to brainstorm about webinars on best practices related to PTSD and training related to the cultural context of asking about elder abuse.
  28. Mark Greenberg agreed to share tribal leaders' concerns about the impact of sequestration on Head Start programs with his Head Start colleagues.
  29. Lawrence Tabak offered to make a compilation of the NIH's research portfolio related to traditional medicine available to the STAC.
  30. Lawrence Tabak agreed to share information about the community-based participatory research in the Native American Research Centers for Health (NARCH) with the STAC.
  31. Yvette Roubideaux suggested that a STAC subcommittee be formed to address how to go from sharing information about traditional medicine to creating recommendations and implementing actions.
  32. Paul Dioguardi agreed to send out notices about vacancies on the STAC.
  33. Yvette Roubideaux agreed to send a list out to notify people of vacancies on the Contract Support Costs (CSC) Workgroup.
  34. Yvette Roubideaux agreed to ask OMB to be present at CSC Workgroup meetings.
  35. Cheryle Kennedy requested that Norris Cochran move forward with inviting Julian Harris to the next STAC meeting.
  36. Yvette Roubideaux invited a presentation by the National Indian Health Board (NIHB) on its work concerning public health accreditation at a future STAC meeting.
  37. Pamela Hyde agreed to have follow-up conversations as a result of Roger Trudell's concerns about Access to Recovery (ATR).
  38. Pamela Hyde agreed to solicit the help of Sheila Cooper to have a follow-up discussion with Chester Antone regarding grant flexibilities, particularly related to providing water.
  39. Pamela Hyde requested suggestions on how to get AI/ANs who meet SAMHSA's reviewer criteria to review tribal applications.

## **DAY 1**

(November 14, 2013)

### **Welcome and Meeting Logistics**

The first day of the meeting began with Ken Lucero, Pueblo of Zia, welcoming the participants and inviting Chester Antone, Tohono O'odham Nation, to give the opening invocation. After the blessing, Councilman Lucero explained that he agreed to chair the meeting as a result of former STAC Chairman Gary Hayes losing his tribal re-election bid and therefore no longer serving as a member of the STAC. Councilman Lucero further indicated that Paul Dioguardi, Director, Office of Intergovernmental and External Affairs (IEA), would address Mr. Hayes' and other members' pending term expirations in his opening remarks. Councilman Lucero proceeded to call the roll. The following STAC members were identified as present: Ken Lucero (National At-Large Member), Aaron Payment (National At-Large Member), Roger Trudell (Aberdeen Area), Rex Lee Jim (Navajo Area), Marshall Gover (Oklahoma Area - Alternate), Arlan Melendez (Phoenix Area), Cheryle Kennedy (Portland Area), and Chester Antone (Tucson Area). A quorum was met.

Mr. Dioguardi greeted the STAC and stated that letters would be released the following week that announce openings for STAC slots (for terms that end in 2013): Bemidji Area, California Area, Nashville Area, Navajo Area, Oklahoma Area, Portland Area, and two National At-Large positions. Additionally, the Albuquerque Area does not currently have representation on the STAC. Next, Mr. Dioguardi directed the members' attention to proposed 2014 meeting dates, saying feedback would be solicited later in the meeting.

## **HHS Budget Updates**

Norris Cochran, Deputy Assistant Secretary for Budget, provided an update on the HHS budget situation. First, he addressed requests from the last STAC meeting, saying a table on funding information had been provided; the topic of 2-year funding was raised with OMB; and Julian Harris, OMB's policy official over Indian Health Service (IHS), decided to focus on engaging with the STAC members through various meetings at the White House during the week. Regarding the latter, Mr. Cochran said the STAC could still request to have Mr. Harris put on a future STAC meeting agenda.

Highlights of the HHS budget presentation included the following:

- FY 2014 started with a government shutdown that lasted over 2 weeks.
- Congress has passed a continuing resolution (CR) with no funding changes, currently leaving IHS at the final FY 2013 enacted budget level that includes the 2013 sequester.
- There is a new budget conference with new rules on how to move the product they produce quickly through Congress. The hope is they can produce a total spending level for 2014 in time for appropriation committees to produce a funding bill for the rest of the fiscal year before the CR expires in mid-January.
- Hopefully the budget conference will reach agreement on 2015 totals, as that would inform formulation of the President's 2015 budget, which is being worked on; OMB is working on 2015 requests from the departments.
- It's not clear how the sequester will be resolved for 2014.
- December 13, 2013, is the deadline for the budget conference.

In other related news, Mr. Cochran said the Health Resources and Services Administration (HRSA) announced that it will put out additional money for new health centers. Following his presentation, Mr. Cochran entertained questions and comments. Throughout this document, questions, answers, and comments are denoted by "Q," "A," and "C," respectively.

C: (Aaron Payment) Regarding advanced funding, the sequester and shutdown underscores the need for it.

C: (Rex Lee Jim) Advanced funding is good, but in the long-run we want to have mandatory funding instead of discretionary funding.

Q: (Rex Lee Jim) What is your prediction for January?

A: (Norris Cochran) We will continue to talk with OMB about the concept of advanced funding. Mandatory funding is an area we've looked at over the years and it has its budgetary advantages.

In general, Congress has not been eager to pursue multi-year funding or mandatory funding for things that have been on the discretionary side. On the sequester, the good news is that all sides seem to acknowledge how poor of a mechanism it is. The bad news is, as of yet, there is no replacement; all eyes are on the budget committee conference to see if they can agree on targeted reductions to get rid of sequestration. The 2014 reduction will hit the Department of Defense, so hopefully it will be fixed for 2014. In terms of the shutdown, few would have predicted it this last time, so maybe it's not good to predict. I would hope real world examples would prevent anyone from considering it again. I think it's quite unlikely to have another shutdown.

C: (Cheryle Kennedy) We need to move forward with securing Mr. Harris from OMB to be at the next STAC meeting, to address advanced funding and to hear from the tribes.

C: (Yvette Roubideaux) Julian Harris was in the Health Subcommittee meeting and he indicated his willingness to hear from tribes.

C: (Rex Lee Jim) We need to continue to advocate for a Tribal Advisory Council for OMB.

C: (Aaron Payment) There seems to be a disconnect between the President's commitment to upholding treaty obligations and communications that don't seem to filter to the OMB. We hope we can sensitize them to not only our assertion that it's a treaty obligation, but that it's also the President's stated commitment.

### **Indian Health Service Issue Discussion**

Yvette Roubideaux, IHS Director, updated the STAC on IHS issues. Admitting her concern about the fiscal situation, Dr. Roubideaux said the IHS is being conservative in its management, trying to reduce administrative costs, and spending cautiously. Regarding the effort to improve IHS, she indicated that work continues in that area, adding that a 2-day (3-hour) virtual Tribal Consultation Summit was held with up to 160 individuals participating at one time. Other highlights from her presentation included the following:

- IHS is working on improvements with contract health services.
- IHS will have a budget consultation and Dr. Roubideaux looks forward to tribal recommendations.
- There will be an upcoming hearing on CSC, as well as the impact of the fiscal crisis and the sequestration.
- The President has said he wants to work with tribes and Congress on a solution to CSC; and a meeting with OMB and tribal leaders is scheduled for the afternoon to look for solutions related to appropriations.
- To expedite CSC past claims, there is a case management plan to prioritize them; there is a fast track alternative approach to get a settlement offer up-front; and additional resources have been committed to add additional staff to generate initial settlement offers for the clinics at a faster rate.
- IHS has been talking with the Tribal Self-Governance Advisory Committee and the Direct Service Tribes Advisory Committee to ensure tribal views are heard; a plan has been established to discuss how to calculate CSC. The CSC workgroup will be reconvened to generate recommendations that will then go to all tribes.

- Regarding the VA-IHS Reimbursement Agreement, all the Federal sites are billing; and IHS and tribal sites combined have received about \$1 million in reimbursements.
- IHS is meeting regularly with the VA, working on coordination of care issues.
- There will have to be a consultation on the distribution for Special Diabetes Program for Indians (SDPI) if it gets reauthorized beyond 2014.
- IHS business office staff has been receiving training on the ACA.
- IHS continues the reforms of improving its business practices; IHS met all of its Government Performance and Results Act (GPRA) indicators this year. Tribes are encouraged to report impacts the budget and/or sequester is having on the local level.

Q: (Cathy Abramson) How does IHS plan to lead public health accreditation efforts and support IHS Area Indian Health Boards, Tribal Epicenters, and tribes?

A: (Yvette Roubideaux) I really appreciate the NIHB's work on that. Public health accreditation is a great opportunity for tribes to show that their health departments provide quality services in the public health arena. It's not necessarily something IHS would seek, because we are not a health department, per se. I'm aware of what NIHB has done, working with public health organizations on the accreditation process. I'd welcome an update on that at some point to see how we could be helpful.

Q: (Roger Trudell) If there is another sequestration and/or shutdown, what happens to the direct service facilities and staffing? Some of Aberdeen Areas are remote and understaffed, medically speaking. What is the status of the doctors and nurses? I think the term is "accepted," meaning they have to show up for work but aren't guaranteed pay. What's the plan to keep them if we can't guarantee pay? We have a hard time keeping them anyway.

A: (Yvette Roubideaux) I hope we don't have another shutdown. We constantly hire doctors, whether it's getting them on board permanently or as contract doctors. When the sequestration kicked in, we couldn't guarantee people their salaries; and we couldn't guarantee in some instances that the contractors would be paid. We tried to give them the "accepted" designation, meaning the obligation would be made in the budget and would be paid later. We will work with the Department on better assurances we can give to people. We are trying to preserve our core mission, which means cutting away at non-essential items (travel and conferences). For Direct Service Tribes and Self-Governance Tribes, the impact is significant.

Q: (Roger Trudell) Because it costs more to contract for medical help, how does that affect when you have even less to work with? Patients need an ongoing relationship with their providers. When you contract doctors, they tend to stay for a short period of time. And when you depend on contract health for care, that is very costly. The "gains" of the last couple of years haven't been effective in that we were so far behind to begin with. Unless something tremendous happens we won't ever catch up. If we don't have a 2014 budget, how can we effectively talk about 2015 or 2016? Everything can't be based on the 2013 budget, because that was poor planning there. How do we address health concerns at home with not enough money to do it? The Indian Health Care Improvement Act (IHCA) is part of the Affordable Care Act and it keeps getting stalled.

A: (Yvette Roubideaux) You're right to be thinking this through and being concerned. We are struggling to meet the need with the resources we have. We don't want to have contract doctors; we want to have permanent doctors. The Aberdeen Area has contracted out with Merritt Hopkins, a national doctors group, which is really smart. Regarding the ACA, we're hoping more American Indians sign-up for Medicaid and Medicaid expansion if it's in their state; and purchase health insurance. Some of the premiums will be very small for those who don't qualify for Medicaid; and with the no cost sharing for American Indians under the 300% of the FPL or if they visit IHS, the cost may be very minimal. I fight for the biggest increases I can in the budget. Right now it's up to Congress, but I will do what I can at the hearing when I testify. It is a crisis, you are right.

Q: (L. Jace Killsback) In terms of IHS, in regards to the ACA and getting tribal members to sign up through the Marketplace, what is IHS doing to change the culture of IHS? My tribe is a Direct Service Tribe in a region with mostly direct service nations. My children fall under Healthy Montana Kids, in Montana. I was a strong advocate for IHS. We took my 5-year old to a dentist and he was told he's in the cavity free club, but then we took him off the reservation to a pediatric dentist in Billings and we were told he had 4 cavities. The treatment we received was night and day in terms of professionalism. With the ACA, how many of us will want to be treated at IHS when you can get better care off the reservation? So, what is IHS going to do, in the business sense, to capture dollars? We haven't seen a change in the culture. Now that we are not being referred out for level 2 and level 3 services, we are being overmedicated. It's almost cliché to say there is prescription drug addiction in Indian Country. In my community, combined with meth, it's an epidemic. Secondly, regarding Crow/Northern Cheyenne Hospital, we have to refer to Billings. We can't use our own hospital. We don't even have an OB-GYN. We can't deliver babies. That's the majority of services our tribal members utilize. Having to refer out, it affects our contract health service dollars. Regarding the idea of going to a level one, I don't think that's appropriate. We will have an increase in bill of collections for our tribal members also. There is already a backlog; they will run to the tribal government. Also, we feel the government wasn't prepared in its response to tribes for the shutdown.

A: (Yvette Roubideaux) You are absolutely right about the customer service, it's a fear we've had all along. We sent out a business planning template and required each CEO to do a business plan for how they were going to keep their patients, improve customer service, and improve billing for third-party billing. I think some facilities have done a great job and others have not. I think there are particular issues at Crow Hospital that are interfering with their ability to do the right thing. We just sent out a deployment to review the quality of care and the services provided. They've been there about 2 weeks and we're going to extend it for another 2 weeks. Just this week we had a team review their OB services. The officers that were deployed will make recommendations and we will hold staff accountable to implement them. We have to be conservative about the budget because we don't know what next year will bring. We will try to get off of Priority 1 if we can at some sites.

Q: (Cheryle Kennedy) Is cost of care information per capita for Indians a part of your testimony? On CSC dollars, we look forward to an end to that scenario. When we receive settlement funds, those funds go back into the health care system, so it's important that you tell Congress that.

A: (Yvette Roubideaux) I have testified on per capita differences; it's always good to remind them. On CSC, we are doing all we can to get those matters resolved. Secretary Sebelius makes IHS a budget priority; she is committed to improving IHS. I have to go testify, but I'll be back later today and tomorrow.

## **Substance Abuse and Mental Health Services Administration**

Pamela Hyde, SAMHSA Administrator, began her presentation by distributing a resource page on SAMHSA. She introduced Mary Fleming, the new Director of the Office of Policy, Planning, and Innovation; and Phillip Ames, Special Assistant.

Speaking about the sequester, Administrator Hyde stated SAMHSA is not a direct service provider and therefore may not be in as dire straits as IHS, but to the extent SAMHSA's dollars pay for data efforts, communication efforts, policy work, technical assistance, work with tribes, and grants, it is causing an impact. The main impact currently is a reduction in the number of grants SAMHSA can give out. Without a better budget, Administrator Hyde said cuts would have to be made to existing grants. Among the highlights of her presentation included the following:

- The new SAMHSA American Indian Alaska Native Team (SAINT) is in place, the charter is complete, and the SAINT agenda focuses on access to services and resources for tribal communities, and increasing staff capacity.
- SAMHSA is working on a new communications strategy, which will include an updated Tribal Consultation Policy.
- Vacancies on SAMHSA's Tribal Technical Assistance Committee (TTAC) include: Aberdeen Area, Phoenix Area, and an At-Large position. [The STAC was told that inquires about serving on the committee should be addressed to Sheila Cooper.]
- The SAMHSA TTAC has been working on data issues, funding issues, and communication issues.
- The Center for Behavioral Health and Statistics and Quality presented at the American Indian Data Summit in Bismarck, North Dakota in July.
- SAMHSA is responsible for coordinating the Department of Justice (DOJ), IHS, SAMHSA and the Bureau of Indian Education (BIE) work around substance abuse through the Tribal Law and Order Act (TLOA). [A map was distributed that shows some of the work being done.]
- SAMHSA's Newsletter Committee has released its latest quarterly newsletter, called Prevention and Recovery.
- SAMHSA will present two new webinars in 2014 for tribes interested in creating Tribal Action Plans. Approximately 30 tribes are currently working on Tribal Action Plans.
- The two previous technical assistance centers have now been combined into a new technical assistance and training center; the contract was awarded to a woman-owned Native company. Eight tribes are receiving intensive technical assistance.
- There is an Addiction Technology Transfer Center (ATTC) specifically focused on tribal issues, e.g., workforce issues, the science of addiction, and technology transfers specifically for AI/AN communities.
- A report from the Tribal Policy Academy is in the meeting packet.

Before ending her remarks, Administrator Hyde shared highlights from SAMHSA's 2013 grant portfolio. Namely, she said SAMHSA gave out 100 discretionary awards to 76 different tribes and tribal organizations, for almost \$69 million; and she noted that the President's FY 2014 budget expanded the Partnership for Success Program to include tribes who have implemented a Strategic Prevention Framework (SPF) grant. Other SAMHSA efforts include work around Tribal and Juvenile Drug Courts; high risk tribal grantees; and suicide prevention. Regarding the latter, she said HRSA, IHS, and SAMHSA are working together on resources for tribes regarding suicide prevention and the resources are being updated. She asked about the best way to get the information to tribes. Finally, she said Tribal Colleges and Universities are eligible for both Garrett Lee Smith Act grant competitions, but can only choose to apply to one; for 2014 more Circle of Care grant opportunities are proposed; and the Suicide Prevention Resource Center has a specific focus area on tribes.

Q: (Cheryle Kennedy) Has there ever been a plan or idea about SAMHSA working with IHS? Prior to 15 years ago, the area offices used to fund psychiatrists and behavioral health specialists. As tribes took their shares, the mental health dollars extracted from that process were very little. It seems that there is a great need for coordination of mental health services. It seems there is more attention given to corrections or the police force encountering more people with mental health issues. I've noticed several members falling into that situation and I'm trying to coordinate care for them. They are being mistreated while incarcerated, because they are hard to manage, and on the outside they usually end up homeless on the street. It seems like that would be a real good effort for SAMHSA.

A: (Pamela Hyde) I couldn't agree more. Part of the reason we did the Tribal Policy Academies was because several tribes were struggling with how to address the juvenile justice issues especially. We were only able to include four tribes in that process, but it was very successful. IHS was a partner with us, along with the Justice Department. We do have some Drug Court dollars that are ours to direct. For those dollars, we have made Tribal Courts and Tribal Juvenile Justice programs eligible for those funds. We want to provide as much technical assistance as we can in this area.

C: (Chester Antone) I encourage us to keep moving towards having more grants flexibility. As an example, one of our grants was unable to use grant funds to purchase water for one of their sessions. It had something to do with the dollars couldn't be spent if there was an establishment nearby that had the product. In our case our store charged several times higher what the outside charged. People were coming in from the outside, who live in town, and they would have purchased it at a much lower price. We live in a desert. Grants should reflect tribal location and tribal needs. Also, we need to use tribal evaluators appointed under our tribal constitutions. They know the process of grants and they know the accounting systems of tribes. In our tribal communities we need to educate our tribal grantees about the budget and what they can spend money on. We need to have our administrators understand what the money can be used for, without having to ask the Federal government. This needs to be negotiated with the contracts and grants. On FASD, it's an issue that has implications on a child's life. A lot of funds are spent on the tribal side because of this issue. The issue still exists. Regarding Ms. Kennedy's question about SAMHSA working with IHS, I know they can. About 3 or 4 years ago we had a meeting with the Centers for Disease Control (CDC), IHS, NIH and others in Rockville,

Maryland. That was during a time when everyone had their areas of jurisdiction, but that can be bridged. So, agencies can work together; I've seen it happen.

C: (Pamela Hyde) On the water issue with grants, it is a frustration for our staff as well. We have been told we can't use dollars for food, period. Sometimes I think we get the instructions and then we interpret them so narrowly, because we are trying not to get in trouble. We can talk offline and get Sheila involved to explore if we have any flexibility in that area. We are trying to do more about evaluators. A lot of times it's hard for us to get people to evaluate tribal applications because they are also applying. We welcome any suggestions you have to get people with the criteria needed to review. Also, we do work with IHS constantly. Yvette's focus is on direct services and we focus on providing grants, but we are working together.

Q: (Roger Trudell) Access to Recovery (ART) III will end in September. I understand that under the Request for Proposal (RFP) for ATR-IV, clinical services wouldn't be an eligible activity because they might be under the Exchanges. The tribes are not eligible for the state block grants. We don't participate in those. Clinical services are vital in our area. If we have people who are eligible for those service but haven't enrolled in insurance, will they be uncovered? Will the ATR-IV allow for clinical services? Will there be consultation on this with existing ATR program managers?

A: (Pamela Hyde) Maybe you are raising the issue of whether we should have some conversations about tribes who are getting those dollars and what changes might happen. This is a program that we have been pushed fairly hard about. People who get services under this program have traditionally been those without coverage or for the types of services that weren't covered, but that varied from state to state. With the expansion of Medicaid in many states and opportunities for enrollment in programs that are now required to provide clinical, mental health and substance abuse services, the idea is to stretch the dollars as far as possible by making sure things like doctors visits or medications are paid through resource that are now focused on that and to save the ATR dollars for things they won't pay for, like recovery support costs or transportation costs. The funding stream has been targeted for reduction, because of the theory that clinical services will be paid for through other sources. We are trying to figure out the best way to put that together. We are trying to live with the choices that are given to us. If there is an insurance-based payment that is possible for a service, that is not what we want our dollars going towards. If you have an individual who is not otherwise eligible for insurance or a clinical service paid for through another funding source, there is no reason why ATR couldn't continue to fund that.

C: (Roger Trudell) Tribes don't have to enroll in the ACA and therefore it would be a service some tribal people would rely on the ones that are eligible for ATR services. Some reservations have 2 million acres and populations are isolated. It's unfortunate that something that could be helpful to them won't be available. That's why I was asking about consultation on this.

C: (Pamela Hyde) Our intent is not to say the dollars can't be used to pay for this service for anyone. We are saying that if a service can be funded through another mechanism, or if that individual's care can be funded through another mechanism, we want to do that first. As we will talk about later, there are all kinds of attempts to get Native people to sign up for coverage because it helps IHS and the tribes.

C: (Roger Trudell) People will say, "We don't have to sign up; we are entitled to these services because of our treaty. If we are not forced to sign up for the ACA then we're not going to do it; we're not required to do it." I was just basically asking if there would be consultation on this before the RPF comes out.

C: (Pamela Hyde) I think we can definitely have some conversations with applicants that want to do the ATR.

C: (Cathy Abramson) I want to applaud your efforts in incorporating our culture and traditions in programming for getting our people healthy; it's not just physical health but also emotional, mental, and spiritual health. Our way is our best for us. We have traditional healers at our clinic and they are now working with behavioral health and they meeting with the doctors to discuss what they do, so people are learning more. They are also very involved in our Drug Courts. Our people will be involved in more sweat lodges and teachings and fasting ceremonies. And when we have ceremonies there is food there and water is a part of it too.

Q: (William Micklin) On November 8, 2013, the final Parity Rule was issued. Can you describe how that is helpful to tribes and tribal citizens? It's difficult for us to get mental health or substance abuse program funding outside of SAMHSA. Does this provide a requirement under Medicare or Medicaid or would there be some equivalent parity requirement for IHS clinic funding? If not, it kind of creates another discrepancy between a requirement for consumer products purchased by the average citizen that's different than what's provided through IHS without having to go through a consumer plan.

A: (Pamela Hyde) The Parity Act/MHPAEA [Mental Health Parity Addiction Equity Act] and the ACA kind of go together. Just for MHPAEA itself, it really doesn't require any mental health or substance abuse services. It just says if you have them they have to be equal to Med Surge benefits. The ACA says mental health and substance abuse services have to be provided by any of the qualified health plans on the Exchanges and by any individual or small group plans in the market. Now, that's all insurance-based. Medicaid and Medicare and IHS and Tri-Care, all government programs, are exempted. However, all of those programs actually have provided better and more mental health services and substance abuse services than other commercial plans have in the past. Medicare has done the least well only because it focuses its mental health and substance abuse services mostly around the dual diagnosis or the disabled population. The point is, the regulation that came out was hugely important for 62 million Americans for offering more opportunities for having mental health and substance abuse services, but it does not make a perfect system. In terms of Medicaid particularly, there is a piece of Medicaid it does cover. To the extent the Medicaid expansion plans/alternative benefit plans, which are often less complete than some of the Medicaid plans out there in the states, those small pieces of Medicaid would be covered by the MHPAEA regulation. The basic Medicaid is not covered, but Centers for Medicare & Medicaid Services (CMS) has indicated an interest in looking at a Parity Rule for Medicaid. In the meantime, they have been working with each of the states to encourage them to see how they could do more equity in their Medicaid plan.

C: (William Micklin) Thanks for the clarification. For tribes' employees that participate in the Federal Employees Health Benefits (FEHB), that is a requirement under the Act. So, we can point to them and say, "You're getting parity under FEHB." There are a lot of tribal citizens that

think if they participate in an ACA plan then they are diminishing the entitlement they have for care, by virtue of our status as Natives and citizens of tribal governments. They are set against the Marketplaces. Thanks for the clarification, it helps the leadership try and move the Congress and the Administration to broaden the application of the Parity Act to Medicaid and IHS programs.

C: (Marshall Gover) So many times veterans display mental health issues and it's PTSD. Different ones might be incarcerated. They are mistreated and misdiagnosed. Sometimes they are shuffled along in the system. In different places they have a Veterans Court and if so they get a VA representative and are sent to a special VA Court and tested for PTSD. IHS often doesn't know how to handle them. I don't know how to begin to address this. Sometimes they seek the help of older veterans. They need a lot of help.

C: (Pamela Hyde) We have a Military Families initiative that works a lot with the VA and U.S. Department of Defense (DOD). The President did an Executive Order, asking HHS, VA, and DOD to work together around military families and veterans' mental health. There is an interagency task force; I represent the Secretary on that task force. The President called on us to help the VA hire peer specialists, with the understanding that veterans need to talk to people who have also been through military service, as well as who have experienced mental health issues. That is much more effective in keeping people engaged and helping with recovery support. The VA just announced that they met their hiring target; I think its 800 peer specialists across the country. SAMHSA has been working with them to set some of the credentialing and criteria for that peer work. The President proposed for the 2014 budget a lot of money for the behavioral health workforce, and part of it was focused on peers. This was one area where the Senate Budget Committee didn't include the money for the peers.

C: (Arlan Melendez) Organizations such as Veterans of Foreign Wars (VFW) and the Marine Corps League and others that are not necessarily Native are trying to get Natives to join, so they can talk to other veterans. There are also Native American ministers that visit hospitals and do a lot of volunteer work. One guy asked why there isn't a Chaplain within IHS that could visit people in hospitals; they do it for free anyway. There might be some way to think out of the box to see if something can be developed to use people like that, that are volunteering anyway.

C: (Pamela Hyde) Thanks for that idea. We have been doing some faith-based work. We will pursue that.

Q: (Ken Lucero) Pam asked for suggestions about getting information to tribes about the Suicide Prevention initiative. Any ideas about that?

A: (William Micklin) It's a huge issue in Alaska. We really need to integrate it in our standard health care providers program. Having it as a standalone program that's subject to competitive funding, and the limitations on use of funds, makes it more difficult. It's an emergency. Even the folks that we succeed with, we just managed to make more flexible some requirements for vocational training for one of our tribal citizens. She got through chiropractic school and is practicing. She is a suicide survivor. We need to find ways to integrate these into our standard health practices. There is a stigma that keeps folks out of these programs. I'd say try to make it more of a health care issue. Everyone at times can be subjected with a problem that if left

untreated could manifest into a mental health affliction that could cause harm to oneself or other people. Everyone needs access and we have to remove the stigma of the programs and the limitations on the use of funds and fund delivery from year-to-year.

C: (Cynthia LaCounte) We have a volunteer initiative at the Administration for Community Living (ACL). I'm looking at training our Senior Advisory Committees to make home visits to other seniors and bring that information to our leadership, our Title VI programs, and our Senior programs. Hearing this discussion has expanded my thoughts because we also have a small Veterans program at ACL. Perhaps we can combine these resources and consider forming volunteer groups to work with veterans. I would be interested in talking with you about expanding what we do.

C: (Roger Trudell) We trained some people and invested tribal money in training. We had a psychiatrist on staff for a while; she is still with us but not full-time. We have people well-versed in the three steps everybody talks about. Sometimes you don't need professionals, you just need local people who want to provide a service in the community. We don't even pay ours; we gave them a stipend while they attended classes. They are available on-call. It's about how you approach the community. This is a national problem.

C: (Rex Lee Jim) Package it as something that is positive and productive. Native traditions are positive. They involve the family, community, and client. We don't isolate the individual. Perhaps you can promote it as community development or cognitive development and/or make it part of a school or community or faith-based event. If you package it that way, the person might be more willing to participate.

C: (Pamela Hyde) We struggle with the positives and negatives of what we work on. We've tried talking about things like emotional health development and positive mental health. Some people want us to be the "Mental Illness Administration." I like your suggestion; and we've been looking at integrative care and how to put it into a regular health care setting.

C: (Chester Antone) That's what I mean by grants flexibility. In our community we have what we call "emic" (sp), that's how you address your relatives. It's a term of endearment rather than a label for purposes of a will. We always run into the research question. I guess another word is practice-based. Some agencies, such as NIH and CDC are more into the discipline itself, and probably not as ready to take our suggestions on how we measure that. We all win when we can look at each others' ways and work within them. In our community in March, we will be doing the last of the Four Directions Run for Mental Health. It's a community event. We do it without a SAMHSA grant. I think the holistic approach needs to be looked at.

C: (Ken Lucero) I like the idea of integrating it into everyday practice. That would be more useful than addressing it as a stigmatized issue. If the resources are there, just get them to the community.

C: (Pamela Hyde) The conversation reinforces for me the vision of giving substance abuse and suicide prevention to tribes that want it, without competition, and have you do it the way you want to do it. At some point we will come back to this.

## **Update: Intradepartmental Council on Native American Affairs**

Stacey Ecoffey, Principal Advisor for Tribal Affairs, IEA, provided the STAC with an update on the ICNAA. She reminded the STAC that at its last meeting they discussed the issue of data and presented a draft data plan. She said the tribal state subgroup, in its review of the plan, discussed how to get priorities set and it discussed what the Department is doing department-wide concerning data. Ms. Ecoffey stated that the Administration for Children and Families (ACF) has been working to come up with one data sharing plan. The tentative plan is to do it in December 2013 or January 2014 and have IEA pay for it. The hope, she said, is to have a solid plan by the next STAC meeting. Before that time, Ms. Ecoffey said representatives from other advisory committees, the STAC, and ICNAA would be convened to discuss the plan and its priorities.

Concerning the grants reports, Ms. Ecoffey informed the STAC that after a few more changes are completed the report will be released to tribes (before the end of the year). She said the report will be available on a jump drive and posted on the web. Additionally, she said a grants training session will be held in January on understanding the document and there will likely also be a webinar. She also said they intend to have a training at the budget session as well.

Q: (Arlan Melendez) Can I join the State Tribal Workgroup? I've been getting questions on data from my area; some are technical. They have been asking about the Hardship Exemption Rule. Some of this is new to me.

A: (Stacey Ecoffey) Sure. We'll add you to the list.

Q: (Cathy Abramson) There was a grants training scheduled, but it got cancelled during shut down. Will you have it available as a webinar?

A: (Stacey Ecoffey) It will be rescheduled. We are going to have it in January, but during that session we will also have a piece that explains the grants matrix. In addition to that, we'll plan for a webinar at some point for those people that can't come. We have to be able to send out the letter with the jump drive, so people have that.

Q: (Ken Lucero) On the grants matrix, will it be a live document on your website? Will it be updated? Will people be able to search it? New grants will be added as they become available and old ones will be deleted as they go away?

A: (Stacey Ecoffey) Yes. We do have a different process for when new grants are made, but we haven't had a lot of money since 2010, so that document really hasn't changed since then.

C: (Stacey Ecoffey) So, for the grants training we are looking at the 3rd week in January. We'll get another letter out. We are holding the spots for the people who already signed up.

Other updates included the following:

- A Request for Information (RFI) was sent out for the Tribal Consultation Report that comes out of IEA. All of the operating divisions, ICNAA, and Federal STAC partners are working on their submissions. The report is on track for a January completion.

- An email was sent to all the regions to start working with their regional organizations for planning the 2014 consultation sessions in the field. This year a focus will likely be on data. Regions were asked to have consultations between February and the end of May.
- IEA, with its external partners, has some new outreach activities that are being done with its non-traditional partners.
- The National Tribal Budget Consultation Session will be held on March 6-7, 2014. Planning calls will start in January.
- The ACF Tribal Consultation will be held on June 16, 2014.

C: (Rex Lee Jim) We will bring up with the Secretary the issue of the Food Safety Modernization Act regulations. There is an Executive Order pertaining to consultation with tribes, but somehow that message is not reaching some agencies, organizations and programs. Approximately \$3.1 billion dollars in annual income to Indian Country is derived from food and agriculture (\$1.4 billion from non-livestock sources). A lot of tribal governments and their economic enterprises own businesses that will be covered by this new regulation. Yet, FDA lacks intensive, sustained efforts to consult with Indian Country regarding produce rules and new annual feed rules. This is unacceptable to Navajo and I'm sure it's the case with other Indian Nations. We are concerned about registration, variances, state enforcement, cost of compliance, agricultural water standards enforcement, and loss of producer registration. The Navajo Nation asks that the FDA: 1) delay the implementation of these rules as [related to] the tribal food businesses and producers; 2) immediately acknowledge that tribal governments have the inherit authority to seek and obtain variances to these rules, just as state and Federal governments do; 3) acknowledge that tribal governments have the authority to create and obtain recognition for comprehensive regulatory regimes to enforce and implement these regulations through contracting and government-to government relationship with FDA; and 4) provide clear instructions to state and local authorities concerning the limits of their authority on tribal lands and related to tribal food businesses.

C: (Stacey Ecoffey) There are a lot of moving parts with that issue. The Hill is very involved in that and there is a big court case. In June, the FDA did a training via webinar in conjunction with the National Congress of American Indians (NCAI). Tribes had requested that the issue and the deadlines be pushed back from the November 5, 2013, deadline. Because of the court cases that are going on, the deadline can't be moved. A webinar consultation was set up during the furlough. That one was scheduled last week and rescheduled for November 5, 2013. After that webinar FDA worked with NCAI to get a small group to go through the comments and summarize the tribal issues. The deadline for comments hasn't closed yet. We could have them come back to STAC after the comment period closes.

C: (Rex Lee Jim) My recommendation is that we need to understand that not all tribes belong with NCAI, like Navajo. The government knows that the Navajo has a huge project, so they should be asking to consult with us. They know we are not members of NCAI. We have gone through litigation and settlements regarding water rights. A lot of the stuff [in the regulation] we simply disagree with because it will cause us to go to litigation based on the way it is written. We need to come to the table to talk about this. Besides coming to the STAC, they need to be talking to tribes with huge agriculture projects.

Following Ms. Ecoffey's presentation, the STAC met in tribal caucus to prepare for its meeting with Secretary Sebelius.

## **Secretary Kathleen Sebelius**

Councilman Lucero welcomed Secretary Sebelius to the STAC meeting, noting that the STAC had five issues to present to her: 1) ACA issues, including data collection for enrollment; 2) concern with the FDA's Food Safety Modernization Act regulations; 3) budget, including the impact of sequestration and OMB; 4) resolving CSC; and 5) regional issues, including the Arizona 1115 Waiver.

### ***I. ACA***

C: (Cheryle Kennedy) First I want to thank you for your commitment to Indian people and for implementation of the ACA. We know there have been some bumps in the road, but we see you standing strong in your resolve to implement the Act. We've been observing the perception of the American people regarding implementation of the ACA. The computer data system is lagging behind and we want to lend our support to you. In Oregon, our tribal health workers have been registering people by hand, and I believe other tribes have been doing the same. I'm interested in hearing what the next step will be concerning changing the perception and raising the hope of American people and tribes concerning the final implementation of the ACA.

C: (Kathleen Sebelius) Thank you for that support. The federal website has had bumps, but you are in Oregon and that is working very well, so I'm hoping people are encouraged to use the website and not paper. Paper is really a two-step process. Someone would then take that information and put it into the Oregon website. The 17 states that are running their own health Exchanges, and Oregon is one of those, are not having a similar level of consumer issues that we are having in the federal market. There are 36 states trying to use our market. We are about 6 weeks into open enrollment and I can tell you that the federal site is much better and more user friendly than it was on day one. You should encourage friends and family who are living in the federal Marketplace states to use it, but remind them that open enrollment lasts until March 31st of next year. They really have a 6-month period of time to pick a plan and get coverage. While there has been daily bad news, driven in large part by people who don't want this law anyway, we need to push back and say, "the law is in place, the website is getting better, the Call Center is in place, and people have until the 31st of March."

C: (Cheryle Kennedy) We are also talking about the data elements that might be associated with our members who are enrolled in the programs and how their information might be extracted so we can stay with our own statistical analysis of improvement of health status for our members. I'm not sure where we are with that today.

Q: (Kathleen Sebelius) Are you talking enrollment data from health insurance or research data?

A: (Cheryle Kennedy) For a combination of both of them.

C: (Kathleen Sebelius) We can't share or gather or send out personally identifiable information that is used for enrollment purposes in health insurance. In fact, we will collect very little of it.

Because of the way the health law is written, since no one is excluded with a pre-existing health condition, no one is giving medical records. There is no medical information collected as part of enrollment in the new health law. We won't be storing or keeping information a lot of the personal information. We could probably figure out, at the end of open enrollment, when people identify themselves as either an Alaska Native or an American Indian, there may be a way to count enrollment numbers, but I'm not sure we can do much in terms of statistics without violating people's privacy. We won't be tracking their claims. We won't have information about what is going on with health issues.

C: (Cheryle Kennedy) I think that's something for the STAC to be aware of, so we can track that and try to be on the forefront of that data. It's an important element that we all need.

C: (Arlan Melendez) In Nevada, as far as Medicaid expansion, we are having difficulty determining eligibility for Medicaid. I'm being told the state determines eligibility, even though the tribes do all the work within the health center. We send the information over to the state. So, it seems like we should be able to do it within our health centers, as opposed to turning the information over to the state.

C: (Kathleen Sebelius) The federal law that is written around Medicaid says it's a state determination regarding who is eligible. I know a number of tribes would love to run their own Medicaid programs and it probably makes very good sense, but we can't do that administratively. Even in a state where somebody comes into the federal website with an income level that looks as if they are Medicaid eligible, all we can do is sent them to the state and then the state actually determines eligibility according to their rules and enters them into the system. We do have timetables that states have to follow to ensure people get enrolled.

C: (Arlan Melendez) On the definition of an Indian, it sounds like if you are an enrolled member you have open enrollment year round, but if you are a descendant you have a limited period to sign up. That's a big issue with how we work with the states. It's a timing issue for all of us.

C: (Kathleen Sebelius) We'd be happy to get specific information if there is an issue in Nevada with descendance or getting people enrolled; we'd be happy to follow-up with you. Cindy Mann, who is our Medicaid Director, can be in touch with the state Medicaid Office the next day. That goes to any of you. If you get it to Paul, we can get it to Cindy.

C: (Cheryle Kennedy) There was a Government Accountability Office (GAO) report that found that the vast majority of IHS Federal Contract Health Services (CHS) Program payments were made at non-negotiated rates and that these rates cost on average 70% more than the negotiated rates. This resulted in Federal CHS Programs paying non-contracted physicians two and a half times more than what it estimated Medicare would pay for the same service. Federal CHS Programs alone would have saved an estimated \$31.7 million annually, if Medicare-like rates applied to non-hospital services. These are all for specialty care that are referred out. We ask that you support the making of legislation, introduction of legislation, to extend Medicare-like rates of all Medicare providers and suppliers; we are asking for support of this legislation. We would do the work.

C: (Yvette Roubideaux) We currently get hospital-like Medicare rates when we pay for services in the private sector for contract health. If we could get out-patient, that would save on our referral dollars. I've heard that tribes want us to work on Medicare-like rates. We are doing an internal review to see how to get that done in the most efficient way; and I think we are working on a letter to tribes where we might make some consultation announcement about this. It's possible that the best option is a legislative solution, but we are exploring administrative options as well. We want tribal input on this. We will be sending a letter out very soon.

## **2. FDA**

C: (Rex Lee Jim) With the Food Safety Modernization Act regulations, approximately \$3.1 billion in annual income to Indian Country is derived from food and agriculture, with \$1.4 billion from non-livestock sources. We feel the lack of intensive sustained effort to consult with Indian Country regarding these produce rules and new annual feed rules is unacceptable. They will impact this income. We have concerns in the areas of: registration, variances, state enforcement, cost of compliance, agricultural water standards enforcement, and loss of producer registration. Especially in the area of water standards enforcement, we feel that these rules do not consider the impact of decades of water litigation affecting tribal water rights and do not contemplate future lawsuits they would ensue if the agricultural water standards contemplated by these rules are made final or enforced. Indian Country will be forced to litigate these matters to the fullest extent. No consultation occurred with regard to these critical issues and they may be the most troublesome and potentially egregious areas of the rules. The last one was loss of producer registration. The Navajo Nation requests that the FDA engage in significant and meaningful consultation with tribes concerning the full range of issues contemplated within these rules. It is discouraging that these rules have been developed without consideration of the STAC. This body's purpose is to advise the Secretary on matters of material importance to tribes, regulations that threaten tribal sovereignty. Tribal agricultural producers would seem to fall within that area. The Navajo Nation asks that the FDA: 1) delay the implementation of these rules as [related to] the tribal food businesses and producers; 2) immediate acknowledgement that tribal governments have the inherit authority to seek and obtain variances to these rules, just as state and Federal governments do; 3) acknowledgement that tribal governments have the authority to create and obtain recognition for comprehensive regulatory regimes to enforce and implement these regulations through contracting and government-to government relationship with FDA; and 4) provide clear instructions to state and local authorities concerning the limits of their authority on tribal lands and related to tribal food businesses. Under the principles of the United Nations Declaration of the Rights of Indigenous Peoples, the FDA cannot through to lack of consultation and subsequent implementation of rules implementing FSMA/Aid, impact the rights of tribes and tribal people to their own traditional foods and the ability to meaningfully engage economic activities related to these foods.

C: (Kathleen Sebelius) I would like to put you in direct touch with Sally Howard. She was my Chief of Staff, but she has moved to the FDA as a Policy Assistant to Commissioner Hamburg. Because she's very familiar with the STAC and because she's a lawyer she is very familiar with the food regulations; I think the fastest way to begin this conversation is to have you talk directly to her. I will commit to doing that. I think that's an important place to start.

### *3. Budget*

C: (Cathy Abramson) I want to talk about the effects of sequestration and OMB. All tribes have suffered immensely with the sequestration and many tribes are trying to recruit and/or retain professionals, keep up employee morale, revise budgets, recruit for Medicaid expansion, and create business plans. Many of our health employees are doing two and three times the work. Tribes don't trust the federal government, for many good reasons. I know the effects at home are that not even an award letter is good anymore. We are trying to provide services and our councils are saying, "I don't know, we don't have the money in-hand." It's affecting our services. Even announcing the money is coming, isn't good enough. It happened to us with the Diabetes Program; the money was coming, the government shut down, and our council said, "We're laying them off because we don't trust the money will come." I think there was a big step backwards with the trust issue. The other thing I wanted to bring up is that the tribes are supportive of having an Associate Director for Native Programs in the OMB. We feel it would be helpful for all Native services and funding. We ask what we can do and if you can help to make this happen. We are also supportive of creating a Tribal Advisory Committee for OMB. We are strongly advising you that we think this needs to be done.

C: (Kathleen Sebelius) We've had talks about sequestration before and it continues to be the President's view and across the government it's seen as the single most important thing in any kind of budget negotiations to get rid of it. As you all probably know, we are living with one level of cuts but on January 17, 2014, automatic second level of cuts go in. It will be devastating across departments and I know it will have a huge impact on services in Indian Country. It will have a huge impact on services in every part of this country. As we look at CR running out in January and we look at the opportunity to put together some sort of economic framework for the rest of the second term, this is priority number one. With OMB, I will talk to the Director about the issues that you raised. In terms of the staffing position, they aren't organized that way. So, whether or not that is a possibility I just don't know. Having an Advisory Committee I think makes wonderful sense, not that the other one doesn't. I will share both items with OMB.

### *4. CSC*

C: (Cheryle Kennedy) CSC has been an ongoing issue with tribes for decades. It hasn't resolved itself. We are asking that quick solutions be made. Court decisions have instructed that the costs be paid in full and yet that is not being done. We have been very patient, we've participated in workgroups, and we continue to raise it as an issue. We negotiate our rates with the federal government and we are very open with our books; annually we submit our audits and allow auditors to come into our tribal offices to go through our records to make sure the funds we receive are spent as they should be. We turn those audits over to Bureau of Indian Affairs (BIA) and IHS and others we have responsibility to. Yet, we are still waiting. The suggestion to cap the amounts paid is not acceptable to tribes. The contracts were made in good faith and we've kept up our end of the bargain. Contracts are legal documents, we don't look at them frivolously. We abide by the rules and we ask for a solution. One solution is that a Special Master be assigned to work with tribes to answer questions directly, so that there is a workgroup setup and they could respond to all of the questions that they have, that this matter can be dealt with expeditiously and that the claims be settled and paid through the Judgment Fund. We have witnessed in a number of cases that the government has acted swiftly. The Keeps Eagle case was

settled and payment was made; other tribes have had claims settled and they have been paid. This too can be settled. We ask that a CSC workgroup be established to address these issues and they work with a Special Master and that consultation continue with tribes on settlement of these recommendations. We ask for support in resolving this.

C: (Kathleen Sebelius) I understand the frustration, having won the Supreme Court case and being in this situation all over again. There is no independence we can exercise on this front. We, as you know, are not parties in the lawsuit, although we are potentially payers. I think you heard the President yesterday. He understands that this is an issue that needs to be resolved. It needs to be resolved across government, not agency by agency. I can assure you that we are pushing for a resolution. We are being aggressive advocates for moving this forward. We are trying to do what we can in the short-term to move things along, but the longer-term solution is how to deal with this across the board. We are pushing on both fronts simultaneously. I hear you loud and clear and I think it's a very legitimate and long overdue claim that we need to get settled.

## ***5. Regional Issues***

C: (Chester Antone) First I want to thank you for instructing Cindy Mann to reply to Terry Rambrandt of the Inter Tribal Council of Arizona, Inc. (ITCA). We received notification of the letter on September 23, 2013. Since that time Cindy Mann has indicated that they will work with Arizona, should they submit a plan amendment. Arizona has until November 1, 2013, to submit an amendment. Regarding continuation of IHS 638 uncompensated care waiver for benefits and contingency planning for children and adult coverage, we ask for your support on that plan amendment.

Q: (Kathleen Sebelius) Just so I understand, you are supportive of what the state is submitting.

A: (Chester Antone) That is what we have at the moment. But, having said that, Cindy Mann indicated at our last meeting that podiatry, emergency dental, orthotics and occupational therapy were subtypes of the essential health benefits. It was good to hear that, but Arizona is saying it's not a requirement; so they are obviously not going to do that. The Arizona Health Care Cost Containment System (AHCCCS) Administration said we are going to have to go back to the battlefield, meaning the state legislature. I just wanted to point that out because to me, when you leave those out, and you have a high diabetic population in Arizona, you are really increasing costs. The whole idea of the ACA is to decrease costs. Arizona will not do that. They are only agreeing to this because of the litigation by the Goldwater Institute. Once that's done we'll move on to 133% [of the FPL]. I just wanted you to understand the "but," because we may want to require Arizona to do it.

C: (Kathleen Sebelius) Because that's not defined in the law as an essential health benefit, I think what Cindy is explaining is that a state can add a mandate in the first 2 years and we will actually pay for that mandate as part of the enrollment, but at the federal level we won't require Arizona to do one thing and California to do something different, for example, beyond the essential health benefits. I think she's saying at this point it really needs to be a state legislative discussion, not a federal CMS discussion. I was pleased to see that they didn't have signatures to

challenge the Medicaid expansion on the ballot. I think that was very good news for tribes and for people who are counting on that.

C: (Kathleen Sebelius) It is always a great opportunity to have you here and to have you share your views and ideas. This committee gives thoughtful dialogue. If not for the STAC, I'm not sure some issues wouldn't be on the radar, like the FDA issue. We will also follow-up with OMB on some of your suggestions. I know that it appears that when you come to town we have the same conversations over and over again. That's because some of these same issues take a long time to resolve. The conversations get carried across government and to the President. Whether it's contract support costs or the impact of sequestration, some of the issues are of upmost concern. Even if you don't see an immediate solution, that doesn't mean no one is talking about it; we are trying to get solutions to these issues. Some of it is within congressional control and we really don't have a lot of opportunity to move on those sometimes; that's why we look for administrative ways that we can move ahead without getting permission from Congress. The budget resolution and getting rid of sequestration cannot happen without some commitment from Congress. You've touched on issues that are not only important for Indian Country, but they are important for all of the people we serve. I will carry the issues with me and continue to seek resources for the most vulnerable populations. Your support in reaching out to your communities who will benefit most either from Medicaid expansion or Marketplace enrollment is terrific. We need your help. We need you to identify folks who might be entitled to benefits before the open enrollment closes, to make sure that people are enrolled in Medicaid in states that are expanding Medicaid and to make sure that they take advantage of the new Marketplace and subsidies that are available. I think those resources will frankly double. So, if you have resources coming in the front door, those resources can be taken and used for people who may not be eligible, or to expand services, or to expand operations. It's a way of drawing down more federal dollars and putting it to work for health in Indian Country. I think in that way it's a win-win situation. It frees up some of the IRS money to do other things if people are paying customers, thanks to health insurance expansion or Medicaid expansion. We'd really love to see that move forward as aggressively as possible. So, thank you for what you are doing. Thank you Ken, for stepping into the leadership role. I wish you all safe travels.

### **Affordable Care Act Update**

HHS leadership staff provided the STAC with various updates pertaining to the ACA.

*Catherine Okar, Office of Health Reform, provide a global update on the ACA.*

- Regarding cost savings to Medicare beneficiaries: Part B premiums for 2014 won't grow at all, they will stay at about \$105; beneficiaries are seeing an average of over \$800 because of discounts being given in the "doughnut hole."
- Folks are saving upwards of \$100 because of the Rate Review provisions, getting rebates in the mail.
- Investments are being made in programs like, Maternal, Infant and Early Childhood Home Visiting; about \$70 million this year went to 13 state Departments of Public Health to provide more voluntary home visits to help with early childhood development, pre- and post-natal care, and education and support for children and new parents.

- New access points for community health centers across the country were recently announced; over 200 more community health centers are being created.
- 25 states and the District of Columbia have decided to expand Medicaid.

***Kitty Marx, Director of Tribal Affairs, CMS, provide an update on the Call Center.***

- The Tribal Affairs Office has been working with the Office of Communications and the Call Center staff to update scripts that are specific to AI/AN provisions in the ACA, including the exemptions for tribal members and the hardship exemption for those eligible for services from the IHS.
- The Tribal Affairs Office worked with the Office of Communications to develop a training module for the Call Center staff so they are familiar with Indian health, understand the Federal trust responsibility, the Indian health delivery system, and the role that CMS plays.
- The Call Center received a September 27th report from the Tribal Self-Governance Advisory Committee that outlined some of their concerns and it appreciates receiving feedback.

***Cindy Mann, Deputy Administrator, CMS and Director, Center for Medicaid and CHIP Services (CMCS), provided an update on the implementation of 2014 changes on the Medicaid and CHIP side; and followed up on issues raised at the last STAC meeting.***

- So far 25 states plus DC will expand Medicaid in 2014, and those that are home to Federally Recognized Tribes include: AZ, CA, CO, CT, IA, MA, MI, MN, NV, NM, NY, ND, OR, RI, and WA.
- The New Hampshire legislature is currently debating the expansion of Medicaid and others are considering it. States can come in at any time.
- When a state adopts the Medicaid expansion it means all individuals with income below 133% of the Federal Poverty Line (\$1300 month) would be able to qualify. Right now children are eligible in every state at a much higher income level. Some state Medicaid programs may have a much lower income level for adults. For people above the income level, they may qualify potentially by paying for coverage in the Marketplace and getting help via financial assistance through advance premium tax credit and cost-sharing reductions.
- Every state is supposed to simplify their Medicaid eligibility rules and vastly changing their application and their application and renewal procedures. [She instructed the STAC to let her know of issues occurring in states that cause barriers.]
- Regarding extending the demonstrations that were granted in California, Arizona and most recently in Oregon to extend Medicaid coverage for certain services and certain individuals who weren't otherwise covered by the state's Medicaid program, the requests have been received from California and Arizona which are being actively reviewed to see if payments can be extended beyond the end of the year. All the demos are scheduled to end December 2013. The extension would really apply to services (provided by tribal facilities), as all three states have chosen to expand Medicaid for their residents up to 133% of the FPL.

- Some states have expressed an interest in what is being called the Premium Assistance Model, to expand Medicaid eligibility. It means they would expand Medicaid eligibility, but instead of providing the services through the normal mechanisms they might have, they would provide the services by enrolling people in one of the qualified health plans that's doing business in the Marketplace in that state. Arkansas has been approved to do this and others are considering it. There is a proposal in from Iowa to do it for a small portion of the newly eligible adults. If a state goes this route they have to be granted a waiver and it would be required that all the Medicaid protections for beneficiaries would continue to apply.
- A consultation was held with Oklahoma Tribes about the Arkansas proposal and as a result several key provisions in the waiver with Arkansas allow for AI/ANs to opt into the premium assistance approach; and we ensured that the cost sharing protections for tribal folks remain available. There is one pending proposal from Iowa and others are working towards this option.
- Proposed regulations were put out around the new option called the Basic Health Program and the rule is open for public comment. If a state uses the Basic Health Program, it covers people above the Medicaid eligibility level, up to 200% of FPL. About eight states are theoretically interested in doing this, Minnesota is showing the strongest interest. Regarding the definition of Indian, the law requires that the definition provided in the Marketplace be used for the Basic Health Program.
- CMS has undergone a mini reorganization and Kitty's group joins Center for Medicaid and CHIP Services (CMCS); an Intergovernmental Affairs Group has been created, directed by Jennifer Ryan.

***Mandy Cohen, Director of Consumer Support for the Marketplace, discussed the Marketplace.***

- Work continues to improve the Marketplace website; improvements to the Call Center and improvements on the Assistor/Navigator side, including a weekly newsletter and webinar.
- 20,000 individuals have been trained to be Assistors; work is being done with IHS to ensure their resources understand the Marketplace and what it means for health care given through IHS facilities.
- The comment period for the form related to AI/AN exemption from penalty closes the November 15, 2013.

***Yvette Roubideaux, IHS Director, discussed IHS items related to the ACA.***

- Geoff Roth is the ACA expert for IHS.
- IHS is focused on training and implementation pertaining to the ACA.
- There is a new ACA website <http://www.ihs.gov/aca> that explains the exemptions and issues related to AI/ANs.
- All IHS sites with the Resource and Patient Management System (RPMS) will have the ability to print out an IHS eligibility letter for patients to apply for the hardship exemption/exemption from the penalty.
- Tribal staff, health directors, business office personnel interested in participating in the weekly technical assistance calls can contact Geoff Roth.

- IHS has a new email address, ACAinformation@ihs.gov, for inquiries related to the ACA.

Before opening the floor for questions, Councilman Lucero acknowledged the presence of members of the Healthy Nations Community Fellowship and thanked them for their attendance.

Q: (Chester Antone) To Ms. Mann, you received a letter of November 1st addressed to Akina Scott (sp) regarding the Arizona waiver, so I clarify that absent any litigation it will automatically go to 133% in January?

A: (Cindy Mann) I'm confident Arizona will go to 133% in January; that will be across the board. What's left in the waiver request is to pick up services Arizona is not otherwise covering in its Medicaid program, but the tribal health facilities are providing and getting Medicaid financing for.

Q: (Chester Antone) I was reading the amendment and it refers to legal challenges. My understanding is that we are still going to go to 133% in January, if the legal part doesn't stop the expansion. Is that your understanding too?

A: (Cindy Mann) I'm not sure which legal challenges you are referring to, but I think the state and we are confident it's going forward.

C: (Chester Antone) It's the Goldwater Institute lawsuit.

C: (Cindy Mann) Yes. This is a time for confidence. It's going to happen.

Q: (Rex Lee Jim) Where is the Navajo Nation Feasibility Study; and what is the status of the dental memo from Dr. Halliday?

A: (Yvette Roubideaux) We saw the letter from Dr. Halliday and nobody thinks it's an official IHS document. We are developing a new, more positive document. Yesterday I signed off on it and I think we'll bring copies of it tomorrow for the STAC's review.

Q: (Rex Lee Jim) Are you retracting the letter? Are you supporting the Dental Health Aid Therapy Program?

A: (Yvette Roubideaux) It does indicate the evidence and the support for the programs that currently exist now, and it has information on what it would take to expand the program in other places. It's a very positively worded thing. Regarding retraction of the letter, I think we will have to send a communication specifically to the American Dental Association (ADA) to say, "Replace it with this, because the other letter is not the correct one." We actually just finalized a position paper and we will send it to the ADA.

Q: (Rex Lee Jim) What's the possibility of the STAC commenting on that letter before it goes to the ADA?

A: (Yvette Roubideaux) Yes, I actually first wanted you to see the position paper to make sure you feel it's sufficiently positive, and then we'll look at the letter as well.

A: (Cindy Mann) On the Feasibility Study, it's the same as I reported last time. It is still in Department clearance, but we'll see if we can get more information on the status.

C: (Rex Lee Jim) The concern is that it was supposed to be submitted to Congress back in March; so if you could speed it up a bit.

C: (Cindy Mann) We will look into it.

C: (Chester Antone) At the last meeting I asked that the IHS put more emphasis on revenue enhancement. We have this opportunity under Medicaid expansion to provide more services under the IHS. When we don't actively pursue claims, then we count on CHS dollars. We need to focus on enhancing those departments because of that shortfall that some areas experience. CHS dollars effects everyone, so we really need to get a handle on this. If we are not pursuing claims on the Medicaid expansion side, the revenues there for the services provisions from IHS, then we really can't expand anymore. For example, Tohono O'odham Nation's IHS now has 24/7 pharmacy services. That was done through the reimbursement process. They have also upgraded some facilities to maintain accreditation. So, we really do need to capture as much as we can to provide services.

C: (Arlan Melendez) We are still having challenges in the state of Nevada, because they've expanded Medicaid. For the Navigator program, I know there was a grant that went out to the Inter Tribal Council of Nevada. As far as implementing that, I'm not sure the status of the tribes that have used the Navigator program. I know Nevada had one of the grants. Nevada was trying to say we didn't really use it, so they were trying to take the money back. There were all kinds of things happening there. Maybe you can follow-up on how the relationship in Nevada going. For requirements for Medicaid, it sounds like they wanted original birth certificates and original Tribal IDs, and finally they said they'd take copies. It seems that through our health directors they are having challenges with implementation of Navigators. Maybe that needs to work more smoothly.

Q: (Cathy Abramson) You said if tribes have concerns about the Call Center that they should contact Kitty; are you talking about our tribal health staff? Are you ready for that?

A: (Kitty Marx) We are interested in the serious incidents, and the feedback helps the Call Center staff tweak their scripts. That's what I wanted to offer.

C: (Chester Antone) On the Navigator grants, ITCA didn't get an award. Just looking at IHS as the payer of last resort, in our tribe our State Benefits Coordinators are doing that function, because they already do it anyway. When you go in for service at the clinic, they will refer you to a Benefits Coordinator for private insurance and see if there's anything you qualify for before IHS will pay for it under the CHS dollars. I'm not sure how many tribes do this. It may be something for IHS to look at, to make sure people are trained.

C: (Mandy Cohen) I will work with Geoff Roth to make sure those folks get our updated information and are in the loop regarding the training we provide.

C: (Yvette Roubideaux) Let's make sure your Benefits Coordinators are on the weekly calls for the business office people. There is also a certified application counselor training, it's an online, interactive training. We gave the area directors the access numbers. We want at least one person at every site to get the training, so if nobody at your site got it please contact us so we can get someone into that training.

C: (L. Jace Killsback) I'd just request that you be redundant in getting that information to tribes. We'll do our part as tribal leaders, but we know tribes in other regions are at different capacities.

C: (Yvette Roubideaux) We want the Healthy Native Community Fellowship to help us teach about the ACA and let people know what's available.

The first day closed with Councilman Lucero thanking Ms. Mann and Ms. Marx for their feedback on the "No Wrong Door" issue in New Mexico. He also noted that the training for the certified application processors was not easy, suggesting that it be made mandatory at IHS sites because otherwise people might not want to do it. Finally, he thanked the panel for its presentation. Mr. Roth indicated that the National Indian Health Outreach and Education project will add supplemental training to the certified application counselor training that is Indian-specific, targeted at IHS-operated, tribally-operated, and urban Indian health programs to look at some of those factors in Indian Country that we need to be thinking about in relation to the Marketplaces. He added that it is required at the IHS-operated facilities that at least one individual has to complete that training. At the next STAC meeting he will have information on those that have completed the training.

## **DAY 2**

(November 15, 2013)

### **Tribal Opening and Review of Previous Day**

The second day of the STAC meeting opened with Councilman Lucero greeting the participants and inviting Councilman Antone to give the opening blessing. Councilman Lucero did a roll call, after which he confirmed that a quorum was met.

### **HHS Federal Member Roundtable Discussion**

During the *HHS Federal Member Roundtable Discussion* session, the STAC was updated on staff and operating divisions' work on AI/AN issues and initiatives. Presenters and highlights from their presentations are presented below, followed by tribal members' discussion on specific issues and priorities to federal representatives.

### ***Health Resources and Services Administration***

Mary Wakefield, Administrator

- HRSA will hold a Tribal Consultation next year, linking it to one of the national tribal meetings. The focus of the Tribal Consultation will be revisiting HRSA's Tribal Consultation process.
- As of September 30, 2013, the National Health Service Corps (NHSC) program supports 373 clinicians serving in tribal facilities; 41 NHSC clinicians identified themselves as AI/AN.
- As of September 30, 2013, 621 tribal clinician sites were eligible to offer loan repayment to eligible clinicians practicing at these sites, up from 494 in 2011.
- On November 7, 2013, HRSA announced new access points, i.e., money to support new community health center sites; seven went to tribal or urban Indian entities, for more than \$5.2 million.
- HRSA's mid-August webcast, HRSA's Technical Assistance - An Introduction for Tribal Entities, has been archived and is available online.
- HRSA is developing materials to strengthen tribal grant application submissions.

### ***Administration for Community Living***

Cynthia LaCounte, Director, Office of American Indian, Alaska Native, and Native Hawaiian Programs

- The ACL, Office for American Indian, Alaska Native and Native Hawaiian Programs, has been working with the Aging Network's Volunteer Collaborative and will focus on having volunteers work with veterans, youth, and in the area of substance abuse; collaborative planning will be done by ACL and SAMHSA to provide training to Title VI programs on their new research-based volunteer engagement strategy. Chairman Melendez will serve as an advisor and much of the ACL volunteer program will be geared towards Indian Country.
- Through the Long-Term Care Ombudsman Program, ACL has been working with the Inter Tribal Council of Arizona and the Hopi Tribe to get long-term care ombudsman going to Indian Country; and talking with IHS' Community Health Representative (CHR) Program about training CHRs as long-term care ombudsman.
- ACL has expanded its Senior Medicare Control Project, which focuses on Medicare fraud, and is looking into training CHRs to be Senior Medicare Control Officers.
- ACL funded a Legal Assistance System Project to the state of Montana to target seniors, including tribal elders, with social and economic legal issues.
- 99 tribes (of 206 applicants) applied for and were awarded FY 2013 Medicare Improvements for Patients and Providers Act (MIPPA) funding.
- ACL is planning for its 2014 conference.
- Title VI grants are in the process of being renewed; resolutions from tribal councils are required and grants are due December 3, 2013, to renew for another 3-year funding cycle (2014-2017) for Nutrition and Social Services Funding.
- Approximately 12 tribes have notified ACL about wanting to come into Title VI that have not been previously funded, which is problematic due to the current fiscal state.

### ***National Institutes of Health***

Lawrence Tabak, Deputy Director

- In its efforts to diversify the biomedical workforce, NIH awarded planning grants for the infrastructure program Building Infrastructure Leading to Diversity (BUILD). Salish Kootenai College, one of the recipients, is creating a consortium amongst tribal colleges to enhance graduation rates of Native Americans from their programs that lead to biomedical graduate tracks.
- NIH hosted 27 junior and senior high and tribal college students (and 3 chaperones) for a week as part of its pilot program to expose AI/AN students to biomedical research and health care opportunities.
- Dr. Linda Birnbaum, Director, National Institute of Environmental Health Sciences (NIEHS), will visit St. Lawrence Island, Nome, and Anchorage in the early summer to hold community forums with local residents affected by environmental disparities.
- NARCH is in its 7th cycle of the program, comprising ten grants with a total of 30 administrative cores, research projects, and/or faculty/student development projects. The National Institute of General Medical Sciences (NIGMS) is investing \$2.5 million and nine other Institutes/centers are providing their support for an additional \$2.8 million.
- Names of potential AI/AN peer reviewers for research projects should be sent directly to Mr. Tabak.

### ***Administration for Children and Families***

Mark Greenberg, Acting Assistant Secretary

- ACF continues to engage with tribes and now has a Tribal Advisory Committee (TAC).
- The ACF Tribal Consultation will be held on June 16, 2014.
- ACF issued Tribal Title IV-E grants, up to \$300,000, to five tribes on September 30, 2013.
- The new Associate Commissioner for the Children's Bureau is Joo Chang.
- The Office of Child Care (OCC) approved 259 Child Care and Development Fund (CCDF) FY 2014-2015 Tribal Plans.
- OCC released the *Summary of Tribal Child Care Activities* at the end of FY 2013; it is available on the OCC website.
- In the Community Service Block Grant program, 20 tribes participated in the first ever technical assistance tracks during the Annual Conference of the National Association of the State Community Services Programs that was held in September 2013.

### ***Centers for Disease Control and Prevention***

Judith Monroe, Director, Office for State, Tribal, Local, and Territorial Support

- The CDC Tribal Consultation Policy is now final and on the CDC website.
- The CDC TAC Charter was approved on November 4, 2013, by the TAC; it is under review at CDC and active recruitment for additional TAC members is underway.
- CDC's Tribal Consultation will be held on February 19, 2014, in Atlanta, Georgia.
- CDC's TAC meeting will be held on February 18, 2014.

- Six tribes received 5-year awards from CDC's Office for State, Tribal, Local and Territorial Support for the Tribal Public Health Capacity Building and Quality Improvement funding opportunity.
- CDC continues to work to ensure the inclusion of tribes in its funding opportunity announcements.
- CDC is working to recruit Native individuals in an effort to expand its fellowships, especially its Public Health Associate Program (PHAP).
- CDC will partner with the University of Pittsburg on a Tribal Judges' Training in the spring of 2014.
- CDC has partnered with NIHB, through a cooperative agreement, on the creation of a public health workgroup, comprised of representatives from NIHB and all of the 12 Indian Health Boards, to support the CDC TAC through information analysis and expert meeting facilitation.

C: (Cathy Abramson) Last week NIHB sent a letter to NIH regarding the grant review standards. I just wanted to say that we acknowledge your response and we are looking forward to the formal response.

Q: (Roger Trudell) Elders coming into our clinic back home are being asked if they are being abused. The reason for the question is not explained. Is there some standard information that can be given to clinics to educate the elders and the community on why they are being asked that question? At the White House Tribal Conference there was talk about pain management and prescription drug abuse on reservations. People have been totally shut off from any pain relief. There hasn't been a real alternative or a gradual phasing down of medication for people, and because there are not enough contract health dollars some things are not treated that might relieve their pain. Is there a plan of action for the gradual implementation to get people off of medication, especially elders with severe health problems? We need to educate our communities about this. There needs to be an alternative from swift removal of people from pain relievers because it does potentially create a black market. If we had a better plan at the local level I think it would reduce some of the doctor shopping that goes on for those drugs. I would appreciate a more defined approach.

A: (Yvette Roubideaux) We'll work with ACL on the issue of education, on why health care providers ask the elder abuse question.

A: (Cynthia LaCounte) We can plan a webinar around it with Title VI programs, and they can start talking to the seniors.

A: (Yvette Roubideaux) On the prescription drug abuse, we had a workgroup of some of our providers putting together a new policy and recommendations about how to handle that. Under the current policy they are supposed to do a "contract" with the patient. They shouldn't be cutting them off cold turkey, and if they are we want to know those sites so we can educate those providers. But, you are right, we need to do more education to tribal leaders on this. The policy is in development and the workgroup is working on outreach and education. I'll mention your comments to them and to the area directors as well, as they are coming to town next week.

C: (Arlan Melendez) At some point we have to define what elder abuse is. I know there is medical elder abuse, but then there is also more of a social elder abuse. Many times grandkids take advantage of elders, is that elder abuse? That's handled to a certain degree through the BIA Social Services. We have to have an interconnection between BIA Social Services and IHS. On pain management, I think you'll find that across Indian Country some health centers are better able to handle pain management. In Nevada one doctor was called "the candy man," because he had a reputation of giving pills to people with no parameters. I heard somebody else say it's a contract health issue, where you would send people out to contract health service to find pain management out there in the city arena, whether or not our health centers or clinics are really equipped to handle pain management. I think it's a little confusing in terms of how equipped we are to really address what pain management actually is. It's an area that IHS can look at across the nation.

Q: (Cathy Abramson) Are health centers supposed to ask about abuse as a standard question?

A: (Yvette Roubideaux) Yes.

Q: (Chester Antone) A comment on the Ombudsman program, last week we approved our MOA with the state to train one of our members to play that role. To Mr. Tabak, what is the status of NIH's guidance document? Is it continuing?

A: (Lawrence Tabak) As far as I know it's continuing.

Q: (Chester Antone) Are there any specific obstacles?

A: (Lawrence Tabak) None that I'm aware of, but I'll get back to you.

Q: (Cheryle Kennedy) To Mr. Tabak, my tribe is located in Oregon and we are the most rural. Because we are 35 miles from West Salem, that puts us almost in an urban area; so we are ineligible for some grants that come out. Our concern is retention and recruitment of physicians and health professionals. We had IPAs with the IHS for placement of some of those professionals. You run into problems because if things aren't working out you still have to pay for their salaries and moving costs. I was thinking about the NHSC, but it also has the requirement of being in a designated rural area. What solutions can you offer?

A: (Lawrence Tabak) We concentrate on a research workforce. My colleagues around the table may be able to respond better to that.

A: (Mary Wakefield) HRSA does field the NHSC program. I'd be happy to take that back and make sure that we're working with your primary care organization in your state so that they are designating your area accurately and that it's current. We have NHSC clinicians that go into underserved urban areas, as well as rural areas. We tend to place the clinicians in the highest need areas.

C: (Cheryle Kennedy) Yesterday I heard that once members are eligible for Medicaid, we can't get the health data that is associated with their visit. I was our Tribal Administrator of Health for almost 20 years. The data is so important. At that time I was able to negotiate with the state of

Oregon for the Medicare/Medicaid tapes. Then you are able to match, so we had a pretty complete view of the health status of our members; we don't anymore. I still think there is a great need for tribes to know health data of its members. I just think somebody needs to be working on this.

C: (Yvette Roubideaux) One of the issues is the kinds of data you are interested in. There's the data that each of the operating divisions has and then there's the health research data.

C: (Cheryle Kennedy) It's the specific diagnoses people are being treated for; information that was in RPMS, but in Medicaid.

C: (Yvette Roubideaux) I think there are some challenges for doing that with Medicaid. CRIHB [California Rural Indian Health Board] was working in this, where Medicaid has data on what things are billed for and IHS had data on who the people are. So, CRIHB did a study where they merged the IHS and the CMS data set. They were kind of able to figure out some of the things you are interested in. We might try to get a hold of that report.

C: (Cheryle Kennedy) We did that in Portland for all of the tribes in the northwest. There was an agreement with the state, but that went away. We even said we'd pay for it if it was a manpower issue. I would think this would be every tribes' concern, because 25% or higher of our people are eligible.

C: (Yvette Roubideaux) We can talk with Cindy Mann about the issues around availability of the data.

C: (Cheryle Kennedy) What I would like to hear is that there will be a commitment to seriously work on this issue and to come to some resolution.

C: (Yvette Roubideaux) I'll definitely talk about it with Cindy Mann, with Medicaid.

Q: (Rex Lee Jim) Regarding the elderly, we are interested in long-term care facilities. Is there any plan on what needs to be done? The other issue is the whole idea of elder and child abuse. Sometimes people are reluctant to work with elders or with children because of the issue of abuse. I think there needs to be some kind of an education program to really define what it is. You don't want to abuse and you don't want to neglect. I'm interested in that capacity building, for our people to work with the elders. For NIH, the Navajo Nation is interested in establishing a Center for Excellence in Education and Health. We want to control our research agenda. How can NIH help us build that capacity? Have you worked with tribes? Do you offer any grants to them? For ACF, we always emphasize working with the states and enforcing the Indian Child Welfare Act (ICWA). Some states are still finding ways to go around it. I want ACF to step up to the plate on this. Regarding Head Start, at Navajo we are having a difficult time putting our Head Start back on course; we need technical assistance to get it back on track.

A: (Mark Greenberg) We are committed to actively working on enforcement of the ICWA. We welcome your specific advice and guidance on areas you'd like us to be providing greater attention to and areas you think our role can be most helpful. On Head Start, we should follow-up afterwards to connect further to discuss specific issues.

A: (Cynthia LaCounte) I will talk to our funded NIJI, which is the National Indigenous Elder Justice Initiative and have Jackie Gray contact you or Larry Curly to do some capacity building in Navajo Country. They can help tribes develop resolutions/tribal ordinances to protect elders and they can also do capacity building. As far as definitions of elder abuse, we, through NIJI, have made some definitions regarding types of elder abuse; but I think it's something that needs to be defined locally as well. Solutions certainly need to be found locally. We are working with NIJI to help tribes determine their own methods of prevention and how the community wants to handle protecting the seniors and looking at this horrible issue.

A: (Lawrence Tabak) In answer to your question, the next step would be to have your staff contact me about your specific interests. We support infrastructure building for the purpose of research capacity. It sounded like that may be at least part of what your interests are. A further discussion would be very helpful.

C: (Aaron Payment) For elder abuse, it seems like we need something to help people to understand what it is. We probably need a campaign of some sort. It will vary depending on the community, obviously. I hear a little push-back sometimes when we ask questions about abuse, because sometimes you stir things up. If you don't provide the follow-up it makes things worse. With the drug situation, we adopted that policy about 10 years ago where we monitor new pain management and contracts. I always get the "They won't give me my meds" calls. I call the health director and she goes through all the steps we have followed. The electronic health records have really helped us to be able to track. The only challenge we have is if somebody has their own method of payment and they go someplace else. In our community we have people who are volunteering to do chore services for the elderly just to get their hands on their prescription drugs. On Head Start, in the BIA budget formulation for 2015, in order to balance the budget, the disability services under BIA are zeroed out. Hopefully we can fix that, but it seems like it belongs more here anyway, under ACF. I really implore people to look at Head Start at a micro level, because they have to hit all the benchmarks and standards, regardless if they have the funding. If disability services on the BIA side come out of the funding, somebody has to make up the difference for that because they still have to meet the benchmarks. I'm looking for some leadership from us to find supplemental funding if the BIA budget formulation follows through in 2015.

C: (Marshall Gover) A lot of times elder abuse and drugs go hand and hand because children over medicate their elderly parents or grandkids overmedicate their grandparents. I'm a big advocate for the VA IHS MOU, and it has some problems with pain management. I get calls from vets who switched to IHS from the VA and they complain about medicine being taken away. We need to go the extra mile to see why some people need pain medication. If they don't get it, they often turn to alcohol or street drugs. Others need psychological help, as many vets have PTSD. We need to get back to our basic beliefs and spiritualism. It seems like when we get back to what our old folks taught us, then we get straightened out.

C: (Aaron Payment) I think a lot of what we are experiencing is because of historical trauma, and then you add to that the PTSD that our veterans may have. We've been participating for over 10 years in pain management, however I don't think I've ever inquired about if we are asking the right questions. When it comes to veterans and their chronic physical and/or emotional pain, are we sensitized in our treatment and asking the right questions. We have a traditional medicine

program that works well, but sometimes we forget to incorporate traditional medicine to supplement pain management drugs. There is a releasing ceremony we do when vets come home to help them to be able to release their guilt and remorse.

C: (Mirtha Beadle) SAMHSA is part of a department-wide group that deals with behavioral health and coordination; and there is a subgroup that is looking at prescription drug issues and trying to come up with some recommendations. Those are pretty close, I think, to coming to fruition. We should probably bring that back here for discussion around how that might be addressed within Indian communities.

C: (Cynthia LaCounte) ACL is also involved with SAMSHA in some discussion on pain management and prescription drug abuse with seniors. That started out of Region 5, out of a Tribal Budget Consultation.

C: (Yvette Roubideaux) The VA IHS MOU, the collaboration, one part of that is sharing behavioral health things, e.g., trainings on PTSD. I'll check on the progress of that.

Q: (Marshall Gover) I know there are PTSD centers throughout the U.S. I think there are five of them. What about seeing if the VA would work with IHS on training those centers?

A: (Yvette Roubideaux) I'll check with my behavioral health staff to see if they are working with them. If not, we will.

C: (Cathy Abramson) Yesterday I talked about what is happening with our traditional healing staff. Our healers are meeting along with the doctors now. The veterans put their PTS legal staff right there with our healers. They are also going to incorporate more into the behavioral health programming, which would include our veterans. I would encourage anybody that has traditional medicine/healers, to make sure they are in the places they should be along with the doctors because that's what they are.

C: (Roger Trudell) A lot of veterans learn how to suppress things and then encounter a change in life that triggers stress. I took a 15-week session; it didn't have the full impact I thought it might have. I know in the Black Hills they have a cohort program where you go for 3 weeks. I wonder if we can't get IHS personnel who have the most contact with tribal veterans to do some of those courses so they can better help veterans. PTSD for Vietnam and other veterans, it's here and now.

C: (Yvette Roubideaux) I'll go back to my behavioral health program and see if they are aware of it. We have started some new national webinars with our doctors to try to help them get continuing education credits. We can use those as forums to introduce people to the topic and then we can see if we can get them involved in more of the longer trainings.

C: (Mary Wakefield) Yvette, if there are opportunities to make sure our NHSC clinicians are part of that training, I'd like to make sure they have at least baseline knowledge. So, please include them. Maybe we can create some special webinars that involve places that are already doing this as best practices. Likewise, if we can link into some of the PTSD and veterans issues, I think our

clinicians have an opportunity to learn so they are even better providers in these communities. So, please keep us in mind. The same goes for the issue of elder abuse. They all know to ask the question, but the cultural context might be new to them and that too might be an area we want to make sure clinicians get extra training in. We'll work with IHS and maybe come back to you guys to try to get some expertise.

C: (William Micklin) Senator Begich is sponsoring and Senator Mikulski is co-sponsoring a Safe Villages and Families Act. It's a justice program for alternative justice in the villages of Alaska. It's a solution to the Violence Against Women Act (VAWA) that excepted Alaska from tribal jurisdiction over non-members. In the rural villages we don't have law enforcement that is equivalent to other states or communities or means for incarceration. If there are going to be these alternative justice systems (alternatives to incarceration), I'm wondering if HHS program officials can talk to Senator Begich and Senator Mikulski, to apply existing programs that exist or can be extended from current practice. In our folder we have the Federal Workgroup on Alternatives to Incarceration on Reservations. SAMHSA is conducting a demonstration project with the Tribal Policy Academy. It's one example of what can be a helpful solution to instead of finding new funds they could be referred to existing programs and programs that are proven effective and could be applied in the context of the Safe Families and Villages Act. And, at the least, help tailor the legislation so it doesn't mandate capabilities that are just not available or can't be done. I think in this instance, a close relationship during the period when the legislation is being crafted, between the Alaska delegation and HHS would be very helpful. Also, in September of next year there is the World Conference on Indigenous Peoples (WCIP). The President will be addressing the conference. It is a forum of the United Nations (UN). Tribal leaders will take an active part in this program. One of the priorities tribes have put forth to the White House is our support for the UN Program on Prevention of Violence Against Women and Children. It would be good if there could be some cooperation leading up to this between what is going to be reported at the conference with regard to this as a priority program for the UN and its agencies and what's being done by the U.S. through HHS and through tribal cooperation. I just put that out there, for HHS to talk with the Department of State. Tribal leaders will likely meet with the Department of State in January 2014, to talk about the WCIP and the lead up to that. It would make sense for HHS to be involved in this. It would be good for the President to report progress or some kind of mutual aid effort, since tribes will be participating in a national arena through this and through our hope for a regular and permanent status at the UN that allows us to sit at the table to have a voice.

C: (Mirtha Beadle) We started meeting not quite a year ago with CMS, IHS, Interior, and Department of Justice to talk about how we bring our existing programs together to do a better job of working with tribes on addressing alternatives to incarceration. That conversation is still ongoing. The Tribal Policy Academy is one aspect of that broader discussion. There has been intensive technical assistance working with tribes on how they can do more localized work and other supports that can be brought into their capacities to do more targeted work. There will be more news coming out this year about ways we can work more specifically with tribes around that. We will do another Policy Academy specifically around youth/juveniles. Also, part of the supports that various departments have been able to bring to the table is the technical assistance aspect of this. So the question is, "How can we provide those planning and implementation resources that would be valuable to tribes?" We have a new technical assistance center that is specific to tribal communities.

C: (William Micklin) On Head Start, we are getting hammered pretty hard by sequestration. We've already had the statutory limitation on indirect recovery. Head Start is a costly program, but it's one of our most effective and sought after programs by our tribal citizens. Even with sequestration, we still have to meet those benchmarks. If we have to absorb another sequestration, I don't know how we can do that. I'm concerned about how we will continue our Head Start program in this context. We don't want to lessen the standards, but something has got to give.

C: (Mark Greenberg) We are very mindful of the impacts of sequestration. We've heard accounts on those impacts. I'll take your comments/concerns back to my Head Start colleagues.

C: (L. Jace Killsback) Regarding cultural competency, Ms. Wakefield alluded to a standard for cultural competency training. Related to veterans and PTSD, at home when a warrior comes back we have a victory dance. We started changing that to have individual dances for them, when in fact the victory dances were supposed to be for all the warriors. Young veterans were seeking out tribal programs and resources to coordinate this. It didn't happen, but the idea is still there. It might happen within this next year. They were looking at suicide prevention and recovery resources, a sort of holistic approach to dealing with these health issues. It reminds me of the SAMHSA Access to Recovery model, which allows for traditional healing and traditional practice. That's a model I think each of the departments can look at when distributing resources or services so they are culturally appropriate, they work, and they promote the revitalization of our cultural ways to deal with long term health issues.

C: (Ken Lucero) Our discussions often come back to our traditional ways. We don't do enough of looking at the research part of this, involving academia and Native studies in the policy pieces.

C: (Lawrence Tabak) I'd like to offer a compilation of the NIH research portfolio related to traditional medicine. It may make it easier to identify the "gaps."

C: (Ken Lucero) That would be great. I'm not just talking about traditional medicine, but also social justice issues.

C: (Lawrence Tabak) Unfortunately, that element is something that I doubt NIH has much of an investment in. I do know we have an investment in traditional medicine.

C: (Yvette Roubideaux) You also have an investment in community-based participatory research in the NARCH. So, having the committee hear some of that work would be helpful also.

C: (L. Jace Killsback) And now you have the charge of protecting the cultural and intellectual properties in doing this type of work. That's always been an issue for tribes. When we share our ways of traditional healing, that has to stay protected and not be exploited in dissertations and public works by people who are not going to benefit our community and are not part of our community.

C: (Lawrence Tabak) Yes, we'll do that.

C: (Chester Antone) I think Dr. Roubideaux should address at the next meeting her consultation on traditional medicine and how that came about. It was 3 years ago you initiated that.

C: (Yvette Roubideaux) I can address that now. We started the consultation and I asked for input. We got two or three letters. It was not the most effective way of getting input on traditional medicine. We held a Tribal Consultation Summit and it was a great session. The question is how do you go from the sharing of information to the recommendations to implementing actions. Please think about this. Maybe a STAC subcommittee could be formed.

C: (Chester Antone) These questions can be very sensitive, that's why the Tohono O'odham Nation drafted a resolution to ask the NIH to establish a Tribal Advisory Committee, so they can be advised on how best to address this. Some tribes are very protective over their practices.

C: (Aaron Payment) As we try to understand traditional medicines, we need to identify people knowledgeable in grounded theory. Regarding the Health Research Advisory Council (HRAC), some tribes are much further along than others in terms of developing IRBs or tribal research review boards to protect the integrity of the data. In my community the council members are very guarded about anybody coming in. Perhaps HRAC can get information out about models that are available because some tribes are doing it really well.

C: (L. Jace Killsback) I'm the Regional Chairman of our IRB and one of our efforts in the region is to get each tribe to develop their own IRB. Three of the seven tribes already have IRBs. We were glad to see the STAC's follow-up on some of our concerns regarding research in health. There's funding for research in health; the next thing is research for health publications. We hope that maybe sometime in Indian Country there is a national Native IRB or a clearinghouse where research can be vetted with some of the best and brightest people sitting on those boards.

Q: (Cathy Abramson) Regarding the Health Information Technology for Economic and Clinical Health (HITECH) project, I didn't get a chance to bring this up yesterday. NIHB has a contract with the Office of the National Coordinator for Health Information Technology to assist eligible health care providers in Indian Country with achieving meaningful use in the implementation of electronic health records (EHRs). We contracted with four regional partners to work with eligible health care providers within the ITU [IHS/Tribal/Urban Indian] system to achieve full meaningful use in Indian Country. We've assisted 2,700 eligible providers. Over 150 IHS providers are not yet fully participating in the regional extension center. At stake is a loss of assistance in obtaining the CMS incentive payments. More importantly, many providers in Indian Country are not getting the full meaningful use. We are requesting that you encourage those federal providers to participate and work with NIHB in achieving meaningful use. We would appreciate it if you would do a letter to help us get the word out, so IHS can improve its health delivery system to tribes across the nation.

Q: (Yvette Roubideaux) Do you know what general percentage of our providers are not working with you? Is it just certain areas or is it a widespread issue?

A: (Jennifer Cooper) [Seat yielded by Cathy Abramson] I understand from our Director that it's widespread, but we can get details to you.

Q: (Yvette Roubideaux) Do you know the reasons why? Is there a misunderstanding about your role or are people just not wanting to do this? I know we had an issue about the IRS, but we resolved that.

A: (Jennifer Cooper) It's just about getting people to stage three. Some of them have made it through the first one or two milestones. We're at a critical stage for hitting the milestone and with that there is a tight deadline. Again, we can get you more information. [Seat resumed by Cathy Abramson.]

C: (Yvette Roubideaux) Great. I'll talk to Dr. Hayes about this as well.

### **STAC Business, Closing Discussion and Comments**

Councilman Lucero asked the STAC to review the upcoming STAC meeting dates and voice any concerns. Noting concerns about the scheduling of the National IHS Budget Formulation meeting during the same timeframe in February, Councilman Lucero suggested that the next STAC meeting be held on February 13-14, 2014; the group agreed. The group also agreed to the following dates on the STAC's 2014 calendar: June 4-5; September 10-11; and December 4-5.

Q: (Cheryle Kennedy) When do the current terms finish?

A: (Paul Dioguardi) After this meeting we will send out notices of vacancies, so people will be in place before the next meeting.

Q: (Aaron Payment) Regarding the Contract Support Workgroup that's going to be put back in place, when will we get a listing of vacancies? Also, there seems to be disconnect with OMB. Maybe we can help to forge better communications and advocate on behalf of HHS at the OMB level. We've already recommended the Associate Director for Native American programs, but in the meantime maybe we need somebody from OMB to be present during the CSC workgroup sessions.

C: (Yvette Roubideaux) The CSC workgroup will not work on litigation. It will work on the appropriations issues. At the negotiations phase and the funding phase, at the generation of the need report phase, and at the claims phases there is a lot of variations in the numbers. So, a purpose of the CSC workgroup is to see if we can find greater agreement in the estimates of CSC in the pre-award or negotiations phase. The conversation about the numbers will help with OMB. They are happy we were having this conversation. Whether OMB goes to the workgroup or not, OMB is interested in what comes out of it. The tribes will admit there are areas we could be in better agreement on. Since the 1990s it's been an issue on whether we agree on what the statute says for CSC. I can take the recommendation back to see if OMB will come. We want to convene the workgroup in early December, maybe the second week. We will get list out to people so they can see who is on the workgroup and identify vacancies.

Q: (Cathy Abramson) Yesterday Secretary Sebelius said a committee for OMB might be a possible, is that this?

A: (Yvette Roubideaux) That's different. You guys made a recommendation for an OMB TAC and she will take that back to OMB for consideration.

C: (Cheryle Kennedy) This is my last meeting, so thanks to everyone for your time and effort. I've enjoyed working with everyone. Thanks to Secretary Sebelius for putting this group together and to the staff that provide so much information.

C: (Cathy Abramson) This may be my last meeting, but I hope to be here in February. This is a good committee and I think a lot of progress has been made.

C: (Paul Dioguardi) It's been a great year; thank you to everybody that served. I look forward to building on the great work that has been done and spreading this practice to other agencies and cabinet departments. On behalf of the Secretary, thanks for your service this year.

The STAC meeting ended with Councilman Antone providing a closing blessing.