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HHS 15th Annual Tribal Budget and Policy Consultation

I N D E X

March 8, 2013

I N D E X (continued)

KEYNOTE: “---“ denotes inaudible in the transcript
“*” denotes word was phonetically spelled

M O R N I N G S E S S I O N

(8:45 a.m.)

Welcome

by Gary Hayes, Chair, Secretary's Tribal Advisory Committee

MR. HAYES: I would like to welcome everybody here this morning. I appreciate the time you are taking to come out. I know many of us –- we have been here since Sunday, and it has been a long week for us. And I know that the snow put a little damper on our schedule but we persevere to overcome. What we try to do is speak for our people as we come to DC.

So before we get started, I asked Chester Antone to offer a prayer this morning for us.

MR. ANTONE: Good morning, everyone. This morning I offer a prayer to the creator for all of us, for all the world.

(Prayer)

MR. HAYES: Thank you, we appreciate that. Now we will go ahead and –- again, welcome everybody here. First off –- Jefferson Keel couldn't join us this morning to address us this morning. I know he had a long week also but he had to return back home. So Cathy, we will go ahead and open it for Tribal opening remarks.

Tribal Opening Remarks

Cathy Abramson, Chair, National Indian Health Board

MS. ABRAMSON: Good morning. I am Cathy Abramson. I am the chair of the National Indian Health Board. It is nice to see you all here. It has been a long week, a long productive week, I feel, and we are very happy that you are here.

I am a member of the Sault Ste. Marie Tribe of Chippewa Indians in Michigan, and I am also a member of the Secretary's Tribal Advisory Committee. And I will tell you what: If only we could have the snowstorms in upper Michigan like they do here.

It is nice to see you, and it is always a good time for us all to come together to discuss our issues and concerns about our health. Thank you.

Tribal Opening Remarks

Gary Hayes, Chair, Secretary's Tribal Advisory Committee

MR. HAYES: Thank you, Cathy. And I would just like to welcome everybody in my opening remarks. I am Gary Hayes, chairman of the Ute Mountain Ute Tribe and the chair, recently elected to be the chair of the Secretary's Tribal Advisory Committee. And it is an honor and privilege to be in this position because the needs of our people are at the forefront of our concern when we meet and gather.

And we know the climate and the environment that we are in. It is a challenge for each and every one of us to

come together. And it is evident by yesterday, by President Obama signing the Violence Against Women Act, that if we come together as partners and really advocate on behalf of our people, things can change. And it may take some time, but we are here to continue to beat the drum, be the voice of our people, and we need to continue that.

So I appreciate each and every one of you for being here today, and again it was a significant and historic moment yesterday for our people when we go back and we talk about -– we always say, mention about the inherent Tribal sovereignty right of our people, and that was evident, and it was acknowledged yesterday by the president signing that.

It was a significant moment for us as we talk about how do we change the understanding and the relationship of understanding Tribal sovereignty.

Yesterday was the legislative branch of the government making that decision because for too long some of our courts, on the judicial side, had been eroding Tribal sovereignty for quite a long time, and this is one way of trying to get back that Tribal sovereignty where we can exercise it, truly exercise it for our people.

And I also want to thank the STAC members and, of course, our federal partners and the Secretary. We handed out, hot off the press, our national Secretary's Tribal

Advisory Committee Report here, and it will be distributed throughout Indian Country.

So it is a report on what we have been working with, with our partners, and we really appreciate this partnership that we enjoy with our federal partners.

So with that, I just want to say again thank you very much for being here, and I will ask Roberta -- she is moderating also today, and she is also a member of STAC -– if she has any remarks.

MS. BISBEE: Thank you, Chairman Hayes. Good morning. My name is Roberta Bisbee. I am a member of the Nez Perce Tribe and I serve on the Nez Perce Tribal Executive Committee. I am also a Tribal participant with the Northwest Portland Area Indian Health Board, and I also serve on Secretary Sebelius' Tribal Advisory Committee.

And so I just welcome all the Tribal leadership here today and look for a good, productive meeting as well as everyone in the audience -– hope you have safe traveling mercies to and from.

I just appreciate the opportunity and all the hard work the STAC and all the other Tribal leaders here today, advocacy for your Tribal nations, and I also appreciate this report and I appreciate the opportunity to serve on Secretary Sebelius' Tribal Advisory Committee, and I appreciate the

federal partners for always being available for questions and providing assistance. So thank you very much.

MR. HAYES: Thank you, Roberta. At this time I will ask Paul to give us some remarks this morning.

HHS Welcome and Opening Remarks

by Paul Dioguardi, Director, Office of Intergovernmental and External Affairs

MR. DIOGUARDI: Great. Thanks, Gary. Good morning, everyone. My name is Paul Dioguardi. I am the director of Intergovernmental and External Affairs here at the Department of Health and Human Services, and I just wanted to welcome you all here today on behalf of Secretary Sebelius, whom we will hear from later, and the entire Department of Health and Human Services.

This is our 15th Annual Tribal Budget Consultation at the national level. I am pleased to say this is my 5th consultation since I have been with the Department, and I feel like every year things get better and better, and we have really strengthened our partnerships.

I think we have enhanced the dialogue, and I think we have really been able to improve consultation to a point where we are truly working with each other, understanding each other and doing so in a way that leads to actual policy changes and improvements that improve lives around the country.

And so I just want to thank you for your partnership in all this. Thank you for working with us in developing what I think is a valuable process that contributes to our work here at HHS. I also want to note that this year is a little bit unusual given the storm and then the signing ceremony.

We have had to rearrange and condense things, so it is going to be a shorter consultation than we normally have, but I think we have structured it in a way that we will give everybody an opportunity to be heard and to listen, so I am hoping for a very productive conversation today.

So I thank everyone for your flexibility and for being here. I know it has been a lot going on this week, as Gary noted, but we want to make sure we use this time well but also respect everybody's time and schedules and give you an opportunity to get out of town and head back home before the weekend.

Just a couple of quick housekeeping notes before we begin. We have an evaluation form that I really encourage everybody to fill out. That evaluation is one of the things that we have used to make changes and to make improvements to consultation, and I think we have seen some very positive results from that.

So I would encourage you to fill out that evaluation and hand it back in to us. As I think everybody probably

knows by now, we do have a protocol in place for how we engage in consultation, and our moderators here today will be enforcing that protocol to make sure that we hear from Tribal leaders first and make sure their voices are heard, and then we will move on through everybody else who has questions or comments that they would like to contribute.

On the federal side, we are going to try to limit our remarks as much as possible to make sure that we have enough time for questions and dialogue. And just a couple of thanks. This consultation here today could not be possible without our Tribal partners who engage in our workgroups, who help us develop the agenda and who will help us run the consultation today.

So this really is a joint effort, and I just want to acknowledge and thank not only all of our federal partners on this but also the Tribal partners who make this all possible.

And just one final thing again, in the interest of keeping things moving along and making sure we have a constructive dialogue, when you do have questions or a comment, please be sure to state your name and your position and whom you are representing.

It is important not only for the conversation but also so that we have a record for the report that we issue coming out of our consultation. So with that I will turn it

over to the moderators so we can get to our first topic. Thank you.

MR. HAYES: Thank you, Paul. We appreciate your comments and we truly enjoy the partnership that we have today, and hopefully we will continue moving forward. And before we get started and we continue on, I would like to welcome again and acknowledge the Tribal leaders, so I am going to go around to my left, and if you would just go ahead and please introduce yourself.

Tribal Leader Introductions

MS. CROMWELL: Good morning, everyone. My name is Cheryl Frye Cromwell. I am Tribal Council for the Mashpee Wampanoag Tribe and I am also a STAC member.

MR. JOSEPH (Speaking Native language): Good morning. My name is Badger, Andy Joseph Jr. I am on the Confederated Tribes of the Colville Indian Reservation Tribal Council. I chair the Veterans Committee and am the delegate for the Northwest Portland Area Indian Health Board, which I chair, and was recently elected to the executive committee of the National Indian Health Board. Good morning.

MS. JOHNSON (Speaking Native language): Good morning. My name is Nancy Johnson, and I am Tribal Council for the Confederated Tribes of the Colville Reservation, and I serve as their Health and Human Services Chair.

MR. FORSMAN: Good morning. Leonard Forsman, Chairman, Suquamish Tribe of Washington state.

MR. GOVER: Good morning. I am Marshall Gover. I am President of the Pawnee Nation of Oklahoma.

MS. HANVEY: Good morning. I am Vickie Hanvey. I am the delegate for Cherokee Nation today.

MS. HOMER: Good morning, everybody. Welcome. I am Sylvia Homer. I am the Vice Chairwoman of the Colorado River Indian Tribe.

MS. DAVIS: Phyllis Davis, Tribal Council, Gun Lake Band Pottawatomi, Bemidji Area representative for the Tribal workgroup.

MS. WATTS: Cara Cowan Watts, Cherokee Nation Tribal Council, and I am here as a co-chair of the Health Research Advisory Council for American Indians/Alaska Natives.

MR. KUTZ: I am Steve Kutz. I am a Tribal Council Member for the Cowlitz Tribe, also on their executive council. And I am Co-Chair of the HRAC also.

MR. ANTONE: Chester Antone, Councilman, Tohono O'odham Nation.

MR. DIXON: Stacy Dixon, Tribal Chairman, Susanville Indian Rancheria, California.

MR. VIGIL (Speaking Native language): Good morning. Gil Vigil, Pueblo Tesuque councilman, and also representing

the National Indian Child Welfare Association, recently elected as chairman of the association, replacing our longtime chairman, Maurice Lyons, who has become ill so he couldn't assume that role any more.

I ask for your prayers for him so he can be better, become better also, because he is a great leader. And also I know Chairman Hayes was talking about our victory with the VAWA signing yesterday, but again we have another challenge in front of us. I don't know if you have heard of it but it is called Adoptive Parents versus Baby Child.

We refer to it as a baby --- case, because it is a child, our child, and it is going to be in the Supreme Court. So we ask for all your assistance, however you can help us, to fight this challenge also. Thank you.

MR. PAYMENT (Speaking Native language): It is a great day. My name is Aaron Payment, and I am the chairperson from the Sault Ste. Marie Tribe of Chippewa Indians.

MS. MONROE: Good morning. Judy Monroe, Centers for Disease Control.

MS. BEADLE: Good morning. Just in time. Mirtha Beadle, Substance Abuse and Mental Health Services Administration.

MS. ABRAMSON: Hello. Do you want me to say hello again? Cathy Abramson, chair of the National Indian Health

Board, Tribal leader from the Sault Ste. Marie Tribe of Chippewa Indians.

DR. ROUBIDEAUX: Good morning. I am Dr. Yvette Roubideaux, the director of the Indian Health Service.

MR. HAYES: All right, thank you all. It is great to have you all here this morning. We will go ahead and continue with our agenda. Next up is Norris, who will go ahead and give us an update.

HHS Budget Overview and Update

by Norris Cochran, Deputy Assistant Secretary for Budget

MR. COCHRAN: Thank you, Gary, and good morning, everyone. It is nice to see all of you. Thank you again for your patience with the change in schedule. With the compressed period this morning, I will try to go fairly quickly and really touch on highlights in order to leave time for questions.

But as you know, we did send up the ’13 budget over a year ago now in February of ’12 with some significant increases for the Indian Health Service and other HHS programs targeted to American Indians and Alaska Natives. The total budget request for ’13 was $6.3 billion, which is an increase of 2 percent over the prior year and 27 percent over 2008.

Most of this funding, 90 percent of it, is through the Indian Health Service. Other activities are primarily in

the Administration for Children and Families that are targeted to Tribal populations, including Head Start, child care, TANF, and child support. The IHS budget, as you know, is about $5.5 billion, and we propose an increase of $116 million. This is about 32 percent over the 2008 year.

And most of that increase was for contract health services. There are also just under $50 million to staff and operate newly opening health facilities. And then targeted increases for contract support costs in health IT.

As you know, Congress hasn't enacted the 2013 budget yet. The House has recently passed a continuing resolution. The Administration's preference would be for the appropriations bill that funds the Indian Health Service to be passed as a piece of legislation. When Congress doesn't do that, they pass what is called a continuing resolution that, for the most part, funds everything flat with the prior year.

We have been working both to try and get the appropriations bill that funds the Indian Health Service included as a specific piece of legislation, but if not, if ultimately Congress decides to fund those activities through a continuing resolution for the rest of the year, we have been trying to get the Congress to still provide an increase.

And within HHS, the list of activities for which we would try and secure an increase under a continuing resolution

is very short, and because these activities are such a high priority, the Indian Health Service is included on that short list, and we were disappointed to see that the House did not include an --- . We are hopeful that the Senate will, and the Senate is now turning their attention to that 2013 appropriations process.

Unlike the House, which only included a couple of full appropriations bills, primarily in the defense area, the Senate has said they intend to add additional appropriations bills so that the number of departments that are funded through that flat continuing resolution mechanism is fewer.

We don't yet know whether the Interior appropriations bill that funds the Indian Health Service and a couple other components of HHS will be included. We understand that the Labor, Health and Human Services appropriations bill that funds ACF and most of HHS's discretionary activities will not be included.

Either way, again, we are hoping that if we are under a continuing resolution for the rest of the year, that we are able to secure that increase regardless, and it is very important given population growth, and inflationary costs and other pressures, and our shared commitment to improve the quality and availability of care, that we get those increases. So we are hopeful that we will be able to do so.

The other topic, and these obviously overlap, that I wanted to touch on, is sequestration. Sequestration is from a separate piece of legislation that was written into the Budget Control Act as a bit of a fallback to hit deficit-reduction targets.

The first attempt prior to sequestration was for a -– what was called a super committee to come up with specific reductions and entitlements and revenues and other changes in order to hit the deficit-reduction targets in that act.

Given that they did not do so, that mean sequestration was in effect, and there was a bill passed at the start of this calendar year, Tax Payer Relief Act, that reduced the size of sequestration by a few percentage points for HHS and other nondefense activities to about 5 percent, and it delayed it into March.

We are now in March, and sequestration, as a legal matter, is in effect. And so what that means is our spending authority under the current CR, which is again flat with last year, is reduced by 5 percent across all budget lines. We don’t have very much flexibility to pick and choose across those budget lines.

We do have some flexibility -- and Dr. Roubideaux and her team, and myself and my team –- are working to figure

out how best to manage that if it stays. The Administration's position is to override sequestration and hit deficit-reduction targets through other mechanisms.

But for now, it is the law, and we are trying to find ways to manage that most effectively. At the national level we don't have a lot of flexibility given that by design it hits every single budget line. At the level of a clinic or even a health system, there is more flexibility in terms of how various funding streams are managed.

We are well aware that these two open items, the '13 appropriation and sequestration, are interdependent in terms of what the final funding level will be by the end of the year.

And we are doing our best both to again get an increase regardless of the legislative vehicle in 2013 and override sequestration entirely but that is being managed by the Office of Management and Budget government-wide, and as you have probably seen in the papers, is something the President is seeking to negotiate with congressional leaders.

With respect to future funding beyond this immediate fiscal year, FY2014 is a big year for a couple of reasons. One is that the Affordable Care Act, which you will hear about shortly, offers a lot of opportunities for additional reimbursements.

And we are acutely aware that reimbursements through private health insurance, through Medicaid, are not direct replacement for appropriated dollars. We understand that, and we are continuing to have a priority on budget for the Indian Health Service and those appropriated dollars.

But at the local level, they are significant, and we are excited that a number of states are expanding their Medicaid programs. The option goes up to 133 percent of poverty, fully federally financed, and we are hopeful that in a number of communities across the country, this impact will be felt in a meaningful way in the coming fiscal year.

There have also been, through the Affordable Care Act, positive talks with the Department of Veterans Affairs on a unique reimbursement mechanism that is included in the act, and some of you may be engaged directly in some of those negotiations at the local level.

And we feel positive about the direction that is now taking and are hopeful that over time that will provide not only additional revenues to specific clinics but also additional opportunities for care and reduce some burdens for our Native American/Alaska Native veterans.

With regard to the 2014 budget, in a typical year, and lately we haven’t had any typical years unfortunately when it comes to budget, but in a typical year we would send a

budget up in February. We are still working on it. The uncertainty of sequestration and of the 2013 appropriations has delayed that process.

We are getting close –- again, the Office of Management and Budget manages this government-wide. Ultimately they will decide when we will deliver the budget to the Congress, but we are making good progress on finishing those decisions and numbers and preparing the documents that go to support it.

So we are hopeful that before too long we will be able to talk with you about the 2014 budget. The bigger picture of the budget environment remains the same, that things are extremely tight. But also what remains the same is the Administration's commitment to improving care in Indian Country.

And we are hopeful that we can get through 2013 soon and have decisions soon on both the appropriations process and sequestration in a way that taken as a whole increase, do not decrease, coverage. And then we can move on to the 2014 process. So given that time is short, I am going to stop there and see if there are questions. And I will do my best to answer them.

MR. HAYES: Thank you, Norris. Are there any questions or comments from Tribal leaders?

MR. HAYES: I will start off. When you regard when the appropriations for IHS –- we know it is under the Interior budget. And we have always been asking, you know, how we can be able to get the IHS budget protected when the HHS budget is appropriated in a separate bill.

You know, we really would like to see that working –- when you were talking about, maybe there is a possibility in the future maybe there will be some discussion on the Secretary being able to do that 5 percent cut across, that there may be some discussion that IHS will be part of that, as you mentioned, a part of that discussion.

But it is really across how Interior is going to be in that partnership also in protecting the IHS budget.

MR. COCHRAN: Yes, it is an excellent question. The appropriations bills, there are 13 of them now that fund all discretionary activities across the federal government. Just over history and jurisdictional battles of the chairman long past, our budget, the budget of the Department of Health and Human Services, is split over three appropriations subcommittees.

Most of our money comes from the Labor, Health and Human Services and Education Subcommittee. That funds the majority of our operating divisions. The Food and Drug

Administration is funded by the Agriculture Subcommittee, and the Indian Health Service plus a relatively small component within CDC, and an Institute within the National Institutes of Health, are funded through the Interior appropriations bill.

The budget though, and the decisions on managing the budget, are still entirely managed by the Department of Health and Human Service for both FDA and IHS. It just so happens that chairmen again in years past have decided to fund the Indian Health Service through –- continue to fund the Indian Health Service through the Interior appropriations bill.

When we formulate our budget, Dr. Roubideaux works with our support with the Office of Management and Budget directly. We don't need to go through the Department of the Interior.

And similarly, when Congress appropriates the dollars, we spend those, and if there are decisions about how to manage those, we work with, directly with the Office of Management and Budget, IHS and the Office of the Secretary, not with the Department of Interior.

We are a partner with the Department of the Interior when it comes to programmatic issues, and primarily with BIA, but with regard to formulating and executing the budget, this history of including IHS in that particular appropriations bill doesn't spill over into how the funding decisions are

made.

MR. HAYES: And I think that is important that the interagencies work together with the passing of the Tribal Law and Order Act. Really when we talk about public safety in our communities, that was to be able to have the interagencies work together, through HHS, IHS, SAMHSA, with BIA, with the Department of Justice.

And I am hoping that, you know, as you mentioned, that relationship and understanding, you know, with the sequestration, with the fiscal environment that we are facing, that those relationships will be stronger to enforce and reinforce the commitment of this administration to try to fully fund IHS and the health care system for our people and our communities.

And I am hoping that as partners that we continue and grow from there and to gain the momentum that we have progressed so far with this administration, that we continue on, in his next term, to continue that. Thank you. Andy?

MR. JOSEPH: I said this before. When our country is in a serious situation, I would say, like when the Iraqi war happened, there were lives that were unwinding, and reports were brought up through the lines of the battle up through the chain of command, and there were special hearings that were presented in Senate and Congress.

Now in the Health and Human Services Department we have the same chains of command and I was wondering if our Secretary has been given any reports on the impact of sequestration, and the lives that will be on the line in Indian Country on the impacts.

I believe there should be special hearings brought forward to show the impacts that will happen in Indian Country, and they would be dealt with severely. Not too very long –- too far back, a few months back, when this nation felt the tragedy in Sandy Hook, I saw a lot of attention was drawn to that community. In Indian Country, that same very thing happens on a daily and weekly basis. And our people need to be given that same attention.

Sequestration is going to cause that same very thing in Indian Country. When my wife and I saw that tragedy on the news, you know, it was hard to keep the tears from our eyes. That was so devastating, and I was really proud of this nation on how they reacted and brought some help to that community that was impacted.

I want the same kind of reaction in Indian Country to be presented by our Secretary. To me it means, it does mean lives. We just buried a young man from suicide a couple days ago. And then I got word that we lost two more people, and we have another elder that was given her last rites.

This is just in this week. I just really want to encourage our people, such as yourself, to make these reports to Congress. Bring it to their attention. Thank you.

MR. COCHRAN: I will just respond. It is an excellent point. It is something I believe you will hear from the Secretary on later this morning and early this afternoon regarding the impact, the projected impact, of sequestration.

We have shared data with the White House through the Office of Management and Budget and with our congressional committees, and again I think you are making an excellent point about the importance of making it clear to people on the front end as these decisions are made what we project the impact to be if this problem isn't resolved.

MR. PAYMENT: So the other day after NCAI, a couple of my council members and I were talking about the trust responsibility of the federal government. So we came up with this fancy slogan –- actually, it is a simple slogan: It is a trust thing. And you know, the way that we perceive is that we prepaid through our treaties the promise of health, education and social welfare into perpetuity.

And so we are not asking for what is rightfully ours, and unfortunately the way that things are funded is that it is considered discretionary funding. And, you know, we see this very differently. We see this as a prepaid treaty right.

It is something that we paid for –- blood, sweat and tears and death of our ancestors.

And the federal government has the duty to uphold that and, you know, we want to distinguish this from welfare. It is not welfare. It is not minority-based. If it were minority-based, we would have all the same types of funding and programs for all other ethnic minorities.

It is not based on the wrongs, and to right the wrongs that were done to American Indian people. It is a trust responsibility of the federal government. And so I know that I am preaching to the converted and to people that, you know, in this division that, you know, have goodness and wellness and the benefit of all people in their heart, but somehow we need to change the dialogue so that we are talking about upholding what is rightfully ours.

And so it seems to me, and I don't want to sound selfish when I say this, but it seems to me our prepaid treaty rights should be exempted from the effects of sequestration because the federal government has the obligation to continue those irrespective of the financial circumstances of the nation.

So I am hoping there might be an opportunity, when it gets back to the Senate, that we can make that kind of a fact and exempt IHS, Head Start, you know, and substance

abuse -– especially in my family that is a very critically important thing.

A lot of those conditions that we find ourselves in are through legacy of historical trauma. Now that sounds like a liberal term, but if you research it, Theda New Breast writes about that. Emile Durkheim wrote about social anomie, and the effects of social anomie show up in terms of alcoholism, suicide, nomadic lifestyle.

We have the lowest statistics on all of the spectrums out of any racial ethnic population. And so there is something there. And it is the fact that we are survivors of and surviving historical trauma. And so everything that HHS does and the various programs are just scratching the surface of being able to address that, to make us whole again.

Again that is a responsibility –- the specific language in treaties was for as long as the rivers flow, the grass grows and the wind blows. And I know there are some environmental concerns, so I don't know how long some of those might last, but we perceive that to be into perpetuity. And so anyway I wanted to make that point. Thank you.

MR. HAYES. Thank you. Any more questions or comments for Norris?

(No response)

MR. HAYES: Thank you, Norris, for –-

MS. JOHNSON: Excuse me. I just want to give you some of my background. I work as a –- I serve as the Health and Human Services Chair but I also worked in Head Start for about 15 years. So Head Start is really close to my heart. And I know and I understand that it is going to take an impact.

I worked primarily when I was in Head Start as health, but the unique thing about Head Start -- and we all know that Head Start is a successful program –- and I think the reason it is successful is because it takes a holistic approach. You know, it looks at not just the child but it looks at the family and it looks at the community.

And we all know that it costs a whole lot less to do prevention than it does crisis. And so when we think of Head Start a lot of people think of just the children but it is certainly not the children. It addresses not only education but social and the health needs of that child in that family. It connects them to a system.

And so I really want to advocate for our Head Start program and hope that –- and I understand that they are looking at a cut. In our Tribe, we fund one of our programs in one of our smaller communities because we see the value of it and we see the uniqueness of it. So we have invested a lot of our own Tribal dollars into that.

We don't have an early learning program in our Tribe, and so we are not meeting all of the needs of our members as it is, and so I hope you take a look at that and value it. Because we come to the table with our stories. And with my colleague here, Andy Joseph, we talk about the impact that it has to our people, the deaths that we see, the people that we know. And you talk about it from a financial piece.

And so there is a real disconnect. So when we come here, we come here with our hearts, looking at, you know, what this impact is going to be with sequestration to our people. So thank you.

MR. HAYES. Thank you for all your comments. Oh, Chester?

MR. ANTONE: Yes, just a quick one. I wasn't going to say anything but since Cochran mentioned reimbursements to Tribal clinics, yesterday I met with IHS and I asked them to really consider or to start working with the IHS area offices to be able to get them to a point where they are submitting claims for reimbursements and for the denials.

That they follow up on them because we do have a report to CMS that was done the other day, approved, but the implications of it sometimes seem to take an opposite effect.

For the Tucson Area, we are very high in reimbursements but sometimes that is used against us when it

comes to contract health services and the health improvement funds. So I just wanted to make sure I bring that up, and also to bring up the Fetal Alcohol Spectrum Disorders, that we need support in making that a medical diagnosis in order to provide services. Thank you.

MR. HAYES: Thank you. And we would like to welcome Willie Bearshield, the councilman from Rosebud Sioux Tribe. Thank you for being here.

MR. BEARSHIELD: Thank you. Good morning. Thank you for having us here. I am also here with another council representative from our health board and our Tribal health administrator. Yesterday we visited with Dr. Roubideaux over some issues.

But it is not only Rosebud Sioux Tribe we are representing but we are representing a group out of Rapid City, South Dakota, concerning IHS and the Tribal membership there. So thank you for having us this morning.

MR. HAYES: Thank you. One of the comments, and I would like to just really quickly, if I may, Gil and Chairman Payment, where you mentioned about partnership. One of the things that we do, we also have an obligation as Tribal leaders to go back -- and from the example with VAWA, Tribal leaders got together, and Tribal governments, and passed resolutions and went to the Hill.

We had many of our Tribal members who were given the opportunity to tell their stories, their testimonies, and to share the heartfelt impacts that are happening, that are happening in our communities that VAWA will impact for future generations for our women. That is the story we also need to tell to the legislators, to Congress.

And I am hoping you go back and we reinforce our commitment to continue that, to continue to be a voice for our people in all three branches of government if we can. And that is important for us as we move forward in this partnership because I know that many of our federal partners today here have heard our stories and they do everything they can to advocate on behalf of the health care in our communities.

So I just want to say thank you, Norris. I know that you do that. And I know each and every one of you that are sitting here, and your commitment in increasing the quality of life of health care for our people. Thank you all.

MR. VIGIL: Thank you, Chairman, for those words, and I also want to echo your sentiments because it is important that we engage our congressional delegation. Just as an example, the VAWA Act, it took us quite a long time because there were a lot of congressional people who were not supporting this.

But I think because we got unified and we made the effort to continue to address this issue and importance of it for Native American people, that we were successful. And we need to continue that. I don't want to say this, but sometimes it is a –- we need more Tribal leaders at the table here. I know we represent our Tribes, but I think -- and I want to commend the Tribal leaders who are at the table here because it does take a lot of effort for us to come to Washington and make our positions known.

But it is important to encourage all our Tribal leaders to be at these kinds of sessions and these meetings because eventually it is going to impact our people. So we need their voices here. And I just want to echo your sentiments about involving Tribal leadership to address some of these issues. Thanks you.

MR. HAYES: Thank you. Thank you, Norris, again. I appreciate your report, and next we will move on to the Affordable Care Act. This morning with us we will have Catherine and then Dr. Roubideaux, Ms. Mann and Cohen.

Comments on the Affordable Care Act

by Catherine Oakar, Senior Policy Advisor, Office of Health Reform

MS. OAKAR: Hi. Thanks for the opportunity to be with you here today. Tribal Consultation, as I am sure you know, is such a critical component of federal and Tribal

relationships, so I am so delighted to be here with you.

I am stepping in for Mayra Alvarez from our office, who is on the west coast right now and sends her profuse apologies that she can't be here. But today I will provide an update on her behalf of some of the recent updates from the department, and we will leave some of the details to Gary, Cindy and Yvette regarding the Affordable Care Act.

So in a few weeks, just a few weeks, we will be celebrating the third anniversary of the Affordable Care Act, which is kind of hard to believe. Among other things, we will be celebrating the permanent reauthorization of the Indian Health Care Improvement Act and the updates it has made to the Indian Health Service.

We will be celebrating that the Indian Health Service is here to stay, and we will be celebrating the improvements to our health care system, our health insurance system, that will provide coverage to so many Americans who have never had it and who need it and deserve it.

And we will be improving coverage to those who already do have it. Since the last outreach call in February, we have made some important announcements that help explain how it is that the health care law builds on what works in our health care system, how it fixes what is broken, and how it gives millions, literally millions of Americans, uninsured

Americans, access to the insurance they need and deserve.

Just yesterday actually we announced four additional states that have been conditionally approved to operate a state partnership Marketplace, and those states are Iowa, Michigan, New Hampshire and West Virginia. And what that means is they are reaching expected progress milestones and demonstrating that they can meet all the Marketplace activities, that they are in line and that they have listed in their blueprint application.

In other words or in simpler terms, they will be ready for enrollment in October of this year, and they will be ready to start providing coverage in 2014. This brings the total number of states that have been conditionally approved to partially or fully run their Marketplace to 24 states and the District of Columbia.

Additionally several other states have suggested their own approaches to contributing toward planned management in their states and Marketplace, so we here at HHS will continue to provide states with these types of flexibility, the resources they need and the time needed to support the establishment of the new health insurance Marketplace.

And as I am sure Cindy will discuss, more and more programs, or more or more states with governors on both sides of the aisle, are expanding their Medicaid programs.

But we are also moving forward with implementation of health information technology. Just this past Wednesday, we announced our plan to accelerate health information Exchange, and build a seamless and secure flow of information that is essential to transforming our health care system.

And what that means is we are starting with a request for information really for ideas and thoughts and input from folks across the country, including you, on ways to accelerate health information Exchange across providers and new ideas that can help implement this, make it feasible and make it efficient.

We want to really accelerate interoperability so that a patient's information can actually travel and easily and routinely follow them regardless of where they receive care. So we encourage you to submit your feedback.

We are also finalizing ways that the law protects you from the worst insurance company abuses. Just last week we finalized rules implementing five key consumer protections of the Affordable Care Act that may help the health insurance market work better. Things like guaranteed availability so that no one can be denied health insurance because they have or have had an illness.

Fair insurance premiums, including making sure that health insurance companies offering coverage to folks in the

individual and small group markets will only be allowed to vary premiums based on things like age, tobacco use, family size and geography.

So no longer can they discriminate based on other factors, including gender, occupation or because you have had an illness. We also have done a lot with our rate review program. Because of the laws, I am sure many of you know, all proposed rate increases of 10 percent or more in the individual and small-group markets, have to be reported and posted online.

And we know that this is working. Just last week we released a new report showing that this is working and showing that rate review has already resulted in just the last two years, in a decline in double-digit premium increases, from 75 percent in 2010 to 14 percent in 2013.

And we are actually increasing these transparency requirements by directing insurance companies in every state to not just report on 10 percent increases but on all rate increase requests.

We are also making it easier for consumers to easily find and compare their options. In late February, so just a few weeks ago, we outlined the health insurance issuer standards for a core package of benefits, as I am sure you are all familiar with, known as essential health benefits.

And through these standards we are not only ensuring that consumers have a simple way to find and compare their options. We are expanding mental health and substance abuse disorder benefits and federal parity protections to 62 million Americans starting in 2014.

In the past, nearly 20 percent, 1 in 5 individuals, purchasing insurance didn't have access to mental health services, and nearly one-third had no coverage for substance abuse disorder benefits.

The rule seeks to fix that gap in coverage by expanding coverage of these benefits by including them as essential health benefits, meaning that all plans in the small individual group markets will be required to offer them, both inside and outside the Exchanges, and by applying federal parity protections to mental health and substance abuse disorder benefits in these markets, making sure that they are covered at equal levels to medical and surgical care.

But we are also improving prenatal care for expectant mothers so they can live healthier lives, have healthier deliveries and have healthy babies. As I am sure these statistics are known to you all, American Indian and Alaska Natives have 1.6 times the infant mortality rates as non-Hispanic whites.

American Indian and Alaska Native babies are 2.4

times as likely as non-Hispanic white babies to die from Sudden Infant Death Syndrome. And so with this announcement we announced 27 recipients of new Strong Start for Mothers and Newborn awards, which will serve about 80,000 women across the country who are enrolled in Medicaid and CHIP.

So it will include things like enhanced prenatal care, improved care coordination and psycho-social support for pregnant women. It will be serving women with the highest preterm birth rates in the country, so this is really an effort to reduce those preterm birth rates and improve outcomes for both women and their newborns.

An awardee is included –- excuse me –- folks ranging from the Indian Health Clinic in Oklahoma City, Oklahoma; to the Peace Health Nurse Midwifery Birth Center in Springfield, Oregon. So it is really across the country.

And as we move forward and the implementation Affordable Care Act becomes more and more of a reality, we are really more and more emphasizing –- I am sure Gary will touch on this –- we are emphasizing outreach. October 2013 and 2014 are really close around the corner, so as we celebrate what we have accomplished in the last three years, including that the Indian Health Service is here to stay, we also acknowledge that the Indian Health Service is not health insurance.

And so the importance of health insurance is hard to

realize until you or a loved one gets sick. No one plans for it obviously but it happens, and insurance is that safety net that protects you when you need medical care. And the key point here is that not only does insurance provide peace of mind and security but it is good for your community too.

It helps you to be a productive citizen, it helps your family members be productive citizens and healthy family members. And if you think about the average cost of a three-day hospital stay can at least be $30,000, or just to fix a broken leg can cost upwards of $7,500.

So having health insurance not only protects you from these unexpected costs, but it keeps you healthy and it helps your community. Reimbursements from insurance coverage get reinvested into your community's health care facilities, not only giving you the care you need but also improving that of your community members.

So as we look to our open enrollment in October and insurance coverage beginning for millions of Americans in January, I am hopeful you will spread the word about the health insurance Marketplace and Medicaid expansion and its importance.

I know many of you probably visit tribalhealthcare.org, which is a tremendous resource that provides a great deal of information to many of you, but I

also encourage you to visit healthcare.gov, and tell your friends and your families and your colleagues and your staffs and your communities to sign up on healthcare.gov to learn about the law for even those who do have insurance and for those who don't, they can prepare for open enrollment come October of this year.

You clearly know your communities the best, and we will be looking to you to help us get the word out about insurance and the importance of insurance coverage and the new Marketplace. And so we look forward to continuing to work together, and I am anxious to hear and have a discussion with you, and before that I will turn it over to my colleagues.

MR. HAYES: Dr. Roubideaux?

Comments

by Dr. Yvette Roubideaux, Director, Indian Health Service

DR. ROUBIDEAUX: Thank you. Well, the Indian Health Service is a big part of all these activities related to the Affordable Care Act and the reauthorization of the Indian Health Care Improvement Act.

We have talked a lot in the last couple of years about the implementation of the Affordable Care Act and the regulations and all the guidance and all those 400-page documents your technical people have been staying up all night reading.

And so really now we are transitioning to focus around the practical aspects of being ready for 2014 and actually being ready for October 1, which is when American Indian/Alaska Natives can sign up at the Marketplaces to purchase insurance or they can benefit from the Medicaid expansion. You will hear more about that from my next speaker.

At the Indian Health Service, we are going very practical this year in terms of operations. And so I just sent an e-mail to my area directors with what a workgroup of federal, Tribal and urban representatives developed. It is basically a template for business planning for all of our facilities on what things they need to do to prepare for 2014.

In includes things like looking at your data, looking at your collections process, looking at your customer service to make sure people will stay, looking at how you organize your clinic and so on. So I have sent that template out to all of our area directors. They should have or will be sending that template to every single facility.

All the federal facilities are going to be required to do that business planning, and all the Tribal facilities, it is for their information, and the urbans as well. The one thing we want to make sure is that if more people get access to insurance, we don't lose them to other health systems, that

they stay with us.

And the other thing is that we want to make sure that we maximize those collections so that we can reinvest, as Catherine said, in our communities. So I encourage you to look at the template that the area directors are sending out.

I will probably post it on my blog soon. It is just basically things that facilities should be doing as a business, making our facilities realize they are a business, and they are in a new Marketplace where there is going to be a lot of completion.

And I know some Tribal programs have done some great planning on that end. This is sort of the IHS Tribal/urban product that we have as a part of this workgroup so we will get that out to you soon.

The second thing we are doing about planning is in the IHS budget, I don't have very much discretionary money because it all goes out in formulas or grants to IHS and Tribal programs and urban programs. But I have a little pot of money. I have put all that money in the last two years into outreach and education on the Affordable Care Act to the national Tribal organizations and then to the area health boards.

So they now have training available for you to learn about the Affordable Care Act, and I definitely hope that you

have taken advantage of that or that you are hearing about that and that you are learning about the Affordable Care Act.

The last thing I want to mention is the implementation of the Indian Health Care Improvement Act continues. We are implementing what we can. As you know, we got new authorities but no new funding for it, and we have been trying to get new funding but it is a tight climate.

So we have implemented a number of things, and we have a table on our Website that summarizes that. A couple things I want you to know about. First, the Contract Health Service, how we pay for referrals, we just had a workgroup meet and make recommendations on how to change the formula for new funding.

I will send that out to you soon in a Dear Tribal Leader letter. I hope you can comment on it before I make a decision. That was a provision in the Indian Health Care Improvement Act, to look at that.

Health care facility construction: The FAAB is back. We will be convening the Facilities Appropriations Advisory Board to look at facilities. Each area finally gave us a representative, so now we can plan it.

The VA/IHS Reimbursement Agreement: We finally signed the national federal agreement on December 5, and it covers all federal facilities, but Tribes can use those terms

when they negotiate with the VA with their Tribally managed health care programs.

I am happy to report that of the 10 sites we have started with on the federal side, one of them is already billing the VA. So that is great. It just took two months. Wasn't drama; we got it done really quickly. So we are going to get the rest of those sites on board and expand to the rest of the federal sites.

The Tribal sites have been able to negotiate with the VA since August, and they can use the terms of our national agreement. And if you get any problem with that, let us know.

And then Alaska has been, of course, since August also been billing the VA, and they have a lot of good experience there. So thankfully these resources are now starting to come into our communities.

The other thing I want to mention is that you may have heard about a draft I/T/U addendum for health plans. Maybe Gary will share some on that. But we continue to try to implement as much of the Indian Health Care Improvement Act that we can.

There are a lot of great provisions. All reimbursements stay at the local sites. You know, providers for Tribes can all have a license in any state, not just the

state they are in and so on. So I encourage you to learn more about all of those provisions, and I am happy to answer questions. Thanks a lot.

MR. HAYES: Thank you, Dr. Roubideaux. Cindy?

Comments

by Cindy Mann, Deputy Administrator and Director,

Center for Medicare and Medicaid

MS. MANN: Good morning, everyone. It is great to be here with all of you again. Good to see you. I am Cindy Mann. I am from CMS and on the Medicaid side at the Centers for Medicare and Medicaid Services, Medicaid, and the Children's Health Insurance Program.

So I wanted to update you on the status of implementation of the Affordable Care Act of the Medicaid changes, which I hope you realize, and I am sure most of you do, are very, very significant.

So there are really two parts of the changes in the Affordable Care Act for the Medicaid program, the 2014 changes anyway. There are lots of other things in the Affordable Care Act having to do with Medicaid. But if you think about the 2014 coverage changes, there are two sorts of areas of big change happening.

One is Medicaid coverage, Medicaid eligibility is to expand dramatically, and the second is the way Medicaid

operates, the way the application works, the way people can actually get on the program and stay on the program will change a great deal as well.

So let me start with the issue of eligibility expansion. So I think as everybody knows, Medicaid eligibility in the states right now is very much a patchwork. Whether you are eligible for Medicaid is not dependent just on what your income is, but it also dependent on whether you have children at home, whether the children are 18 and younger, whether you may be pregnant.

But there is not a universal eligibility for Medicaid in every state simply because you may be low income. That is supposed to change under the Affordable Care Act, and what the Affordable Care Act did is say that everybody in every state whose income is below about 130, 133 percent of the poverty line, will be eligible for Medicaid.

And it got rid of all these categories that say, well, but if you are a childless adult, if you are this and this, you may not be eligible in your state.

I think, as people know, the Supreme Court looked at the Affordable Care Act, issued a decision just last summer, found all aspects of the Affordable Care Act to be valid but did strike down one portion of the act, which was the Secretary's authority to penalize a state if it didn't do the

Medicaid expansion.

So the Medicaid expansion is still on the books. It is still there but it now is a decision for each state to make as to whether or not they will go ahead. And then to be very clear, what is also still on the books is that the federal government will pay for all of the costs of the expansion. 100 percent, all of it, for the first three years: 2014, 2015, 2016. And then we will continue a very generous support after that.

So it never gets less than 90 percent federal support, so it remains at a very, very generous match rate, unlike anything other than actually what we do for services provided to Native Americans, which is 100 percent.

So it is a hard deal for states to pass up and yet there is quite a bit of debate still going on across the country on whether or not they will take up the expansion. Where we stand now –- I am sure, as many of you know, your states are still in their legislative sessions. And so we have a lot of state of flux in terms of where we will come out for this next year in terms of the Medicaid expansion.

Right now we have 26 governors that have announced their support for the expansion. We have one state, Minnesota, that has actually enacted the expansion. Governor supported it, the legislature voted for it, signed into law.

So we have one state that actually has a signed deal.

We have 26 other states where the governor has supported it, and in some of those states there is strong legislative support, and in some of those states it still will be a legislative battle as to what happens in terms of the Medicaid expansion.

And we have got still a lot of other states where it just very unclear, where it is very much in the undecided column both for the governor and for the state legislature. So let me tell you a few states where we do have gubernatorial support, where I know there is a lot of presence in terms of Indian Country.

We have New Mexico. The governor supported it. Nevada, California, Arizona, Colorado, Montana and North Dakota. Those are not all done deals but the governor has issued support in all of those states, and I hope that in those states but in every state where you have Tribal presence, where there is Indian Country, you are very much engaged.

There probably could be no more important coverage decision that is going to be made that will affect people in Indian Country than the decisions states are going to be making about the Medicaid expansion. Let me give you some examples.

Right now in most states, if you are a parent caring for kids, your kids are going to be eligible for Medicaid or CHIP because Medicaid and CHIP have much more generous eligibility levels than for the parents. But for many parents, even when they are earning $9, $10 an hour at their jobs, they are over income in their states for Medicaid.

And there will be a gap between their ability to get -– if their state doesn't expand, those parents may be uninsured, even though the Exchange will come in at a higher income level, and Medicaid might be there for a much lower income level, people in that circumstance will remain uninsured even though the Affordable Care Act was supposed to insure everybody, if the state decides not to expand.

Similarly, if you are what is called a childless adult –- I say if you are what is called a childless adult because some of the childless adults have kids, right? But their kids have grown, their kids have left, so you are a 55-year-old couple.

Your children are no longer living in the home. You are not 65. You are not considered elderly yet. You are not disabled. You are not pregnant. You are going to be uninsured in that situation if you have lower income if your state doesn't expand coverage to the Medicaid program.

Think also about our youth, right? You have someone

who is 21, 22, 23, just starting out. Maybe they are in community college. Maybe they are working but they are working at a job that doesn't offer health insurance coverage. Those individuals, many of them will remain uninsured depending upon their income, unless their state decides to move forward with the Medicaid expansion.

So we have quite a bit at stake over the next couple of weeks, over the next couple of months, in terms of whether states go forward. It is not our last chance because a state that decides not to come in this year, they can take a vote later. They can come in at any time.

But if we want all coverage to be intact by open enrollment on October 2013, and by the effective date of the changes, January 2014, then states really do need to act this legislative session.

So we hope you are very much involved. I will be eager to take questions and talk about what can be happening across the country. Let me talk about the other part of the Medicaid changes for 2014. These are changes that will happen in every single state regardless of whether your state expands coverage for the Medicaid program.

And these are the changes that we have been talking about for some time about how Medicaid is going to –- the rules for the Medicaid program will change to be much simpler.

It will just be an income test not an asset test. There will be reliance on –- less reliance on people coming in and bringing paperwork to show that they are eligible. A much simpler process for renewal.

People will be able to apply not just in person or by mail but also online and also by phone. And there will be one single, streamlined application that will be for Medicaid, for Children's Health Insurance Program and for the premium tax credit and cost-sharing reductions on the Exchange.

One application, people being treated the same regardless of what program they may be eligible for. They don't have to know beforehand what they might be eligible for. They are just saying, I would like to apply for health insurance, and I need some financial help with the cost of health insurance. That single, streamlined combined application is their route to get coverage no matter which program is available.

Every state should be involved in consultations with all of you about how they are implementing these changes. We want to make sure they work for people in Indian Country. We want to make sure they are as simple as the law intends them to be.

On the single, streamlined application we have been doing some consultation. We have had some great input from

Tribal leaders about the content of that application. I want to thank you all for providing that.

We will be doing some more consumer testing, and then coming out with a final application expected sometime in April. Lastly in terms of 2014 implementation, and I just have a few other items, I want to get to the issue that Dr. Roubideaux mentioned, which is around outreach.

We are very much at the time of planning and getting ready to make sure people know what the insurance options will be available for them. Starting October 2013, this October, is when open enrollment will begin.

And we want to work very closely with you in the next few months to train, make sure everybody has the information you need, you have the information to how to branch off and tell, you know, get others in Indian Country to be involved.

We know at CMS that the kind of work you have all done in Indian Country around kids' enrollment has been enormously successful. Really some of the best work that has happened in terms of making sure that children who are eligible for Medicaid or CHIP have gotten enrolled have happened in Indian Country.

So we know you have a great repertoire of ways to make sure that the community knows about available coverage

and gets enrolled. We want to take those learnings that you all have developed through the great work that has happened and broaden it and make sure all of the new coverage that is available for people is made a reality.

You know, we can put the rules in place. We can put the regulations in place. We can put the money even on the table but, you know, at the end of the day where the rubber meets the road is talking to communities, talking to people, helping them get through the process, which hopefully will be much simpler, and really making sure that promise of coverage actually becomes a reality for everybody who is eligible.

So let me just mention a few other things so we can turn to Gary and then I will open it up. Just in terms of some sort of day-to-day business in the Medicaid program, many of you know that we reached an agreement in principle with the state of New Mexico on their waiver.

They have been looking to do a waiver to do –- expand their managed care, and after lots of consultation with Tribal leaders, we have come to an agreement with New Mexico not to do mandatory enrollment for Native Americans, to keep the voluntary enrollment that has been in place that the Tribal leaders had urged us to do so that there won't be mandatory enrollment in that new waiver.

And we want to make sure people are aware of that.

We have been making progress in California. There has been a long-standing effort in California to get a waiver in place in California to replace some of the benefits that were cut by the state of California. There is consultation now going on, on the change.

We are totally in agreement at CMS to approve that. We want to see what comes in to us from the consultation and we are poised to move that quickly through and are very encouraged. We had a meeting with Tribes on the amendment when I was in California in late January so I appreciate all the help on that and the patience of getting that forward.

We have got some new regulations for comment, and I know we have gotten comments from many of you making sure our rules are as expansive as the law allows in terms of exemptions from cost-sharing in the Medicaid program. New rules on documentation of citizenship to allow all the Tribal documents to serve as documentation.

We did announce a new outreach grant, round of outreach grants, in the middle to end of June –- January. Sorry, it is one of these J months. And hopefully we got a lot of applications from Tribes but we will also have one more -– we have one more solicitation for grants that will specifically be for Tribal communities.

We have $4 million, so we will be working on that

RFP soon, and obviously reach out to you specifically. As already mentioned, we issued some Strong Start grants that are particularly around trying to improve birth outcomes, and we are very excited about those.

And there is also the Navajo feasibility report study that has been completed but is now working its way through review within the Department but that is on track in terms of finalizing that report. So there are lots of other things to potentially catch you up on but I want to make sure there is time for Gary to talk about what is going on in the Marketplace world and for our discussion.

MR. HAYES: Thank you, Cindy. I will turn it over to the other Gary.

Comments

by Gary Cohen, Deputy Administrator and Director

Centers for Consumer Information and Insurance Oversight

MR. COHEN: Thank you. Good morning, everyone. I am Gary Cohen. I am director of the Center for Consumer Information and Insurance Oversight in CMS. We call ourselves CCIIO. We are responsible for the implementation of the Affordable Care Act as it affects the private insurance market.

I want to share some information with you today about the new insurance Marketplaces that we are building,

what they have to offer American Indians and Alaska Natives, and also talk a little bit about some of the ways in which you can help us in this effort.

So in the interest of time to make sure that we have the opportunity to be able to hear from you and answer questions, I am going to kind of just try to hit the high points and concentrate on three areas: eligibility, Tribal sponsorship and the QHP addendum.

So as Cindy mentioned, we are in the process of finalizing a single streamlined application for all insurance affordability programs: Medicaid, CHIP and the opportunity to get premium tax credits for purchasing coverage through the Marketplaces.

And we have worked closely with Tribal communities to design questions in a way that will accurately capture information to determine eligibility for Medicaid and CHIP enrollment in a qualified health plan, advanced premium tax credits, cautionary exemptions and special monthly enrollment periods.

The goal of all this work is to make sure that the Marketplaces are designed in a way that will enable American Indians and Alaska Natives to take advantage of the particular opportunities that are available to them, like no co-pays or other cost-sharing for certain members as they purchase

coverage through the Marketplace.

Now the application process will provide for an American Indian or an Alaska Native to attest that he or she is a member of a federally recognized Tribe, and that attestation will be used to determine eligibility for cost-sharing exemptions and monthly special enrollment periods.

We have assessed whether there is an electronic data source available from IHS and the Bureau of Indian Affairs, but we have determined that the data collected by those agencies does not contain the specific data elements necessary to verify Indian status as defined in the Affordable Care Act.

So at this point we are not able to approve a national data source for the verification of Indian status for purposes of determining eligibility for the special cost-sharing provisions and the monthly special enrollment periods.

Now we understand your concerns regarding the definition of Indian and the process for verification of Indian status. At this time, in accordance –- as described in our regulations, the federally facilitated Marketplaces will verify Indian status through a paper documentation process in accordance with standards that are provided in the Social Security Act.

It should be noted that in accordance with the

regulation and current practice, the federally facilitated Marketplace will accept attestations without further verification regarding Indian status for purposes of eligibility for special cost-sharing provisions in Medicaid in CHIP.

We look forward to working closely with Tribes to implement the paper documentation process in a way that will minimize burden. We anticipate a process that allows applicants to upload documentation through the federally facilitated Website or with navigators, who I will talk about in a minute.

And while this is not as desirable clearly as an electronic data match, it will be a more efficient and still provide an opportunity for an online process.

We are continuing to explore options for the electronic verification of Indian status in the future, and we also note that state-based Marketplaces may work directly with Tribes to develop relationships for purposes of electronic verification.

I want to talk for a minute about Tribal premium sponsorship. We have worked over the course of several months to assess our various systems to determine whether we can establish a process to facilitate Tribal premium sponsorship, enabling Indian Tribes, Tribal organizations and urban Indian

organizations to pay premiums on behalf of American Indians and Alaska Natives.

We have concluded that the federally facilitated Marketplace will not be able to establish a process that would facilitate Tribal premium sponsorship for October 1 of 2013.

Now we understand the importance that Tribes have placed upon the ability to pay premiums on behalf of their members. We agree that this is an important way to increase enrollment, and we share your disappointment that we are not able to do this for year one.

The task that we have before us to build our basic systems and be ready to operate the Marketplaces by October 1 of this year is a huge challenge, and that is the reason, you know, the only reason we are having to put off our ability to do this for year one.

We do note that Tribes will still be able to work with issuers or Tribal members directly to pay premiums, and also again state-based Marketplaces may be able to develop and implement processes for Tribal premium sponsorship, and we encourage Tribes to continue to work with the Marketplaces that are being established by the states.

Lastly I want to talk about the model QHP addendum. The addendum is designed to facilitate the inclusion of Indian Health Care providers in the qualified health plan provider

networks, and to help health insurance issuers comply with qualified health plan certification standards.

The utilization of the addendum will enable qualified health plan issuers to contract more efficiently with Indian health care providers and ensure that American Indians and Alaska Natives can continue to be served by the Indian provider of choice.

And as Yvette mentioned, will also have a benefit for everyone in Indian Country because the more reimbursement there is to providers, the more there will be an ability to expand those services. As we finalize the addendum, which we expect to be quite soon, we are considering the comments of Tribes and of issuers.

We want to use the addendum to highlight key provisions in federal law that apply when contracting with Indian health care providers, and we also want to make sure that the addendum acknowledges the perspective of all parties and can be used to form relationships between issuers and Tribes.

I know my staff has been working very closely with you, and we appreciate your input and feedback on the addendum. And finally I want to talk a little bit about outreach. I know many of you have been eagerly monitoring the status of grants for entities to be navigators, as provided in

the ACA.

Tribes are eligible to receive these grants. There will be a grant application or funding opportunity announcement that will be published very soon. The program is designed specifically to serve the needs of specific populations in a culturally and linguistically appropriate manner, so we know this is a great opportunity, and we encourage Tribes to apply and take advantage of it.

We are working on trainings and other materials for people who will be involved to encourage them to both apply, and we will have trainings on how to fill out the application as well to make that as easy as we possibly can.

We have also partnered with national Tribal organizations, regional Tribal health boards across the country, to assist in education and outreach on the Marketplaces through the National Indian Health Outreach and Education Project.

People are available to come to your Tribe to do outreach and education for you and for your nation. We look forward to doing this work together to help get as many people in Indian Country enrolled in coverage as possible. Thank you.

MR. HAYES: Thank you, Gary. I appreciate that and the comments from all those who have spoken regarding the

Affordable Care Act. At this time I will yield to Tribal leaders. First I would like to acknowledge Cathy Abramson and Jim Roberts after her, who is replacing Ron Allen at this time. So, Cathy?

Tribal Leaders' Comments

by Cathy Abramson, Chair, National Indian Health Board

MS. ABRAMSON: I am Cathy Abramson, and I am council member from the Sault Ste. Marie Tribe of Chippewa Indians. I am here as the chairperson of the National Indian Health Board, and I am representing the health board, and I would like to thank you for inviting us to participate in today's discussion regarding the Affordable Care Act.

Since 1972, NIHB continues to serve all the federally recognized Tribes by advocating for the improvement of health care delivery to all American Indians and Alaska Natives. The Affordable Care Act and the permanent reauthorization of the Indian Health Care Improvement Act are important vehicles to increase access to health care for all Americans including the First Americans.

From the beginning of the legislative debates, the fundamental principles for Indians Country's participation in health care reform must continue to be adhered to through implementation.

Rooted in honoring treaty obligations and trust

responsibility, those principles are to ensure that health reform supports and protects the Indian health delivery system through Indian-specific provisions and to ensure that American Indian/Alaska Native individuals in the Indian health care delivery system have full opportunities to participate and benefit from health care reform.

Much is being done in states to prepare for the health insurance Marketplaces that begin on January 1, 2014. At the last TTAG meeting, we heard from Oregon's health insurance Marketplace about their Tribal premium sponsorship program, which offers a one-door policy for applying for health coverage on the Exchange.

Verifying American Indian and Alaska Native status, training staff on American Indian and Alaska Native cultural perspectives and benefits and encouraging the use of the Indian addendum with qualified health plans.

Oregon is a great example of a state-Exchange developing program to encourage American Indians and Alaska Natives to participate on the Exchanges. Unfortunately many states are not following Oregon's lead.

While Tribes recognize the need for the Department to grant states' flexibility, implementing programs like the health insurance Exchanges and in Medicaid expansion, Tribes need to have an equal seat at the table with states as these

programs are implemented. Consultation with Tribes on the development of Exchanges has been inconsistent across the country.

We understand that in a few states, Tribes have been brought on as meaningful participants in the development of Exchanges. In most states, however, Tribes do not have a seat at that table and are not being consulted with. My state, Michigan, is one of those states, and where Tribes do not have a seat at the table, they need your assistance in facilitating state consultation.

While we do commend CMS for requiring state consultation with Tribes, states should be required to establish and implement a written policy on consultation with Tribal governments for implementation of provisions of the Affordable Care Act, especially in the Administration of state-based Exchanges.

If Tribes are not allowed to meaningfully participate in the development of these programs at both the state and federal level, it is unlikely that American Indians and Alaska Natives will be able to reap the benefits they are designed to provide.

The federal government must not only ensure that states consult with Tribes but it also must continue to consult with Tribes as it implements key aspects of the

Exchanges at the federal level.

Although the Department consulted with Tribes on some of the regulations that govern all Exchanges, Tribes have not been consulted prior to many of the notices of proposed rule makings that will affect the participation of American Indians and Alaska Natives in Exchanges.

In addition to consultation on regulations, Tribes want to be involved in decisions about implementations of those regulations. Some states have shown that with meaningful Tribal Consultation, that regulations can be implemented in a way that will have the greatest chance for success for Tribes to participate as Tribal sponsors, navigators and health care providers in qualified health care plan networks.

However this has not happened with federally facilitated Exchanges. Tribes and states with federally facilitated Exchanges remain in the dark on how this is going to work in their state. We have been working with parallel tracks, both on administrative and legislative --- , for over two years for Tribes to address and resolve the multiple definition of Indian that are included in the Affordable Care Act.

Yet the issue remains and we are running out of time. There will be American Indians and Alaska Natives who

are currently eligible for Indian Health Service benefits, but in 2014, they will be forced cost sharing or penalized for not having insurance.

Enabling American Indian and Alaska Native individuals to access the benefits and added protection under the Affordable Care Act and the Indian Health Care Improvement Act, as well as Medicaid through the single streamlined application, requires an identification of who is American Indian/Alaska Native that is clear and easy to implement.

To have a more efficient process for the identification and documentation of who is an Indian, and to minimize potential confusion, we want a single operational definition to be adopted. We need CMS to provide operational guidance to resolve this issue.

We want IHS resource and patient management system, the RPMS system, to facilitate enrollment to thousands of Indians into the Medicaid program. We need to make this as efficient as possible for states, for the Exchanges, whether state or federally operated, for Tribes and for Indians to make sure that American Indians and Alaska Natives are able to receive the benefits.

Many of the states where Tribes are located have not accepted the Medicaid expansion program. We know that expanding Medicaid is a win-win for states with American

Indians and Alaska Natives. The report that the Alaska Native Tribal Health Consortium produced documents this.

We appreciate that HHS has proposed a hardship waiver to exempt people from the tax penalty if they live in states that do not have Medicaid expansion and they would otherwise be qualified.

What happened in Arizona to --- the I/T/Us was critical, and many Tribes would like their states to replicate Arizona's demonstration by seeking 1115 waiver to provide Medicaid expansion to American Indians/Alaska Natives in states that refuse to expand Medicaid to the entire state population.

NIHB and TTAG would like to work with CMS to facilitate this approach. So on behalf of NIHB, I thank you for the opportunity to provide these comments on the implementation of the Affordable Care Act and the Indian Health Care Improvement Act. I believe we share a common goal: the enhancement of the quality of life and health for American Indians and Alaska Natives.

We will continue to work diligently with the administration to improve our Indian health care delivery system, and we count on the federal government for continued relationship and to meet their trust responsibilities, obligations. Thank you very much.

MR. HAYES: Thank you, Cathy, and I will yield to Jim Roberts.

Tribal Leaders' Comments

by Jim Roberts, Policy Analyst, Northwest Portland Area Indian Health Board

MR. ROBERTS: Thank you, chairman. Cathy, thank you for your remarks as well. My name is Jim Roberts. I am a policy analyst the Northwest Portland Area Indian Health Board. And unfortunately Chairman Allen, with the change in venue, was not able to attend and provide his comments and testimony so I am grateful to fill in on his behalf.

Testimony has been developed for this session, and if it hasn't been submitted to you we will get you a copy for the record. But I am not going to read the testimony and I will summarize in the interest of time.

Insurance Exchanges or Marketplaces, as they have been rebranded, will provide a great opportunity for Indian people to gain access to health care coverage as well as the financing that is important for our programs through that process.

Unfortunately, due to the complexities of the Indian health care system and the way it is structured, unless the Exchanges or the Marketplaces do some things to effectively integrate our system into their process, they won't work well for Indian people, and Indian people may not participate.

As well Indian people have a federal right to health care, and because of that, Congress exempted them from the tax penalty for not complying with the what is called now the minimum essential coverage requirement. So these two things taken together kind of pose challenges for us as Indian people and how we work within the insurance Exchanges.

To address that, Tribes have developed a two-part solution. And one of them involves sponsorship of premium subsidies and the ability to group pay the premiums on behalf of Indian people.

Another one, recommendation, is to require qualified health plans inside the Exchange to contract with Tribal programs so that we can coordinate benefits, we can be paid, we can refer into their networks. It would streamline the process for Indian people to participate.

But unfortunately the Administration, as we have come to understand, has not mandated these recommendations. To some extent, the state-based Exchanges are requiring some of these things. For example, in Oregon, as has been mentioned, Tribal sponsorship is going to be a feature of that insurance Exchange. A Tribal portal has been developed.

The data, as we just heard, will not, from IHS, cannot be used, but it will be used, the same data set in Oregon, will be used. So we are not quite sure why the data

at the national hub for the FFE cannot be used but yet Tribes are going to upload their practice management system into the Oregon Exchange in a couple different ways.

So that will not be existent, the FFE. So, you know, some of these things pose challenges, and I think we -– I would like to spend some of our time, rather than reading from the testimony, to perhaps have a dialogue about how we can address some of these issues.

Cathy has talked about the individual or the exemption –- not the exemption, but the exemption from the tax penalty that is associated with the Indian definition issue. So I think we have a challenge there about how we can operationalize that in a way so that we can streamline the application process so that Indian people can participate in the Medicaid site and the Exchange site using one common definition.

So I will stop there. As I indicated, I will submit our testimony for the record if you haven't already received it. We do thank you for the support and the opportunity to present these issues with you today. I will stop there, and perhaps we can have a dialogue about some of these challenges that have been discussed.

MR. HAYES: At this time I am going to go ahead and open it up. I don't want to be disrespectful but I would ask

that Tribal leaders -- many of us have traveled –- give them the opportunity to ask you a question and give other Tribal leaders an opportunity to speak.

So I am going to go ahead and open it up, and we have got to give some time for some responses to some of the questions that were brought to the attention of our federal partners. So I will go ahead and open it up. Chester?

Questions and Answers

MR. ANTONE: My first question is to Yvette Roubideaux, director of IHS. And that relates to the business plan that you mentioned. Just in short, I didn't get all of the stuff that you mentioned to be in there, but I wanted to know if the qualified health plans and contracting with the insurance agencies within the state, between Indian Health Service, is that a part of that?

DR. ROUBIDEAUX: Yes, a part of the business plan is for each facility to look at the context of the health Marketplace within which they operate. And so, you know, in the past, IHS has kind of sort of not really thought about, a lot about the business relationships that it has with -– and some places have done better than others.

So what we are saying now is it is just critical. They have to reach out to all the insurers. They have to reach out to all the local hospitals, all the providers. And

if they have poor relationships, they need to strengthen those relationships and they need to actually have a more active role reaching out to the various pieces of the Marketplace that they have to interact with.

And so we are encouraging -– and the thing about it is we can't, it is not a one size fits all because the insurance and provider Marketplace for each facility is so different. The Phoenix Indian Medical Center is a lot different than San Carlos. It is a lot different than Yuma. It is a lot different than Rosebud. It is a lot different from Tohono O'odham.

So we are encouraging our CEOs to sort of map out the landscape of the Marketplace they are in to have better understanding of how they remain competitive and how they can form those relationships with the providers that they deal with and the insurers that they deal with so that I/T/U addendum, that is really going to help generate those kinds of relationships as well.

MR. ANTONE: Thank you, because I have some concerns regarding the federally facilitated Exchange, and that is the income eligibility requirements and how that is going to be, if that is universal or if the state -- I mean, I know Arizona retains that part of it –- and also on the, everything having to do with the Affordable Care Act, Arizona has

designated Don Hughes to work on that and Tom Belluck* for the income, because of access.

Previously we were working on an insurance Exchange that the state put together under that planning grant, and contracted to Inter Tribal Council of Arizona to do that work for a state-based Exchange, and I know Cindy Mann had indicated last year, I believe, we thought Arizona was going to be going to a state-based, myself included, and Brewer did an about-face to us and opted for the federally facilitated Exchange.

Now all the work that has been done has been focused on the state-based, and so we kind of, we are kind of left at a little bit of a quandary here because of the consultation that we had been doing with the state. So now we are asking if -– I know that a lot of consultation has been going on with New Mexico and California. Those are the priorities at this time.

But we asked CMS, or I asked CMS yesterday if –- because at the STAC meeting I made a request on behalf of Arizona Tribes to have a consultation with CMS exactly for this federally facilitated Exchange. There was no feedback on that but I understand now that the IGA is working at doing regional rather than going to specific Tribes.

I asked yesterday, and was encouraged to ask or to

relay this to Mr. Cohen, that if that is what is going to be done out of IGA, if that is the recommendation, then they need to really highly consider Phoenix as one of those areas for our regional consultation on the federally facilitated Exchange because California is state-based, Nevada is state-based.

Arizona opted for an FFE. Now that poses a lot of questions because originally one of the questions we had was the interface between Healthy Arizona FFE and the federal contract with the IT. How is that going to work? So there are so many questions that we have that we feel it is necessary that we need to sit down and discuss everything regarding the federally facilitated Exchange.

In some instances it might be easier for IHS rather than having a state-based, but we also know that a lot of blocks get put up in the federal process on us, and the most recent is the 115 waiver. The state was really agreeing to everything else. It was the federal level that gave us the block.

So I just wanted to let you know, Mr. Cohen, you really should consider having, if you are going to have a regional consultation on the federally facilitated Exchange, as I understand that is the direction that IGA is going, then I really think you need to consider Phoenix because we do have

22 Tribes and they are quite interested in it. Thank you.

MR. COHEN: Thank you, and I will take that back. Appreciate the comment and the input.

MR. HAYES: Steve?

MR. KUTZ: Stephen Kutz with the Cowlitz Indian Tribe of Washington State. I have questions and comments to Director Roubideaux and also both Cindy Mann and Gary Cohen so I will start with Dr. Roubideaux.

It is great that the Affordable Care Act made allowances for National Health Service Corps reimbursement or programs to all Tribes and IHS facilities for loan repayment across the United States. I wish that IHS did the same thing internally because it is pretty hard to keep track of how you keep on IHS' list.

I thought I was on IHS' list. I have somebody who is on loan repayment, and yet when the list comes out, I am not on the list. And so then an attempt to get back on that list is not very expeditious. So I don't understand why every facility within the IHS system is not automatically on the list for IHS loan repayment.

That is, I guess, my first comment. I don't know necessarily whether you have a response or whether you just want to take that under advisement.

DR. ROUBIDEAUX: I will check on that but I want to

clarify: Are you talking about the National Health Service Corps loan repayment or the IHS loan repayment?

MR. KUTZ: I am talking about the IHS loan repayment. National Health Service Corps recognizes every facility for automatic ability for staff to apply. IHS does not automatically do that.

DR. ROUBIDEAUX: Oh, okay. I will go back and talk with the staff about that. Thanks.

MR. KUTZ: So my next comment that I have around the Affordable Care Act is as this Affordable Care Act rolls out across this United States, Tribes -- both 638 Tribes, Direct Service Tribes, IHS facilities –- are going to have disparities about how this is implemented.

There is actually going to be disproportionality, and the reason why that is happening is because of some of the decisions that have been made at the federal level. Some of that has been due to congressional action the way that we understand. But HHS needs to fix the things that have been mentioned here.

They need to work hard with us to fix those things, and as this plays out, I would ask HHS to look at what the disproportionalities are and how Tribes and Tribal members have been harmed across the United States in differing ways. And the disproportionate ways the Medicaid expansion are going

to be applied or not applied are exactly one of those ways, and that is going to go directly to impacting the health of all of our people across this United States.

So I would ask that you look at doing some data analysis and some gathering of information so we can keep track of what that is so that when we go and try to fix some of these things, we have some of the facts.

Because there are ways that we could get together with you to help figure out how to do end runs around the state that doesn't want to give the federal resources to our Tribes, and they take our Tribal government right out of the mix and don't even allow us to make those benefits available. Thank you.

MR. HAYES: Thank you. Cara?

MS. COWAN WATTS: Thank you, Chairman Hayes. This is to Mr. Cohen and Ms. Mann. As I listened to your testimony, I was unclear –- I know that NIHB as well as --- and I think most of the technical advisory groups or national groups have called for a single definition of American Indian/Alaska Native but the way I understood your testimony, it appears that there are two definitions now under the Affordable Care Act?

Could you please clarify that because we have a federal registry list of federally recognized Tribal citizens,

and as the federal government you should refer to your own list. So I am unclear how we are getting into these different definitions.

MR. DIOGUARDI: I will answer that question. There are multiple definitions written into the statute of the Affordable Care Act, and that is an issue we have working to resolve with feedback from all of you, and we have heard some more of that feedback here today.

I do want to say we have been addressing this at a high level, and when the Secretary is here later, she will have more to say about that.

MS. COWAN WATTS: And to address the seriousness of the issue, I think for some folks they understand, but because the infamous Cherokee princess -- there are groups out there that for $35 you and your dog can both be Cherokees in part of these groups –- and so anytime you water down your own definition of what a Tribal citizenship is, we get into a risk of adding all of these kinds of folks in.

So it is very serious. Thank you. And it impacts our health care research because operationally we need that data to be reflective of our populations and not someone's dog or box checker or whatever that is. Thank you.

MR. HAYES: Thank you. Nancy Johnson from the Colville Tribe.

MS. JOHNSON: Hi. My question is for Director Roubideaux. I come from a non-self-governance Tribe, and we were looking at Tribal sponsorship on the premiums. Is there any opportunity, are you discussing at all, for contract health dollars through Indian Health Service to be utilized for Tribal sponsorship in those premiums?

DR. ROUBIDEAUX: We have been looking at that issue. We hope to share information on that sometime soon.

MR. HAYES: Did some of the federal partners –- do you want to respond if there are some questions, if there is any clarification or any more comments?

MR. DIOGUARDI: Let me just jump in on the consultation question. I think we hear you loud and clear on that. I do want to note a couple of things.

One is we have been consulting over really the past three years as it relates to all the provisions of the Affordable Care Act, including the operation of the federally facilitated Exchange and state-based Exchanges.

But what I am hearing today is that there is an increased desire and request to have a more intensive consultation related specifically to the federally facilitated Exchange now that it is more clear as to which states will be operating a state-based Exchange and a federally facilitated Exchange.

So I think now is the time for us to go back and take a look and provide additional opportunities for consultation specifically on federally facilitated Exchanges in particular states, and so we will follow up on that.

MR. HAYES: Thank you. We will go one more round. Go ahead, Jim.

MR. ROBERTS: Thank you, Chairman. Yes, in terms of the Indian definition, I think, just to kind of clarify so we all have a same understanding of what we are talking about here, is that the definition in the Affordable Care Act for an individual, if they are a member of a federally recognized Tribe, is that you have to be a member of a federally recognized Tribe.

And the benefit for that is that Indian people who are members of federally recognized Tribes are exempt from the tax penalty for not having health insurance. Now Indian people –- switch to the IHS side -– Indian people who may be eligible for IHS do not necessarily have to be members of federally recognized Tribes. We have descendants, we have mixed households where perhaps mom and dad are enrolled as members of the Tribe, and perhaps the children are not.

But the point being is they have access to health care. In those instances, those households could be subject to the tax penalty for not complying with the minimum

essential coverage requirement. And what we would like HHS to do is to align the definitional use of Indian with kind of the same definition that is used for IHS eligibility for services. So that is what we are talking about here.

But in terms of that regard, and I don't want to belabor it too much, and then talk about the administrative issues about what has been promulgated in regulations but I am wondering if HHS could agree that, you know, this is an issue that should be fixed, and I think everybody at this juncture is in agreement that it needs to be addressed legislatively.

But would HHS support a legislative fix that would align the Indian definition in the ACA with the Medicaid cost-sharing regulations that are in place. I think that would help us to understand perhaps, you know, where your level of support is on this.

But I think if we could have a meeting of the minds that, yes, we think this is a good thing to do. Yes, we believe that this is the definition that should be used. And it will help our interfacing with Congress about how to address the issue. Thank you.

MR. DIOGUARDI: So just real quick on the definition issue, I think what we have said to date is we agree that it is an issue that there are multiple definitions written into the statute, and that it would require a legislative change.

We have heard your feedback on this and have been working on it really over the course of the past year. The decision now is with the Secretary, and she will have more to say on that when she is here.

MR. HAYES: Chairman Payment?

MR. PAYMENT: So it seems like it was just yesterday, even though it was three years ago, that this was enacted, and I think that is in part because for some of us it was just yesterday. In Michigan, Cathy's a council member from my Tribe, is the chair of the National Indian Health Board, and for two years successively, during our Tribal accord meetings with the governor, she has brought up the issue of getting into the Exchange, getting going.

And I think in many ways we are light years ahead of the state. And that doesn't say all that much because we are still very confused about what the implementation is going to look like. So, you know, the Michigan legislators and governors were waiting to see whether or not the Supreme Court, how they were going to rule. Then they were waiting whether or not they were going to throw Obama out of office or whatever.

But in Michigan, we have been meeting and we have been pushing the envelope to try to get the state where they should be with us. And so we just had a meeting with them at

our United Tribes meeting, and their appointed person used terms like dialogue, conversation, discussion, and you know, for me it was like chit-chat.

And how many remember watching the Peanuts gang and Charlie Brown's teacher was like, wah, wah wah, wah, wah. Clearly they don't understand what we are talking about in government-to-government relations and consultation.

So what we are doing is –- Phyllis is here as well, and she is a leader in health for our community in the Bemidji Area, and also a health director and council member, so she is in a unique position, and we have talked about having some kind of a session with the governor's office to say, look, here is what the federal government and several different agencies, how they define consultation. Here is the president's definition of consultation.

This is what we are talking about, because it seemed like even the lower level staff member that was in front of us was trying to be forthcoming and he is stuck in a position trying to make good on something that isn't so good. And, you know, clearly there is a language barrier problem.

I don't mean --- versus English, but we are not talking the same language. So what we are doing is we are pulling together all that consultation definition, and we are going to work through and try to prescribe what that should

look like, and then hand it over to the state.

However, it would help if HHS would say to the state, this is what we think you should do in -– not this is what you are required to do, but this is what we think you should do in consultation, what the elements of consultation should look like.

And then the other thing, just really quickly, and I know we keep deferring to the Secretary when she gets here on the Native definition issue is I can understand the reason why that definition wasn't put into the act, because if it was put in the act, we probably would have been fighting to take it out of the act because we have such different views about who is an Indian.

And in our community, you know, we have a descendancy because at some point we looked at it traditionally, and if you are in our community, have Indian blood, whether you are quarter blood or half blood or full blood or less than that, you are the same.

And so, you know, I would like to remind people that Dawes Severalty Act is where the blood quantum requirement was invented. It is not an Indian cultural value. It was invented, and we have accepted it, some communities, and communities where per capita is an issue, if there is an incentive to define who is and who is not Indian.

And so that is up to us though. That is a sovereignty issue, up to us to define that part of it, and I would hope that Tribes, once we implement –- because it will probably be limited, it might be limited to just enrolled members. And if it is limited only to enrolled members, then it is up to you to decide whether or not your people, your blood relatives, will qualify or not.

Earlier the term was used, “dogs.” Only dogs and Indian have to prove their pedigree. The blood quantum requirement that was adopted by the federal government was defined by the federal government and given to us, and we have assimilated that and adopted it into our culture.

It is not indigenous. It is not our own value so -– however, it is up to Tribes to decide that. So I am hoping the provision allows for descendants for Tribes that can’t figure that out, and if they still want to limit who is an eligible member, but they do want to care and have concern for their descendants, I am hoping we have the ability to continue to provide for that.

MR. COHEN: Just to respond on the state consultation, which I am hearing loud and clear, and thank you for those comments. You know, to the extent that states have grants from us or are seeking certification from us for their Exchanges, consultation is a requirement, and so I can take

your comments back and work with the state teams to make sure that we are communicating accurately with the states as to what their obligations are, and we will do that.

MR. HAYES: Okay, I would like to remind –- you know, we are trying to keep on track, but I think because of circumstances, as was mentioned by Chairman Payment regarding the Affordable Care Act, when it was passed, everything was kind of hold waiting the outcome of the election, waiting for the Supreme Court decision and now everything is kind of accelerating.

And we are trying to get as much information or conversation here going but if it –- I am going to address to the Tribal leaders –- we also have another opportunity at 11:45 to continue this type of dialogue, especially when we have the Secretary here to discuss what her comments will be regarding the definition of Indian.

Because as Paul mentioned, at STAC we had been addressing this issue, and it is very controversial in Indian Country, and we already heard comments about that. But I think it is a topic that needs to be continued to move forward, and it would be good to have the Secretary address -– hear your concerns directly.

So if it is to that point, if you can make your comments brief or questions brief, and we will continue moving

on. Thank you. Andy?

MR. JOSEPH (Speaking in Native language): I am going to talk about the definition of Indian. The Affordable Health Care Act has some new laws that are in the Indian Health Care Improvement Act, and I remember saying this last year.

And I know there have been some meetings with IHS on long-term care, but I am really glad that Cindy is sitting next to you, and I think last year I said the two of you need to get together and come up with what the inpatient encounter rate would be for our Tribes that have rest home facilities so that we can move that part of the act forward.

And if there was an inpatient encounter rate that could be agreed upon, then we would be able to start billing for those services. My reservation is 1.4 million acres, and we have our elders scattered throughout the whole reservation, and a lot of our elders want to continue their life and finish it in their own homes so we need to –- there is also a need for an encounter rate or some kind of a billing rate that we can bill for in-home care, for hospice care that is provided.

If we can do that, then we can move forward with this excellent law that was brought forward. Dialysis is another part of that law that I believe Tribes would like to be able to engage in also. Thank you.

MR. HAYES: Thank you, Tribal leaders, for your comments and the dialogue that has been going on. Next we will continue with the Human Services budget priorities. What the federal partners -– we have asked George to go ahead and start it off, and I think with the dialogue we will go ahead and just go directly after you, George, we will go to the Tribal leaders' discussion.

We will have Leonard Forman, the chairman from the Suquamish Tribe and then we will have Gil Vigil from Pueblo Tesuque.

Human Services Budget Priorities

by George Sheldon, Acting Assistant Secretary, Administration for Children and Families

MR. SHELDON: Hello, thank you. I appreciate the opportunity to be here. I joined several of you at the bill signing yesterday, the Violence Against Women Act, and really kind of, as I sat there, really thought about how significant that legislation is in Tribal communities.

And also –- and I think those of you who were there heard the events that Diane had gone through in terms of the lack of ability for Tribal communities to really enforce violence against women on Tribal lands that this legislation really corrects.

I think it points out how significant the legislation is, and so I wanted just to kind of open with that

because as slow sometimes as the process is, as slow as the federal government is sometimes, I think it is important when you do have a win like that to really sit back and recognize it.

We have got representatives from family assistance from our Administration of Children, Youth and Families as well as Head Start. And I think we can talk about some of the budget priorities. I know everyone is concerned about sequestration, as I am. This is not –- I think as the vice president has put it, this is a dumb way to run government but we are trying as best possible to make adjustments, within the confines of sequestration, that have rationality.

Which means that we are trying to cut things like travel, like conferences -- regrettably, technical assistance is on the chopping block as well -- before we cut services. And that is a fundamental goal of the department. It is a goal that the Secretary has and I reiterate.

With those few comments, I would be happy to open it up.

MR. HAYES: Thank was quick, George. We will go ahead –- what we will do is go ahead and hear from the Tribal leaders. We will start with Leonard.

Tribal Leaders' Comments

by Leonard Forsman, Chairman, Suquamish Tribe

MR. FORSMAN: Thank you. Leonard Forsman, chairman of the Suquamish Tribe, home of Chief Seattle. And I would like to echo the remarks regarding the Violence Against Women Act, the signing. I was honored to be able to attend that yesterday as well. We are pretty excited in Suquamish about the jurisdictional fix that was accomplished and will help us to protect our vulnerable populations.

I just have a few comments primarily regarding Head Start and a little bit on the Office of Child Support Enforcement. Of course we operate a Head Start program in Suquamish. Director Fuentes has been out, and we are really proud of our program and invest a lot of our own money along with the federal help that we get.

And we do have a few concerns, just mainly some that affect us, some that affect the Tribes as a whole and some that probably affect other Tribes and maybe not as much us. But the issue of designation renewal is one that is most immediate, and in the one-on-one session I was able to address this and didn't get a response.

But I just wanted for the record to note that the state that, in the regulations it says for the transition period each Head Start or Early Head Start agency wishing to be considered to have their designation as a Head Start or Early Head Start agency renewed for a five-year period without

competition shall request that status from ACF within six months of December 9, 2011.

According to program instruction dated October 5, 2012, letters requesting consideration for the five-year designation needs to be submitted to the Office of Head Start by January 1, 2013. There has been no communication from Head Start explaining the process. The Suquamish Tribe submitted their letter to Head Start on October 8, 2012. We still haven't received communication on the status of it being designated as a five-year grantee.

Mr. --- yesterday let us know that they do have our letter, and they will be forwarding a response soon. So I just wanted to put that into the record that we would appreciate getting a verbal confirmation that the letter has been received.

We also have -- some of the consultation issues are being addressed as well, and during that consultation, teacher credentialing is of course an issue I am sure you are aware of. We have been fortunate to have the resources to have highly qualified teachers in all of our classrooms, but not all Tribes have those opportunities I know you are familiar with.

So we are just asking to help our associated Tribes and our friends to provide them opportunities through waivers

or however we can be creative to help them to keep their teachers, many who are part of the community, in their schools.

We do have some issues with the review, the class reviewers that come out to our homelands to review our programs. We just want them to be more culturally knowledgeable of our, as best as they can, to have a full understanding of our adult-child relationship and then recognize our cultural values.

And I did hear yesterday from staff that they are working to get more Native people involved on the class review teams, so that is good news. We look forward to more progress in that.

And you mentioned a little bit about the technical assistance. One of the things that is going on is most of the money of course is going to high-risk institutions, and we understand the need to do that, but we do have needs as well and just feel that sometimes maybe some of that money could be used to help all of the programs, not just the high-risk ones.

We know that is a first priority. We appreciate that. But just to put that into the record as well. And with that I would also want to mention we just wanted to work on encouraging that a training program be implemented –- I know there are some training programs, but other agencies have had

training programs for program specialists and grantee specialists that aren't familiar with Tribal protocol.

I know the Department of Defense has been able to do that fairly well and also the Environmental Protection Agency. I also would just like to make a few comments on the child support enforcement rule. We have seen great improvement under the direction of Commissioner --- , and we are just eagerly awaiting the model training system, child support case management software that is on its way, we understand.

And then there are also issues, I am sure you have heard, about the Tribes wanting direct access to the Federal Income Tax Refund Intercept Program and the Federal Parent Locate System. And we understand that Congress needs to help us out a little bit on that, and we are awaiting that as well.

So this one last comment I would like to make is regarding consultation. Head Start has a pretty aggressive consultation process that they get out to the areas.

And I just wanted to encourage HHS, the senior agency as a whole, to remember that Head Start needs help in that as well, and sometimes it feels like there are two separate consultation processes.

And if we can make them more seamless, that we could –- I think we would see more success out there in meeting the trust responsibility because Head Start of course

is a program that serves not only Tribes but a number of other organizations around.

And sometimes I think there is –- this is what we have been hearing through this Exchange, health care Exchange issue, sometimes I think we get caught up in some regulations that may be more appropriate for other organizations and not as much for the Tribal trust responsibility that exists out there between us and the United States. So with that, thank you for your attention.

MR. HAYES: Thank you, Chairman. Gil?

Tribal Leaders' Comments

by Gil Vigil, Council Member, Pueblo of Tesuque

MR. VIGIL: Thank you, chairman, and good afternoon. My name is Gil Vigil. I am a Tribal Council Member from Tesuque Pueblo. I will be providing testimony on behalf of the National Indian Child Welfare Association and the National Head Start Directors Association.

Currently I am the chairman of the National Indian Child Welfare Association, and is it still morning? Good morning, Mr. Sheldon, Mr. Samuels and Ann -- talked to you a little bit earlier.

First of all, we want to thank the Department of Health and Human Services for their continued commitment to a

robust consultation policy which includes this meeting on the formulation of a DHHS fiscal year 2015 budget request. We would also like to thank DHHS for their ongoing commitment to a recognition of the unique needs of American Indian/Alaska Native children and families.

Having said that, and I know we are constrained for time, but I think we need to design this consultation session to allow more dialogue between Tribal leaders making their presentation versus agencies making their reports. It is important that we hear that, but I think we need to design it so there is a better consultation for some of our issues to be presented to the administration.

We are very happy to have this consultation session. We urge DHS to continue to:

One: Expand the funding programs to which Tribes can apply.

Two: Provide culturally relevant technical assistance services, and

Three: Increase support for the programs that include Tribal grantees.

We also understand the role that sequestration plays in the development of the DHHS budget, but we ask DHHS, to the extent possible, to hold harmless those funds and set-asides that support Tribal welfare, children's mental health and

family support programs.

It is critical that we try and do that. That support is like -- Mr. Forsman was saying about Head Start programs also in that sense. We also ask DHHS to remember the trust responsibility that the federal government has to support Tribes and to ensure their continued existence and success.

I think that has also been alluded to, so we want to continue to stress the trust responsibility to the federal government. I will highlight some of the concerns that we have for the Indian Child Welfare Association.

First is the establishment of a commission to eliminate child abuse and neglect fatalities. The Protection of Kids Act of 2012 established a commission to eliminate child abuse and neglect fatalities. To conduct a study and make recommendations on how to eliminate child abuse fatalities.

The commission would be set up of 12 members who will be appointed by mid-April 2013. Six of these members are to be appointed by President Obama. That act specifies that commissioners are to represent a wide array of backgrounds and encourage the president and Congress to select individuals whose background is not only represented on the commission.

The commission will study the use of Federal Child

Protection and Child Welfare Services funds, many of which Tribes are eligible to administer, to ensure that the study process and recommendations will have a meaning and benefit for Tribal governments.

We recommend that DHHS work with the Administration and a National Congress of American Indians to identify two tribal representatives of the six that the Administration will be appointing for this commission.

There are very significant differences in how Indian children are served, what access they have to federal funding streams, and the types of recommendations that will get at the underlying issues that lead to child-abuse fatalities in Indian Country. --- will be glad to assist in this process also.

On Title IV-E, foster care, adoption and guardianship assistance, the passage of the fostering connections to success, an Increase in Adoption Act of 2008, which made Tribes, Tribal organizations and Tribal consortia eligible to apply and administer these Title IV-E funds directly was a huge step in the right direction.

We thank Congress for passing this law and appreciate the efforts of DHHS to improve the programs with the Tribes. Still there is more to be done to make this Title IV-E program accessible and feasible for Tribes.

Because the Title IV-E program contains many significant, programmatic and fiscal requirements, Tribes need to have access to technical assistance that not only explains the federal requirements but also reflects their unique community and governmental structures so that Tribal governments can design programs that are both compliant with federal requirements and effective for the populations served.

Tribes and Indian organizations have worked diligently to help inform that process, but more Indian well-child expertise with the Children's Bureau is needed. Other DHHS agencies have created positions staffed by Tribal members with experience in the subject areas to help Tribal governments communicate and access services.

The Children's Bureau, to our understanding, has never had such a position in Washington, DC, and we think it would be very beneficial and timely to create this position.

Not only effective technical assistance but also experienced leadership is essential to the success of this and other federal child welfare programs with Tribal governments. Previously in 2008, the Children's Bureau has always had the benefit of a political appointee in the role of an associate commissioner for the Children's Bureau.

This key leadership role was essential to promoting the administration's goals and policies in the day-to-day work

of the Children's Bureau, and was especially helpful for Tribal leaders as they engaged the administration via the government-to-government relationship. We recommend that this position be reestablished also.

We would also point out that having an appointed position overseeing the Children's Bureau directly can help clarify and create more continuity regarding the development of policy affecting Native children and Tribes within the Children's Bureau also.

Title IV-B, subpart II, the court improvement, Tribal justice systems are chronically and historically underfunded. They continue to face complex issues of justice with far fewer resources than their state counterparts. For this reason we appreciate the administration's support of Congress's efforts to create new programs for Tribal justice systems.

The funding of $1 million has provided grants to 70 communities in the first year of the program. Still there are over 100 Tribes that operate their own court system and over one-third of all Tribal children in child welfare systems have their cases adjudicated in these courts.

In addition, this funding will help Tribal judicial systems not only improve their efforts, but it will also empower them to work more effectively with state juvenile

courts.

Yet there is no other funding stream available to Tribes specifically to support the work of their dependency court. For this reason we request that the $1 million set aside in this program be extended to $3 million so more Tribes can increase their dependency courts' capacity and improve outcomes of Tribal children.

TANF, Temporary Assistance to Needy Families: The opportunities offered by the provisions of the welfare reform to create Tribal TANF has allowed Tribes to restructure and innovate Tribal programs and resources to create jobs, support new workers, fund transportation solutions and provide child care.

As of fiscal year 2012, there were 68 Tribal grantees serving 299 Tribal communities. Due to its flexibility, Tribal TANF creates incredibly important support for Native children and families. More and more Tribes are using TANF programs to provide creative support to families via out of home child care placement, child care solutions and financial and emotional support to new mothers.

In addition, Tribal TANF programs have strengthened families and improved child well-being by working with partners and faith-based organizations for formalization of the responsibility of fatherhood and reducing teen pregnancy

rates.

With reauthorization on the horizon, we ask that these issues be considered and that the Administration continue to work with Tribes to ensure that Tribal issues are addressed in the Administration's TANF priorities.

In addition, one particular TANF discretionary fund has done a great deal of increasing family stability in Tribal communities. The child welfare services to Tribal families at risk of child abuse and neglect grant program has allowed Tribes to fully integrate their family services to focus on family preservation, something not only good for the well-being of the child but also the financial stability of families.

By coupling TANF and child abuse and neglect programs, Tribal grantees have designed new and innovative wrap around services to help prevent entry of children into the system, reunifying parents and children and work on permanency planning that deals not just with the symptoms of child abuse and neglect but also the larger problem of poverty.

Tribal TANF programs are working with large case loads of hard-to-serve individuals, and in spite of the challenge, Tribal TANF has had great success. Nonetheless, changes must be made to strengthen this program and improve

access to Tribes.

For this reason, NICWA supports and reiterates those changes discussed in the NC --- solution and as described in the NCI-DHHS testimony.

Circles of Care mental health program: The Circles of Care grant is funded under the Substance Abuse and Mental Health Service Administration programs of regional and national significance, but it is only specifically authorized. We commend the Secretary and SAMHSA for continuing to recognize and support the need of Circles of Care funding, even without a specific authorization statute because it is essential to the many communities it has supported.

Native youth experience Post-Traumatic Stress Disorder at higher rates than the national average, struggling with alcohol abuse at a higher rate than the general youth population, and have the highest prevalence of major depression.

Yet the Circles of Care grant programs is the only source of federal funding that specifically supports Tribal children’s mental health service delivery. The need continues for increased Circles of Care funding available and its mental health data and demonstrated and measured effectiveness of the program.

To date Circles of Care have enable 38 Tribal

grantees communities to develop culturally competent community based children's mental service delivery models. Circles of Care use measurable long-term positive outcomes. These grants have significantly increased Tribal community awareness, facilitated community ownership and responses, and helped Tribes develop capacity for children's mental health.

To continue this good work, we recommend that Congress enact a specific authorization for the Circles of Care program. Without this, Circles of Care is at the risk of being reduced or even eliminated from the SAMHSA budget annually.

Defunding Circles of Care would have devastating effects, literally creating a vacuum of children's mental health planning and capacity-building funds available to the Tribes.

A specific reauthorization or a specific authorization would eliminate these threats and illustrate the government's commitment to funding programs that work in Indian Country. By designating an order to make the program even more responsive to the needs of the Indian Country, we recommend that the funding made available, Tribal grantees be increased to $4.5 million, an increase of $1.5 million.

The program has made an important impact in the communities it funds, and expanding the grant program by $1.5

million will allow at least four to five more grantees to get this grant.

Systems of Care Children's Mental Health Program: Systems of Care grants funded under Comprehensive Community Mental Health Services for Children and Families program were established in 1992.

These funds support the development of mental health programs that follow a philosophy and framework that encourages collaboration across government and private agency providers, families, and youth to improve access and expand the number of types of community-based, culturally competent service available to children with serious mental and emotional health needs.

Systems of Care is available to states and Tribes on a competitive basis starting with the first Tribal grantees in 1994. Over 30 Tribal communities have received either 6- or 4-year inflation grants and 1-year expansion grant.

SAMHSA is currently considering a new funding strategy for these two Systems of Care grant programs that would rely on accessing third-party resources and leveraging other available federal funds such as mental-health block grants.

While this may be a strategy that will work well for the states, it will have a devastating impact for Tribes.

Unlike Tribes, states have a direct access to mental health block grants, Medicaid and Medicare funding that can support mental-health services. They also have significantly more infrastructure and the access to third-party networks to help them recover funds from third-party sources such as the private insurance.

Considering these position outcomes and the behavioral health needs of Tribal communities, continuing the Systems of Care program funding is vital to Tribes and a blow to the design and the success for children's mental-health programs.

It is essential that SAMHSA continue to fund Systems of Care at the fiscal year 2013 enacted levels to protect the integrity of the programs and to allow for a new four- and six-year implementation grant as well as to provide funds for one-year expansion grants. This will ensure that the Systems of Care model is successful to all Tribal communities.

Behavioral Health Tribal Prevention Grants: The president's FY 13 budget proposed $40 million for new Behavioral Health Tribal Prevention grants funded under the Affordable Care Act, which would support behavioral health services that promote overall mental and emotional health in Tribal communities with a focus on substance abuse and suicide prevention.

We commend the president and SAMHSA for having proposed this critically needed funding and recommend that it be funded to the fullest extent authorized in legislation as it would be the only source of federal funding focused on the intersection of mental health, substance abuse and suicide prevention.

Additionally, as data collection would be an important part of the implementation of these funds, SAMHSA should consult with Tribes on the development of data requirements to ensure that the most accurate, helpful and useful data is collected. We recommend that there be data collected to make it possible to understand how much of these funds and services supported are provided to children and families.

We thank DHHS for the ongoing attention to the unique needs of our Tribal families and children, for the exemplary consultation policies and for this opportunity for the National Indian Child Welfare Association to share this testimony on these important matters.

I do have specifically testimony on the Indian Child Welfare compliance. We want to begin by commending the Secretary for her interest in ICWA and commitment to explore how DHHS can better assist Tribes and states in the proper implementation of ICWA.

The Secretary's Tribal Advisory Committee sent out a letter to Madam Secretary on January of 2013 asking for assistance in improving oversight and assistance regarding implementation, and is looking forward to working with her.

The Indian Child Welfare Act was signed into law over 35 years ago in 1978 in response to the troubling practice of public and private child welfare agencies with regard to Native American children and families. At the time of the enactment, removal of large numbers of Native children from their homes was commonplace and often resulted in the placement of these Indians in non-Indian homes far from their Tribal communities.

By creating procedures for public and private child care and adoption agencies as well as state courts, ICWA aims to ensure that Tribal children and families are protected by curbing biases in the child welfare system and replacing practices that end the placement of Native children outside their homes and practices that strive to keep Native American families' kinship networks, communities and Tribes together.

Nonetheless data show the Native children are disproportionately represented in state children welfare systems and nationally as well. The percent of Native American children in the child welfare population is over 2 percent whereas the percentage of Native children in the

general population is under one percent.

In a number of state foster care systems, Native children are represented at a rate that is over three times of that population rate. Additionally, Native children are three times more likely to be placed in foster care than are white children. We also know that at major decision points in the state child welfare system that disproportionately increases, starting with cases investigated throughout placement and out of home care.

This is evidence that state social systems and courts are struggling to implement the requirements of ICWA and the children and families are facing biased treatment. Noncompliance is likely due to the fact that there is minimal oversight concerning Indian child welfare and implementation.

ICWA however does not give any federal agency responsibilities for states' compliance with the law. However ACF does review some very limited information as part of their general efforts of oversight for the Title IV-B and Title IV-E funding programs, and that have oversight relationships with states on many other child welfare programs and laws.

Via the Child and Family Service Plan, states are required to develop, in consultation with Tribes, plans to ensure compliance with ICWA on three measures that are reported to ACF. These measures include how the state will

ensure

One: The identification of Indian children in child-welfare cases.

Two: Notification of relevant Tribes when their children are involved in a child welfare case.

Three: That the placement preferences of Indian Child Welfare Act are followed in child welfare and adoption cases.

The reports of states to ACF on these matters have been deemed insufficient for ACF to assess the states' efforts to implement the laws required by GAO in a study released in 2005. Consequences of ICWA noncompliance go beyond just overrepresentation of Native children in state child welfare. Individual children and families face consequences that include invalidation of state court proceedings, disruption of long-standing foster care placement, voiding of final adoption orders and disconnection from the cultural and family connections that are critical to their long term well-being.

We also note that the Indian Child Welfare Act has long been considered a best practice standard in Indian child welfare outside of Indian Country in the field of child welfare generally. Federal child welfare laws continue to move closer to the standards contained under ICWA, giving more emphasis to the efforts to promote proper implementation.

We believe there are several actions DHHS can take under existing authority short of supporting legislative changes to provide a federal agency with specific authority to conduct comprehensive reviews that can improve the Indian Child Welfare Act. These include

One: Enhanced data collection by ACF on issues pertaining to ICWA compliance. ACF can work with Tribes to improve program instructions and internal administrative product procedures regarding state ICWA compliance.

Two: Policy changes can be established that require action and follow up by ACF in states where there is knowledge of ICWA noncompliance. When ACF becomes aware of ICWA noncompliance, they should provide clear action steps in state performance improvement plans as part of the federal child services review, including technical assistance and training.

Work with the Tribal governments and national organizations with expertise in this area to develop improved technical assistance and training to help state effectively implement Indian child welfare on an ongoing basis.

This is my testimony for National Indian Child Welfare Association. I also want to include some for Head Start.

MS. BISBEE: Mr. Vigil, we are 10 minutes into the next agenda item.

MR. VIGIL: I will be brief with the Head Start.

MS. BISBEE: If you could summarize, please?

MR. VIGIL: You know, Head Start is one of the most successful programs, and it has been proven so using a holistic approach in developing programs akin to Native values, it has been the front line of defending and protecting Tribal culture and language.

The State of the Union Address for President Obama put emphasis on support for early childhood education. However, sequestration will have a devastating effect on Indian Head Start and might impact them for generations.

So we request that the agencies stand firm on all budget discussion in defense of Head Start, which truly serves the most valuable resource, and that is our Indian children. So with that, thank you for this time.

MS. BISBEE: Thank you, Mr. Vigil, and we will allow Mr. Sheldon a response before we go into the next agenda item.

MR. SHELDON: Well, thank you, and governor, thank you. I have made several visits in Indian Country since I have gotten here, the first being the pueblos there in New Mexico, and I appreciate that opportunity.

And one thing I really have learned here is the value of not only these consultations but the value of ongoing communication. It is for that reason that we are establishing

at ACF a Tribal Advisory Council, and would encourage all of you –- we have got some memos in the back. We would encourage you to make nominations for that advisory council.

I have seen how well the Secretary has utilized it. Just a couple points I would like to make. The Secretary has made a commitment, as have Commissioner Samuels and I, to really attempt to provide as much leadership on full implementation of ICWA as we can.

I appreciate the recommendations you have made. In addition to that, in conjunction with ACYF and the Administration on Native Americans, we will be holding listening session in our regions at the same time we are doing our Tribal Consultation to get input. As most of you know, the Casey Foundation has also developed a Tribal working group that meets again, I think, one more time here in Washington, and then in Tulsa next month.

I intend to be at the Tulsa meeting, and I am hoping that some of the recommendations that working group can provide, we can incorporate. Now I also recognize that our statutory authority is limited, but it doesn't mean that our guidance and leadership has to be restricted by that.

So we are looking at are there ways that we can provide additional guidance to the states and are there ways that we can assist Congress in providing some additional

enforcement authority. We have also intervened in the Supreme Court case as an amicus on behalf of, in conjunction with the Cherokee Nation and the Native American biological father in that case.

I am concerned about that Supreme Court case because I am concerned as to why they took it in the first place because I think the lower court decision should really dispense with the case, but it is something that we are watching.

On Head Start, which I recognize the concerns you have raised, I think this issue of teacher certification, of having sufficient class reviewers, is something we are trying to work in Tribal communities with because I think in order to really respond to the whole issue of decertification of some of these grants, we have got to make sure Tribal communities have the resources available both in terms of technical assistance, teacher certification and class reviewers.

The other point that I would make –- oh, and let me really quickly on the commission on child fatalities. As you know, the president has six appointments. I am confident he recognizes the recommendation you are making to have a Tribal input there. Whether that can be two or not, I will pass that recommendation along.

But because of the way the statute is written, there

are specific categories that have to go into that. So I will pass that recommendation along. I can assure you the White House will include and assure that Tribal views are heard. I think that is an important commission as they look at child fatalities resulting from child abuse and neglect.

The other thing that I would lay out, and I appreciate your comments both on TANF -- Earl is here from the Office of Family Assistance. We want to continue to work with Tribes to see if we can better coordinate what we are doing in TANF with child welfare, with some of the other grants that are out there.

In addition to that, my last point is we have four vacancies right now for regional administrators: Seattle, Kansas City, San Francisco and Philadelphia will be coming up. I would like to see us recruit at least in one of those regional administrators a Native American.

I think that too many times we have brought Native Americans into the Administration but we have also locked them into our Administration for Native Americans, and I think a broader scope would be very helpful. I can't assure you that with the career service system that we can identify one, but I would really encourage qualified individuals in the Native American communities to apply for those positions because I think it would be not only a significant statement.

I also think it could be a significant help to us as we really expand our regional operations. I hope that is responsive to some of your questions, but I recognize the time limits that we have.

MS. BISBEE: Thank you, Mr. Sheldon, and we are 15 minutes before the Secretary is scheduled to be here so we will start with the Indian Health Service Budget Formulation Team testimony. If we want to continue with Mr. Hayes and Mr. Joseph.

Indian Health Service Budget Formulation Team Comments

by Andy Joseph, Councilman, Colville Confederated Tribes

MR. JOSEPH (Speaking Native language): Hello, good day. My name is Badger. I am Andy Joseph Jr. I serve as a co-chair on the National Tribal Budget Formulation Workgroup, and I am a Tribal Council Member from the Colville Tribe from the Portland Area.

Presenting with me is Chairman Gary Hayes, chair of the Secretary's Tribal Advisory Committee and also the Chairman of the Ute Mountain Ute Tribe from the Albuquerque area. On behalf of the National Tribal Budget Formulation Workgroup, we are pleased to present our budget recommendations for fiscal year 2015.

President Obama has strived to live up to the promises to restore funding for Indian Health Services. He

understands our unique government-to-government relationship and shares our vision to achieve optimal health for our people. Under this administration, the IHS budget has gained an historical increase of 29 percent in his first term.

We know that to achieve this vision we must work in partnership to fully fund the true Indian health needs base budget of $27.6 billion. Only then will we be able to eliminate the health disparities that cause needless suffering and death of our people.

Since the creation of IHS in the 1950s, we have been challenged to accomplish this vision and are even more challenged given the mandatory decreases in discretionary funding and the recent harmful cuts enacted through sequestration. Because of this we must build stronger partnerships with each other to find initiative solutions to phase in the $27.6 billion needed for the Indian health care system.

Doing so will create a legacy worthy of this Administration and fulfill the constitutional and treaty-based promises of justice, health and prosperity for our people. The United States has a unique legal and political responsibility to provide health care services to our people.

This trust responsibility is established in the Constitution and reaffirmed through treaties and executive

orders as well as congressional actions and judicial decisions.

As stated in the findings of the Indian Health Care Improvement Act, it is a declaration of national health policy to provide the resources, processes and structure that will enable Indian Tribes and Tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States.

We strongly urge this Administration to continue embracing this policy to create a legacy and honor and trust. To our people, the federal budget is not just a fiscal document but a moral and ethical commitment. It reflects the extent to which the United States honors its promises of justice, health and prosperity to Indian people.

When funding falls short, our people are forced to live under third-world health conditions with little hope of living the American dream of health and prosperity. The high costs of health care are further complicated by the inflation and population growth and sequestration, which pits Tribes against Tribes for inadequate resources.

This results in Tribes having to make choices of what services to provide. This is no different than asking a parent to decide which child to feed and which will go hungry.

Where is the justice and honor in this? We must have a new era in Washington, one that says no to continued neglect in trust responsibilities to Tribal nations.

This duty must not be approached reluctantly, but must be embraced in a way that defines the character of our great nation. It is a matter of honor Tribes gave up in Exchange for trust commitments to provide the health and welfare of Indian people.

This federal trust responsibility is the foundation for provisions of federally funded health care to the 566 federally recognized Tribes, bands, Alaska Native villages.

We have government-to-government relationship. That should not be confused as just another federal program. Although the Indian health care system has made significant improvements in mortality and morbidity rates for our people, serious health disparities persist. More needs to be done to finally end long-standing inadequacies in health status.

As shown by the blue lines in this chart, our people die at higher rates than other Americans. Examples include 514 percent higher from alcoholism, 177 percent higher from diabetes, 82 percent higher from suicide. These statistics are unacceptable. More important, they are preventable.

In my own community, when we were working on this budget, I let our workgroup know that, that week we had to lay

to rest about six of our people on our reservation, and just this week alone I have gotten word of one suicide and two of our people that are quite a few years younger than myself.

One of elders, my good friend, told me that his mother was given her last rites, and like I stated in the beginning earlier about when the United States goes into battle, and you have got a platoon sergeant who needs things, and if he is not able to get what he needs, he has to ask for more body bags.

In Indian Country it almost seems like we are fighting that same kind of battle, just trying to survive. I would like to take a moment of silence for those lives lost in all of our Tribal communities, as my Tribe is one probably average of any Tribe in the nation. So I would like to request a moment of silence.

(Moment of silence)

I would like to thank you for your time today, and it is my honor for me to introduce Chairman Gary Hayes of Ute Mountain Tribe.

Comments

by Gary Hayes, chairman, Ute Mountain Ute Tribe and chair,

Secretary's Tribal Advisory Committee

MR. HAYES: Thank you, Andy. As you can see on the slide, in February, when our recommendations -– in February,

Tribal representatives from each of the 12 IHS areas reviewed the area budget recommendations and consolidated them into one national set of budget priorities.

The National Tribal Budget Formulation Group identified these three major budget recommendations for fiscal year 2015 as follows:

First: Phase in full funding for IHS total need-based budget of $27.6 billion over 12 years.

Second, increase the fiscal year 2015 IHS budget to $5.3 billion.

And third, not only to protect prior year health care gains but to also advance health care outcomes.

Ten years ago a similar workgroup met to develop a Tribal national budget recommendation for FY 2005. They were disheartened at the disparity between the funding needs of Indian Country and the funding available for IHS. And that trend still continues today.

They warned that continued underfunding would thwart their efforts to address the serious health disparities experienced by our people throughout Indian Country.

To address this shortfall, they proposed a 10-year plan for Congress and the Administration to increase the IHS funding to meet the total funding of the need in Indian Country. Since 2005, the IHS needs based budget has grown

from $19.5 billion to $27.6 billion. Due to the inadequate increases, this neglect has resulted in the need to now phase in the new base budget of $27.6 billion over the next 12 years.

If we continue to kick the can down the road, another generation our people will needlessly grow sicker and will die younger. To give you an example, I asked my Tribe to review from the past 10 years what the average age expectancy in our community is. It is appalling: 54 years for females. 54 years. For males, 50. The average in the last 10 years of our people passing away is 52.

While our primary recommendation remains for full funding of the IHS total needs based budget, Tribes in each area were asked to prepare budget recommendations for specific funding levels.

Taking the area recommendations, the national workgroup determined that a minimum increase of 19.7 percent, or $871 million, was needed to address the disease burden and the health care delivery system issues brought forward by the Tribes.

This increase includes a $163 million for pay costs, inflation and population growth necessary to maintain current services. The workgroup also recommends an increase of $178.8 million for IHS to meet its binding fiscal obligations to

staff new health facilities, pay contract support costs and to plan and to construct health facilities on the health care facility construction priority list.

Beyond these costs, the workgroup recommends additional $528.4 million for the critical health services and new facility authorities aimed at slowing the growth of health disparity rates in our communities. Lastly, uncertainty about the FY 2013 and FY 2014 budgets, as well as the effects of sequestration, compromises this Administration's ability to provide future increases to the IHS budget.

Remember, IHS is not a government program. It is evidence of the commitments and the promises made by the federal government to provide health care services to our people through treaties, legislation and court decisions.

With a commitment to serving America's most vulnerable populations, the IHS represents less than 1 percent of the HHS operating budget. While sequestration poses an immediate threat to all HHS agency funding, the Secretary may have future discretion in restoring these across-the-board cuts. We request and recommend that if this happens, IHS will be given the highest priority.

As we work to improve access of quality care, we must leverage existing funding through partnerships, taking full advantage of proven strategies and promising practice.

Extending self-governance to non-IHS programs within the HHS provides tremendous opportunities for collaboration, synergy and maximization of resources.

This administration should advance the Title VI governance pilot project. We must work together as true partners to improve the quality of and access to health care for our people. An example of this success is seen through the unprecedented creation of a first-ever, cabinet-level HHS Secretary Tribal Advisory Council, which I am proud to serve on.

Even with the political landscape of fiscal cliffs and sequestration, we don't view success as impossible. The Tribal budget recommendations of fully funded would be less than 3 percent of the HHS $941 billion budget.

It is feasible, and it is a moral and ethical thing to do. And it fulfills the trust responsibility accepted in good faith by our forefathers and our Tribal leaders. Tribal governments have upheld their responsibility and expect the United States to perform its duty in this binding covenant.

While we acknowledge and celebrate the steps this administration has taken to improve the health status of our people, these cannot be the only steps. For generations we have been working to repair the starved health care system for our people. All the stars in the sky cannot capture the

number of lives lost in our communities because of the chronic underfunding.

President Obama has secured a legacy of reforming America's health care system. However, the task of reforming the Indian health care system, so our people benefit on the same basis as most Americans, can only be achieved by fully funding the Indian health system.

To do anything less would only continue to contribute to the declining health status of our people and negate the gains achieved by this administration. In closing I would like to thank the National Tribal Budget Formulation Workgroup and also the National Indian Health Board for its outstanding and great effort in preparing this presentation.

We ask this administration to stand with us and to move forward on the path of health parity for our people. As a turning point envisioned by President Obama in his address to the White House Tribal Nations Conference, let this second term be remembered as a turning point for Indian health care.

And as eloquently stated during his last White House Tribal Nations Conference by our President Barack Obama, he stated, "We are going to keep working together to make sure that the promises of America are fully realized for every American Indian."

On behalf of our children, our grandchildren and our

grandchildren's children, for generations to come, we thank you for this opportunity.

(Speaking Native language) Thank you.

MS. BISBEE: Thank you, Chairman Hayes. And I believe the Secretary is going to be here, so we will hold off for any questions from the Tribal leadership until the discussion and roundtable time if that is okay with the Tribal leadership.

(No response)

MS. BISBEE: Right, she should be here any moment. Thank you.

MR. HAYES: She is standing out there. You know, as I was giving the presentation, you know, as Andy Joseph mentioned about how many lives we lost because of the neglect of our people, we have got great hope through our Creator that we have always got to remember that the prayers of those who have gone before us continue with us today as Tribal leaders.

And those who are here today, that we may continue that mission of trying to secure the proper, adequate funding for our people in Indian Country.

(Pause)

MR. HAYES: We would like to welcome you, Secretary Sebelius. We appreciate the opportunity to have –- to be in your presence, to be here with Tribal leaders and to have this

dialogue. One of our priorities in Indian Country, of course, is health care for our people, and the environment that we are in, in the fiscal environment that we are in today, it is extremely important that we continue this dialogue.

And as we mentioned in our presentation with our Tribal Budget Formulation Team, we want to extend and appreciate the first ever cabinet position in this administration, that your commitment to be with us and to hear our concerns, and to be an advocate on behalf of Indian Country, we really appreciate what you have done.

And we hope that this continuation of this relationship will help us overcome these difficult times that we face. So again, we appreciate it and would like to welcome you, Secretary.

Secretary's Remarks

by Secretary Kathleen Sebelius

MS. SEBELIUS: Well, thank you, Chairman Hayes. It is nice to have a chance to be with you and with leaders from across the country.

I want to thank you all for being here. You got an up close and personal example of DC's inaccurate weather

predictions. I am sure all of you had trouble digging out of the snow this morning to make your way over to the office.

I actually saw a news clip last night, and the weatherman, when they got to that portion of the news, was sitting in the corner in a chair with his back to the screen and he said he was giving himself a timeout because he thought he had done such a bad job.

Anyway, we are delighted to have you here, and I want to recognize the fact Gary Hayes has just been elected chairman of the Secretary's Tribal Advisory Council, and I know Roberta Bisbee and Cathy Abramson and other council members are here, and I just want to thank you all for that effort and that ongoing discussion.

And I know that you all know, and they will be with you during the course of today, is that, you know, here at the table are the senior leaders of HHS, representing not only Indian Health Service but everybody from the Department on administration to our mental health services, legal department, our legislative team, and I think it gives you a notion of how seriously we take this consultation process.

I want to particularly recognize Paul Dioguardi, who leads our Government Affairs and Outreach Division as well as Stacey Ecoffey for putting this consultation together and making sure that it happens year in and year out.

Your advice is taken very seriously. It not only provides our opportunity to get your policy ideas but also your priorities in terms of funding. I just want to make a couple of opening comments and then hopefully leave the major portion for question and answer.

But I hope you all saw the Washington Post today, Dr. Roubideaux's picture front page at the signing ceremony for the Violence Against Women Act.

And I think it was very appropriate that she and some others in this room were in that photo because I think it was the last efforts of Tribal leaders to push that bill over the finish line and make sure that the reauthorization of the Violence Against Women Act not only occurred but occurred giving stronger protections in Indian Country.

So congratulations. That is a big victory. It is -– yes, give yourselves a round of applause.

(Applause)

MS. SEBELIUS: A huge step forward. This is clearly very uncertain budget times. As you know, we don't have a 2014 budget that has been released yet, so we are not trying to be coy with you over spending amounts. We don't know what the signoff is at this point. And we are not quite sure when that is going to be out.

We do know unfortunately that we are in this

arbitrary cut situation where what we had thought we agreed upon for 2013 funding, when we also didn't have a budget, has now been cut, and in our department has been cut by $15.5 billion for the remainder of 2013.

So that cut has an even bigger significance than it would because you have got to take it out of a, just a portion of the year. We know it will mean about 3,000 fewer inpatient admissions and 804,000 fewer outpatient visits at the IHS facilities. We know that we will have about 70,000 children who will lose Head Start slots. Some of those are in Indian Country.

April 1, we will cut every Medicare provider's payment by 2 percent across the board, so every doctor, every hospital, every drug company, every medical device company is cut, and those computers get reprogrammed next week on the 15th of March, and those cuts will just automatically take effect.

The president clearly is eager to work with Congress but he continues to insist it has got to be balanced. You don't cut your way out of a long-term deficit situation. We have to make smart, strategic investments.

We will continue to work on reducing expenditures but only making cuts on the discretionary side of the budget and doing it in this arbitrary fashion where our hands are tied about who we can spare and where we make cuts is my best

example of really stupid government. And it is impacting uniformly across our department, across government, and it is the worst possible way to move forward.

Having said that, as difficult as it is with these uncertain budget times, we know that we have to continue on a mission, and a mission working with all of you. So the FY13 budget request to Congress was a $6.3 billion investment in Tribal programs, again an increase from the year before, including an increase to IHS, which continues the increases that we have had since 2008.

They are not just IHS increases, but Tribal programs in the Administration for Children and Families would be increased. Child care and child support and foster care services. But as I said, not only do we not have a 2014 budget, we don't have a 2013 budget.

So we are still a bit uncertain about what our overall funding levels are. We hope that your voices, while you are here in the District, will be heard up on the Hill, because members of Congress have to hear from their constituents about how critical it is that they come to the table, that they work with the President, that we have some certainty.

I also know that one of the issues that has come up in the past is the issue about having a single definition of

Indian, and it is a critical component of lots of different laws and –- you all know better than anybody that there are three different definitions in the Affordable Care Act, much less different definitions across the way.

We agree with you that, first of all, having a single definition makes sense. And also we are very much in support of the definition that matches IHS and Medicaid eligibility. We do need a legislative solution.

We will be working with you to promote that legislative solution as quickly as possible, but having not only the more expansive definition but also a definition that makes it easier to determine eligibility we think is the best way going forward.

So I just wanted to tell you that we are providing technical assistance to Congress. We are making it very clear we are weighing in on the side of the definition that the Tribes have recommended. And we will continue working with you to try and protect funding as we go forward.

As I said, sequestration gave us very little ability. We will have proposals in the 2014 budget, assuming that they are signed off on, that will continue the progress that we have made. But I am, again, happy to see you all here, delighted to have a chance to meet with you, and I will turn it back over to Gary and see if you have some questions

for me or more importantly some advice to give me.

Questions and Answers

MR. HAYES: Secretary, we appreciate your comments, and there are a number of items that were brought up prior to your arrival here. One of the –- we have discussed this in our STAC meetings, and we looked at the priorities, and you know, of course No. 1 was funding increases and funding initiatives.

And the Affordable Care Act we discussed. The third one was the Tribal-State relationships that we have been discussing. And I appreciate what you have done, sending letters to the state governors that have Tribes in their states to be able to consult with them regarding the Affordable Care Act.

And I think we have seen some progress but we still need some work and clarification to understand that. You know, some of our relationships with states aren't as positive. And with your advocacy, I think we can continue having more feedback, positive feedback, from states on this relationship.

MS. SEBELIUS: Mr. Chairman, as you know, some of you probably were at the Congress meeting the other day, and one of the things we did announce was that we were moving forward with New Mexico around a waiver but deferring and

supporting the Tribal view that waiver should not include mandatory enrollment of Native Americans in managed care programs, which was very much disputed by Tribal leaders and also some other initiatives that you all put on the table.

I think that, again, I would just urge coming to us with as much specificity as possible as early as possible when things break down. I know it is difficult to say we weren't at the table if you weren't at the table because sometimes you don't even know that the table was there, and don't learn about it until after the fact.

But as soon as you learn about it, coming to us, we can do what we did with Kansas and a couple of other states and send their proposals back knowing that there had been no consultation.

So we are happy to follow up but as timely as you can make the input to Paul and Stacey and others, and as specific as the issue is, that is really helpful so we know what we are going back for.

MR. HAYES: All right, at this time I am going to go ahead and ask Tribal leaders for any items they would like to bring up to the Secretary but I would ask that you be mindful of the time to give other Tribal leaders an opportunity to address the Secretary.

She will listen and then afterward she will respond

to those concerns that you may have. First, I would like to open the session, and we will go with the chairmen first if there are any chairmen or presidents. Chairman Payment?

MR. PAYMENT: First of all, thank you for being here and being an advocate for us on a continuous basis. We appreciate that. So I said earlier, we don't see what we receive from the federal government to benefit our communities as entitlements. We don't see it as discretionary funding. We use the term prepaid treaty right because there was an Exchange.

There was an exchange from the land to the federal government, and the promise for health, education and social welfare for as long as the rivers flow, the grass grows and the wind blows. And so that seems like it is a long time, but with environmental challenges maybe not so long.

So we are not asking for anything that is not rightfully ours, and we feel it is the federal government's obligation to uphold this trust obligation. And sometimes people will ask us, well, why should we uphold the treaties? They are old documents. They are almost 200 years old. And I like to remind people that they are younger than the U.S. Constitution and they are pursuant to the U.S. Constitution.

And so, you know, we see this as a trust obligation of the federal government, and we are trusting the agencies to

continue to be our advocates. We don't see our pre-paid treaty rights as welfare. They are not discretionary. They are not entitlements. They are not based on our minority status as minorities.

They are not to right the wrongs that were done to our people. A lot of people who are sympathetic and supportive think that it is somehow reparations. If that were the case, there would be reparations or benefits for other racial ethnic groups.

And so, you know, our people paid through blood, sweat and tears and the death of our ancestors for our prepaid treaty rights. So I am asking that any communications that can be shared by Tribal leaders or by agencies to Congress to help them understand that there is something bigger in play here.

And that if there is any way to exempt some of our programs or even soften some of the effects of sequestration, we would greatly appreciate that. Thank you.

MR. HAYES: Thank you, Chairman. Councilwomen Cara Cowan Watts.

MS. WATTS: Thank you, Chairman Hayes. Hello, Secretary Sebelius. We appreciate your time today. I am here representing the HHS/OMH Health Research Advisory Council for American Indians/Alaska Natives. I am co-chair along with

Councilman Steve Kutz from Cowlitz.

We will be sending you a letter highlighting the need to remind our states, under the Affordable Care Act, that state Tribal, or that the Tribal epicenters of the relationship for data, as a public health authority, as that status has been granted under the Affordable Care Act.

As specifically right now, our Tribal epicenters are not able to obtain the data that they need from both the state health authorities or possibly counties. And that is inhibiting their ability to deliver the research data that they need to further health care in Indian Country.

And of course we always welcome improvements with our Indian Health Service data sharing as well. Then also our NIH Consultation Policy. We believe after meeting with NIH yesterday, that possibly seems to be moving forward.

Of course with the 27 centers, that is always going to be difficult, so we welcome your office continuing to provide support to the office of –- the director's office at NIH to coordinate those centers to give an NIH-wide policy on data research with Indian Country and the many complicated issues that go with that.

Also we welcome the work that the National Children's Study has done in progressing to address the issues that we have brought forward to your office and the National

Children's Study specifically around the Alaska and the Plains areas, which were not sampled at all, where we see great health disparities under the National Children's Study.

So in response, they have come back with a sub-sample of 10,000 that we should be able to affect, we hope, by providing specific guidance or recommendations or consultation in the next year in order to effectively, hopefully bring actual sampling in Indian Country with actual identified instead of self-identified American Indian/Alaska Natives.

And hopefully provide oversampling so that it has meaningful results for Indian Country in such a substantial study. So they have been responsive but we still have work there to do.

Also we ask that the HHS Data Council -– and all of this has been submitted in writing, of course -– but the HHS Data Council actually adopt an HHS-wide research policy for Indian Country so there is consistency in sampling, identifying American Indian/Alaska Natives under a consistent definition as well as oversampling so that our population is represented in the many health care needs and research priorities.

We also ask that scholarships and fellowships -– because those are significant, and some of them

are very meaningful in the amount of money that would lift up our American Indian populations –- that is no longer go to box checkers. That is actually go to a consistent definition of American Indian/Alaska Natives.

Whatever that definition ends up being, but at least, at minimum, federally recognized Tribal citizens. And that would be referring to the Federal Register.

MS. SEBELIUS: Can I just –- I am not sure I just understood what you are saying. So you are saying some people self-identify, and they would not be –- may self-identify as an American Indian but they don't meet what you're asking as a member of the federally qualified Tribe or –- is that what you are talking about, box checkers versus –-

MS. WATTS: Yes. Correct, Secretary Sebelius.

MS. SEBELIUS: Thank you.

MS. WATTS: Also data sharing in terms of data ownership oversampling. Those issues -- and we will be sending letters. And specifically that Tribal IRBs are consistently recognized in research done in Indian Country. That requirement is there before any awardee receives their funding, and that Tribal IRBs are honored throughout that relationship in terms of research in Indian Country.

I mean there are still many agencies unfortunately within HHS that don't understand Tribal governments and

structures, and that there should be an IRB-type process.

There are a number of general research recommendations, but the other thing that we will be seeking assistance with is possibly a Native Research Database Clearinghouse.

There had been a form of it at the University of New Mexico that was funded. That funding had stopped, so now we are looking to the National Libraries of Medicine to possibly look at a single database of sorts in order to house research findings and possibly data, and also recognize whether Tribal IRBs were honored throughout those processes even historically. Thank you for your time today, Secretary Sebelius.

MR. HAYES: Thank you. Chester?

MR. ANTONE: Good morning, Secretary. I just have a few things that I wanted to make you aware of. First being the cuts that are going to happen. And for us, what it means is cuts to funding for IHS, CDC, HRSA, JHS grants. It may mean we won't get refunded or may see significant cuts in funding for our diabetes program HOP.

MSPI, Meth Suicide Prevention Initiative, and the Office of Violence Against Women. And our carryover requests may be denied. You know, that is the picture that we are facing. And also, with all the BIA funded programs such as

family assistance, child welfare and adult care -- they will be affected.

We may see cuts in the IHS --- grants, contracts, such as the CHR program, HIV/AIDS and behavioral health. Title III and Title VI reduction in workforce and reduction in services delivered to our elders. You know, that is -- off hand at first glance, that is what we see happening. And I just wanted you to be aware so that with the effort of trying to protect funding that benefits Tribal program would go forward, that effort.

Earlier I had spoken about the Centers for Medicaid, Medicare Services, about consultation with Arizona. You can't hear? Okay. Earlier I had spoken about the consultation that we are asking for the Arizona Tribes regarding the federally facilitated Exchanges.

A lot of that detail we have relayed already to –- and Paul Dioguardi did respond that they were going to be looking toward that. And I ask that Phoenix be considered as a place to hold consultation if the IGA is considering regional consultations. I guess due to the travel stuff, because it is a major airport and easy to get into and get out and not as expensive as some places.

So we are making that request to you, that hopefully the IGA will honor that. The last thing I just wanted to let

you know is we did submit, last month at the STAC meeting, I submitted a waiver request to CMS, and I indicated at that time that Stacey Ecoffey had a copy of that for you and one for her files.

Whatever action CMS takes in recommending to you whether or not to do that, we would like that response from your office to the nation, whatever it may be. And that is all we ask. Thank you.

MR. HAYES: Thank you. Councilman Willie Bearshield.

MR. BEARSHIELD: Good afternoon, Ms. Sebelius. Thank you, Mr. Chairman. I would like to thank you all, first of all, for last year coming to visit the Westover Tribes in South Dakota. I don't know if you remember me or not. We met and had a little pow wow and all that stuff, and we sure appreciate the effort.

But I think some of our unmet needs and the needs of the Westover Tribes are, you know, still pretty much there. Of course, we are very disadvantaged as far as coming from some of the poorest counties in the nation. So those are still there.

We did leave some unmet needs and some priorities with Dr. Roubideaux yesterday. Visited with her, but there are a couple of IHS's that we represent, Rosebud being one and

also the Rapid City Indian Health Service.

We will start with Rosebud here. There are some things that have happened that have –- we have made some pace. The pace has picked up. We have done some good things but yet many of the needs are still there.

We would hope that those fundings that we are asking for in our unmet needs will continue to receive some high priority. As long as resolutions from Tribes and what have you –- we also left, there are some issues with the Rapid City Indian Health Service that we would like to see addressed concerning just a couple of them with administration and with the facility itself.

They are very much in need of a facility in Rapid City. The population there continues to grow in a Native American community, and we talked with Dr. Roubideaux, and they are working on some of those issues, but we would still like to see those as priorities.

So with that, I would just like to thank you again for coming to visit us and you are most welcome there at any time. Thank you.

MR. HAYES: Thank you. Cathy?

MS. ABRAMSON: Hello there. It is nice to see you. On behalf of the National Indian Health Board, I would just like to –- I know that travel restrictions and everything are

in place but I just wanted you to be aware that we will be having our annual Consumer Conference in Traverse City, Michigan, for the National Indian Health Boards.

And if you have to make a choice, I would like you to know that you are extremely invited. We would be happy to have you come because there is a lot –- again, it would be nice to hear and learn from you. Thank you.

It is the end of August and Jennifer, if you have the dates, exact dates? We will get it to you. Thank you.

MR. HAYES: Thank you. Next we have Chairman Marshall, Pawnee Nation.

MR. MARSHALL: Good morning. It is good to see each and every one of you this morning, and the Secretary and Dr. Roubideaux. I come from a Direct Service Tribe, and we have a little different issues in self-governance.

I have talked to Dr. Roubideaux about them. I hope you have a chance to talk to her and get to see some things that I have pointed out. I don’t want to take time now because if I get on roll it will be for a while, but we have some concerns and we would like to have you hear them and address them. Also come to our national convention in July.

But we chose to leave our health with the federal government. Like the chairman said, as long as the grass grows and the wind blows. And sometimes it seems like the

fires darken the skies. Sometimes drought dries up the rivers but still we depend on the federal government for that health.

Right now the funding is at 54 percent, and my Tribe gave up 36 million acres for 658 acres in Oklahoma. We would sure like to have that federal health. And the Cherokees talk about their Trail of Tears. When we left Nebraska we had about 12,000 people in 1875. In 1900 there were 670 of us.

And I believe we deserve that health care and deserve the full extent of it. It wasn't a complete genocide but it was close to it, and we have served this country faithfully. We have a history going back to the Indian wars that is unblemished. And we would sure like to have at least part of those treaties honored and observed.

I know it is trying times for everybody. And a lot of people have a lot of questions. But I want to at least present that, that we are very interested in our health for our old people and for our young ones and the ones who are yet to come because we pray very hard for our people and their health. Thank you.

MR. HAYES: Thank you. Next is Vice Chairwoman Sylvia Homer from the Colorado Indian River Tribe.

MS. HOMER: Good morning, everybody, Secretary. I concur with Mr. Gover. You know, we look at the care of our people, you know, and that is what we are all here for.

Earlier Ms. Roubideaux, you know, was telling us she sent a business plan template to all of the area reps, you know. But when you look at Indian health care, when you look at health care, it is not an 8 to 5 job. It is not a business. You know, it is a trust responsibility of the federal government to take care of our people.

It was a promise, and the promise is dwindling, and we see that. You know, we -– I watch, I am a patient, and I watch myself get herded in like, you have got 15 minutes. The doctor has got to get you in there. Get you all in the computer. They don't have time to talk to that patient any more.

And it is one time. They are in there one issue. Our elders don't have one issue. We have chronic diabetes. We have heart disease. And I am sure you are aware of all of these things, but what I am saying is that it is the responsibility of the federal government to take care of the health care of our people.

You know, this expansion, you know, we should be exempt from that. It is the responsibility of the federal government to take care of our health care of our people. But we are not seeing it. And I just hope that in this business plan it looks at the fact that it doesn't take away from taking care of our people and running them through like a herd

of cattle.

You know, because like I said, doctors arrive at 8. They leave at 12, come back at 1. Leave at 5. It doesn't work. You know, but I just would like to reiterate that it is a responsibility. It is not something to be taken lightly. We don't take it lightly. That is why we are here. And we all have that concern. It is for the care of our people. Thank you.

MR. HAYES: Thank you. Next we will hear from Nancy Johnson from the Tribal Council from Colville Tribes.

MS. JOHNSON: Thank you, Secretary Sebelius, for being here and honoring that government-to-government consultation and relationship. Thank you. I wanted to address two things. One was there is a way -– and I am new council. I am newly elected by my people, so I humbly too say that I am learning the ropes.

The one thing that I am learning is that there appears to be a real staffing inadequacy at IHS, and I would like to request that there could be like a staffing audit done across the country so that there is some consistency there.

I know out where I live in --- , Washington state, we have –- I come from about 10,000 members that are Tribally enrolled, and that is probably four times that in the descendants that were served, you know, there in a 1.4 million

acre, so we have a large land base.

And we have a lot of challenges with health care. One of our districts, our largest district, in Omak, the people have to travel over one mountain pass about 40 miles to –- and we all know the rates of gas. That is a challenge for them to get to health care, to Indian Health Service.

They have one outlet station there where they have one doctor there every day. IHS told me last week where they had I think 400 patients seen by that one provider out there, so that was pretty significant. We really need a facility there to take down some of those barriers for that. But we need the staffing that can provide the health care for our people.

The Affordable Health Care Act will provide those expansion of Medicaid and opportunity for more insurances but if we don't have the providers there to provide that service, that is a challenge for us. The other thing that I would like to ask is if they could activate the facilities workgroup that was done about 10 years ago.

There was a lot of work that was done and a new scoring system than what was there, and I am hoping when I talk about our Omak community, that I believe we will score really high on some of the work that was done there so I would really like to see that, the workgroup for facilities

reactivated. Thank you.

MR. HAYES: Thank you. Next we will hear from Councilwoman Frye Cromwell.

MS. CROMWELL: Thank you. Thank you, Secretary Sebelius, and it is good to see you again. Just a couple of questions and remarks. On the definition of Indians, do you know when we could expect an official statement on the definition of Indians?

MS. SEBELIUS: I don't know where we would quite issue that but this is an official statement, so I mean we could get you a letter or do something but what I have just made is an official declaration. It is what we are saying to Congress right now. It is what we will be providing in terms of technical assistance.

MS. CROMWELL: Okay, let me just kind of rephrase that.

MS. SEBELIUS: So what do you need? That is what I am trying to figure out.

MS. CROMWELL: Something like a real timeline of what we are looking at.

MS. SEBELIUS: Oh, well, the timeline unfortunately is not ours. So we are looking at a legislative bill that would move. So we will be making it clear to Congress that this is the definition that we think is most appropriate. We

will be urging them to act on a piece of legislation but we won't control –- I wish we did –- we won't control their calendar. I don't know if that answers that.

MS. CROMWELL: That is fine. Thank you. So I just –- I am the Vice Chair of the Direct Service Tribes, so I just wanted to let everybody know that we did attend, I did on behalf of the Direct Service Tribes, attend the Tribal Self-Governance Advisory Committee, and we are going to be working together on, you know, maximizing benefits, talking about issues we all face.

So I just wanted to let everybody know that was happening between the Direct Service Tribes and the Tribal Self-Governance Advisory Committee. And also just personally from the Mashpee Wampanoag Tribe, I would like to thank you. A year ago when I sat here I did talk about how we just received federal recognition in 2007. So we are pretty much a baby into this federal arena.

But we have been here forever and a day, as we all know, and since last year we did receive some child care grants, so we have over 100 Tribal children, babies, that are in full-time daycare, and it has increased the ability for our Tribal members to go to work or school. So I just wanted to thank you for that opportunity through the agency.

And also we received some funding for our Tribal

court infrastructure, a three-year grant from ANA, and I would like to thank you for that as well, and also we have received some money for our --- department to promote stable and healthy families. So we are receiving some funding from the HHS and we really appreciate it, so I just wanted to thank you on behalf of the Mashpee Wampanoag Tribe. Thank you.

MR. HAYES: Thank you. Next we will hear from Councilman Andy Joseph.

MR. JOSEPH (Speaking Native language): My name is Badger. My language –- my Christian name is Andy Joseph. I am from the Colville Tribe, and just –- Nancy is one of our new council, and our new council have set some priorities. In recent information that we got from one of our Tribal members was that we are ranked No. 3 in the world of potentially losing our language.

And anyway language is put at one of our high priorities, and the ANA grants we get to help with bringing language to our young people in our Head Starts and in our classrooms and even to our older people, people my age that really need to understand our language.

To me it is really important, and the work that is going on is really beneficial when you see a young child that is actually almost becoming fluent and able to read and write and sing and dance with the language.

And when they learn that, it is really healthy because a lot of our language works along with our cultural beliefs and our traditions, and anyway I see the future of our children benefiting as a more healthier community because the language is being reintroduced to a lot of our people so I thank you for bringing those resources to us.

MR. HAYES: Thank you, Andy. Now we will hear from Councilman Stephen Kutz.

MR. KUTZ: Good morning. Stephen Kutz with the Cowlitz Tribe in Washington state. As we move forward with the Affordable Care Act and we look at all the work that we are going to need to do to engage and do outreach with all of the Indians in our community, and I say all of the Indians because we serve a lot of Indians besides just our own Tribal members.

Alaska Natives and Indians, a lot of them in our facilities. When we are working with the state trying to figure out how we take care of this business, one of the ways that I think we can take care of this business and put some resources in place to take care of this is through Medicaid Administrative Match.

And in our state, we have been bumping heads with your agency for years on all of the work that we have to go through regarding our time studies. And we came to an

agreement with one of your predecessors, your immediate predecessor, who made some commitments to us and walked away from the table from those commitments.

And this is work that we take seriously, and when I talk to some of my people who are here from other Tribes around, they don't even understand Medicaid Administrative Match is. And so maybe the federal government is trying to figure out a way to do away with this because it is one of the tools that many of us use to do some of the work that we do, but we need to get back to working together and come out with a way that makes sense.

And also something that does not go to the point of ridiculousness on the time studies that we are going to have to do, which is what your proposal is right now, or at least the proposal of your agency. Thank you very much.

MR. HAYES: Thank you. Next we will hear from Councilwoman Roberta Bisbee.

MS. BISBEE: Thank you, Mr. Chairman, and thank you, Madam Secretary for being here today. I have been kind of quiet. Usually I am on the other side of the table, and I think some of your staff is probably wondering why I have been so silent. But I had a lot of the one-on-ones, which were very helpful, with the individual op divs.

But just a couple of the comments I had was in the

past, on the last three years, I have heard a lot about the interoperability approach. Mr. Sheldon mentioned it a couple of times, working with the Department of Education, working with HHS, Interior, you know. There is a lot of different cross-funding opportunities between HHS programs.

And one that really impacted us from the Nez Perce Tribe was the Head Start program. The Head Start program, and with that new designated renewal system, you –- one of the triggers is complying with the Child and Adult Food Program, the CACFP, which is actually funded through the Department of Agriculture but then administered through the State of Idaho in our situation.

So you have different agencies that all have to be involved when running the program, so it creates quite a burden when you get a trigger from the designated renewal system now, and then you have to –- because you have to have CACFP, Child Adult Food Program –- and so then you are communicating with different agencies.

We met with Department of Agriculture, and then they distribute the money to the state of Idaho, but it is a requirement from the Head Start Act or within ACF, and there is really no liaison for Tribes. It is kind of the Tribes have to figure their way through the madness.

And I would just encourage that you really evaluate

the HHS operating division, and if there are certain requirements within that you have to comply with using, you know, another program of another agency, that maybe somehow inform the Tribes of that or kind of help communicate that.

Because it becomes, it becomes quite complicated, especially if you are sanctioned, you know, or if any penalties, you know, or you are under sanction or a penalty, you have to navigate other hearing components and then not really know where you stand with ACF.

And so that has been one of the -– so within HHS, you know, you have USDA, Department of Agriculture, HHS, then you have the Department of Education with the state. And so just as that example with Head Start, you have three different agencies.

So I just hope that maybe your op divs can evaluate that funding and funding requirements from other agencies and help the Tribes understand how to navigate through that or find liaisons for that.

Another is the grant process. I attended the resource day, and we were provided, you know, the grants that are available through HHS. And we know that is a working document. It is a draft but it is going to be very beneficial for Tribes.

But within that grant process I had asked -– there

was a report done in 2006, I believe in 2009, evaluating, you know, for the grant opportunities, and I asked at that time, is there a certain grant model that was shared at Tribal Consultations regionally or nationally that works best for Tribes.

You know, is there something within HHS that has a great model such as -– I am going to give the example for the ANA grant -– that has higher competitive, it is more competitive across Indian Country. It is –- their grant application is more, I know it is a difficult process but it is more simplified than some of the others.

They also have Indian review boards, board members, so they have Indian members who are on the review panels.

And we had met with SAMHSA on the one-on-one and they said they are looking at that grant application model. I would just highly encourage that. Maybe through consultation with the Tribes, a model is suggested from Tribes -– you know, I know we are not all going to agree –- but a majority of a good model that fits for Tribes be implemented across HHS, all operating division. Thank you.

MR. HAYES: Chairman Payment?

MR. PAYMENT: I apologize because I didn't really understand the format. I didn't get into any of my substantive issues. I will start with a quote from Colonel

Platt, the BIA director at the time when the Department of War, the philosophy of the federal government was spare the child and kill the Indian.

And a lot of the effects in our community flow from that, the boarding school, the forced assimilation. I did my master's thesis in public policy, on U.S. Indian policy, and it took me 2 ½ years because that era was so difficult. I had to keep putting it down because the practice was to take wooden blocks and to wedge them into Indian children's mouths if they tried to speak their language.

And when you try to, you know, think about that. You think of the effect of that and how we would deal with that today. And so I want to underscore the importance of our language programs and bringing back our language programs. They are very critically important.

My Tribe put $17 million -– we are a gaming Tribe, we are not a per capita. We are too big. We could never be. $17 million of our revenue goes into programs and services, so 100 percent of that goes back into programs and services, and we don't even come close to scratching the surface of our need.

Our health care delivery system is self-sufficient. We generate $7 million a year in third-party revenue and so it is self-sufficient based on our existing need. But I want to

talk about and echo the data concerns. We have 41,000 members. 11,000 members live in the service area. And so about 40 percent of our population benefits or takes advantage of our health-service delivery system that we have.

And so when you look at trying to interpret the needs of the people based on that anecdotal picture, you know -– I am a doctoral candidate now. I am post comps, and so I studied statistics more than I ever thought I wanted to, but I love it actually. But there is an issue called ecological fallacy. And what that is, is projecting to a population the sampling of a sample.

And if it is not done correctly –- and so I want to underscore the need to oversample those populations, because right now even the U.S. Census is plus or minus a level that would never make it through a doctoral dissertation.

So I want to also promote the retention of our Head Start program. Once the sequestration affects –- if we have to get rid of one teacher, that means we basically shut down the whole program, because that means the classroom shuts down. Because we usually maintain the required student-to-teacher ratios, and if you have to get rid of a teacher, you get rid of a whole classroom.

I have to tell you that because I am a member of community action in my community and I am also over that Head

Start program, and I am a proud Head Start graduate from 1969.

Substance abuse is really important to me and my family, and my testimony included the need to be able to have available beds at the time they are needed. Right now it has to be timed right, and in the real world it doesn't work that way.

If you come for service and if you find someone who is willing, because of the effect of forced assimilation and all of that, you have to come at the right time, otherwise you don't get treatment. An example in my community just two weeks ago, my sister, who is chronically alcoholic –- very serious problem –- she has been in and out of jail for five years now.

Nothing serious, just petty theft and stuff like that, but she came for treatment and there was no bed available for three weeks. And to get, to sustain the commitment to stay sober -- I have 16 siblings, and there are only two of us that are sober.

And I think God that whatever happened in my life that protected me from that, I am grateful. But we have to not forget those who are affected and be able to reach out to them to get them the help they need when they need it.

Contract support: Our arrearage in our community is over $5 million. So earlier I said the $17 million. That is

30 percent of what we put into our annual budget. It is huge. It would make such a difference, and unfortunately we are potentially litigating. We are looking at the possibility of litigating but obviously we would want to come to some easier resolution.

And I know Dr. Roubideaux has promoted that there is a process for that so with that, I just wanted to make sure I came back, circled back around and hit the points I was intending to hit. Again, thank you.

MR. HAYES: Okay, one more.

MS. CARLISLE: My name is Deidra Carlisle. I am from the Ak-Chin Indian Community in Southern Arizona. I know we have a lot of work ahead of us in dealing with all sorts of issues as we are here today, but I thought I would bring up something.

Last year I stood in this room and talked about my daughter going through breast cancer. And I was sitting over there in the corner, and all of a sudden, this yellow balloon came flowing in here. I don’t if some of you might remember that. But I am happy to say that she is now cancer free this year.

(Applause)

MS. CARLISLE: But it still took a lot of work to go through the whole process of coverage, whether it was private

insurance, access –- she was eligible for contract health. Going through that process, like I said, there is a lot of work ahead, but I think if we look at a lot of the positive outcomes, it just makes the work –- I don't want to say any easier, but we know, that old cliché, there is a light at the end of the tunnel.

It is just going to take a little while to get there. So again, looking at all the cuts, trying to understand that for our people –- and we have another incidence of a cancer in our small Tribe, and so it is mind boggling with everything that has to do, what we all have to do.

But on the other hand, I do want to kind of jump on Chester Antone's recommendation about a regional consultation in Arizona because so much work was put -– like he had mentioned earlier and it is so true -– on the thought that it would be state based, and now we get the federal.

We focused this way and now we have got to hurriedly focus over this way. But again, I just wanted to bring that up because I know some of you were in here, and wherever that yellow balloon is, that was a very good sign.

But I do too want to appreciate all the efforts that have been, that are being made. And Dr. Roubideaux speaking with us yesterday about our concerns of having to put more

money into the contract health dollars, into the service unit, because there are never enough moneys to cover that.

So again, I appreciate all your other comments, and this year I have an Ipad, so I am learning on this. So instead of writing notes, I get to record it and play it back, so thank you all for that.

MR. HAYES: Thank you, thank you for all the comments. And I will turn it over before the Secretary has to leave for her final comments.

MS. PRESTON: I apologize for interrupting, Secretary Kathleen. My name is May Preston. I am the president-elect for San Juan Southern Paiute Tribe out of Arizona, and we do have some territory in the state of Utah. And I am really honored to be sitting at the table with you Secretary Kathleen, and with Dr. Roubideaux and the rest of the Tribal leaders.

I too am the newly elected president of a very small Tribe and a very new Tribe, and I am just really –- I really appreciate your sitting at the table with the Tribal leaders to uphold a promise of America fully realizing services to Native Americans. And I also support softening the sequestration based on the trustee relationship because I come from a very small Tribe.

We have right now, due to some historical

challenges, we have no services right now for my Tribe, and to get to health care, my people have to travel at least an hour to two hours based on the weather, and these are homelands where my people reside.

So we have very limited health care to no health care for my people. So I am in support of what Gary and this gentleman here put together about increasing funding for health care to Native Americans. It was an excellent presentation that was made right before you came in so -– and I trust you will get that delivered to you.

And I am fully supportive of that that information and recommendations since we are sitting at the table in Consultations. I wanted just to thank you also for being here again. I am just honored to be here, and coming to these meetings –- I was telling Dr. Roubideaux that I am learning more on the processes, and through the education, information, our Tribe is becoming more empowered.

So I just thank Roubideaux's office that we have these meetings. I am just really thrilled to be here. So I thank you for your time, and I would like to invite you to San Juan Southern Pointe Tribal Country too.

MR. HAYES: Thank you. Secretary?

MS. SEBELIUS: Well again I am pleased to have a chance to be with you, and want to assure you that the HHS

leaders around this table are not just here for decoration. They are significant agency leaders who are here to listen, be informed, have a dialogue and take back the issues and problems and challenges that not only you raise but we share together.

I just want to acknowledge that the opening statement and a number of you have repeated it, that the promises and commitments to Indian Country are not entitlements or discretionary. They were treaty obligations. And I believe that. Unfortunately I can't execute that.

But I believe that and support that and drive that in every way that I can. We, as you know, still operate under the laws that Congress passes so when this latest sequestration happened, we literally were given no discretion about where to make cuts.

And in fact, the law is very specific that cuts have to be executed from every agency in an equal fashion, so I don't even have the discretion to make cuts bigger in some agencies and smaller in others.

That is one of the items that is currently under negotiation, and it is one that we press forward all the time because it is not only a terrible way to govern but it does not allow us to understand the gaps that may occur in Indian Country and make up any difference. But we are pushing that

forward.

I hear the issues about data research and certainly oversampling because often a Tribal population is so small that unless you oversample you don't have a statistically accurate sample, and we will pursue that with NIH and with our other agencies.

I also think that the suggestions made about the grant applications, I know we have made some progress and we certainly are eager to find ways, but the notion that we would have a couple of templates, if you will, for what a successful grant could look like and what the elements are, I think may help that move even further.

I was not aware frankly of the Medicaid Administrative Match issue that was raised, and I have asked Paul, and he is not aware of it. So we will follow up on that and try to figure out what is currently pending. I certainly don't have any idea what my predecessor may have agreed to or not agreed to, and frankly we just need to start over and have the discussion with this administration.

I want to put one thing on your radar screen, and this is just being developed but if you heard the president in the State of the Union, he talked about a new range of investments around what is being called the ladders of opportunity, and it really is investments that will be aimed

at some of the highest poverty areas in the country.

And everyone across this government agrees that many Tribes automatically fit into that prototype, and this will depend, in many cases, on recommended funding that is in the budget but it is everything from early childhood education to investments in housing and infrastructure, ways that the federal government can work differently with areas.

But we are very much at the table. There will be a variety of opportunities coming forward, assuming we ever have a budget and can move forward with a budget, but it is a commitment that the President feels very strongly about, and will certainly have some very positive impact for Indian Country.

So we will keep you posted. It is just being unfolded and unveiled, the policy issues, but it is everybody from the Department of Housing and Urban Development, the Department of Agriculture, our partners at the Department of Education, Health and Human Services. It is a cross-government effort that will have a variety of components.

So I just wanted to put that on your radar screen saying we will know more and keep you well informed as that goes along, and again I thank you for being with you today. I look forward –- my leadership team will certainly be giving me

a lot of specifics as a result of the longer conversations where I wasn't in the room. And congratulations, Madam President, on your new election.

And I look forward to having a chance to be with you in the future. Thank you, Mr. Chair.

MR. HAYES: I just want to make a quick comment before we turn it over to Paul. He is going to do the wrap-up. Chester, you mind again just offering a prayer as we leave today, after we conclude? I appreciate it, this morning or this afternoon, after we wrap up.

But I just wanted to thank everybody for being here, the federal partners who are here, the National Indian Health Board, the staff, for everything they have done in putting this together. Stacey and the staff for making this possible for us here.

(Applause)

MR. HAYES: We thank you very much, and again, you know, many of us Tribal leaders, as we sit around, we need to –- we have got work to do also as the Secretary just mentioned about Congress. She only does what is authorized through law, but I think it is important for us to be at the table.

We have great progress: The Tribal Law and Order Act that was implemented that gives us interagency cooperation

and engagement. I think it continues, as the Secretary just mentioned, about the president's statement about the ladders of opportunity. I think that is probably another format where we can seek additional resources for our communities.

So again I just want to thank you and I appreciate this opportunity. Paul, take it home.

HHS Wrap-Up

by Paul Dioguardi, Director, Office of Intergovernmental and External Affairs

MR. DIOGUARDI: Sure, just really quickly, just thanks again to everybody for your participation and all of your help in setting up this consultation. I want to remind that we will be conducting regional consultations across the country in the coming weeks, so I certainly invite you to participate in those as well.

And I think based on what we heard here today, that will inform the agenda and topics for those consultations. Thanks again, everybody, and I look forward to continuing the dialogue as we move forward.

MR. HAYES: I will turn it over to Chester.

MR. ANTONE: Thank you all for the discussion on health care.

(Closing prayer)

(Whereupon the meeting adjourned at 12:59 p.m.)