Department of Health & Human Services
16th Annual Tribal Budget and Policy Consultation

Friday,
March 7, 2014

Held at the

Hubert H. Humphrey Building
Washington, DC

I N D E X

March 7, 2014

KEYNOTE: "—, --, or ---" Indicates inaudible or interruption in the transcript
"*" Indicates phonetic spelling in transcript

MORNING SESSION

(8:30 a.m.)

Tribal Opening

MR. PAYMENT: We are going to begin in our traditional way and open with a prayer. And we have asked Chester --

(Prayer)

Tribal Opening Remarks

by Cathy Abramson, Chair, National Indian Health Board

MS. ABRAMSON: Good morning, everyone. It is good to see you all here. I have been here since — I am over here. I am Cathy Abramson, and I am chairperson for the National Indian Health Board. That is our spirit speaking. They are with us. Our ancestors are all with us here today, and it is nice to know that.

I am chairperson of the National Indian Health Board and I am the — and I also serve as the tribal councilperson for the Sault Ste. Marie Tribe of Chippewa Indians. And good to see you here. Robert Two-Bears, good to see you. Got to see you out in DC to see you.

So I have been here since Monday and we have been very busy. And it was very nice that DC provided the Michigan weather. I felt right at home. I am not kidding. I couldn't even believe that it actually could get as cold as Michigan. And it did.

So today we are going to be discussing the Department of Health and Human Services FY2016 budget request for our tribes. FY2016 represents an historic opportunity for this Administration as it will be the last year President Obama is in office.

This means, with the help of our federal partners, that we can continue to make measurable progress in the IHS budget and other HHS agencies in order to help eliminate the health disparities for American Indian and Alaska Native people.

NIHB thanks the Administration for continuing to propose budgets that are aimed at reducing these disparities. But we know that we are not done yet. American Indians and Alaska Natives have a life expectancy that is 4.1 years less than the rate for the U.S., all races and populations.

According to IHS data, our people die at higher rates than other Americans from alcoholism, diabetes, unintentional injuries, homicide and suicide. In fact, suicide is the second leading cause of death in our children, pointing to an unanswered crisis in Indian Country.

America is too great a nation to stand idly by while we live with these realities. Proposing an FY2016 budget that does not aggressively tackle these issues would be tacit approval of the state of affairs in Indian Country.

Indian Health Service: We will hear later today from the Tribal Budget Formulation Workgroup co-chairs on the specifics of the FY2016 tribal request for the Indian Health Service later today but I would also like to give you a few highlights from this budget. Under this Administration, the IHS has seen its first yearly budget increases in decades and with an historical increase of 32 percent during the past 6 years. However, funding for Indian Health Service's programs still falls significantly short of what is required to bring health parity to Indian health in line for other federal health care program.

For FY2016, tribes recommend a total needs-based budget of $28.9 billion. If this is not possible, we also ask for a 17.58 percent increase over the President's 2014 proposed budget.

While we understand that the ultimate decision will be made by Congress, tribes also insist that the FY2016 budget support the fact that IHS would be entirely exempted from sequestration should it occur in FY2016. Tribal priorities for IHS program expansion include purchase referred care, otherwise known as contract health. But we are going to call that purchase referred care from now on.

Hospitals and health clinics, mental health, alcohol/substance abuse, health care facilities, other authorities: We also hope that the FY2016 budget request will support key policy changes such as support for advanced appropriations for the Indian Health Service and expansion of Medicare-like rates for non-hospital purchased and referred care.

And also later on we will be talking about the Affordable Care Act in our testimonies. Now in CDC, while access to health care is critically important, Indian Country also needs the resources to prevent disease and injury. Preventing problems before they happen saves money, saves lives and improves the quality of life.

Because the federal government has the duty to provide for the health and welfare of the tribes, and this duty to the tribes runs from the whole federal government to the tribes in the area of public health, the federal government can and must respond to these urgent and unmet needs with CDC resources.

For FY2015, the President's budget will cut some valuable and innovative CDC programs such as a National Public Health Improvement Initiative. This is one of the few resources tribes can utilize as they prepare for and pursue public health accreditation.

The funding impacts more than the tribes receiving the funding. The approach's best practices and lessons learned stand to assist Indian Country more broadly as tribes build their public health infrastructure and improve the quality of their programs.

Likewise the FY2014 budget cut in the CDC Community Transformation Grant Program, which was available to and utilized by many tribes working to improve health with a community level public health approach.

Both of these programs should be restored in FY2016. Other successful programs making an impact on American Indian/Alaska Native disparities such as the Traditional Food Program and the Tribal Tobacco Control Program should be expanded to allow more tribes to participate.

In its funding request, CDC should also make clear the concerns it has heard in tribal consultation, namely that funding should be provided directly to the tribes not routed through block grants to the states. Funding that goes to states often is allocated based upon data that includes the needs of American Indian/Alaska Native populations.

Unfortunately, that funding often does not take, does not make its way back to the tribes or does not return in anything close to fair proportion.

Expansion of 638: NIHB also echoes recommendations of Indian Country by supporting the expansion of self-governance to non-IHS programs within the HHS to provide tremendous opportunities for collaboration, synergy and maximization of resources.

Several years ago, HHS concluded that it was feasible to extend tribal self-governance to 11 select programs within the Department and recommended that Congress do so. We highly encourage this recommendation to be supported by the Department.

On behalf of the National Indian Health Board, thank you all again for being here today. This Administration's important legacy of creating a greater health care system for this country will not be forgotten.

Today's consultation is a key opportunity for us to build on the health care legacy for Indian Country, and I look forward to hearing from my fellow tribal leaders and our federal partners today. Thank you very much. At this time, I will introduce Chairman Aaron Payment, and he is also a member, Vice President, of the Midwest region for NCAI.

Comments

by Aaron Payment, National Congress of American Indians

MR. PAYMENT: Yes, thank you. I just want to let you know that the weather we have here doesn't even come close to back home. I don't know if you were back home, but it was 34 below in one of our communities. You can take a cup of hot water and throw it up — anybody try this back home? — throw it up and it turns to snow instantly.

All right so I am here on behalf of the National Congress of American Indians, and I appreciate the Administration's engagement with Indian Tribes and listening to our concerns in the FY2016 budget.

NCAI applauds the Administration and Secretary Sebelius and Dr. Roubideaux for supporting Indian health determination and providing tribes full funding for contract support at IHS. This is a major step in the right direction.

NCAI also appreciates that IHS has finally seen some of the most significant budget increases in decades with historic increase of 32 percent during the past six years. But we all know that funding for IHS still fall significantly short of what is required to bring health parity to Indian health in line with other federal health care programs.

In FY2014, IHS received an increase of $304 million over FY2013 enacted levels. Most of this increase was designated to fully fund contract support costs as well as new staffing packages at the direction of Congress. NCAI and tribes hoped that funds

would be available to restore sequestration cuts in FY2013 and adjust for inflationary increases and population growth.

Tribes are insisting this year that the Administration and Congress fully restore FY2013 sequestration cuts and provide funding to maintain current services as well as provide meaningful increases in the services line item.

This may seem difficult considering the politics in Congress and the constraints of federal funding. But as a tribal leader, I need to remind you that this is a trust and treaty obligation and we hope that you will honor these promises. Remember, and Jefferson is here, it is a trust thing.

The damage done by the FY2013 sequester is still being felt in Indian Country. In our community, the shutdown and sequester and the insecurity with Special Diabetes caused us to lose several of our Special Diabetes practitioners. They are gone.

And we are trying to find others to come work for us, and now it is difficult because they are watching the insecurity with the funding and they are second guessing as medical professionals whether or not they want to invest and come to our community as a result.

We also have policy recommendations that could assist tribes in meeting the needs of our people. One is to provide and support advanced appropriations for IHS. We will team with IHS and push this through Congress if the Administration gets behind it.

The second is the administrative support for legislative changes to enact Medicare-like rates for all IHS in purchased and referred care program, formerly known as contract health.

On a very personal level for my community, I support reauthorization of Special Diabetes. About a month ago, Director Abramson asked me if I would start weaving that into my conversations when I meet with members of Congress. And I had to

stop and think, because I have tried to live a healthy lifestyle myself, what do I have to say about diabetes?

And then on the way out here I was thinking, well, wait a minute. Every one of my siblings, and I have 16 siblings, every one of my siblings is affected by diabetes. Every single one. Our family life expectancy used to be 80 and 90 years old. It is currently 60 years old. I don't have any of my family members who live past 60 years old.

I am 47 years old so that is a little scary. I had a sibling who passed away at 30 years old of heart disease and diabetes, and sometimes people think, well, you know, if they would only change their diet or exercise or live a good lifestyle — which really kind of victimizes the person who has the disease.

I have a nephew who is 22 years old who is, who was a juvenile diabetic. He has to take three shots a day. He didn't do anything to become diabetic. He is diabetic. So we need Special Diabetes to be supported, and we will work as a team to try to get this through Congress.

So with that, on behalf of NCAI and President Cladoosby, who wasn't able to be here, I thank you for allowing us to speak.

Welcome and opening Remarks from HHS

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

MR. DIOGUARDI: Good morning, everybody. On behalf of Secretary Kathleen Sebelius and the Department of Health and Human Services, I want to welcome you all here today to the HHS Annual Tribal Budget Consultation. My name is Paul Dioguardi, Director of the Office of Intergovernmental and External Affairs here at HHS.

Before I begin, I want to recognize a few people who made this consultation possible. First, Cathy Abramson, who will be helping us to facilitate today.

Also Vice President Rex Lee Jim, who will be joining us later, who will be our tribal moderators for the day.

Certainly of course I want to thank all the tribal leaders who are here with us as well. I know it has been a long week and another long week next week. But I thank you for joining us around the table for this important annual consultation.

I also want to be sure to thank the HHS staff who have been working very hard for a number of weeks to pull all this together and make this possible. Liz Carr, who is probably still managing the check-in table out there, whom you probably saw walking in, is the person responsible at the staff level for pulling all this together.

And of course everybody knows Stacey Ecoffey, way back there in the back. Stacey, wave, who, I think as everybody in this room knows, is sort of the essential leader of the team for all of our interactions with tribes here in the Office of the Secretary at HHS.

The Annual Budget Consultation is now in its 16th year. And in many ways it is the cornerstone of our department-wide commitment to consultation. We have strived over the years to ensure that our consultations are meaningful and all of our efforts are driven by a commitment from the highest levels of the Department. We see consultation as one of many steps toward a shared vision for healthy, strong and secure tribal communities.

Since the inception of the Secretary's Tribal Advisory Committee, we have coordinated with members of the STAC, as it is known, and their advisors, to take the priorities that we hear here today and reinforce your message with the Secretary and other HHS leadership at our STAC meetings throughout the year.

So please know that today is not the only time that your message is being delivered during the formulation process for the FY16 budget. With that, I look forward

to the conversation today and thank you for taking the time to participate in this important consultation. Thank you.

Comments

by Lillian Sparks-Robinson, Commissioner, Administration for Native Americans

MS. SPARKS-ROBINSON: Good morning. My name is Lillian Sparks-Robinson. I am the commissioner for the Administration for Native Americans and member of the Rosebud Sioux Tribe, and so I welcome you all here to Washington, DC. And I believe we are going to get started with the tribal leader introductions. So if we could quickly go around the table, and please state your name, your title and the tribe you are representing.

We have plenty of time this afternoon and this morning for your actual testimonies so if we could at least get a sense of who is in the room before we get started, that would be great. So I am going to ask quickly if we could start on my left.

(Introductions)

MS. SPARKS-ROBINSON: And if we have any tribal leaders in the audience, we invite you to come sit at the table. We still have plenty of seats available and we like to have a full table. So please, if we have any elected officials in the audience, please feel free to make your way to the table.

At this time I believe we are going to turn it over to Norris Cochran, who is going to provide us the HHS budget overview and update.

HHS Budget Overview and Update

by Norris Cochran, Deputy Assistant Secretary, Office of Budget

MR. COCHRAN: Okay, thank you. Again it is really nice to see all of you. I am glad we have such as a great turnout this morning. It sounds like you have had a full week, and we are hopeful we can make this last day of the week for you as informative and productive as possible.

We find it very valuable. I always look forward to these meetings. I am going to start with three things that we had heard from some prior sessions. The first is a request that we deliver to one of these meeting the policy official at OMB who is over health programs. That is now Dr. Julian Harris.

We tried a couple of times and we tried again for this meeting. He is very interested in coming. He again had a conflict. So I think that it would be valuable to have him here and we as a result are going to keep trying to make it work so we can get him here to hear from you directly.

Two other things, and Cathy and Aaron, I think, mentioned this again this morning. One is this issue or this concept of advance appropriations. The other is protecting Indian Health Service funding from the sequester.

As you know, these are big, kind of structural budget-rule type issues. I know Dr. Roubideaux is having dialogue with the Department of Veterans Affairs to hear more about how the advanced appropriations process works for them. And we have noted to the Office of Management and Budget that this is a priority for all of you, and we will continue to raise it with them and try to have that dialogue that I think would be valuable to everyone.

What I plan to do this morning is just give a quick overview of the 2014 appropriations. First of all, we are very glad that we have 2014 appropriations to begin with. And then talk about the 2015 budget.

So for 2014, IHS, in the discretionary annual appropriations bills, is funded at $4.4 billion, which is $300 million about the '13 level. In addition, IHS projects collections, and those are projected to rise by about $150 million.

As was noted earlier, Congress did officially change the name of contract health services to purchase and referred care, consistent with what many of you had been pushing for. And we are very pleased that was included in the bill.

And then in the '14 bill, they funded a number of priorities that you had flagged, including purchase and referred care, which received an increase of $77 million. Contract support costs, the estimate for those expenditures is fully funded, and we understand the importance of that in supporting tribally managed health care programs authorized under the Indian Self-Determination Education Assistance Acts.

We are very pleased to have that accomplishment in the '14 process. The bill also included $72 million to staff and operate new and replacement health care facilities. Congress has been very good about maintaining support for those joint venture projects once they get to the point of being operational, and we are pleased that the funding is there to staff them.

The diabetes program, we should talk about both for 2014 and 2015. In 2014, as you know, this is a so called mandatory program. It is not funded through the annual appropriations process. On the discretionary side, the annual appropriations process, the Administration and the Congress have, you know, found a way out of the sequester this fiscal year, which is good on the discretionary side.

On the mandatory side, it is still in place. That affects Medicare. It affects a number of HHS and of course other government programs, including the Special Diabetes Program, which will be cut about $3 million this year. And Dr. Roubideaux and her team were able to work very hard last year to help mitigate the impact of those reductions and may have fewer levers this year.

And we are concerned about that reduction. We know that those dollars are critical given the burden and the need in your communities. Overall, we are pleased with the 2014 process. We are pleased that we are making progress with the Congress and we want to build on that with the 2015 budget.

And now, as you know, we release the budget this week. One of the documents that we spent time on, and hopefully you would find worth reading, is our budget in brief. This is a summary of HHS's entire discretionary mandatory budget. It is available on our website, HHS.gov/budget, and is a good reference through the year on HHS funding.

The White House also put out — and I don't know if we have distributed this but they put out a fact sheet on funding in Indian Country that is not specific to HHS. It touches on other departments, and so I am taking from Aaron you have seen this or many of you have access to that. It is high level but it could be a good reference document for you.

Our more detailed documents are the congressional justifications. And those are on schedule to be available on our website later today. They will — they are probably at the printer now as we speak, and we are hoping to deliver those to the Congress on Monday.

But those should be available to you and your teams to review, including for the Indian Health Service, Administration for Children and Families, Substance Abuse and Mental Health Services Administration, other components of HHS.

The 2015 budget request for HHS overall in the discretionary side is for $77 billion. It is a reduction of $1.3 billion overall, which means we do have difficult cuts in our budget for 2015. Some of the reductions Cathy noted in the Centers for Disease Control and Prevention. We do have reductions in Pam Hyde's world. Also to the Agency for Health Care Research and Quality.

We have reductions to the Low-Income Home Energy Assistance Program, which I know, in previous meetings, has been flagged as a priority. And we have reductions in the Office of the Secretary here in our general departmental management funding.

However despite that total coming down from '14 for HHS, we have been successful in funding key priorities in Indian Country, and I will start by very briefly describing the Indian Health Service, where the total has increased on the discretionary side by $200 million. Again we estimate collections will increase.

We also assume no sequester for the Special Diabetes Program. The President is eager to work with the Congress to eliminate the sequester, and the budget for 2015 reflects that goal.

It also proposes to continue this vital program. The budget assumes three year extension for those resources and we are eager to work with the Congress to make that happen.

There are also increases for inflationary costs at about $63 million within the Indian Health Service. We have increases for purchase and referred care proposed

including to expand the program as well as that portion of the inflationary costs. And some money specifically for new tribes.

We are proposing to increase funding for new federally recognized tribes as well as for staffing and operating costs for new health care facilities scheduled to open in FY2015. And then again we built and continue the success of 2014 around contract support costs and propose a $30 million increase to match the current estimate of those expenses.

The budget request, the core budget request, also proposes $85 million to fund four construction projects from the Health Care Facilities Construction and Priority List, and these are, you know, vital in those communities. They are under way, and it is critical that we secure that funding.

In addition, as you probably have heard, the President has set out a vision for additional spending above the current totals that Congress is assuming for this coming budget year for FY2015. So the President signed a budget deal prepared by the House and Senate that set the spending limitations for 2014 and 2015.

And the President's budget, including the $200 million increase for IHS, fits within those totals. However, the President would like to engage the Congress on revisiting those to the extent that there is a lot that the nation can do in areas of investment and opportunity and growth and security.

And so the budget includes a $56 billion proposal that is equally split between defense — and this is again on the discretionary budget side at $28 billion, and non-defense at $28 billion. And within that set of proposals, HHS has four components for discrete initiatives.

One of the four is the Indian Health Service and it is a proposal to add another $200 million to fund construction of additional facilities from the priority list. So

this is — it is different from the core budget but it is a reflection of the Administration's priorities, and we are very pleased that this final package does have a component for IHS in it.

I mentioned the Special Diabetes Program. The other resources outside of the discretionary mandatory budget, we are assuming again additional collections including through the agreement with the Department of Veterans Affairs, and I will leave it to Dr. Roubideaux to discuss the progress there. But we are pleased that has been moving forward.

We do have other funding outside of the Indian Health Service that I want to just mention quickly. Within the Administration for Children and Families, the 2014 budget funded an Early Head Start/Child Care Partnership. So this was a proposal in the 2014 budget. Congress provided an appropriation of $500 million for that activity.

We are then proposing to build on it with an additional $150 million in the 2015 budget. We are also proposing to grow Head Start, the base Head Start program, by $120 million. That activity is new. The Administration for Children and Families is working on the various funding announcements but we are very excited about it.

The activities will include funding for training and technical assistance management. Of course, the delivery of service and work toward meeting Head Start level performance standards. And tribes are eligible to apply for the general funding announcement. There is also a tribal set-aside for that program.

We, within — I mentioned earlier that there four HHS portions of the President's Opportunity, Growth and Security Initiative. One is the $200 million in IHS. A second one is to continue to grow this Early Head Start/Child Care Partnership. So we are hoping that if Congress engages in that separate initiative we could also get additional dollars above the base proposed increase.

Pam Hyde in her budget is able, despite reductions that she has had to take in her total, she is able to continue the targeted funding for behavioral, mental health and substance abuse among American Indian and Alaska Native youth, and we are very pleased that will be continued in 2015.

Within the Health Resources and Services Administration, we have proposals to increase funding and increase the number of health center sites. One other item I wanted to mention is the National Service Corps.

Dr. Roubideaux and Mary Wakefield have worked for years now — time goes quickly — to make it easier for that field strength, for those providers that are supported with federal dollars to work in Indian Country.

And the budget for 2015 would grow the ranks over time to 15,000 providers, with a proposed $527 million increase to the National Service Corps. It is part of a larger workforce initiative within HHS, and that increase that I described is both on the discretionary and mandatory side of the budget.

We are hopeful that we can secure that with Congress because expansion of those providers addresses not only the need for health care provision as we expand access to health insurance nationally, but more important, the placement of those providers because we know that in some areas of the country we don't have provider shortages. In other areas, many of yours, they are persistent and very harmful.

And so we are hopeful that we can secure those dollars.

(Pause)

MR. COCHRAN: Yes, it is a very big expansion and it is something that we are working on. It is a multi-year proposal and we are thrilled that it is in the budget.

Within the Administration for Children and Families, there are also increases proposed that would be of benefit in Indian Country, including to the Child Care

Entitlement and to the Child Care and Development Block Grant as well as tribal child support and foster care funding.

So I know I have rattled through a lot of program names and numbers. I think I will stop there and make sure that we leave time for questions.

MS. SPARKS-ROBINSON: Do we have any questions from any folks at the table?

Questions and Answers

MR. VIGIL: I am sorry. I didn't get your name again?

MR. COCHRAN: Norris Cochran.

MR. VIGIL: Mr. Cochran, where can — I know it is probably somewhere on a website but a lot of times it is so much information in one area it is cumbersome. Can we get a copy of your brief report that you put together?

MR. COCHRAN: Sure. Yes. We have — I think there are a couple of things that we could leave with the team here to make copies of that would be useful. One is a tracking table we put together on an annual basis that has funding specific to Native American programs so we can make copies of that.

I don't know if you all have access to the White House fact sheet or not. If not, we can make copies of that and then Caitlyn, I don't know if we have any more physical copies of the budget in brief. If so we can — I don't know if this would be helpful to you or not but if we do we will —

MR. VIGIL: That would be helpful but something brief would also be more, because —

DR. ROUBIDEAUX: In this budget in brief document, there is a four page section on IHS that is pretty clear and has just the basics on that so I will ask my staff if

maybe we can get a copy of that four page part of the budget in brief. You can print it out. It is a PDF on the HHS budget website, so those of you who have computers you can just take a look at that.

But we will try to get some printouts of the four page IHS section.

MS. ABRAMSON: Okay, thank you. And that was Councilman Vigil. Anybody else that wants to speak, please state your name before you speak.

MR. PAYMENT: Aaron Payment, Sault Ste. Marie Tribe of Chippewa Indians. The document is opportunity for all standing with Indian Country. And what it is, is it pulls together President Obama's Administration's commitment to different areas that we have been pushing for.

And so it kind of crosses agency lines and pulls it all together. I have a question regarding — and I don't know if Pam is going to be able to talk about it later but one thing that I really liked in the budget, and the focus was on the enhanced effort toward behavioral health and suicide prevention and additional funding that is going to be available for that effort.

So I don't know if you are going to talk about it later? Okay. But I appreciate that because at STAC we have been saying — and since I have been back in office we have been seeing just an inundation of suicides and accidents related to drug use.

And so we put together a task force under the Department of Justice, but we kind of took like that program and we just kind of morphed it into a behavioral health plan. But tribes need much more resources in that area.

We are trying to develop kind of a novel sort of project, a new project, in modeling it, but we are doing it, we are making it up as we go along sort of thing. But there are more resources that are needed there because I believe that it probably at

epidemic levels at this point, the number of young people who are OD'ing whether through suicide or through accidental deaths.

And again it originated here at STAC or in our STAC group that we started asking for — and NIHB has really been focusing on the need to pay attention to this issue. I think Stacey had said there was a conference, a White House conference on suicide and there wasn't any mention of the issue and its impact on our community.

And she was there. And if the Administration wants to show the most critical need that is in this country, it is with our population. We have talked about it and it might be related to historical trauma. You know, maladaptation as a result of reservation policies and you know, concentration policies and stuff.

So it is still there. It seems strange, 150 years later, but it is still there. So we need that focused attention, and I appreciate that there is a new effort dedicated to that.

MR. COCHRAN: I should have flagged us for the National Service Corps expansion. A result of that growth, if we can secure it, would be a variety of mental health providers. I think the estimate is for about 5,000 mental health providers as part of that National Service care.

DR. ROUBIDEAUX: And I also want to mention that HRSA, SAMHSA and IHS got together this past year and sort of took a look at all of our suicide prevention efforts so far and to figure out if there was anything we could do together. And one the big things we realized is we have a ton of tools that are — could be helpful to tribal communities.

And so we had talked about trying to make those available. I think a lot of them are available on the SAMHSA website. So I will let Pam Hyde talk about that when she has a chance.

MR. GOVER: Just a quick question: Talking about suicide but has SAMHSA and IHS talked with VA on combining maybe an effort with the young returning vets on this suicide?

MS. HYDE: Absolutely. We do a lot of work with the Veterans Administration. In fact, on behalf of the Secretary, I represent HHS at a tri-department effort — DOD, VA and HHS — around veterans and families and military service members and their families' mental health.

So it is broader than suicide. But suicide and suicide prevention and suicide research, research on suicide, is a huge portion of that work. In fact, this year's annual report about all that should be coming out within the next few weeks.

MS. ABRAMSON: I just want to introduce Vice President Rex Lee Jim. Good to see you.

DR. ROUBIDEAUX: One thing I want to mention is the fiscal year 2015 President's budget is the Administration's proposal. We really need your partnership and help to help it be a reality.

And so Congress will be working on that over the next several months and, you know, I am certain there are things in that budget you might like or other things you would like to see but we are really very interested in partnering with you to try to make sure we can increase areas of the budget.

Not just for Indian Health Service but the entire Department of Health and Human Services. So I hope you do get a chance to take a look at the materials. This budget in brief, if you can get your hands on it. The congressional justifications when they are posted later today or next week.

And this Native American cross cut as well because we really need your help. The Administration proposes the budget but it is Congress that passes it so we are

anxious to work with you this year to try to make sure we can get as much funding as possible.

MR. BREWER: Brian Brewer, Oglala Sioux Tribe. Ms. Hyde, I would like to ask you a question. You know, I am from the Oglala Sioux Tribe. We have over 3,000 veterans on our reservation. And I am just wondering how the IHS is going to meet those veterans' special needs when IHS has problems meeting the needs of our people.

MS. HYDE: Actually I do Substance Abuse and Mental Health Services Administration, and we collaborate with IHS, but IHS as a vet — I don't know if you want to respond to that or if you want me to?

DR. ROUBIDEAUX: I think there is — we have been working on opportunities to make sure all of the resources of the Department of Health and Human Services can be brought forward. So IHS provides the direct health services, and you are right. We are limited by the lack, the limited resources we have, we do struggle to provide the care we need.

We appreciate the resources from SAMHSA because they are often additional grants and contracts and programs and resources that our communities can use as well. HRSA also. And so I think one of the things we are trying to do is to mobilize all the resources of the Department of Health and Human Services to help.

And also I know that the Department of the Interior is very interested in this issue, especially working with the schools. And so Secretary Washburn has worked with us on some of these issues.

So what would be very helpful for us is letting us know sort of the priority areas — I mean, we need to address the whole issue but if there are specific gaps or priority areas that you are seeing that we could all work together on, we are happy to do that.

MR. BREWER: I mean, when we have over 3,000 veterans with special needs, our mental health — I believe there are only two mental health providers in Pine Ridge right now. And I mean they are so busy right now they just don't have the time to see all of our veterans.

And that is what I am wondering: What the IHS plan is? Are they going to ship us all off somewhere or are you going to provide the services in the reservation?

MR. JIM: Good morning. We would like to get back to — are there any other questions for Mr. Norris Cochran? If not, we will go into Ms. Hyde's presentation and then you can ask all the questions you want about mental health. Any questions for Norris? If not, thank you. We will move on to the next. Ms. Hyde?

Human Service Budget Priorities

by Pamela Hyde, Administrator,

Substance Abuse and Mental Health Services Administration

MS. HYDE: Thank you, Mr. Chairman. There are several things I just wanted to say really briefly. But I mostly want to answer any questions you have.

First of all, I think most of you know Sheila Cooper. She is our liaison to all of you. And if you have any questions or want more information or need some pieces of paper or anything of that nature, Sheila can help you. Sheila, stand up and wave.

The other person who is here with me today is Daryl Kade. She is our Director of our Office of Financial Resources. We really wanted to hear from you and so it mattered to us to get people here who do our budgets as well as myself and Sheila to hear your comments.

We also want to tell you, it goes to Aaron's comment, we are actually in the process of redoing our website. And in fact I am going to a meeting about that after we

are done here today. And one of things we want to do is bring some more attention on our website to Native American issues, AI/AN issues, because you do have to kind of know what you are looking for to get stuff on the website.

So know that we are working on that to try to make it a little better for you. There are a couple of programs that we have open right now. If you are interested in residential treatment for pregnant and postpartum women, the deadline for that grant program is the end of this month, March 31, so hopefully your folks are back working on those proposals.

Hopefully, they are also working on a program called Circles of Care, which is one of the programs you all have consistently told us is a very high priority for you. So we actually made sure that we did more of those grants this year. We had some options of putting it in one place or another. We put more of it in Circles of Care.

That grant program actually closes today. So hopefully your folks have been working on their proposals for that. We have a number of child traumatic stress grant programs and services that are everything from the Urban Native Center for Life Empowerment in Oakland, California; to the Youth and Trauma Center in Rapid City, South Dakota; to the Minnesota Continuum of Care for Child Trauma Program in Twin Cities.

So we have programs of that nature all over the country. The thing I wanted to just mention, and it has already been mentioned a couple of times, is you have heard me sort of be the broken record about our need to respond to your issues that you have raised consistently around substance abuse and suicide issues.

We proposed, the President proposed two years ago $50 million for that program. Congress did not fund it. Then we proposed $40 million for that program. Congress did not fund it. Finally this year Congress did a down payment on that program.

So it is only $5 million but it is a beginning, and we are very pleased that they finally did that. That grant program is targeted by Congress to the tribes that have the highest rate of suicide among their young people. It is for youth suicide and substance abuse and promotion of mental health issues.

The reason we are so pleased about that is Congress doesn't typically let us blend those dollars in that way. But in this case it is a very specific recognition that they go together, and in your communities and in your tribal traditional practices and other things, you may not make clean distinctions between those things. So we hope that you are going to be able to do more of what you would like in that grant program.

The downside about it is because it is so small, we had proposed it as an application process that anybody who wanted it could get. That is not the case now because it is such a small program. It will be competitive. But it will be competitive just among the tribes, nobody else.

So that grant program should be out on the streets sometime in the next few weeks so watch for that. And we will try to make sure you are especially aware of it through either a Dear Tribal Leader or some other fashion so you are aware it is coming.

It is new, and again as I said we hope to expand it in years to come. It also is included in the President's 2015 proposal. So he proposes to continue it, not just as a one time deal.

The other thing I just wanted to bring to your attention is our Office of Indian Alcohol and Substance Abuse continues to do its work across the federal government, working with IHS, with BIA, with the Department of Justice and others to try to put out information, educational seminars, communications efforts, and work with each of you who are interested in doing the tribal action plans.

And more and more of the tribes are doing those. So we are really pleased about that. We did a Juvenile Justice Tribal Policy Academy that some of you participated in, and we are going to do another one this year. We have had some help from the MacArthur Foundation on that.

And then I want to just do a plug for — we still need a Phoenix Area and an At-Large representative on our Tribal Technical Advisory Committee for SAMHSA.

So if you fit in that category, see Sheila and we will try to see what we can do. The one thing I want to say about budget for fiscal year 2015, one program — all the programs that you all have consistently told us were priorities for you are continuing or increasing for 2015.

The one thing that is reducing is our Access to Recovery program, and I want to acknowledge that because it is something that some of you get some dollars for. It does go to the states by congressional design. But a lot of the tribes get those dollars because it is a voucher-based program.

It is going away. So that is one program that if you have some resources through that, you should be aware that it is an issue for 2015. I think I want to stop there and just take any additional questions that you may have or things that we can tell you about SAMHSA's programs.

MR. JIM: What we are going to do is go through the speakers first and then have questions for them at the end. So next will be Moniquin Huggins to speak to child care.

Comments

by Moniquin Huggins, Office of Child Care

MS. HUGGINS: Thank you, and good morning. It is my pleasure to be here with you. Our director, Shannon Rudisil, and also our Deputy Assistant Secretary and Inter-Departmental Liaison for Early Childhood Development, Linda Smith, send their regrets. They are not able to be here with you this morning.

But what I thought I would spend this time doing is really talk about the Office of Child Care and what we have on the horizon. I also want to bring your attention to a letter I brought today to introduce some consultation with you.

The Office of Child Care administers the Child Care and Development Fund and it is a $5 billion program that provides funding to tribes, states and territories to help low-income families access quality child care so parents can work, attend training or education.

Currently we fund about 260 tribes, which represents over 500 tribal grantees because some of those tribes are part of consortia. Of the $5 billion, the tribes receive approximately $100 million. Tribes have a great deal of flexibility in administering the program.

A big portion of the money is used for subsidies. Tribes can also use a portion of the dollars to improve the quality of care, which means that providing funding to providers to meet health and safety and also to provide funding for training for providers because we know that providers who have the skills and the education are more qualified to provide the high-quality care that our children need.

And so professional development is a big portion of what we are — our main purpose, our goal is to increase the number of low-income families' access to high-

quality care. That is our primary goal. So we work very closely through our regional office with our tribal grantees.

But I also wanted to bring your attention to the Early Head Start/Child Care Partnership. Many of you may have heard of the new activity or the new money that is available.

In the 2013 State of the Union address, President Obama announced plans to grow the supply of high-quality early learning opportunities from children birth to 3 so that more children from low-income families can develop and learn from an early age through Early Head Start and child care partnerships.

And so Public Law 113-66 provided $500 million for these partnerships between Early Head Start and child care programs. The Secretary can reserve no less than 3 percent, which means that $15 million of those dollars are for Indian Head Start programs.

We are working very closely with the Office of Head Start, working on the funding announcement, which we hope to have out if not later in March, early in April, that will give all of the information about how programs can apply for these funds to have Early Head Start and Child Care Partnerships.

We also have convened a number of webinars, one specifically that does outreach to tribal programs to talk about this funding and to provide the information. In the upcoming weeks we will have additional webinars.

Our goal is to really reach out and inform tribal communities as well as local and state agencies or community organizations about this funding so that when the funding announcement goes out, that people will have a knowledge and can start to, even before the funding announcement goes out, start to look at what those partnerships might look like between Early Head Start and child care.

I also wanted to update you on the FY2015 budget request released earlier this year. The Administration requested an $807 million increase for the Child Care and Development Fund. That will bring the total funding to $6.1 billion. And tribes would receive approximately $122 million compared to the $105 million that they currently receive under the funding.

The Administration again provides the maximum amount allowable under the law to the tribes. In addition, the Administration targets a significant portion of our funding to technical assistance, and we in the Office of Child Care have a technical assistance that was specifically developed to provide technical assistance to our tribal organizations.

And we are also developing or following the developments of Congress on the reauthorization of the Child Care and Development Block Grant. I said earlier that I wanted to — and then again I don't know how many of you have heard about the CCDF regulations. We proposed new regulations to strengthen the standards to better promote health and safety in child care in May of 2013.

That was out for Federal Register announcement. That new proposal would require that all CCDF funded child care providers receive health and safety training in specific areas; receive comprehensive background checks, including fingerprinting; and receive on-site monitoring from tribal staff.

We are working very — we received the comments and so our office is really responding to all of the comments that we received on the Federal Register, and I will say that we received 534 comments and 29 of those comments were from tribes and tribal organizations. So we did receive feedback from the tribal organization so we are working to analyze those comments.

And we plan to issue a new CCDF regulation sometime this summer. We really — our goal, as I indicated earlier is to provide support to our tribes, states and territories so they will be able to develop high quality programs for the children in their communities. And as part of the application for the CCDF, our grantees must submit plans to us every two years describing how they will spend the money, how they will develop programs that fit the needs, specific needs of the families in their community.

And so our central office and regional office staff along with our technical assistance staff, we work very closely with our tribes to help them in their efforts to develop these programs. And so every year, every two years at the same time, we receive over 300 applications because they are coming to us all at once, 260 from the tribes and then the states and the territories.

And we have sat back and we are really looking at options about how we can really target our technical assistance efforts and target our staff resources.

So one of the options that we are looking at is staggering the application process, meaning making a cycle for states and territories and making a cycle for the tribes so that our staff resources, our TA resources can be really targeted to helping the grantees.

And so I brought a letter today and we will plan to send out this letter widely to all the tribal leaders just outlining our proposal. Which means that — we would extend the current plan, which expires in 2015, to expire in 2016, and we would allow tribes to then in 2016 to submit a two year plan.

We think that, by extending that year, would do two things. It would really help us target our technical assistance and our staff resources, but it would also give the tribes and tribal organizations an additional year to fully come in compliance or fulfill the requirements of the new rule that will come out this summer.

So those are the options, and we really would like your feedback on this because we think — well, we know that your feedback is critical for us making decisions on this proposal.

I have letters here today. I just wanted to make sure I disseminated here at the consultation. But also I will be doing an additional mailing to include probably the same people here next week to make sure that we get feedback from the tribes and tribal leaders about this proposal that we are considering.

But we will be taking comments until May 14 and so we would encourage you, whatever your thoughts are about this proposal to really let us know and give us feedback. And so Lillian, what is the best way to disseminate the letter here that I have? Can we just pass them out? Okay.

MS. ROBINSON-SPARKS: You can just pass them out and we will make copies—.

MS. HUGGINS: So I think I brought enough but in case — so I thank you for this opportunity to be with you here this morning, and I will be here in case you have any questions.

MR. JIM: Thank you. So we will go on next to Lillian Sparks, who will also speak to the issues that Linda Smith was supposed to cover. So go ahead.

Comments

by Lillian Sparks-Robinson, Commissioner, Administration for Native Americans

MS. SPARKS-ROBINSON: Thank you, Vice Chair. So again Linda Smith, our Deputy Assistant Secretary for ACF sends her regrets and apologizes for not being able to be here but she has been called to do a meeting with the Secretary off site. And so at least she has a good reason for not being here.

In the meantime, I do have a couple of updates, just touching upon what Moniquin said because I think she gave a lot of the highlights with regard to our budget for FY14 and FY15. But we do have a couple of things to follow up on from our last year's Budget Consultation session.

So there are a couple of changes at ACF. George Sheldon is no longer our Acting Assistant Secretary. He has gone back to Florida. And our current Acting Assistant Secretary is Mark Greenberg, whom many folks know due to his conversations and his involvement with the 477, and we do have a quick update with regard to that.

But also because he has been our deputy assistant secretary for policy for this entire Administration and is currently our principal deputy assistant secretary as well. I think what most folks don't always realize is that ACF has a large budget but more than that is that we have the largest budget for Indian programs outside of the Indian Health Service for HHS.

For FY13, our total ACF budget authority was $49.5 billion. For our current fiscal year it is $51.1 billion, and for the proposed budget for FY15, it is $51.3 billion. And out of that, I have approximately $700 million — and Norris can certainly correct me. His office is the one that comes up with these numbers every year after we get them.

But about $700 million out of our total ACF budget authority typically goes out into Indian Country in the form of grants. And these grants come through our Head Start programs our child care programs, our TANF, LIHEAP, Indian child welfare, Family Youth Services Bureau as well as child support enforcement activities.

And then our ANA grants. And ANA grants are the programs that I oversee. And for our past fiscal year, we have been incredibly busy with regard to following up with what we heard during our last Budget Consultation session in particular.

There was a lot of conversation with regard to the need for better progress on 477 activities. Progress with regard to self-governance when we are talking about programs outside of Indian Health Service, in particular some of our ACF programs. And then also just increased opportunities to do some partnerships and funding to support that.

And so we are really pleased with the FY14 budget request that not only restored $500 million to Head Start that was part of the sequestration cuts but added an additional $500 million for the Early Head Start and Child Care Partnerships, of which no less than 3 percent will go to tribal communities.

And so we strongly encourage you to learn more about this, to look for the funding opportunity announcement that will come out it sounds like in the next month or so. But also to apply, and to really think about how we might be able to make sure our Head Start/child care programs, which serve the same families in many of our communities, are actually working together and how you are able to actually bridge the gaps between those two programs.

With regard to 477, I can tell you that, you know — many folks know it has been a long time that this group has been meeting, since November 2011. That the tribal representatives of the 477 projects, along with federal partners, which include OMB, DOI, HHS and Labor.

We have been meeting weekly to address issues concerning the law as well as the reporting and auditing requirements relating to 477 projects. In January, the end of January, the workgroup agreed to conclude deliberations on the pending issues and disagreement and to move forward with new reporting forms and instructions to the Paperwork Reduction Act review process as well as a concurrent tribal consultation.

And I believe the tribal consultation will take place next week during the NCAI meeting. And — from the Department of the Interior is actually leading that. And so we encourage you to reach out to him is there are any questions.

But we at ACF believe that this represents significant progress for all of the parties. Tribes will have consistency in the way in which 477 projects are reviewed, and they will be able to tell their stories through more flexible reporting mechanisms.

The federal partners benefit from strengthened relationships across all of our departments and will have greater assurance that 477 funds are being spent in the best interest of the tribal members. And I think what has become crystal clear is that the communication wasn't always there among the federal partners.

And so this certainly has strengthened that and has allowed us to understand more clearly exactly how 477 dollars are being spent. So as we move forward we will regularly convene to update materials as needed and to hear from the tribes about suggested improvements to the programs, and certainly we will have representatives from the federal workgroup here joining us shortly in the audience. And if there are questions, Dr. Felicia Gaither from the Office of Family Assistance will be able to help us answer that.

Additionally quickly I just want to tell you that we have already kind of taken the initiative at ACF without the funding to really look at how we might be able to do a better job of helping tribes partner their Head Start, child care, as well as their home-visiting programs.

And our Deputy Assistant Secretary Linda Smith started an initiative called Tribal Early Learning Initiative, wherein four tribes have been participating over the past two years through small supplemental funding, how they might be able to break silos in their communities to make sure that early education is happening.

And we are using our Tribal Early Learning Initiative as the group that we are vetting some of the recommendations that came out of the Tribal Federal Self-Governance Workgroup with regard to how that might work.

And so because the home-visiting, child care and Head Start programs are already working together in four communities, we are wondering how that might look if it were to be something that looked — that was able to move the priorities of the Tribal Federal Self-Governance Workgroup.

And those priorities that have been identified are the ability for tribes to reprogram those grant dollars, to rebudget those grant dollars, to be able to redesign but also to be able to have reduced administrative burden.

And so we have had a conversation with the TELI already, sharing with them the report, the final report that was issued June of last year.

But we have also begun thinking about ways, how we might be able, under our current legislative authority, to find ways to make those programs work together more cohesively and to look — something that would be, we would hope to model for other grant programs at ACF if we were to do any sort of self-governance expansion.

During the last tribal consultation session for HHS, George Sheldon announced that he was convening a Tribal Advisory Committee for the first time ever for ACF. We are really pleased that this committee has been established and has been meeting since June of last year.

And I would be remiss if I didn't recognize the chair of our ACF Tribal Advisory Committee, Liz Mueller, who is the vice chair for Jamestown S'Klallam Tribe as well as the vice chair for our Tribal Advisory Committee, Tino Batt, who is the treasurer for Shoshone-Bannock Tribes.

And then I believe we also have another TAC member in the audience, Sue Smith, from — Tribe. And so we welcome you and we appreciate the work that you are doing on behalf of your regions, but more importantly helping us to prioritize the work for tribal communities at ACF.

Our next ACF Tribal Consultation session will take place June 16 here in Washington, DC. We will have a Tribal ACF Grantee meeting following that, which will take place June 17-19 here in DC. And then on June 20 we are partnering with the Department of Education and the Department of the Interior to host a Native Language Summit.

And so that is going to be a very busy week for ACF. June 16 again is the consultation session. 17th-19th is our grantee meeting. And then on the 20th is a Native Language Summit that we are doing in partnership with Interior and Education.

And so I will conclude now because I know folks have questions, and certainly I will try my best to answer them but I know we have a few program staff also out in the audience who will be able to assist with the answers as well.

MR. JIM: Thank you. We will go next to Mr. Vigil for the tribal leaders' discussion.

Tribal Leaders Discussion on Human Services Budget

Comments

by Gil Vigil, Pueblo of Tesuque

MR. VIGIL: Thank you, Vice Chairman Lee. And to members of the federal group I guess and then tribal leaders who are present with me this morning. Good morning, again.

My name is Gil Vigil, and I am from the Pueblo of Tesuque. I am a former governor, and by virtue of that I am a lifetime council member, so I serve as a councilman for my pueblo. I am also currently now the executive director of the Eight Northern Indians Pueblos Council, which is a consortium of the Northern Pueblos of New Mexico, including Taos, ---, Picuris, Santa Clara, San Ildefonso, Pojoaque, Tesuque and Nambe.

And then also I am the president of the National Indian Child Welfare Association, which I was bestowed the honor by our former president, Maurice Lyons, former chairman of the Morongo Tribe.

And so I took over the role as president for the National Indian Child Welfare Association. Again thank you for having this consultation meeting. I was just at the Indian Pueblo Council Center the other day and I was looking at some pictures from some tribal leaders from New Mexico in the early 1900s who were coming to Washington to meet with I guess the leadership then.

And I was reflecting from that day to today where we have come so far. And I think those needs that they were probably coming and asking for help at the time based on treaty obligations on trust responsibilities are probably the same reason we are here today again.

A little bit of a different time but also important that some of the needs for our people are still important to us. Today I am going go talk about the child welfare budget and the HHS mental health budget.

And so with that, I know Ms. Abramson gave a good report on the Health Board and some of the needs of Indian Country at all areas but — and we know, like today, Native Americans and Alaska Natives are at a higher risk of child abuse and neglect than any children in the country, and data have always shown that.

The tribes know their children and families better than anybody. And invested in the welfare system and developing an effective culture of services. Again federal funding has not been living up to the level that it should be. It hasn't kept up with the needs of our communities.

Tribes especially need funding for services that prevent the removal of children and to strengthen families. Promoting safe and stable families is only one of the few programs that allows tribes the right to provide services to keep Native children, Native families together.

At a time when state systems are removing Native children at alarming rates, providing tribes with funds that increase tribal capacity to prevent removal and keep families together is critically important. For this reason, we recommend increasing the discretionary portion of this funding by $50 to $75 million.

Of the 566 federally recognized tribes, over 2/3 depend on child welfare services funding to fill gaps in child welfare programs that are offered, including training and family services. We recommend this funding be restored to the fiscal year 2011 level of $280 million to allow tribes to provide a complete range of child welfare services.

We are pleased with the Administration for Children and Families' recent endeavors to improve efforts to educate states about their obligations under the Indian Child Welfare Act. There is still much more to do to improve implementation of these federal protections, and we encourage DHHS to continue working with tribes to explore additional opportunities.

Children's mental health budget recommendations, tribal communities have historically experienced trauma at unparalleled rates but efforts to address this trauma have been hampered by lack of funding again. While many tribes have mental

health programs, they are very few that have mental health programming and professionals specifically for children.

Untreated trauma in children cause our communities to have high rates of suicides, increased juvenile delinquent behavior, poor school performance, excessive violence and long-lasting substance abuse problems.

In the budget under the programs for regional and national significance and children and families program is the Circles of Care Program. This is the only program within the federal government that provides tribes development of children's mental health systems. It is only one of the two behavioral health programs where tribes do not have to compete with states for funding.

Because this funding is at the heart of children's mental health care in tribal communities, we recommend that $6 million be reserved for the Circles of Care Program. We also recommend DHHS requests $40 million for funding for the Tribal Behavioral Health Grant Program originally proposed by President Obama in 2011 and include it in the fiscal year 2014 appropriations budget.

This is the other funding besides Circle of Care where tribes don't have to compete with states. It can be used to address important challenges in tribal communities such as substance abuse, suicide and mental health.

I refer to some of these programs briefly but I think the Circles of Care Program is something that we are thankful that they are allowing non-competitive funding for tribes because these are the types of programs that are working.

It allows communities to develop programs that address these issues more on a comprehensive basis, collaborative basis, where it brings all the different programs together.

And I also want to make a comment about I think we are trying to re-energize the efforts of the children's agenda.

That was a project a few years back that included the National Indian Education Association, the National Congress of American Indians, the National Indian Health Board and the National Indian Child Welfare Association to develop some programming that would address all these issues on a comprehensive basis, collaborative basis, and I think that needs to happen.

But I think funding is needed to make that happen also so maybe somewhere in all these billions of dollars we are talking about, maybe a small portion could be set aside to do that work also.

When we talked about these millions of dollars and we are talking about the $50 million, the $49 million, the $51 million and then only $700,000 for tribal programs, somehow there has got to be more than that. The need is more than that, and I think tribal leaders that are here at the table with me have come with that concern over the past few years.

And I can understand the situation of our country at this time being in a deficit that we are. But when we talk about human life and when we come here as tribal leaders, and we are requesting this funding, we have to go back to our communities and tell our people, well, we are sorry we didn't get this funding, because that is where the impacts are.

Our people, the services that they need, whether it is in health care, whether it is behavioral health, or whatever that area is. And sometimes it is hard for us to go back and tell them we didn't get the funding we needed.

So I just implore again on you as the directors of these different agencies to think about that because tonight while you go home to your comfortable homes and

probably enjoy a nice meal, remember the people that we have to go back to in our communities that are suffering right now for lack of food, for heat in the Dakotas up in the north. You know, they are suffering right now.

And so I implore you on behalf of our people to listen to our words that we have come to speak to you about today. Thank you.

MR. JIM: Thank you. Ms. Sparks was so nice to cover for you. All right, Ms. Smith, if you would just introduce yourself to the group.

MS. SMITH: I will

Comments

by Linda Smith, Administration for Children and Families

MS. SMITH: My name is Linda Smith, and I am the Deputy Assistant Secretary for Early Childhood Development here at the Administration for Children and Families. And I apologize for being a little bit late. But one of the things we were doing was calling attention to the President's early learning agenda and the increased request for funding for our early childhood programs across the board.

So I just want to say welcome to everyone. Last week or two weeks ago I guess it was, we had, I think, an amazing thing happen before the Committee on Indian Affairs. The first committee hearing out of under Chairman Tester was on early education. And I think we made some very significant points before the committee and some that I think are going to end up in changes in funding in early education.

And so we have to see on that but I think there were very positive things that happened out of that and there has been an immediate response to the testimony and I want to say the panel that followed me really made some very significant points.

Another thing that I would call attention to that the federal government is trying to work on is an increase in funding for the Tribal Home Visitation Program. That we are not funding nearly as many as we would like. We have 25 programs in tribal home visitation funded and we have had over 100 applications for that money.

So the response to the program has been great and we are working very hard to see that we receive more funding in the next budget for that, and I think in the President's budget there is a $100 million increase in home visitation money. Some of that will go to the Tribal Home Visitation Program.

So I think the last thing that I would say, and I know Lillian talked a little bit about it is the Tribal Early Learning Initiative we are doing on four reservations. I visited two of those myself and we are learning a tremendous amount of how we can break down the barriers between our federal funding streams in early childhood between the early education, Head Start, child care and home visitation programs with amazing results.

So we are learning not just for the tribal community on this one but for the nation as a whole in terms of how we can make these programs work better together and create less complication for our programs as we get them down on the ground. So thank you Lillian for doing that for me.

MR. JIM: Thank you. We will go ahead and open it up to questions from the tribal leadership. Please be brief and to the point. We only have 20 minutes. We are going on to the next subject exactly at 11:00. So Mr. President, go ahead. Mr. Keel?

Questions and Answers

MR. KEEL: Good morning, thank you. My name is Jefferson Keel. I am the lieutenant governor of the Chickasaw Nation and I will try not to take more than 19 ½ minutes.

(Laughter)

MR. KEEL: I want to follow up on a couple things. One is when we talk about the need for suicide prevention and all the other mental health — all the components that go with that, and the other agencies, there is a program somewhere now, I am not sure who is funding it or if it is even funded. It is called Healthy Native Communities.

And it is designed to get our youth and our young people involved in activities that will get them moving. I know that the first lady has an initiative to get youth and get young people moving and Let's Move and that sort of thing. This Healthy Native Communities, it started out as another initiative, and I believe that right now it is in danger of just going away because it is not being funded by anyone.

And it easy to pass it around from one agency to another. When we talk about Native Americans and Healthy Native Communities, all of it, no matter where the money comes from, it benefits all of our young people.

And every community in this country can benefit from what those folks do. It does help, even in early childhood when we talk about getting them healthy. We need to start getting them involved in other things other than just, you know, basketball or some of the other activities. Team sports.

We need to get these young people involved at an early age moving toward taking care of themselves and understanding. But it is more than just the young people. We have to educate the families also and involve them in this development because without the family support, these young people don't have a chance.

And I know that we are suffering across the country. With the President's budget — and we have seen the increases in the IHS budget or HHS budget across the board in the last several years. What we can't do though is lose sight of what we are

doing. And start to take it for granted that we are going to get an increase here because we are really nickel and diming the federal government when we talk about that.

We represent less than ½ of 1 percent of the HHS budget for Native Americans, you know, in this country. Not even 1 percent. That is not even a drop in the bucket for what we are talking about. And I know that we can do better but we need the federal advocates, the agency directors and all of you to continue to advocate on our behalf and take that up to the highest level. Thank you.

MR. JIM: Mr. Shippentower?

MR. SHIPPENTOWER: Thank you, Mr. Chairman. I have a question on veteran's issues. Is there anything new on the reimbursement policy from — the Veterans Administration would reimburse tribal clinics for providing health care, direct health care services to veterans?

MR. JIM: Thank you. What we will do is have three or four questions and then respond to that. Mr. Batt?

MR. BATT: Thank you. This is regarding the provision of the CCB. Quick question: You know, when we hear these new mandates and requirements for early interventions, we are asking that there be direct funding following that. For example, background checks. You know, we need funds. If not, that takes away from our services.

Buildings: You know, if we have to be up to date, coded, funding needs to follow that as well so it doesn't burden the direct service funding purposes and so we don't have to scramble around trying to find funds. So that would be my recommendation. Thank you.

MR. JIM: Thank you. Mr. Bear Shield?

MR. BEAR SHIELD: Good morning. William Bear Shield, Rosebud. Dr. Roubideaux, I know we had visited earlier but getting back to the veterans portion, Mr. Brewer here was mentioning earlier, you know, out there in South Dakota, it is very hard.

We live — I mean we are stretched over, you know, millions of acres. And as far as getting those specialty doctors to at least come and visit Pine Ridge and Rosebud and Cheyenne River and some of those remote areas, that is definitely a need there.

But along those same lines, between Mr. Brewer and myself, some of the veterans — you look at Mr. Brewer, who is 100 percent disabled and I am down to the point where veteran wise I am a co-pay. If you can address co-pays and everybody in between co-pays and 100 percent disability. Some of those veterans can't afford to make it Hot Springs or Fort Meade to their appointments.

But yet they are saddled with that co-pay bill. And I know there are some ways around it, some IHS facilities do pay those for those individuals but yet on a national front we still look forward to free health care for all veterans. Thank you.

MR. JIM: So let's go ahead and respond to the questions and comments.

DR. ROUBIDEAUX: So the VA thing, I will try to be brief. The reimbursement agreement update, we have implemented it in all IHS federal facilities and we have received over $2 million of reimbursement so far. Most of our facilities — all of our facilities are billing. And then the VA has started reimbursing us.

On the tribal side, the VA said that they have implemented about 39 agreements. They are supposed to be able to just let the tribes sign off on the VA/IHS federal national agreement, so if you are having trouble with that, let us know. We are projecting that we should be increasing those reimbursements by quite a bit this year now that all the federal sites are doing that.

The co-pay issue is an important one. If you think about it, the VA by statute, by law, you know, charges veterans co-pays. But if you look at any other federal programs like Medicaid and IHS, we don't charge American Indians and Alaska Natives co-pays. And so, you know, if you think about that, it would make sense not to.

We have actually been talking to the VA about the co-pay issue. We just sent a letter to them to say if we refer someone over to the VA from IHS through our contract health service program, they are not supposed to charge the veteran a co-pay.

So if that is happening let us know. But this overall issue of the VA charging co-pays, that is something we are trying to provide technical assistance to them, how, you know, we have laws authorizing no co-pays for American Indian/Alaska Native veterans. So we are just trying to work with them to find resolution on this issue.

And we have the MOU with the VA. We meet monthly with them on a number of issues trying to get some of their specialists to come to our clinics, trying to get some of our patients over to them and coordinate the care better and to look at sharing arrangements of providers and/or facilities.

And so we meet monthly with them. We report annually on the progress and we will take your comments back to that group.

MS. SMITH: I appreciate your pointing out the issue on the background checks and the cost of them, and it something that we are aware of the cost of. Some of the things we are proposing both in the new child care regulation, which is now in final stages of development as well as the reauthorization of the Child Care and Development Block Grant includes that same requirement.

So where that, we have, for the last two years proposed and included in this year's budget a $200 million set-aside to help pay for the additional expenses that will be incurred because of the regulation. We are hopeful that this year, because we are

moving forward with this, we will be successful in getting that set-aside to help with that. We are also aware of some of the rather unique circumstances of background checks on tribal reservations and so we are looking at that as we finalize the reg. There are multiple issues with who the regulation applies to and we are looking at that. That came up in the comment period, and thanks to everyone who commented.

My final thing on this issue is that we also, as I said earlier, as a result of the hearings and the possibility of, you know, perhaps increasing somewhere down the road the set-aside for tribal child care, I think one point I would like to make on this to this community is that we do struggle. I hear the comment about less than 1 percent. And that is painful to hear that said in child care.

What we need to know more about is what is the unmet need for child care, and we have spent some time with the Office of Child Care trying to get a better handle on what the real need is within the tribal population.

We know what we are providing but we don't have a benchmark right now to measure against. And so we are working on that and would appreciate any suggestions that you might have on how we might approach that issue because it, right now, is one of the things that I think is stopping us in terms of additional funding.

MS. HYDE: Mr. Vice Chair, there was a comment made earlier about the need for workforce professionals especially to provide behavioral health services for young people. I wanted you to know that the President's Now Is the Time Plan, which is specifically around young people, is new dollars, and we were able to double our minority fellowship program this year.

And so while I know the word minority is not one we like to use for this population, the fact is if you have a young person who is in school to become a behavioral

health professional and needs some assistance, please ask them to check out our Minority Fellowship Program because they are eligible for that.

MR. JIM: Thank you. The four tribal leaders, your questions answered and your concerns addressed? If so, we will move on.

MR. GOVER: This is a comment for Administrator Hyde. Did I hear you say that the dollars for recovery being cut, and that really disturbs me because of — you know, I don't even know how to put it into words.

We have in — not just in Indian Country but all over we have the problem with alcohol and drugs. And then we hear recovery dollars are being cut. And that is really a shame. But at home we find that when we have the dollars cut and we go back to our old ways of the sweat lodge and Native American church and those ways, that they really help.

But still those dollars being cut have a big impact on our community, on the town, just on the whole community in general. And it hurts when they cut something very important like that out.

It seems like since the '80s they just whack away at the recovery dollars, and that just — the more you try to help in that mental health and that SAP program and they just cut. Sometimes you get tired of hitting your head against the wall sometimes it seems like. And you wonder, you know, they enact SAMHSA but yet let's just keep taking dollars away.

You know, I wonder why they even set you up? It doesn't make much sense sometimes to me.

MS. HYDE: Thank you for your comment.

MR. JIM: Excuse me, we have a few questions before you guys respond. Ms. Metcalf?

MS. METCALF: Thank you. Ronda Metcalf, Sauk-Suiattle Tribal Council. First I want to say what is not working in this meeting right now. And what is not working for me is that we are jumping around. It is really hard to go from one topic to the next. It is hard to take notes. It is hard to stay on topic because we are jumping back and forth, and that is not working.

It would be really helpful if we could stay on topic and do gov-to-gov consultation because that is what we are here for. The other thing is time limits. I realize that we have a rushed time but maybe time would go a little bit better if we stayed on topic and finished the topic and then moved on. Just my comments, because it is not working for me.

But what I really wanted to bring up again is what is not working as a tribal leader in Indian child welfare. Coming from the great state of Washington, they have chosen to go to privatization. This is a big problem, and it is big problem for the tribes, and I am only here to talk about my tribe.

It has taken a lot of dollars, and it is focusing on keeping children in foster care. I think that the chairman's comments about increasing the funding to 75 is great but I think we should go a step beyond that. I think we should really start talking about doing funding agreements between the federal government and the tribes when it comes to child welfare.

Our dollars get diminished as they trickle down, and so if we were to go to a funding agreement, so that the tribes can maximize reunification efforts when it comes to child welfare dollars — my tribe, the Sauk-Suiattle Indian Tribe, we don't terminate parental rights. So to work with these outside agencies that are non-Native agencies, to tell us that we are inappropriate because we choose not to terminate parental rights is really difficult, especially when those agencies monthly get about $9,000 per child. That is

just a terrible waste of money, especially when they don't want to help with the reunification plans. So something to think about.

We were talking about some children's mental health. Another big issue is medications. Our children are being medicated at a high, high rate. And nobody is providing mental health services. Children are — parents are taking children to medical doctors. They are giving them medications. Children are going through puberty with these medications. We don't know what it is doing.

We need to look at some of those things and start regulating some of those things.

The veterans issues — I am a veteran. I have never had to pay a co-pay for anything. So I find it very concerning to know that other Natives are having to pay co-pays as veterans. I would really like to know more about that. Okay, I am done. Thank you. But I really do hope we can stay on one topic.

MR. JIM: Thank you. Duly noted. We will do that in the next panel and see how that works out. Anyone else? Mr. Peercy?

MR. PEERCY: Thank you, Mr. Vice President. I will be quick. Again Mickey Peercy, Choctaw Nation of Oklahoma, and mine would be about Access to Recovery, following up on President Gover's comments.

Access to Recovery, several years ago, came out as the best thing since sliced bread. And by and large it went to the states, and by and large in Oklahoma it was basically non-existent for the tribes. We do know that, I think CRIHB, California Rural Indian Health Board, had Access to Recovery, and now we hear that it is going the way of whatever.

Will there be — there was a lot of money put into Access to Recovery, and I am curious if there will be — now it is going away. Was it successful? Was it not successful? Was the voucher system — did it work? It didn't in Oklahoma, or for Indians.

But I was wondering will there be a report that says how much money was spent on Access to Recovery? Are there percentages? Are there metrics that show that we helped in any way? And then if it was successful or wasn't successful, why?

And I think programs come and they go and then you never hear about them. And we spend millions and millions and millions of dollars on them but there is no accountability on the federal side, and I hope there will be on this one to what really happened. Thank you.

MR. JIM: Any response to the last few comments and questions, concerns?

MS. HYDE: Yes, on Access to Recovery — Roger, thank you for raising the issue and thank you for following up. It gives me an opportunity to clarify a little bit.

This is a program that was voucher based. We appreciated that voucher approach. As I think in some states it worked really well for tribes getting opportunities to provide services on a voucher. In other states it did not, so it was really kind of up to the state on how well they did that.

I think as the Affordable Care Act has come into place and as there have been other services that have been brought up, I think the feeling was that program could move on and other services that are specifically tied to recovery that we are trying to put into, for example, the block grant. And I know in many states the block grant is not good for some tribes. It works better for others in other states.

So there is a fairly big increase in the block grant of both '14 and '15 for substance abuse treatment and prevention and recovery, and we are also in the

application process going to put the concept of vouchers into that to see if we can get the states to use that program for some voucher assistance.

I also just want to — and I may throw a softball here to ACF, I know there is a new ACF proposal with CMS this year about addressing the psychotropic medications for children issue. We have been working with ACF and CMS Medicaid folks about how much psychotropic medication is being given to children, much higher than children who are not in the child welfare system.

And there are going to be some incentives on the CMS side as well as some grants on the ACF side to try to address that issue. But I am going to punt to the ACF folks to address that.

MS. SMITH: And I do know there has been a lot of focus on that within — over at ACYF, and we can probably provide more information back to you.

MR. STEIGER: I am Doug Steiger, and I work with the Secretary. On the psychotropic, Pam is exactly right. It is a much broader problem. It is not limited to Native children. The rates of using medication to modify moods and behavior among children in the child welfare system is extremely high, and it is pretty evident that a lot of clinicians are resorting to these drugs rather than therapies that would address the traumas that the children have faced.

And so we are attempting through a combination of funds through ACF, which works with child welfare systems, and CMS, which works with Medicaid, because obviously Medicaid pays for a lot of these medications, to develop, to support alternative approaches and incentivize the direction of the child welfare and Medicaid system so they don't over-rely on these treatments.

We are very hopeful that Congress will look at this problem because there is a lot of bipartisan interest in helping children in the child welfare system.

MR. JIM: Mr. Antone?

MR. ANTONE: I think before Lillian, are we — is the Title VI program under your administration?

MS. SPARKS-ROBINSON: Can you repeat that question one more time, please?

MR. ANTONE: Title VI senior services, is that under your —

MS. SPARKS-ROBINSON: That is now under the Administration for Community Living.

MR. ANTONE: Okay, so it is not a part of your --

MS. SPARKS ROBINSON: No, it is not. It is separate.

MR. ANTONE: Okay, so who would be the person to address a question to regarding that?

MR. SPARKS-ROBINSON: Cindy LaCounte who is in the back — I am not sure. Let me see if it is on the agenda this afternoon. No, but she could certainly help answer any questions that you have.

MR. ANTONE: The question I was just going to ask was I believe we had a discussion with Ms. Roubideaux yesterday. If I recall, the long-term care services? Do you — Ms. Roubideaux, we had discussed that. Do you know if the Administration for Community Living, are they helping in that regard for senior services as far as the authorities granted in the Indian Health Care Improvement Act?

DR. ROUBIDEAUX: Yes. Our staff are meeting regularly with ACL and CMS actually.

I remember that long-term care conference we had in 2000 — I want to say ’11 or ’10. The recommendation at the time was while we are trying to get funding for

the authorities, tribes wanted us to try to resolve some of the outstanding issues among federal agency collaboration on the issue and more technical assistance for tribes.

And so in our meetings with ACL and CMS, we have been having sort of annual technical assistance meetings for tribes because tribes have told us they want to be in the lead on long-term care services. And our ACL — can give you more updates about that. But there is a lot of activity, a lot of training and technical assistance that is now better available than it was before.

MR. ANTONE: So in order to gain some sort of access to possible funding, that will require the tribal folks to push that initiative or issue?

DR. ROUBIDEAUX: Yes. We have the authorities but we don't have the appropriations and so I think one of the recommendations we are going to hear later today is that the tribes want us to try to seek funding for more of those authorities in the Indian Health Care Improvement Act, and we know long-term care is a top priority.

MR. ANTONE: Thank you.

MR. JIM: Mr. Payment?

MR. PAYMENT: I just wanted to underscore and give you a picture of the impact back home of some of the sequester cuts to our children. We have been collaborating between Head Start and child care for a long time. Actually we have all of it clustered under our Head Start director who is, we are proud to say, is probably one of the best in the country.

But with sequester we have had to make choices back home. 100 percent of our net revenue from our gaming, we are a gaming tribe, 100 percent of it is already invested in programs and services.

So it is not like we could take more from gaming but in order to survive sequester what we did was our Head Start director and professional staff volunteered

furloughs. And they took one month furloughs. So we had our fingers crossed and we were hoping for sequester to be completely corrected.

And unfortunately it isn't. To the extent that it is to some extent. Unfortunately the people who were already furloughed, they are out 1/12 of their salary. And think about that for a second if it were any one of us. If 1/12 of our salary was gone.

And so now we are faced with — with some of the funding that is coming back into the budget, I was very encouraged and said, well, we will go back and correct this. And we tried to put a budget mod back in to fully fund our team members and our professional staff who serve our kids. And unfortunately that didn't move quick enough and now because we have such a wonderful director who puts kids first, we have a shortfall in our child care development fund for our child care program.

And by merging those two programs together, by the way, you can bring in education initiatives much earlier that you otherwise wouldn't have, so it is a very quality program.

But now we have a shortage of funding over here in child care development, and rather than reinstate the funding for the professional staff, our excellent Head Start director is recommending that instead we use that funding to pick up the shortfall so that we don't have to cut any slots.

So you can see this crisis that is created in Indian Country by all these battles between Congress and sequestration.

And I don't know that we can push for mandatory funding or nondiscretionary, you know, classification for everything that we do but ultimately it really should because all of these things that we have that are distinct and different from other populations is because of the trust obligation and the treaty obligation.

So just to recognize that these things have real impact on people's lives and we are so fortunate that we have a Head Start director who has put the children first, and she is not leaving. Thankfully she is not leaving. Other professionals would leave. We do have health professionals who are leaving because they don't like the insecurity of not having the funding.

So I just felt it was really critical to make that point. Thank you.

MS. SMITH: I would just like to respond to that. It was a painful year for Head Start and for child care with the sequester cuts. There is no question. We lost 57,000 slots in Head Start and it was painful.

We have been successful, as many of you know, in restoring those cuts in the appropriations bill, so you should be getting the funding restored. That doesn't make up for what happened last year. There is no question that people suffered for that.

But I do think that moving forward, we are in a much better position. The one thing I would like to call attention to that you are doing, and that will help as we develop the Head Start — the Early Head Start/Child Care Partnership, it sounds like you are in a prime position for those because you are doing exactly what we are trying to do with the new funding, which is to create these partnerships and take down these stovepipes.

We will have about $15 million available within the next few months for tribes to apply for, partnership funding. It will be a competitive program but $15 million worth of funding will be available to do exactly what you are describing, so I would encourage you to be thinking about that.

MR. JIM: Thank you. Go ahead.

MS. FREDEEN: Amy Fredeen from Cook Inlet Tribal Council. First I wanted to thank HHS for participating so fully in the 477 workgroup on administrative flexibility.

477 is one of those programs that really looks at the long-term impact, where people — and just as we look at the long-term impact in 477, I would request from the Office of Child Care that some of the technical assistance that is going to be provided go beyond looking at the new regulations around health and safety which, of course, are really important to our kids.

But also looking at how many of our kids are ready for school. If you look at Anchorage alone, less than half of our kids are graduating from high school. So what that means, you draw a line down this room, everyone from this side over wouldn't graduate and they would end up on the TANF rolls later on.

And this also speaks to the unmet need, that question you had. You know, Head Start programs are great. I think the early learning focus is phenomenal, but there are often long waiting lists, and so those early learning centers, whether they are Head Start or other community-based early learning centers, they just don't have enough capacity.

So a lot of our kids are in home-based child care. So if you look at, for instance, the way we structure in Anchorage, there is our Early Head Start center, and then the child care subsidies we use to cover those participants who can't get into the early learning centers.

And so often time they are at homes. And so I would request that some of the TA be set aside to really look at ways to implement early learning in home-based care settings. Thanks.

MS. SMITH: I appreciate both of those comments, and I will tell you on both of those issues we are taking a serious look at the TA. One of the things that we know with the new funding coming about with the President's Early Learning Initiative that we really need to rethink our TA, and how do we maximize that between both Head

Start and child care but as we move forward with some of the new initiatives, how do we support those?

One of the things that you are talking about, and the whole area of the partnerships, again, should address some of what you are describing there because one of the ideas around the partnerships is for Head Start and Early Head Start programs to partner with some of the family child care providers to get them the resources they need to improve the care.

And I think — so it is again targeting exactly what you are describing and that we need more capacity. We don't have a lot of infrastructure right now so by using home-based programs and other types of settings, we can build quality into what we have out there, and that will be within the tribal community as well as nationwide. We know we have that problem.

You said — there was one other point that you made and I am just trying to remember what it was.

MS. FREDEEN: Well it has more to do — I mentioned the dropout rate and Anchorage but that is more of a kind of — you look at what the problems are now, and it was really a point on saying where are the areas where we can impact?

And honestly HHS is one of the few departments that has several areas that can impact high school graduations. It has the healthy families. It has the child care. It has Head Start.

And so by having collaboration through the programs, and I think the alignment of the Head Start and the child care funds is a really great start.

MS. SMITH: The other thing that I wanted to say in response to that, I do think that one of the things we are working on with our tribal home visitation programs is we are working — we have been looking at, in part with those TA funds, the development

of a screening instrument in Native populations that is culturally relevant and evidence based within Native populations.

And what that would mean is that children would be screened with an appropriate tool at the earliest time to try to pick up on issues that might — we can correct easily when they are 2 or 3 but become major problems when they are 7 or 8.

And it will be our — we are looking at that. We have had a number of listening sessions with various communities to work on that. And the next step will be to validate, actually validate a screening instrument in the tribal communities.

And I think that is a big step forward for us. There has never been one done that is culturally and evidence based for tribal populations so I am really excited about that. We should have that work done this year. And I think that will help identify, which I think links to some of the issues around later dropout problems. When children's delays are not picked up early, they exacerbate over years.

MR. JIM: Thank you very much. We will go ahead and go on to the next agenda item. And those who presented, thank you. And again I would like to remind you that we already cut 15 minutes into the next group. We need to be respectful of the presenters and your time as well. So let's try to be brief and to the point and stay on schedule.

So what we are going to do next is at the end of each speaker, the idea of sticking or staying on one topic is to ask questions and engage in dialogue. We probably need to limit it to 10-12 minutes at most. And then we will move on to the next one so we give time to everyone to present. So Affordable Care Act. Ms. Mann?

MR. COHEN: I think she is not here so I think I am going to go first.

MR. JIM: Mr. Cohen?

MR. COHEN: Yes.

MR. JIM: Go ahead.

Affordable Care Act

by Gary Cohen, Center for Consumer Information and Insurance Oversight

MR. COHEN: Thank you so much. Good morning. It is great to be back with you and have the opportunity to talk with you and share with you our progress on implementing the Affordable Care Act in Indian Country.

Before I turn to some of the specific issues that are affecting American Indians and Alaska Natives, I want to give you a sense of where we are more broadly with enrollment in the Marketplaces. Enrollment is growing. Last month we announced that 4 million people had enrolled in Qualified Health Plans, and we will be releasing data for the month of February quite soon now I am sure.

And as of the first four months of open enrollment, more than 6 1/2 million Americans had signed up either for private health coverage in Qualified Health Plans or in Medicaid through the Marketplaces. For that period, October through January, young adults accounted for 25 percent of total plan selection, and the momentum was growing.

We saw faster or greater enrollment of young adults 18 to 34 in January than we had in the prior three months, and we are expecting as we move to the deadline of March 31, for open enrollment for coverage in 2014, that that trend will continue to grow, and of course we are expecting a real uptick or spike in enrollment as we move toward the end of the month.

For those who had selected Marketplace plans, 82 percent, more than 8 out of 10, were found eligible to receive financial assistance to help them pay for their premiums.

So now I would like to talk about some of the issues that we know are of specific concern to you and to your communities.

First, with respect to the exemption application, from the shared responsibility payment for American Indians and Alaska Natives and others who are eligible to receive health care from Indian Health Service, tribes and tribal health organizations and urban Indian clinics, the application is available now on the healthcare.gov website.

The instructions for the application are being finalized and we will have review at the Office of Management and Budget. And then they will be published as well, and of course we will share with you when they are published.

At this time, members of federally recognized tribes and Alaska Natives may apply by submitting the application and their supporting documentation along with their federal tax return.

However those who are eligible for ITU services and other members who want to apply for the exemption now before tax time will submit their application through the Marketplace. Now we recognize that this is not an ideal solution because it will result in some family members being able to submit an application with their tax return and others having to submit their application through the Marketplace.

So CMS and IHS have reached out to the Internal Revenue Service, which has jurisdiction over this, to talk about how we might remedy the situation. At this point, the discussions are ongoing. What I can say is that they have turned to sort of more technical, as to how we would do this, which is a good sign if we are talking about how to do it.

That is some indication that it may be possible, but we are moving forward with it but we can't promise at this point that we will be able to fix that issue. But as soon as we know more obviously we will let you know.

I do want to share with you our appreciation for the tireless and unending expertise that the CMS TTAG, IHS and NIHB have given us regarding the development of the application, the instructions, which documents are available and appropriate to be asking to be presented as proof of eligibility for the exemption. We received a great deal of help and we are grateful for that.

I want to turn to some of the issues with the website. I think everybody knows that there have been issues with the website. And they have been issues that have affected many people and quite broadly. We are working very hard every single day to put in fixes to correct the problems.

And some of the problems have affected American Indians and Alaska Natives specifically. We have tried to deal with those. When healthcare.gov first went live, some tribes were not listed under the right state. And there was — so you looked at the dropdown box for the tribes and there were mistakes there. I believe we fixed all those.

We have added all of the local Alaska Native corporations, some of which were missing. We are still working to add regional Alaska Native corporations and we expect that to be done soon.

We are addressing other problems as we hear about them, and again, we appreciate all the feedback that we get to help us identify and be able to, you know, solve those problems. There was an issue with Blue Cross/Blue Shield Bronze plan in a number of states as to whether in-patient hospitalization was covered. Obviously in-patient hospitalization is an essential health benefit.

And so it was covered but the information was not correct, and I believe we fixed that problem in Texas and Oklahoma and North Carolina. We are still waiting to

hear if that has been fixed in the state of Maine as well. So we have been working aggressively to completely correct that problem, make sure that we don't have it again.

And part of the fix is reaching out to people and making sure that they understand that their enrollment materials, which reflect the accurate information, you know, are something that they can look at and turn to, to make sure they understand what coverage they have.

And so again we do want to hear from you with respect to any issues that come up or problems that you see or errors that need correcting and we will do our best to resolve those as quickly as possible.

In terms of some things that are happening right now on the policy front, on February 4 we posted a draft letter to health insurance issuers who plan to offer Qualified Health Plans, and the letter outlines what an issuer has to do in order to submit plans to us to be offered as a QHP now for plan year 2015.

We held a tribal outreach call on the letter on February 11 and we had a comment period that just closed on February 25th. Right now we are reviewing comments and are in the process of finalizing the letter. It should be going out before too long.

I think there are two things in the letter that will be of particular interest. One is that we are signaling our intent to propose a rule making that in order to be certified as a Qualified Health Plan, a plan would have to demonstrate that at least 30 percent of available, essential community providers or ECPs in each plan's service area participate in the provider network. And that is an increase over the standard that we had for 2014.

And then most importantly the issuer would have to offer contracts in good faith prior to the benefit year to all available Indian health providers in the service area using the model QHP addendum.

So we think that would be a good step forward in terms of making care available to American Indians and Alaska Natives. So let me conclude by saying thanks again for all the work you have done to ensure that people throughout Indian Country have affordable, quality health care coverage. And we look forward to continuing our partnership with you as we move forward for the rest of the year. So thank you.

MR. JIM: Thank you. Questions for Mr. Cohen?

Questions and Answers

MR. VIGIL: Thank you. Gil Vigil from the Eight Northern Pueblos Council in New Mexico. We at Eight Northern are implementing a program to enroll our people up in the eight northern pueblos. My concern is after the deadline, what if we don't get everybody? What if there are one or two out there that, for whatever reason — what happens to them? That we can't get them some kind of coverage?

MR. COHEN: Well of course if they are eligible for Medicaid they can sign up for Medicaid year round. There is no deadline.

MR. VIGIL: Well, that is our strategy, is to first get them qualified for Medicaid or Medicare whatever they qualify for. But there are going to be individuals that we are not going to get to. That is my concern. And I don't know — many reasons we will not.

So I am just concerned — is there a fallback or is there going to be some kind of continuation extended or something just to make sure everybody is covered? My concern is coverage for everybody.

MR. COHEN: And I totally understand that and agree with that. I think people need to appreciate though that March 31 is a deadline. The deadline is not going to be moved. We have been pretty clear about that I think, and so it is very important to reach out to as many people as possible.

There might be circumstances in which — I think the most important thing is to get people started through the process of submitting an application. If they can get started with the process and get into the system of submitting an application, then there may be some flexibility in terms of what happens if they are not able to complete it and get all the documentation in or there are issues there.

But if they don't have — if they haven't actually even started by March 31, that is a problem.

DR. ROUBIDEAUX: And if they are a member of a tribe, they can enroll monthly even after that deadline. The people who really have to meet that March 31 deadline are people who are otherwise eligible for IHS who are not members of tribes or people in the families that don't meet any of those waivers or exemptions. But we really do want everybody to look at the website, everybody to see what their benefits are as soon as possible.

So people might not realize that they actually have to meet the March 31st deadline, so anything you can do to help us make sure everybody at least looks at what their benefits are before then. But members of tribes can enroll monthly after the deadline but we still want everybody to take a quick look.

MR. JIM: Ms. Metcalf?

MS. METCALF: I hope my question goes here. So on the — well, my tribe employs 68 people, which 33 of them are tribal members or other Natives.

So I just was in the process of negotiation with our insurance provider, and one of the comments that I had never heard throughout the whole Affordable Care development process was insurance companies being able to add more taxes because of the losses that they are accruing over the Affordable Care Act.

So my tribe, which is a very small tribe in the state of Washington, has to every month now besides the premium pay an additional $360 in taxes. Can you expand on that? And then what the real relationship is with the IRS?

MR. COHEN: So I actually don't — we should talk and I should get some more detail from you as to the company and what is going on there because I actually don't understand what they might be doing. I mean, you know, they had to submit rates, you know, last year for what they were going to charge for this year, for the 2014 policy year.

And they are not permitted to make any changes in those rates once they are set. So I don't understand how they could justify adding any, you know, additional tax on or whatever they are calling it because the rate that is approved by the state is the rate that they can charge.

So I am a little puzzled but maybe we can talk and I can get some more detail and we can follow up and see what is happening there.

MS. METCALF: That is fine. Thank you.

MR. COHEN: Sure.

MS. METCALF: Oh, but could you expand on the relationship between the Affordable Care Act and the IRS?

MR. COHEN: Oh, okay, so --

MS. METCALF: That is a bad word toward my tribe, the IRS. We believe it is an unlawful organizational.

MR. COHEN: So I will be careful what I say.

MS. METCALF: Just so we are clear. I really want to know what the relationship is.

MR. COHEN: So HHS and IRS have jurisdiction and authority over different parts of the law. And HHS and — generally speaking has authority over all of the new rules that affect the insurance market that were part of the Affordable Care Act and oversight of those rules and oversight of the insurance companies that, you know, that are offering health insurance that have to follow those rules.

And we are responsible for setting up and operating the Exchanges and so forth. Because the premium assistance provisions in the ACA are — it is in the form of a premium tax credit, the IRS comes in because the way people get premium assistance is through a tax, a credit on their taxes.

And so the IRS has jurisdiction and authority over how that tax credit part of the law works. The IRS also has authority over the personal responsibility payment, but that is not — and we have talked about the exemption process and so forth.

And so they have some authority over that process as well. So that is kind of the relationship. When it comes to the tax credits and exemption from the responsibility payment, the IRS has jurisdiction. For most of the other parts that are, that would be relevant here, it is HHS's jurisdiction.

MR. JIM: Mr. Payment, Mr. Peercy and then Mr. Vigil?

MR. : Oh, not me.

MR. JIM: Oh, not you? Okay, Mr. --

MR. PEERCY: Just really quickly — we can talk off line. But I know there are some folks, you said from the eastern side, who want to have a discussion about

Coventry, North Carolina, and hospitalization. So before you leave today, if they can get with you.

MR. COHEN: I would be happy to.

MR. JIM: Anyone else on this topic? Mr. Bear Shield?

MR. BEAR SHIELD: Good morning. William Bear Shield from Rosebud Sioux Tribe. The glitches at first, which they continue to be worked out, you know I had questions and somebody had asked, you remember the President always said you get a choice of either keeping your own health care coverage or going into the Marketplace and finding one better. Then all of a sudden you hear people saying, we are getting dropped by our current health care.

Was that because they were applying and — or I guess I don't understand that part of it.

MR. COHEN: What happened there? So the law said that policies that were in existence already before the law was enacted could continue in effect as long as the companies that were offering those policies didn't make any significant changes to them.

And that was what was called grandfathering. So they said if you have an existing policy, that can continue to be offered, but in regulation we said if you make some significant changes in the benefits or the costs of those policies, then they are no longer grandfathered.

So that was up to the insurance companies to decide what they wanted to do. Some continued to offer the policies that they had in the past. And some made changes, and then when we came to 2014, there were a number of policies that were out there that did not comply with all of the rules that went into effect with 2014.

So for example in the past, insurance companies could either refuse to cover or charge more to people with pre-existing health conditions. And now they can't.

So when we came to 2014, as those policies that were not in compliance had to make changes to come into compliance with the ACA, insurance companies sent notices to people who were in those policies and said, the policy that you have now is not going to be offered anymore.

And in most cases they said, here is an alternative, a different policy that you can sign up for, you know, if that is what you want to do. Or you can go and shop and look for something else. As a result of that, there were people who were in existing insurance policies who were being told their policies were going away.

And so in order to provide more people with the opportunity to keep what they had, we announced that, during a transitional period while the law is coming into effect, companies could continue to offer and continue to renew those previous policies that had some provisions that were not consistent with the new provision that were coming in.

And we made that an option that states could choose whether to permit it or not, and issuers or insurance companies could choose whether to offer them or not.

So right now there are going to be some policies that will continue that are not, you know, don't have all the protections of the law. But people, of course, have the choice of whether to go into the Marketplace and choose a policy that does have all the protections that are in the law.

And in most cases if they are eligible for tax credits and subsidies to help with their premiums, they actually will find that they can get better coverage and oftentimes for less money than what they had before. But we are giving people sort of the range of choice.

MR. BEAR SHIELD: Okay, one final question, and it concerns, you know, a broader picture of tribal employees. In either the Marketplace or the Act, is there a provision in there that would aid tribal employees? We have got a thousand tribal employees, and we just cannot get a blanket coverage for health care for them. Up until, you know, hopefully something can come through with this. Is that a possibility?

MR. COHEN: And these are people who are not necessarily members of the tribe? These are people who are working for the tribe? Is that the --

MR. BEAR SHIELD: Yes, exactly.

MR. COHEN: So I mean at this moment there isn't any special provision for people who are tribal employees I don't believe, or maybe you can correct me.

DR. ROUBIDEAUX: There is one provision in the Indian Health Care Improvement Act that allows for tribes to purchase federal employees health benefits insurance for their employees, and it is related to your 638 contracts and OPMs. If you go to OPM.gov and then just search for the tribal section, you will see the information about FEHB.

MR. BEAR SHIELD: Thank you.

MR. JIM: If there are no other questions, we will go to Ms. Mann.

Comments

by Cindy Mann, Center for Medicaid and CHIP Services

MS. MANN: Thank you. Good morning, everybody. I am glad to be with you this morning, and I echo Gary's ongoing thanks for all the help that you and our TTAG also has continued to provide as we have been moving forward on implementation of the Affordable Care Act.

Let me give you a little bit of an overview of where we are on the Medicaid side, Medicaid and the Children's Health Insurance Program and a new program we are giving birth to today, the Basic Health Program. And then I will address a couple of issues that I know are on your minds as well and we will open it up.

The Affordable Care Act, as you all know, anticipated that Medicaid would be expanded for all adults up to 133 percent of the poverty line. Children are already covered in Medicaid at least up to that income level.

But there is a big gap of course for adults, parents, as well as adults not necessarily caring for children. The Supreme Court made that expansion, however, optional with states.

So where we are right now is we have 25 states plus the District of Columbia that have made the decision so far to do the expansion. It is a very important decision obviously for members of tribes, for American Indians/Alaska Natives.

We generally calculate about 60 percent, more than half of the 700,000 uninsured American Indians/Alaska Natives, would be covered by Medicaid if they lived in a state that took up the expansion, so there are a lot of people who will lose out on coverage. There will be a gap and a hole in coverage if you are living in a state that has decided not to take up the expansion.

So right now we have half the states doing so. We have — what is very important to remember is that there is no deadline for a state to come in, meaning that a state can come in later this month, two months from now, a year from now.

So states are continuing to debate this. We just had a vote in the New Hampshire legislature. The senate yesterday voted to go forward. They still need another vote in the house. There are a couple other states — Utah, Virginia — that are considering it in this legislative session.

There may be some others, and we think many more states coming forward. It is a very generous offer from the federal government to the states. We will pay for all of the costs of the newly eligible individuals covered through the expansion for the first three years.

Even after that, we will pay for almost all of the coverage. It never gets below 90 percent. So these are largely not fiscal problems that the states have. They are more political issues.

And so we know many of you have been very active around the country in your states in trying to make sure that every state makes the right decision. I think you have heard me say this before, and I will say this again, we care deeply about whether states take up this expansion. We are not sitting on the sidelines.

The Secretary — every speech she gives, every visit she makes, and so to with the President, makes it clear that there is, if they are in a state, they talk about the gap, the number of people who are sitting there whose income is too low to qualify for the premium tax credit and yet too high to qualify based on current Medicaid eligibility levels.

The Secretary talks about how many dollars that state is losing each day, millions of dollars each day the state is losing, when it doesn't take up the expansion.

So we are very energetic about it. We hope you will continue to be very energetic about it. And keep the faith that we will get every state in. When Medicaid was passed in 1965, it is not mandatory that every state join the Medicaid program, and it took a few years before we got all states in.

So that is a few years too many in terms of people not having coverage, but it also gives you a perspective that this list of states that we have now that leaves off a lot

of people is not the list that we are going to end up with. And we need to keep working hard to get more states in.

Happily we do have half the country expanding and that means a lot of new people will be eligible, are eligible as of January 1 for coverage when state's expansion is effective. Michigan is effective April 1, so those people in Michigan will gain their coverage next month.

For all the other states or for all states, I should say, whether they are expanding or not, there are big changes in the Medicaid programs — lots of simplification, coordination with the Exchange, the 36 states for which there is, where the federally facilitated Marketplace is operating healthcare.gov.

Those state Medicaid programs need to coordinate closely with the Marketplace and make sure applications are coordinated and eligibility is looked at for all programs within one application. The same thing happens for the states that have State-based Marketplaces. They don't connect up with the federal Marketplace but Medicaid and CHIP programs have to connect and closely coordinate with the State-based Marketplace.

We have also made lots of simplification changes in the Medicaid program, in the CHIP program over the last year, all of which were in effect January 1. Those changes, you know, just like frankly here for healthcare.gov, states have not always made all those changes on day one.

For every state that is not quite there yet, we have an agreed, for almost every state, we have an agreed-to what we call mitigation plan. Meaning, okay, you are not doing exactly everything by January 1 maybe because of IT problems, but we have a schedule for when those changes will be happening so improvements will continue to happen.

That being said, if you are experiencing — if members of your tribe are experiencing any difficulties accessing Medicaid and things that are to be promised from the Affordable Care Act like online applications, streamlined applications, no asking about the asset test, those kinds of provisions.

If you experience any problem, we always want to hear. And we are very, very engaged on it literally on a daily basis with states to work on implementation and make sure it goes as it should.

A couple other things I want to note. One is the issue we talked about a minute ago, which is for Medicaid and the CHIP program, there is no open enrollment.

And so while it is very, very, very important, just as Gary and Yvette said, to make sure people understand there is as March 31 deadline for some people to get coverage, it is also very important for people to understand if it is after March 31 and they are potentially Medicaid or CHIP eligible, they can go in and apply at any time.

So we need to keep our messages clear, that there is a deadline for some people. But we don't want people who could get coverage in April and in May and in June and in July to think they can't now make an application for coverage.

So the door is always open in the Medicaid and the CHIP program, and we want to make sure people have opportunity to apply.

It is also true that if you are on Medicaid and CHIP and your income goes up, such that you now become ineligible for Medicaid or CHIP but you become eligible for the premium tax credit and to enroll in the Exchange, even outside of the open enrollment period, that gives you what is called an special enrollment period.

So if your Medicaid coverage ends because your income went up a little bit or a new family member, whatever the situation is, and you become eligible for the

premium tax credit as a result of that, you are not stopped from getting into the premium tax credit because it is not an open enrollment period.

You get a special enrollment period. There are a couple of circumstances where people have special enrollments. So all those rules are on the healthcare.gov website and I know also on the IHS website. So let us know if you need some further information to make sure people are clear about it.

It is the first year we are going through all this so I am sure it will be confusing for everybody. We want to make sure that everybody has the information.

So from our perspective on the Medicaid and CHIP side, outreach enrollment, keep it going this month and keep it going throughout because so many people in Indian Country are eligible for Medicaid and CHIP and we do not want the efforts to get them covered to stop at the end of March.

To that end I also want to say that we are soon to — not ever sure when exactly it will go through its final stages but hopefully in the next month we will have grant solicitation, our second grant solicitation under CHIPRA. The Children's Health Insurance Program Reauthorization Act provided some grant dollars and this is specifically a solicitation for outreach and enrollment for tribes.

And it will be a $4 million solicitation and it allows — it is focused on children but children have family members. So we made sure the solicitation, you are allowed to bid on the solicitation and not just confine your outreach and enrollment efforts to the kids. But certainly you can be mindful of other members of their families who may need health insurance coverage.

So we will certainly get the word out to everybody when that solicitation comes. And we know it has been so important to have trusted community members

reach out in Indian Country to make sure folks get enrolled. So we are very excited to offer this opportunity and hope we will have a lot of interest in the grant solicitation.

Let me just mention a couple other things. We have been able to do — I know it is of interest to many of you, some waivers we have been granting in states to allow for some additional payments to tribal health facilities for services that their state Medicaid program may not be covering.

It started actually with Arizona after some cutbacks in services and cutbacks in eligibility. So we have been able to renew those waivers in a couple of states.

The other thing I want to mention, and I apologize for saying this too many times, the Navajo study, which I know you are all interested in, it is in its final stages of clearance. I wouldn't say final stages a couple months ago but I will say final stages now.

That being said, I never want to be untruthful to you so I can't really tell you exactly how long that final stage will take. But we are ever hopeful that it will be finalized. People are giving it close review. I said this to the TTAG last month and I will say it here: I do think in this last stage of review, it got strengthened, it got improved in ways that people will be pleased with.

I think some of the administrative costs that were identified in the earlier version of the study, we have now been able to say, you know, it may not be that high of an administrative cost because we have learned a lot, because some of the systems that have been developed don't have to be developed anew.

So hopefully the wait was worth the while but it should be coming out soon. So why don't I stop there again with a thank you for all the ongoing help, consultation, information, advice, suggestions that you have all been giving us as we have moved through this period. Both as we have implemented generally the Affordable Care

Act and the Medicaid and CHIP programs and also state by state as states are moving forward in their Medicaid and CHIP programs.

Questions and Answers

MR. JIM: Thank you. We will go into the questions session but I will actually ask the presenters to stay until the end because you need to listen to the tribal leaders' discussion. Mr. Cohen already left. We would appreciate that because we don't get that much time with you. Questions? Mr. Antone?

MR. ANTONE: My question is regarding uncompensated care costs reimbursements for the state of Arizona for IHS and 638 facilities. As I am aware, that was extended.

MS. MANN: Right.

MR. ANTONE: The concern is whether or not we are able to continue beyond 2014, and if the tribes in Arizona choose to push this initiative forward, would there be any support from the Centers for Medicare & Medicaid services? The last STAC meeting, they indicated they would support that.

But on top of that, I did have a discussion with Director Roubideaux yesterday regarding this because it means a lot for the Indian Health Service to be able to get reimbursed to providing services and to sustain additional services using those reimbursement dollars. And so I was wondering, is it absolutely, is it an absolute to have it under an 1115 waiver or are there other vehicles to pursue?

MS. MANN: That is a good question. It has to be under an 1115 waiver because the state — what we are doing is compensating IHS and 638 facilities for services that the state of Arizona could be covering in its Medicaid program but have chosen not to cover.

And so, so there are two ways in which money can be spent. One is that the state chooses and puts it part of the state plan. And the second is through the waiver.

So we don't need a waiver if the state adds those services back into its state plan program. So the state is — had those services in the past, as you know, and can restore them with simply submitting a form to us, a state plan amendment. And we automatically approve that because it is their option to add those services back.

If they don't add those services back, then the only way we would have to pay for those services would be through an 1115 waiver.

MR. ANTONE: So you are saying the only way we can do this is through the state 1115 waiver, right?

MS. MANN: Or if the state puts them back into its program.

MR. ANTONE: Okay. So we would be addressing the optional benefits.

MS. MANN: That is right.

MR. ANTONE: Okay, and that is podiatry --

MS. MANN: That is right.

MR. ANTONE: — those four.

MS. MANN: That is right. So if the state adds them back, they had them before, if the state adds them back you wouldn't need an 1115 waiver.

MR. ANTONE: Okay, so there are two ways --

MS. MANN: That is right. Two ways.

MR. ANTONE: Okay. Yes, I wanted to know because along with that we needed to have an — and I addressed this with CDC and IHS and the young lady back here, Kitty Marx.

Yesterday concerning the CMS contract with CDC for data analysis because I think we would like to ask if we could maybe somewhat focus on the AI/AN population in

Arizona because as I stated before in the STAC meeting that we are looking at maybe an increase overall in the Native community as far as health costs are concerned and yet the idea for ACA is to reduce costs.

And we won't need justification. And a decision by the tribes in Arizona to pursue the optional benefits issue with the state, and I know the state, conservative as it is, has — access is kind of afraid to approach the state but I think with maybe tribal participation we may be able to get somewhere with that.

MS. MANN: So you are thinking the CDC data, if we worked with you on that, that might help you make the case for the restoration of those services?

MR. ANTONE: Yes, yes.

MS. MANN: That is a good thought.

MR. ANTONE: And I think maybe we could have a brief sidebar with yourself and Dr. Roubideaux because I don't want to take too much time right now because there are other --

MS. MANN: Be glad to.

MR. ANTONE: All right. Thank you.

MR. JIM: Other questions? Comments?

(No response)

MR. JIM: Dr. Roubideaux, you are on.

Comments

by Dr. Yvette Roubideaux, Acting Director, Indian Health Service

DR. ROUBIDEAUX: Thank you, Vice President Jim. And I will just say two quick things. I know we are getting close to lunch.

With regard to the Affordable Care Act, the Indian Health Service right now is all about implementation, all about outreach enrollment, education, trying to make sure the people who need to meet that March 31st deadline know about it and making sure all of our patients are aware.

So our business offices have the — train the people on the federal side. We have, you know, weekly calls with them to give them technical assistance. We have weekly calls with leaders. We have the website. We have an e-mail ACAinformation@IHS.gov. So if you are having trouble, we have staff dedicated to answering questions around that.

We also are working on contracting guidance with the insurers and those sorts of things. We are grateful to our NIHOE partners, NCAI, NIHB, NCUIH, and all the regional health organizations in areas that are helping us with education. Also the self-governance organization is helping us provide outreach and education, so thank you for that.

And there are Native American Navigators. If your communities need help, if you go on healthcare.gov, there is a section that says find local help. You can put in your zip code and it will tell you where Navigators, assisters, anybody is that can help other than our facilities.

But our facilities should be able to help you. And if they are not, let me know. But the people who need to meet the March deadline, it is really important. Even though members of tribes can enroll monthly, moving on forever because of the law, we know Indian families are diverse.

And people's spouses, partners, nieces, nephews, aunts, cousins, friends, might not be eligible for the exemption as member, may or may not be eligible for IHS and that exemption and may need coverage somehow.

So please help us to get the word out that we want everybody just to look on the website at what your benefits might be. There is the call center. There is a 1(800) number you can call. And any of the local help you can find.

And then the last thing is the Affordable Care Act includes the reauthorization of the Indian Health Care Improvement Act. And we don't have time to go over our updates for that today but you can find that in a handout that we have out on the table.

There is a cover letter and there is about an 11 page table that summarizes all of tribal consultations since 2009. And that has numerous updates on several provisions in the Indian Health Care Improvement Act. So I will be here all day if you have any questions about those Indian Health Care Improvement Act provisions, you can let me know.

But overall we really need your help to make sure those people who need to meet the March 31 deadline make sure they get help. So go to our business offices, talk with the Navigators, talk with NCAI, NIHB, NCUIH, your regional tribal organizations, local Navigators, assisters.

And if you are having any trouble let us know. And Geoff Roth is our lead for the Affordable Care Act. He is sorry he can't be here today. But we want to do everything we can to help everybody with the Affordable Care Act.

MR. JIM: Thank you. Questions for Dr. Roubideaux?

(No response)

MR. JIM: I must have done such a wonderful job.

MS. MANN: Or lunch.

DR. ROUBIDEAUX: They are hungry.

(Laughter)

MR. JIM: We will go on to the next tribal leaders' discussion. Ms. Abramson and then Mr. Peercy. Go ahead.

Tribal Leaders Discussion on Affordable Care Act

Comments

by Cathy Abramson, Chair, National Indian Health Board

MS. ABRAMSON: Okay. For those of you who weren't here this morning. I am Cathy Abramson. I am chairperson for the National Indian Health Board. And I am a tribal council member for the Sault Ste. Marie Tribe of Chippewa Indians. I am from northern Michigan. Thank you to the representatives from CMS, CMCS and CCIIO for participating in the important tribal consultation.

Today I would like to speak on behalf of the National Indian Health Board about how the Affordable Care Act is impacting Indian Country and the resources still needed to provide adequate outreach and education to tribal communities and consumer groups.

Established in 1972, the NIHB is the nation's only intertribal organization that advocates on behalf of all federally recognized tribal governments for the provision of quality, care, health care to all American Indians and Alaska Natives.

The NIHB, in service to the 566 federally recognized tribes, offers the following written comments regarding the Affordable Care Act and the delivery of Indian health:

As you know, the federal trust responsibility is the foundation for the provision of federally funded health care to all members of the 566 federally recognized Indian Tribes, bands and Alaska Native villages in the United States.

The provisions of federal health care services to American Indians and Alaska Natives are the direct results of treaties that were made between the United States and tribes and reaffirmed by executive orders, congressional actions and two centuries of Supreme Court case law.

Through the secessions of lands and execution of treaties, the federal government took on a trust responsibility to provide for the health and welfare of Indian peoples. NIHB has a cooperative agreement with IHS to provide outreach and education to Indian Country on the Affordable Care Act.

This includes maintaining a web presence, preparing a training curriculum, conducting training sessions both in person and through webinars, social marketing and audio visual presentations.

NIHB provides national leadership and plays a collaborative role to provide national coordination of effort for tribal outreach and enrollment, and does so through partnership with the tribal area coordinators from each of the 12 service areas of the Indian Health Service, Tribal Self-Governance Advisory Committee, National Congress of American Indians and the National Council on Urban Indian Health.

In addition, NIHB is responsible for special and specific outreach to Native elders and Direct Service Tribes.

NIHB also developed a tribal training supplement to CMS certified application counselor curriculum for administrators and staff at Indian tribal urban facilities so that they may better assist American Indians and Alaska Natives with enrolling in Qualified Health Plans.

In addition, through its collaborative Medicare, Medicaid and Health Reform Policy Committee, NIHB works diligently to help ensure that the complex regulations and subregulatory guidance developed by CMS to implement the Affordable

Care Act reflect and are respectful of the unique needs of Indian Country and the federal government's trust responsibility to provide health care to Indian Country.

As you know, the MMPC shares with CMS Indian Country's views and concerns on the wide variety of policy issues, and supports the work of the CMS Tribal Technical Advisory Committee, TTAG. Resources are not sufficient to conduct effective and thorough education about the Affordable Care Act in Indian Country.

Several Affordable Care Act provisions and regulations are specific to American Indians and Alaska Natives, and it is critical that these are known and understood. It is also a fact that not all tribes are wired for the internet and Native language must be considered as relevant, making outreach through such means impossible and the realities of outreach costly and arduous.

In addition, since the IHS is not deemed to be health insurance, the concept of private insurances is new to many American Indians/Alaska Natives. American Indians/Alaska Native participation in the Affordable Care Act requires outreach efforts that advance the cultural shift.

Many tribal nations are standing on treaties and the federal government's trust responsibilities to provide health care and wonder why they would ever need private insurance when it is a responsibility of the federal government to provide for their health care.

When the government fails to honor its trust responsibility, then private insurance becomes a concept and reality that many American Indians/Alaska Natives are forced to consider. If the Affordable Care Act is truly one method the federal government can utilize to honor its trust responsibility, then carefully crafted, consistent, culturally competent information needs to saturate Indian Country.

Lack of knowledge could lead to tax penalties, poor enrollment numbers and missed opportunities that are specific to American Indians/Alaska Natives. We call upon HHS to increase its investment into the National Indian Health Board and the tribes to ensure that culturally competent information is developed and shared by trusted sources.

Successful implementation of the Affordable Care Act, including its all-important permanent reauthorization of the Indian Health Care Improvement Act, is a key component of the federal government's strategy to meet its trust responsibility for American Indians/Alaska Natives health.

It is important however to remember that federal trust obligation to meet the health care needs of American Indians/Alaska Natives long predates the Affordable Care Act and must be honored regardless of the performance of the Affordable Care Act.

Enrolling American Indians/Alaska Natives under the Affordable Care Act through the insurance Marketplaces presents real challenges in Indian Country. First, tribal leaders and those they represent must be certain that benefits offered under the Affordable Care Act through private insurance can be accessed through the Indian health system and the providers they know and who know and understand them.

This requires that all Qualified Health Plans offering plans in Indian Country offer network participation to all Indian health programs in the areas they serve. Such offers must be made in good faith and must include the Indian addendum. This is the responsibility of CMS.

It is not altogether clear that in all cases, such offers have been made. Nor that CMS oversight of this process has been as rigorous as necessary given the critical nature of this activity to the success of the Affordable Care Act in Indian Country.

We encourage CMS to confirm that its outreach and oversight efforts in this critical issue in both the federally facilitated and State-operated Marketplaces are working as part of outreach to QHPs, and CMS must also make it clear that private insurance comes without co-pays for any person accessing services through Indian health care program providers.

Insurers must accept premium payments from tribes on behalf of their members. A foundation for Affordable Care Act's success in Indian Country is QHPs that understand and are committed to building a strong partnership with Indian health care providers in their service area.

Several of the obstacles American Indian/Alaska Natives are experiencing as we try to enroll with the Marketplace have been shared with CMS as they have arisen. Among them are Marketplace call centers staffed by individuals who do not understand or cannot explain well how insurance will work with Indian Country.

Marketplace website drop-down boxes that fail to identify all federally recognized tribes. Typos on QHP plan descriptions that, if read literally, indicate that in-patient and hospital care is not available through the plan.

The inability to upload tribal membership documents necessary to complete enrollment. Paper applications that take weeks if not months to process. The time it takes to attempt to enroll and the frustration that results.

The National Indian Health Board asks your consideration of establishing an American Indian/Alaska Native call center that would be culturally sensitive to the needs of American Indians/Alaska Natives.

The call centers would preferably be staffed by American Indians/Alaska Natives highly trained on all aspects including the tribal components of the enrollment process. We believe this would vastly increase Marketplace participation from the

American Indian/Alaska Native people. We believe that CMS is making good-faith efforts to resolve these issues, and we are very much appreciative of that.

But the fact remains that issues are likely to continue to arise and perhaps to increase in volume and complexity as more Native Americans/Alaska Natives enroll through the Marketplaces. Addressing each of these issues in a timely professional, consistent and culturally competent manner must remain a priority.

And when there is a problem, those engaged in outreach and enrollment must understand what the problem is. Then it will be fixed and how. And the commitment to fix within the time specified must be honored. Credibility is on the line here.

Medicaid expansion is a very high priority for CMS and for the tribes. Unfortunately there are states that have failed to expand their Medicaid program under the Affordable Care Act.

We strongly encourage CMS to explore every avenue, and we do appreciate what you have been doing so far, including some that might not have been tried before, to provide all American Indians/Alaska Natives, without regard to the state they live in, the opportunity to enroll in and receive all the benefits of Medicaid available under the ACA.

Section 1115 waivers are one avenue that should be pursued. Technical assistance from CMCS, particularly in the complex but all-important issue of budget neutrality is important and appreciated. Creative thinking by CMS is all important here. Additional creativity is necessary where waivers may not be available due to states unwillingness to cooperate.

Such creativity is appropriate given the federal responsibility to the tribes for the health care of their members. Data on results, there are several metrics that can

and should be used to measure the efficacy of effort to enroll American Indians/Alaska Natives in Medicaid through the Marketplace.

But the paramount measure of the success of the Affordable Care Act in Indian Country will be the number of American Indians/Alaska Natives who have successfully enrolled and begun to use the benefits.

We understand that the data on American Indian/Alaska Native enrollment will be available after March 31. We know that collecting good data has its own challenges. However, unless CMS and its partners, including tribes and tribal organizations, can access the data, it will be increasingly difficult and challenging to sustain the effort to enroll American Indians/Alaska Natives in the Marketplace.

Process policy and resource adjustments may be necessary to maximize enrollment. Stories and anecdotes are very helpful. The name and face of one real person whose health care has been improved because of the Affordable Care Act could be an effective feature in enrollment materials specific to American Indians/Alaska Natives.

Data is necessary to make the best efforts, the most effective efforts, in enrollment. American Indians/Alaska Natives have the right to participate in the Affordable Care Act in all that it may offer our people. We need to ensure that every American Indian/Alaska Native has the knowledge necessary to fully benefit from and participate in the Affordable Care Act.

NIHB will continue to work with HHS, IHS, CMS and whatever other alphabet letters that are out there to get the job done, to help make it possible. Support these efforts through tangible actions and resource allocations appropriate to meet the challenges, and together we will meet them. So (Speaking in Native Language) for this opportunity to speak and provide this testimony, and I appreciate your listening.

MR. JIM: Mr. Peercy?

Comments

by Mickey Peercy, Choctaw Nation

MR. PEERCY: Ditto.

(Applause)

MR. PEERCY: I am going to be really quick and really brief but I do have one rule that nobody sleeps. Nobody sleeps. Jim Roberts back there is asleep. Really quick, I am kind of the third stringer. Mr. Allen, Honorable Ron Allen was unable to make it, and the chief — was unable to make it so you have got me. And I am going to be quick and probably a little painful but quick.

I wanted to say that I am here representing the Tribal Self-Governance Advisory Committee to the director, made up of 340 tribes across the country. We also, in terms of working with all health matters, it affects the direct-operated tribes as well as the urban programs so we like to think we do a good job.

And just really quick, a little history: My first meeting about this was with Donna Shalala a long time ago, and she offered us $70 million, and we were supposed to leave and divide it up. And then we moved forward and then the first TTAG, the Tribal Technical Advisory Workgroup with Mark McClellan who says as the CMS head, we will do no harm. And I think you all have held that tenet that you have done no harm to the tribes.

Having said that, that is the good stuff, and also thank you for allowing me to be here. Speaking for Mr. Allen who is also the co-chair of the TTAG, Tribal Technical Workgroup for CMS and I am the alternate to Mr. Allen, to Chairman Allen, and to tell you how dedicated he is, I have never had to make a meeting so I quit coming a long time ago.

So he makes his meetings, and it is really important. We appreciate the hard work with CMS. With that, we work really closely. I need to say that — I am not

going to talk about it. It is going to be for Carolyn and the rest of the budget folks to talk about contract support costs and those other issues — sequestration, which was mentioned by Aaron a few minutes ago, which really causes pain.

But for you also understand that we — most of the tribes in their health care delivery systems and/or other systems are basically 50 percent funded. So money is a real issue. And the complexity of CMS has been a real issue for all of us and we have a cadre of — I was going to say my name is Mickey Peercy and I was going to say the MMPC was named after me but it is not quite. But I was on it from day one.

But to have the technical experts that we have and we appreciate the support from CMS and Indian Health Service in helping to provide that support, the tribal leaders — you could give a test all around this table and probably out in the audience and people couldn't pass the test on the complexities of CMS.

Medicare, Medicaid, private insurance, my goodness. Especially the tribal leaders don't have — they don't have time, and they don't want to. That is why they hire people to do that. And we appreciate that. Oklahoma, we talked about those states that for whatever reason, mostly political, choose not to have Medicaid expansion.

We are working hard in Oklahoma and have been for two years because we know as long as Governor Fallin — I won't mention names — but as long as Governor Fallin is in office, Medicaid expansion in Oklahoma is not going to happen so we go for what was called uncompensated care.

And did you mention something about the House, was that in Oklahoma you mentioned, Cindy? Well, in Oklahoma yesterday and the day before, at least in a House Subcommittee, uncompensated care is starting to roll out. So we can't even mention Medicaid expansion in Oklahoma. You have to call it something else.

But it is an issue, and again we appreciate the work that everyone — IHS, CMS and everyone connected helps with. However — there is always a however, isn't there? There is a but in the audience and a however and a but. Slightly different story when we talked about the federal funding for health care. I am going to read this part because it is important.

That it be channeled through the Marketplaces, when the states have refused to participate it becomes a federal responsibility to see that the Marketplaces are implemented. CCIIO has also developed the regulations that states are using as a minimum for their Marketplace activities.

In both cases, CMS could and should have done a better job for American Indians/Alaska Natives. For example, tribes have not received Navigator funding. And the call center scripts and training for call center staff have been inadequate with regard to Indian questions.

And those are tough questions. I know the questions overall are tough but when you start talking about tribal questions, it is a real problem. The application is confusing with regard to Indian questions. The pull-down menus of tribes has not been complete, and there are barriers to designated and authorized representatives to assist in the application process.

We understand that the focus has been fixing the many technical problems, the computers, that plagued CCIIO. It feels like it has been — and they used the term drinking from a fire hose. You know, just too much. We continue to stand ready to assist. You know, we are not powerless. We can assist in remedying situations but we really need CMS to step up.

Measurements, as was mentioned by Cathy. When do you start measuring? It was kind of like what I asked Pam a while ago about Access to Recovery. It

is gone. Well, what did it do? We need the metrics, we need the measurements. How will you know? Well, you will know when tribal folks are signed up: Who they are? where they are at? What are the enrollment numbers?

We will know when we see the tribally operated facilities are part of the networks for providers' health plans, QHPs, offered in the federal Marketplaces. We will know when the tribally operated programs are paid for service that provide people who are enrolled in the Marketplace.

We expect CMS to be a part of that collection process. We expect moneys out of tribal coffers in dealing with California and northwest area, in trying to come up with some measurements on many things going on with CMS, Medicaid, Medicaid especially.

We are requesting that the data that we were talking about a while ago especially be made prior, be made available to the annual Self-Governance Conference, which will be May 4 through the 8th here in Arlington, Virginia. And I would certainly ask for that and expect that.

In terms of structural approaches, we have been told the numbers will be forthcoming after the open enrollment is over. If participation in the Marketplaces is not what we hoped, then we have all got to roll up our sleeves and go to work because we are getting folks left out.

And in certain areas I have talked about Bob but I am not going to talk about Bob today because people who have heard me shudder. But it is that tribal person who is — doesn't have to buy insurance but he is in an area where there is not, you know, so he doesn't have to go in so he doesn't enroll. So he shows up at a clinic. What do we do about Bob? So those are questions we need to talk about.

Trying to explain the Affordable Care Act to American Indian/Alaska Native communities is more difficult by the complexity of the law and the regulations. Definition of Indian, that is out there and that is kind of all over the place. So where do we define that?

Medicare Part D: Boy, we remember that. We need more money, outreach and education. Medicare Part D was a real outreach and education — where is Roger when you need him? But a lot of money went that way, and we need more of that, more assistance in tribal country, Indian land, on what this is all about.

And this is more — I hate to say anything is more complex than Part D but this is more complex than Part D was. And we talk about the strategic plan, the CMS strategic plan with the TTAG. We have asked for dollars. We have asked I think $13. We have cut back by some 12 to 14 percent. We need those dollars as whole as possible. And they are in the testimony so you can see all the way up through 18.

Strategic plan for American Indians/Alaska Natives assumed for push in enrollment in '14/'15. If funding does not occur and enrollment does not occur, there will be a pent-up need for the problem in '16. You are just delaying the inevitable.

With that I am going to — you know, it is just 11:25 in Oklahoma, so it is really not an issue. But with that I am going to turn it back over and let it go. Thank you, sir. Thank you, ma'am.

MR. JIM: Thank you. Any response from the federal side to the tribal presentations?

MS. MANN: First of all, I want to thank you both for the thoughtful comments and information. Some of it is things we have talked about before. Some of it is new and we want to look at it closely with you. I think all of it is quite legitimate and

we, you know, there is — it is a start up year and I don't want to make apologies for anything that didn't go right but it is an ongoing, continuing improvement process.

So we want to make sure that we keep making it better every day, every week, every month and get it right. So thank you. We will look closely at your comments.

MR. JIM: Thank you very much for being here, and we will go ahead and break for lunch. Be back by 1:00 p.m. We are going to start on time.

(Whereupon luncheon recess was taken.)

AFTERNOON SESSION

(1:13 p.m.)

Opening Discussions

by Rex Lee Jim, Vice President of the Navajo Nation and Co-Chair

MR. JIM: I hope you enjoyed your lunch. What we are going to do is we are going to move the next presentation until after the Secretary's — or our with her. Yesterday we reviewed this and it took 23 minutes. So, we do not have 23 minutes between now and 1:30.

Well, what I would like to remind everyone is on your agenda it states the order in which we are going to be listing people to come to make remarks to the Secretary. And that is the presidents, chairmen and governors will go first. And after they are done then you go to the next, the vice president, lieutenant governors and vice chair persons and then to the council members and delegates and so on. And these have been sent to you ahead of time so you are aware that is what is going to take place.

And there are 21 of us here. So, if each — every one of us would like to speak we need to make — limit it to two minutes. And normally the Secretary engages in

a dialogue format. You have a comment, she will respond and so on. So, sometimes that will stretch it out to three, four.

The other recommendation is if a tribal leader already covered an area — you do not have to repeat what they said, you could know — add something new to it or cover a different — I would recommend a one or two major issues that you have concerns with and go with that.

So, if you look around you, the person sitting to your right and to your left, they are tribal leaders so we need to respect one another's time, so let us try not to hog time. So, we would appreciate that and — certainly this is an important meeting where the tribal leadership, they would all like to say something to the Secretary.

Any questions of how we are going to do this? Mr. Antone?

MR. ANTONE: It says here that discussion will be about the findings from the Tribal Budget Consultation. Is that — for that first discussion? It is going to be the same for the tribal leaders' discussion or are we able to deviate from that and be able to provide brief testimony on other things?

MR. JIM: What are your recommendations?

MR. ANTONE: I will like to address some in brief, some testimony but is outside but I just want to outline a few things. And that should not take more than a minute. Well, that is what I am asking, is it going to be on the budget or are we — I mean personally I think I need to address what I need to address here, because we are consulting with the federal government.

MR. JIM: Okay. Well, I will let Doctor Roubideaux address it. Go ahead.

DR. ROUBIDEAUX: So, I think that the — if you think about what is most timely right now, the Secretary will be deciding on the 2016 budget proposal probably in

June or July. So, this is an opportunity to give her your thoughts about the HHS budget, not just the IHS but all the other operating divisions. So, I think — I would recommend that is kind of a priority.

However, this is also an opportunity for you to bring to her level issues that you would like her help with. She is a great advocate for tribal programs. And has consistently emphasized, prioritizing funds in the Department. And she also has been very helpful in getting problems fixed. And whenever something is mentioned in these forums she usually will tell the agency head the — try to help with fixing that.

So if I had to suggest, probably focusing on the budget needs is probably the priority, but if there are other issues and solutions and recommendations you have, that is welcomed as well.

MR. ANTONE: That is all.

MR. JIM: So, we will go ahead and do that — focus on the budget issues but if you have other areas that is urgent and necessary, you can address that.

But again, I — I am appealing to your sense of being fair to others, so keep your comments short and to the point as much as possible. And be specific and clear. We want to bring up as many issues as possible from as many tribal leaders as possible. So, she hears from different people. Go ahead.

DR. ROUBIDEAUX: She is going to begin a round of testimony on the 2015 President's budget to Congress, probably about six hearings — she is going to have. And they do not usually ask us about — ask her about Indian health issues, but she is going to be studying up the budget in the next couple of weeks. So, there are things in the 2015 budget that you heard from Norris today that support Indian programs.

You could also reemphasize the things you like about the President's budget, you know, to help her know that that is what you want her to pray for, so it is another opportunity.

MR. JIM: The other is Ms. Sparks will be keeping a list so — you do this, not waive at me — to Ms. Sparks, she will be writing down the names and we will go by that.

And other is, just out of respect for leadership, when the Secretary enters, we will all need to rise. Thank you for that.

Are there other comments, concerns? Go ahead.

MR. QUETAWKI: Arlen Quetawki, governor for the Pueblo of Zuni, New Mexico. I know a — they walked in here and I was informed about the time limit. Just my comment is that I think as for tribal leaders to be here I think be respectful for tribal leaders, because this is a consultation that, I think, that for future recommendation is a future that we allow this to happen possibly for a two day session because tribal leaders need to express a lot of their own issues and how they bring that to the attention of who they want to meet with, especially for the federal and —

I have been attending a lot of these consultation meetings and I can now understand the fact that tribal leaders are very frustrated because when we meet — when we meet with federal agencies we go on your time. What about our time. We have traveled a long way, spending a lot of monies to get where we are at and to advocate on behalf of our constituents. And here in D.C. we are told you stay within two — two minutes or stay in this — I think that is very disrespectful to tribal leaders.

So, I think one of the recommendations is to see if we can get another day of sessions for tribal leaders to be here. One of the things that I have heard was that, again we have 566 plus recognized tribes. Not all of us are here. Not all the regions are here to speak on their behalf.

So, I think that is a — very much of a concern for me personally, is that when I am told to stay within two minutes, to — yes — with all due respect, Vice President Jim, is that we have to be precise to the fact — to the point and address that issue. But I think with just respect to the tribal leaders is to give them as much time as possible to address their issues and concerns.

Because we are all here on behalf of our constituents that are out there that expect us to bring this message here to Washington, D.C. We may not expect results when — by time we get home. But I think all of our efforts — this is a team effort. I think what the whole focus is, is how can we address these issues and concerns, and lot of it has to deal with funding is, that the main player that deals with money issues, OMB. You said that they were not — unfortunate due to their time and what now.

I think we have been hearing that a lot of times — OMB, they are also the decision makers. The decision makers are also Congress — congressional people.

As for tribal leaders, that is an advantage that we have that sometimes the departments do not have. They are limited — you are limited to what you can say and how you can lobby on behalf of us. So, as tribal leaders we have that opportunity when we meet our — we meet with our congressional people is to address these issues. And hopefully that the message you are sending out and the message that we are sending out is of one voice.

But again, how can we all work together when I am told, we are told, that you limit yourself and then — I think it is — that is what I think. That is what I feel here.

So, I think one of the recommendations is that we need to take a look at providing another session, not just a one day session, for a two days session, for most of the tribal leaders that have been coming to a lot of these sessions, are starting to notice

that the time is getting shorter and shorter and not allowing us to present our point of view.

So, I think those are some of the recommendations that we serious need to take a look at. Because this is a team effort — in order to address a lot of these issues that we have been talking about, and primarily that is funding. And how we deal with that and working with each other, I think we can move forward.

And I feared — positive things are happened. If we are doing something positive, let us stick to that. Let us stick to that positive things and move forward so that we can for the future will be allowed to — be providing more funding for our people, for our constituents who we represent. Thank you.

MR. JIM: All right. Thank you, governor. Your point is well taken. We are all aware of that and we do agree that we need more time. So, we will just have to work on the process that would allow us to do that.

So, Mr. Vigil.

MR. VIGIL: Gil Vigil with the Eight Northern Indian Pueblos Council, Pueblos Tesuque, former governor. Again, I want to express the same sentiment as Governor Quetawki just made.

I have been coming to these sessions for the last four or five years or maybe longer, and it seems like every time I come our agenda is getting shorter and shorter. Our time is getting shorter and shorter. And I agree with governor, that if we are going to invite tribal leaders here, then we should respect that — their time and their efforts to be here because it cost a lot of money to come to D.C. to begin with. And time is of importance.

And I agree with time management, Vice President, but also I think if we are going to bring tribal leaders and engage them, we got to give them that opportunity

to make their presentation and not limit them to — I mean, some we have to limit like — Lieutenant Governor Keel, then.

(Laughter)

MR. VIGIL: Just kidding. Some of us can talk forever also. But I think it is just a matter of courtesy to allow the tribal leadership the time for them to express their concerns and their issues. And that is all we are asking for.

So, maybe recommendation that Governor Quetawki is making, making this a two day session. And while the first part of the day yesterday was important, I think that can be covered somewhere else.

I know you go out to Indian Country to do consultation also, but sometimes we do not get to those ones either. So, it is just a matter of courtesy is what we are asking for.

MR. JIM: Okay. Well, again, thank you for your comments. Maybe one of the — you can bring that up to the Secretary and say we need more time with you. And just state the reasons why. Mr. Payment.

MR. PAYMENT: Well, I just — was just going to say that — so, when we come we know we do not have time to cover everything that I want to cover. So, we bring out testimony and then we hit the highlights.

Throughout today — because this is the first time I have come to this consultation, but throughout the day what I have been doing is I have been peppering my comments on the different agencies at that particular time. But I know that I am not going to hit everything. And for me to do my whole testimony would take the entire time that is allotted.

So, we can submit written testimony, right?

MR. JIM: Yes.

MR. PAYMENT: And then hit the highlights. Okay.

MR. JIM: Yes, you can always submit written testimonies. Ms. Metcalf.

MS. METCALF: Thank you, Mr. President, Ronda Metcalfe, Sauk-Suiattle Indian Tribe, Tribal Council.

One of the things I — one of the biggest reasons I think we need to be able to have more time is because once again as us tribes are put around a table with a pot of money set in front of us, which is very little, and certainly not sufficient to meet the treaty obligations that the federal government has with my tribe, but yet we are all expected to sit around this table and negotiate as to why we should get our fair share. And for my small tribe I certainly know that this is going to take more than two minutes of time with my trustee.

And so I would like the table to think about that. We have a little pot of money and all of us have responsibilities to our tribal members, our elders and our children. So, I did want to add that onto the table. That is why we are here. We are here to fight over a small pot of money. So, we do need more time.

MR. JIM: All we all agree with that. Lieutenant Governor?

MR. KEEL: Mr. President, I resent the remarks that Gil Vigil made.

(Laughter)

MR. KEEL: No, I just want to follow up very quickly. And one of things — and in fact we are probably making those remarks publically, but these remarks should be made to the Secretary. The fact is that giving us one hour for negotiations out of her schedule, realizing that she is a busy — busy lady, got numerous things on her plate and all those things. But to — but for her to grace us with one hour for time is not sufficient for these types of negotiations.

Because when we talk about consultations and negotiations and all those words that we talk about, we can do that with agencies just as we did — some did yesterday, talking one on one in our consultations, in our negotiations.

But — but to make these points known publically, these remarks need to fall on the Secretary's ears. She needs to hear this from the tribal leaders, not from the staff, because we are — we are pointing fingers at the staff and it is not your fault. We understand that.

But redoing the schedule, allowing tribal leaders input, for the time that they need to negotiate certain portions of the HHS budget, which is huge, for us, for Indian Country, we certainly believe that it requires more time. Thank you.

MR. JIM: Thank you. Governor?

MR. QUETAWKI: Arlen Quetawki, governor for Pueblo of Zuni. I think the reason why I brought this issue up is that — I am ready to go home. I have been here two weeks. Here in D.C. and I am ready to go home. And I want to go home with results and at least — at least — not only representing the Pueblo of Zuni, but I am here also as a tribal leader to represent all the tribes, from big tribes, small tribes, and middle tribes.

We are here to represent for the budget itself and the money-wise. I think that is why we have representatives from each region at a certain time, that they are coming before and talk about specifically money issues like IHS, BIA budget hearings. Where we have our representative to go in and advocate for us.

But here, we are talking about the overall HHS issues and concerns that we are bringing up for the best interest of our constituents. We have best practice and we have others that we need to make sure that we all come up evenly and move forward.

So, that is basically — I guess through frustrations I have brought these issues up. But — I am looking at working with each and every one of the tribes, too, to

make sure that our voices, our issues and concerns are brought to that level. And where we are moving as a team to address that.

Because as I mentioned earlier, OMB, and our congressional people need to listen to these. And because they are the ones that are the — the purse-holders of money. And that is what we are talking about. And we as tribal leaders we need to really truly band together and advocate and move forward so that we can all help each other out so that when discussions like these do occur that we can tell each other that we are moving positively because of our efforts when we do team work.

And so, again, here I am looking forward to working with each and every one of you and listening to the tribes on how we can all move forward. Thank you.

MR. JIM: Thank you. Is the Secretary on her way? Okay.

(Pause)

MR. JIM: Other comments or —

MR. BREWER: Bryan Brewer, Pine Ridge. You know, this is probably — today is probably as close as we will ever get to a true consultation. Actually being able to talk with the Secretary. But I agree with Arlen, two minutes, you know, hour, half hour, that is not enough time.

I have been to consultations where the people are very low level --

MR. JIM: Excuse me.

(All standing)

MR. JIM: Thank you very much, Secretary Sebelius for your time and commitment. We will go ahead and give you the floor for some remarks and then we will open the floor to the tribal leadership.

Tribal Leaders and HHS Secretary Budget Remarks

by Kathleen Sebelius, Secretary Department of Health and Human Resources

MS. SEBELIUS: Well, thank you. Thank you all for being here for this important consultation. I am happy to be here with you. I am spending a lot more time on airplanes these days then on the ground, given the time table on enrollment issues, that I am trying to make — I am earning my frequent flyers miles, I will tell you that. But often do not know quite where I am from day to day.

I want to start by thanking Stacey Ecoffey and the Tribal Affairs team for again putting the consultation together. And recognize Vice President Jim and the leaders here today. Thank you for your time. I know you are all busy and take time out to come to Washington and make sure we get your input and advice. And more importantly, hear your priorities and concerns.

We did a slightly better job with the weather this time. I think it is getting a bit warmer and that is all good.

I want to start by just talking a little bit just about the framework of the budget and touch on some issues that I know are critically important to you. But also recognize that, I think, having our leadership team at the table is also part of this important work going forward.

We finally have a budget, as you know, which I think is a step forward. We have not had a budget in three years, so that is an improvement. And as part of the budget deal made in Congress the sequestration that involved discretionary programs was sort of — gotten rid of as part of the deal.

Having said that the sequester of the mandatory side has not gotten rid of and I know that that does affect programs in Indian Country. For instance, a Special Diabetes Program for Indians is reduced $3 million in 2014. And that impacts directly the

work to prevent diabetes. Medicare sequestration stays in place. And Medicare is not only important to elders in Indian Country, it is important to elders across the court. And $11 billion a year, a two percent cut, flat cut, out of Medicaid — Medicare, I am sorry, is still in place.

And I just want to share that with you because a lot of our — the way our budget works, as you all probably know, only eight percent of our entire budget is on the discretionary side, 92 percent is on the mandatory side. So, the mandatory cuts that stay in place really cut across all programs and impact and affect a lot of issues and initiative.

We are going to work as hard as we can with you. I know there is an ongoing concern that given the huge gaps in Indian Country you should be exempt from sequestration. But I have to tell you that is not currently the way the law is written, unfortunately, and it is not the way that we can administer it. But at least we have through the work of the President and I think the leadership team, gotten rid of the sequestered numbers on the discretionary side.

In the 2014 budget bill, again, HHS' budget in 2014 is set for the first time, so we actually know what is going on. And the funding level, I think, continues to demonstrate support for Indian Country. We got about $6.7 billion for tribal programs and compared to where we were, the last time we had a budget in 2010, it is up about 13 percent.

There is an increase in Indian Health Service which actually is about 35 percent higher in this year's budget than it was in 2008. And outside of IHS we have got about an eight percent increase in the important programs that are run through the Administration for Children and Families. So, it also increases staffing for the newly opening health facilities, the purchase referral care and contract support costs, all tribal priorities that you have shared with us over the past.

The estimated contract support costs for 2014 are fully funded. And I know we have discussed that, not only with the STAC, a number of times, but going forward. And looking outside of the Indian Health Service, the Substance Abuse and Mental Health Services Administration, which Pam Hyde runs, received an additional $5 million to provide competitive grants to tribes and to — to promote mental health and address substance abuse.

Again, I know a priority that you have talked about money for Early Head Start/Child Care Partnership, are in the ACF budget. With come competitive grants. And a five — I am sorry, a $15 million set-aside specifically for tribal programs. So, I think you will see in the 2014 spend a lot of priorities that you have talked about.

We also now have the proposed 2015 budget which was rolled out earlier this week. And again to tell you what the entire Department's budget looks like, because I think it is important to understand the context of these budgets, our discretionary budget across HHS for 2015 actually has a lower spending level than 2014. So, we actually go down in funding. And we are decreasing by about $1 billion.

Having said that, the recommendations that the President is making in our budget for Indian Country have an increase. And I just want you to put that increase in prospective because lots of the programs within the Department are actually seeing a cut. And the programs that directly affect — First Americans, are not seeing a cut.

So, the IHS Budget, the recommendation is almost at $6 billion which would be a four percent increase over last year's budget. It includes some priorities, again, that I have heard about, from all of you, medical inflation is taken into account, again, staffing of the newly opening health centers, the PRC Program, and contract support costs are fully funded.

The President also, he wrote the 2015 budget to the budget numbers agreed upon by Senator Murray and Chairman Ryan, the House and Senate Chairs of the Budget Committee, so they set the targets for both 2014 and 2015.

But the President said, you know, I will give you the proposed budget, but in addition I think it is important for me to talk to the American people about what we should be doing, over and above what those budget numbers allow us to do. So, I will write a budget to the budget members and then make a proposal which he is calling the Opportunity Growth and Security Initiative. It is a series of investments that he is very strongly recommending that Congress consider making. And he has offered a series of pay-fors, most of them closing a variety of tax loopholes in order to fully fund this initiative.

And in that Opportunity Growth and Security Initiative there is an additional proposal for $200 million for IHS infrastructure investments in Indian Country. So, one of the targeted areas that he is saying we are not spending enough and we are not doing enough and we need to kind of double-down on our investments is certainly in Indian Country.

The budget also increases for other divisions, again, in 2015, outside of IHS, who fund programs in Indian Country and those increases are almost $110 million. So, again, at a time where most agencies are seeing a reduction, we are seeing an increase. So, we are trying to work hard within the resources that we have and within the law that we have, as frustrating at that is, to hit the targets and listen to the priorities.

And I do not go anywhere these days without reminding people that we are still in March and open enrollment is under way. And two very important messages for all of you that I will make once again, one is that anything you could do to help us do outreach to tribal members, residents in your community, who may be eligible and

uninsured between now and the end of March is enormously helpful. I think a lot of word of mouth, a lot of validation from leaders is terrifically helpful.

We are also very much continuing the conversation with governors and others states across the country that have not yet taken up Medicaid expansion, because frankly I think it is unconscionable that there is a very generous offer from the federal government and that because of politics people are willing to play — with lives and well-being of way too many hard working Americans and leave their health care on the side of the road.

So, that conversation will continue, not just during the month of March, but as we go forward because we want to make sure that folks could qualify for Medicaid or CHIP coverage.

We do have well working website at this point, at Healthcare.gov. We know that all of you are making your voices heard. But we have got a little over three weeks left. We are seeing a lot of enrollment issues, a lot of enrollment surges, but want to make sure that we do not miss the opportunity to get people signed up who may well be eligible for very generous tax credits, may qualify for very low or almost no cost insurance. And that they take advantage. Because if they miss the thirty-first deadline they will not be able to sign up again until the end of the year for coverage that does not start until 2015. So, it is an opportunity we do not want to see go by the board.

And with that I will stop, Vice President, and turn it over to you because I am really hear to listen to the priorities are — turn it over — I am not sure who I am turning to over to.

MR. JIM: Thank you. We will open it to comments and questions by tribal leaders. Mr. Payment.

MR. PAYMENT: Okay. So, I have a couple of things. First of all with the Affordable Care Act, and I have been saying this since I got on STAC, and I will keep saying it just because I think it is an area that — I do not know that was fully contemplated but — it is something that hopefully time will help us credit. And that is under the Affordable Care Act there is an exemption for American Indians. And I think there is a presumption that IHS is able to cover the, you know, the difference basically for people who do not have to sign up for health care.

But the reality is, in many of our communities, and my community especially, 50 percent of my population do not live anywhere near, and we are talking like 400 miles, 300, 400 miles from one of our clinics. Some do live a — a large concentration live in the Detroit area. And there is an Indian Health Clinic in Detroit that serves all tribal people. And we probably comprise about 60 percent of their population.

But they are horribly underfunded. They do not have prescriptions, they do not — you know — my second cousin is the medical director there and doctor, and their need is just so great.

So, on an ongoing basis, not as a criticism, but as an ongoing basis, you know, we need to find a new commitment and new funding for members who do not live — who are geographically challenged, let us say that way, who do not live close to their homelands to reach out to them. Because I do not think it was anybody's idea that they could be exempted from the Affordable Care Act to not have something to pick them up. So that is just ongoing.

MS. SEBELIUS: Could I just say, I think it is again — the members that you described are exactly the folks who should be signing up for coverage, so that they --

MR. PAYMENT: I agree.

MS. SEBELIUS: — have could have an option and a choice. And the exemption, again, is really an exemption to pay a penalty or a fee. It is not meant to limit their choices but I think anyone who is that kind of distance from an IHS facility, anybody — is the perfect candidate —

MR. PAYMENT: Yes.

MS. SEBELIUS: — to take advantage of what are a full range of benefits under the law. And — my guess is for the vast majority of members, the kind of financial assistance to come into the Marketplace would be very limited based on eligibility. So, I am hoping that we can, you know, reach other the other way. But I hear what you are saying.

MR. PAYMENT: Well, I agree. And I also think that for a good number of our people they will qualify for Medicaid --.

MS. SEBELIUS: Yes.

MR. PAYMENT: — and we are lucky enough to be in a state — when I came back to office, Cathy is our representative on NIHB, challenged our governor to, what are you doing. And his response was well, we are not doing that. And she asked him the year before that. And so as it turns out they are doing it.

MS. SEBELIUS: Yes.

MR. PAYMENT: Because the politics shifted a little bit. And they are doing it. But we are lucky enough in Michigan, but we have — a third of our population who live outside of Michigan. So it is kind of a hit and miss --

MS. SEBELIUS: Yes, I agree.

MR. PAYMENT: — and that is an unfortunately in those states that do not see the opportunity.

What I also wanted to say and you have heard this from me as the challenge to the President's legacy, and you know, these monumental things that risk it, and so that is not on Obama, that is an issue that Indian Country comes to the table where we finally have somebody that is willing to listen, you know, with the trail of broken treaties and broken promises and — the trust obligation provides for health education and social welfare for the land exchange. We are not talking — welfare or charity.

For the land exchange to allow American to become this great country we were promised this into perpetuity. It is forever. And it does feel challenging when we have to fight for what is rightfully the exchange that is obligated to us.

But and you hear that in our voices when we come to the table and we get a chance to speak. And it is because we have not really had that opportunity, I think, like we do in this Administration. And under your leadership with STAC, which is creating a model for other agencies to be able to create that. We really have not had that.

And so, so I would hope that when you hear our voices sometimes, when we are very tenacious and we are very pushy on some things is it because we have not really had that opportunity.

So, I appreciate the advocacy of this Administration. The full funding for contract support costs — we are making great strides under Doctor Roubideaux's leadership with our work group. And I am speaking positively but it is not always easy because we have our little challenges and fights, but we are finding the solutions. I appreciate the Administration's ability to find the savings in the operations as opposed to cutting into our services.

But I also want to make a pledge from Indian Country that I am prepared to work with the Administration to safeguard the agencies as well because the services that IHS provides are essential whether it is direct funding or it is the Administrative support to what we do. And we cannot keep cutting into those.

And so I will team and pledge my support on — with Congress to fight for that. So, I just wanted to express my appreciation ongoing and — again, to put in context our voice, sometimes it is strident, it is because nobody in the past has really listened. And I think that this has been the best agents — the best Administration that we have had to date. So, thank you.

MS. SEBELIUS: Thank you.

MR. JIM: Thank you. Mr. Antone.

MR. ANTONE: Madam Secretary, Chester Antone from --

MS. SEBELIUS: Yes.

MR. ANTONE: Tohono O'odham Nation.

MS. SEBELIUS: Nice to see you.

MR. ANTONE: Just a few remarks in order to leave enough time for the tribal leaders. We express our gratitude for all the hard work that was done for the increase for the IHS agency. We also express gratitude for full funding of the contract supports costs. And I just wanted to also let you know that at the Tohono O'odham Nation we have 24 percent prevalence rate of diabetes. So — we really — would encourage efforts from us and the Department of Health and Human Services to advocate for the SDPI funding.

And we also would encourage a look at the authority granted in the Indian Health Care Improvement Act for long-term care.

And the other issue is the 1115 waiver with Arizona, the Uncompensated Care Cost Reimbursement, got that possible continuance of and I just want to say that your staff has already engaged before I engaged them yesterday and today and along with Doctor Roubideaux. So, just so that you are aware that we are pushing for that.

Lastly, as I — I do not know but I am a member of the Health Research Advisory Council. I have a few recommendations for that I want to pass on.

And one of the issues, number one, is the Tribal Epidemiology Centers are having a tough time with the states at assessing data. And our recommendation is that the fees that are charges should not be more than what is normally charged to any other entity. Because some places are pretty — steep.

We are also recommending the National Children's Study include over sampling of American Indian/Alaskan Native populations, so that way we get a — a good sampling. Because we do realize that that is what — 26 year study and we need to be a part of that.

And we request that the HHS Data Council hold a consultation with tribes for the purpose of developing a department-wide policy on data management in Indian Country.

And we just also want to know — we want to encourage the National Institute of Health to move forward with their Guidance Document on tribal consultation. And yesterday I was encouraged to hear from NIH that they are considering at least having one meeting in 2014.

And that is all I want to let you know about. Thank you very much.

MS. SEBELIUS: Thank you. And I promise I will not interrupt much again. I do want to say and I should have said it in my opening comments, that — one of the reasons I think that you see in the 2015 budget, finally, a full funding commitment for

contract support costs is the absolutely tenacious and constant leadership from Doctor Roubideaux with not only our colleagues throughout the government, but certainly with OMB to say that this is something we have to put in the budget, we need to go forward.

I know she has been in the unfortunate position of having budgets in the past that she has been expected to defend which did not fulfill the decision of the United States Supreme Court and I know that has been frustrating to tribal leaders.

I can tell you, having watched very closely, the internal dynamics that was not her chosen position and it was not her advocacy failing. It was that we do not write the budget at the end of the day, within HHS, I wish we did, but it is a cross-government.

But you all really should know that part of the reason that that is fully funded in the 2015 budget is that we have never given that up as a top priority and I think you are finally seeing the results of that. It is slow coming, I know. But I failed to say that in the opening comments and I just wanted to circle back.

MR. JIM: Thank you. Ms. Abramson and then Mr. Bear Shield.

MR. GOVER: I am Marshall Gover, I am President of the Pawnee Nation of Oklahoma. And I am a Direct Service Tribe.

MS. SEBELIUS: If you pull the mike just a little bit close, I think we can hear you. Thank you, sir.

MR. GOVER: I am Marshall Gover, I am President of the Pawnee Nation of Oklahoma and I am one of the Direct Service Tribes.

And one of the questions that we have had is why cannot we have one of the abilities that the Self-Governance Tribes have. And that is that the local service unit is to be able to move money around from one line item to another line item. Not the same way that the Direct Service Tribes has, we are just asking for the local service unit when there is a need to move from one item to another item.

And the reason I say that is in our service unit we have one tribe that is compacted, that is up by Kansas. And they have been without a health provider for several months. So, all of their people come down to our service unit. And the Natives in Kansas, instead of going to that service unit — that compacted tribe, they come down to our service unit. They are not even in the user pop.

So, we are getting hit with that compacted tribe and user pop and in another state, and we lose a — medical provider — and we cannot move money around to get another provider in there. And this time during the sequestration and — budget cuts, it would really help direct tribes to be able to do that.

And sometimes we wonder why we have to leave that money there, why can't we move it from one line item to another line item when we could use it in this time to help our people because it is there to help our people, it is there to help our people with health.

And we would just like to know how can we get around that? How can we do that instead of waiting to end of the year to move it? We here, we can do it one time, they say it is a million dollars but it is agency-wide.

MS. SEBELIUS: I am going to ask Doctor Roubideaux to respond to the direct issue that you raised. And I will confess that while I am bias to Kansas, I do understand that this is a — dilemma that you really need to really — and that you --

DR. ROUBIDEAUX: I will just briefly mention that we appreciate your advocacy on this. And we have been working with the Direct Service Tribes and our budget office, trying to find solutions when tribes take over the management, they can — as you said move money around really easily. For the federal side it is a little harder.

But we have not given up. We are still working on possible solutions. And I think this really is similar to the tribes wanted lots of flexibility for their funding through

the Department, as well. And we are often limited by statute or regulation on how we can move money around.

I do not — I do not believe that anything is not achievable. So we will continue to work with you.

MR. GOVER: Thank you.

MS. SEBELIUS: Yes, sir.

MR. JIM: President Brewer.

MR. BREWER: Yes, thank you. So happy that you are here. This is probably to a true consultation that I have ever sat in on. I really appreciate that.

One of the things that Ms. Roubideaux, no matter how much money she gets, what her budget is like, it is never going to be enough to meet our needs. The federal government cannot meet the tribes' needs and as a tribe we cannot meet our people's needs. I mean we are actually having people at home dying now.

You know, you have some discretionary monies, I know I realize it is only eight percent, but we really wish you would consider helping us out with some other programs. And I think it is very important that President Obama knows that we have to — the federal government has to honor our treaties, they have never done it, and — what they are doing, you know, it is hard — it is frustrating for us. We are all sitting here as leaders. And we wish we had more time with you so you could understand, you know.

But I just want to say that our people back home are dying. They need to know this. It is hard for me to get our people to sign up for the Affordable Care Act. One of things our people are saying is if I sign up for it am I going to get better services. Will I get what I need from IHS? There are the treaty obligations. I do not have to do this. It does not say in our treaty that I have to sign up for the Affordable Care Act. Our needs should be met.

And I just want to thank you for being here and listening to us. Thank you, Secretary.

MS. SEBELIUS: Yes, sir.

MR. JIM: Thank you. Ms. Abramson.

MS. ABRAMSON: Secretary Sebelius, I would like to thank you for all the — that happened last time, too. It is my ghost. My spirit goes around all over the place, I guess. But I would just like to say thank you for all the hard work that you do for our tribes. I know it is not an easy task. And you are responsible for a lot of things.

And I do want to say I appreciate — I know — we wish we could — we had more time with you. But I do appreciate the fact that you have the Secretary's Tribal Advisory Committee, the only one that is made up of — tribal leaders and at this high level of the Administration.

And a — I just want to you all to know that we — you know, we meet quarterly and — we, meaning tribal leaders, and we do talk about the — the concerns and the issues of our tribes back home. So, she hears it — quite often. And I think we are pretty good representatives --.

And if you have anything that you would like — her to know, get a hold of your rep, because if you bring it forward, and — it can be put in writing and we can hand it to — we can read it, we could hand it to them, and they will have it for the record and that is consultation, also. So, actually, you know, we can take advantage of that.

So, I just — again, I just — and thank you again for the work that you do. Appreciate it.

MR. JIM: Okay. Mr. Bear Shield.

MR. BEAR SHIELD: Thank you. Good afternoon, Ms. Kathleen Sebelius, I am William Bear Shield from the Rosebud Sioux Tribe. It is good to see you again. And I thank you for coming to visit Lakota Country a few years ago.

You are always welcome back. And a — we would like to see you dance again.

(Laughter)

MR. BEAR SHIELD: On the other side, you know --

MS. SEBELIUS: You are just making fun of me.

MR. BEAR SHIELD: Yes. No --

(Laughter)

MR. BEAR SHIELD: President Brewer, I just wanted to touch base on a few more things. You know the remoteness that you see from our tribe, you know, is a long way to some of our communities and what have you. But you know the contract health care dollars, for us to be referred out to Rapid City or Sioux Falls is just not there. So, we got cancer patients, people with tumors that are sitting there and they do not want to be straddled with bill or the — you know, the — the bill for airfare to Rapid City. Those, I mean they are real problems. And I can say there are people dying because of it.

Detox centers, suicide — nursing homes is a big issue for us now. We own our own but yet we still need them. I mean they are a big issue for us.

And one other plug I would like to put in for the city of Rapid City, the Sioux San facility, it is an old facility. And they are putting a lot of dollars into a very old building. And, you know, I contract — or I mean — construction dollars in the future, I would like to see — we would like to see — someday we would like to see our people get flown to a very nice facility in Rapid City where we will not have to pay a Rapid Regional, you know. And we could have our own specialty doctors there.

Because as the Mayor of Rapid City, he comes to visit the western tribes a lot, you know, the federally recognized tribal members that live in Rapid City is upwards of 20 percent now.

So, I just want to thank you once again for taking the time to come and visit with us. And we look forward to seeing you down there again. Thank you.

MR. JIM: Governor Quetawki.

MR. QUETAWKI: Good afternoon, Secretary. Arlen Quetawki, governor for the Pueblo of Zuni. It is always an honor to be able to be part of these tribal consultations meetings.

But there on behalf of not only the Pueblo of Zuni, the Pueblos of New Mexico, currently also I am the Chairman of the All Pueblo Council of — Vice-Chair of the All Pueblo Council of governors in New Mexico.

One of the things that I would like to recommend to you, while we are all here, is that one of the things for recommendation is to allow the tribal leaders to specifically be allowed, afford, more time to bring a lot of their issues, because right now we are very limited and with respect to tribal leaders, traveling far, coming from their reservation with limited resources and being able to be here to represent their constituents, to be allowed to be given more time.

Today, with this very limited time line, it does not afford the other tribal leaders to express their issues and concerns. I do appreciate again, under your Administration, too, is allowing tribal leaders that were selected to be on advisory committee members to sit at the table and advocate on behalf of their regions and who they represent. But again, this is a unique situation where tribal leaders actually come here and actually come face to face and meet with you and the federal agencies and their — the departments, who they represented here under HHS.

But as mentioned earlier, we have an opportunity to provide written statements. Most of us, we can do that. Most of us cannot do that. So, I think it is an opportunity to actually come here and meet with you.

But what I am also looking is that it has to be a team effort. It is great that we are hearing that there is increase funding, but how long will those funding keep going. And I think it should be a team effort from all of us, from tribal leaders to your agency, to work together hand in hand in — to make sure that we still have these increased funding for specifically what we are addressing.

Right now, currently, we have 566 plus federally recognized tribes. Out of all of those there is what, only less than 20 here representing tribes. And that is kind of a concern to me too where — and I can understand again limited funds to actually come here and meet. But I think what needs to also happen is looking at the future, how many of tribes that are out there that have not been federally recognized.

The piece of the pie is so small that 566 plus tribes are trying to go after that piece of pie. Our strategic plan should be increasing that pie because of the fact that how many of the tribes have not really been recognized. Because once they are federally recognized they are going to go after that small piece of pie.

I think the strategic future funding needs and that is going to take both of us, specifically on HHS. We have other federal agencies like BIA and other agencies that we have to have that concept where it affects all of us. So, I think a team effort.

We were here yesterday when it was presented to us about how the funding cycle goes. And what we all need to be doing. And one of the things that really is very important, and unfortunately the missing element of all of what we are discussing is OMB. OMB also has that ability to make decisions. Maybe we like it or don't like it. But most of the time we don't like because of the fact that they do not understand what we

are talking about when — with regards to tribal issues. That is missing and they should be at the table.

Along with the fact with the departments, hands are tied regarding to how they lobby. We as tribal leaders should be working together to — that is when we have the opportunity to meet with our congressional people, Congress, who really truly actually also has able — ability to set the dollar amount, is to work with our congressional people, especially the Appropriations Committee, the Finance Committee and those that are truly understanding tribal issues, to all work together and make sure that we all are moving in a favorable direction.

Because you do have to come before committees to address your needs, but if we all talk together and specifically address the same issues and concerns that our voice can be carried further. Because my concern is the fact what is the future funding for HHS, which really truly impacts all of us.

One of the concerns that I have really been having is that why are we put under discretionary funds. Because as far as I understand, probably you can correct me if I am wrong, is that unfortunately when a lot of these issues, trying to find out other — where they can get other monies, guess where they look it. Discretionary funds. That is where they are going to get the dollars. And that impacts all of us when we are all under discretionary funds.

So, we being, for some of the tribal leaders we have been saying that based on trust responsibility and also treaties and what not, why can't we be wholly separate line item for tribes specifically, get their funding. And so that we can deal with these funds all the time, instead of having to look at other areas. But to have a separate line item specifically for tribes so that we can deal with a lot of these issues and move forward with that.

So, but I think — again, those are some of the recommendations that I would like to make is that for future tribal consultations that to afford the tribal leaders more opportunity to speak and so that they can address a lot of their issues.

Yes, I understand we have to be short and concise, to the point, but unfortunately some of us are not like that. And some of us, because again when I read a piece of paper somebody telling me what to say, when I talk I got to talk from here. (Indicating heart) I got to speak on what I want to say. Because this — whoever wrote this is somebody else's words.

As tribal leaders we have a lot of issues on our plates. And what we are talking about when it comes down to equal issues, Head Start issues, IHS issues, those are some of the individuals that are solely responsible. But as tribal leaders we have a whole gambit of issues that we have to deal with.

We are not experts, I can tell you the truth. I am not an expert on a lot of these issues. But as long as I get directions from my people to advocate for them, I will do that.

And I am very fortunate that we are going to have a Region VI and VII consultation meeting in Albuquerque, next month, and hopefully we can get the Pueblo governors and leaders to be there at the table to address a lot of these issues. Unfortunately, the majority of them are not here to express their issues. But those are the recommendations.

I have been here in D.C. for two weeks. First one was Native American Indian Housing legislation. Now, I was here for ICWA Issues. Part of the Tribal Working Group to address ICWA issues.

And some of the points or things that they asked me to present was the fact that again identify specific funding to be provided directly to the tribes. The funding

must be flexible thereby allowing each tribe to design and implement the infrastructure systems and programs according to their needs. Interpreting Title E as flexible as possible. ACF will commit to using the authorities under the Title B — Title IV B E, TANF, et cetera, to maximize state ICWA compliance and the capacity of the tribal child welfare programs. The implementation plan should be done in the coordination with the Department of the Interior and tribes, and completing within 12 months.

The plan should include one specific responsibilities for each group, with bench marks and time frames. Two, available authority including any applicable oversight and sanction systems. Three, coordinate and maximize funding sources for tribal partners with maximize flexibility. Four, ensure close coordination and involvement with tribes. Enhance and implement them, fund data collection systems for ICWA to include more complete services, prevention, foster homes, recruitment, retention and outcomes. Such systems provide an accurate count and tracking of Native families. Additionally, this allows for more accurate reporting that demonstrates all services that tribes are providing, which in turn supports requests for increase funding.

Mandate states to collect additional data on Indian children and families. Example, child placement and identify tribal affiliation. To ensure equal compliance can be monitored.

So, when I am meeting with a lot of these program people, the front line people who actually do the job, to be there to support what they are doing and making sure that — a lot of our issues and concerns are addressed and moving forward with it.

But I am here as other tribal leaders to advocate for our constituents, for those people that are at the front line actually making things happen. We are here, we have a unique position to really truly do the government-to-government relationship with not only the Department itself but to our congressional people.

And for those that have been very lucky to be sitting down with the President of the United States during their tribal leaders meeting with the President, that they send that message to him and specifically for the Pueblo of Zuni. We do not care who is the President of the United States. It is a Democrat, a Republican, a Tea Party or whatever party they belong to, as long as they work with us as tribes, we are there to work with them, hand-in-hand to make sure that our issues are moving forward.

With the continuing change in our congressional outcome here a lot of new congressional people that come on board, does not really truly understand the trust responsibility and the treaties. So, they totally ignore that. The only thing that they look at it is oh, tribes are the cause of the deficit. Well, I think they need to get away from that. So, they are to move on and make sure that things are positive and be able to work there.

But we are willing to work with you and make sure that, again, future funding is positive funding are still occurring is going to be a team effort.

But I would like to thank you for allowing me to speak on behalf of Zuni and those that I represent.

MS. SEBELIUS: Thank you.

MR. JIM: Thank you, Governor. Mr. Vigil.

MR. VIGIL: Thank you, Vice Chairman Lee. Secretary Sebelius, thank you for being here. My name is Gil Vigil. I am Tribal Council Member for the Tesuque Pueblo. Former governor of the Pueblo. But also I wear a lot of hats. I'm also the Executive Director for the Eight Northern Indian Pueblos Council. And I am the President of the National Child Welfare Association. And that is what I am representing today.

But let me first thank — also thank you for the opportunity to be here. And to your staff for the opportunity that we have had to talk to them earlier today and

yesterday. But before I go on I just want to let you know I supported you when — the website didn't work the first time.

(Laughter)

MR. VIGIL: Everybody criticized you and said that it was her fault. And I said, well, when you introduce a new system it is always going to have some glitches. And, so, I supported you and I said it wasn't her. It's probably her IT person that messed up.

(Laughter)

MR. VIGIL: But having said that, we also — NICWA provided its written testimony for the record, so that it is on record. But also I support National Indian Head Start Director's Association. I understand they submitted their written report also. And, of course, both of them funding is an issue. The level of funding. And we do appreciate the additional funds that have been made available.

But as Ann Linehan would say to me, governor — here comes Governor Vigil telling us about too many rules and regulations. Head Start has got too many standards. And I think those standards have been lax. But there are still a lot out there that are needs to be lax a little bit more so that we can do the work that we need to do to educate or to prepare our young children to begin their life in their communities and in society. Because to me, I think, that is a critical stage of how our child, life begins and what their outcome is.

And being a Director of the Eight Northern Indian Pueblos Council we just opened a facility and we are calling it the Butterfly Healing Center. And actually it is a residential treatment center. But I have been of the opinion that sometimes we talk about it's a rehabilitation center, it's a treatment center and that's how we act. We act

rehabilitate. We act to treat. Well, we are calling it a healing center because that is basically what it is. It's a healing center for our youth.

And so we need funding for that. And I am going to be working with Pam — of course, Pam is from New Mexico so she says she is going to give me all the money —

(Laughter)

MR. VIGIL: Sorry, guys. Just kidding.

(Laughter)

MR. VIGIL: But anyway, so we are going to be working to address the — because like everybody we have suicide, we have drug abuse, alcohol abuse and more certainly the types of drugs that the kids are taking today are really dangerous. And so we are addressing that in our healing center.

And so, again I know there is a lot of funding, but sometimes we are inundated with too many laws and rules and regulations that prohibit us from doing the actual work that we need to do. And so, in our — in our position statement that is basically what we are saying, provide us enough funding to do the work that is necessary.

Head Start, amend your laws so that we — of course, she is not here — but Head Start, you know, we do not have construction money. Many of our institutions, our schools that are out there are converted old day schools, bureau schools, that were there forever, and now are falling apart and they converted to Head Start or other facilities that they converted to Head Start when it wasn't designed for Head Start use. So, for us we need construction money to do that.

And earlier like, as Governor Quetawki was talking about, more time for leadership to spend time with you. Councilman Bear Shield just mentioned that you were up in Lakota Country and you ---, danced with them. I don't think he was criticizing your dancing.

(Laughter)

MR. VIGIL: But if you could do that with us. Come to Pueblo Country and have a meal with us, and sit down and — like we do it in Pueblo Country, we just like to eat a lot. So, come to our Feast Day, sit with us, have a meal with us and spend the day with us in talking about our issues. Come out to see us, also, so you can see firsthand what we are talking about in our communities.

And again, thank you for offering us the time to be here. But — we want just more time to talk with you. Thank you.

MS. SEBELIUS: Yes.

MR. JIM: Go ahead.

MR. : As you may know if you are talking to Ann Linehan, Head Start is engaged in a very thorough process to streamline and simplify their performance standards for every Head Start, not just tribal Head Starts. It's a very complicated process. So, you probably will not see the proposal until the fall, but hopefully that will help operate your Head Start programs in a simpler or in a better way.

MR. VIGIL: And thank you for that, because that is what I want to hear. I mean even if it is all in the future, at least you are addressing those type of things.

And I will be making — giving testimony, I think, the Southwest Head Start Consortium, which is having their conference and I know Ann and I think Robert are going to be there for the consultation on Monday morning or Monday afternoon.

MS. SEBELIUS: Good.

MR. VIGIL: Unfortunately I am just — have to come back Monday for NCAI. I just flew in last night. I am flying out today because I don't think I could stay for two weeks here.

(Laughter)

MR. VIGIL: So, thank you.

MR. JIM: Thank you. Ms. Homer and then Mr. Two Bears. And we are getting close to 2:30.

MS. HOMER: Yes, Sylvia Homer, the Vice Chairwoman from the Colorado River Indian Tribes in Parker, Arizona.

And I don't want to go over everything that we have already gone over. I think — these gentlemen have touched base on a lot the things that Colorado River is looking at.

One thing I do want to emphasize is the construction on a Head Start, our Head Start. Like he said it's — is — almost 100 years old, the building, you know. And we get dinged on it every time. But whenever we're looking for funding to build a new Head Start for our babies, for our future, it's never there, you know, so that is one thing I want to — advocate for.

The other thing is in a perfect world we would — each one of our tribes would be a government-to-government basis with you, exactly like the states. We wouldn't be going through the states, we wouldn't having to deal with the states in our business. But unfortunately that is something that we are still working toward, you know.

But I did want to commend you on the fact that we're sitting here with you, not your staff, you know. And that is one of the things that I've noticed that we've had with the other federal government agencies. Is we go to tribal consultations and we're sitting there with staff who they have to take — take all the information that we're giving, that we are testifying to, and take it back to you where it loses the — what we have. Like he said, you speak from the heart. We speak for our people and we speak from the heart.

And it loses that in translation when they write it down and then they present it to you in a format, you know. So, I commend you for being here and listening to us and hearing us face to face. Doctor Roubideaux does the same thing. But I have been to so many consultations where all we get is the staff, you know. And it is disheartening sometimes to pour your heart out and then know that it's going to get taken back and it's not going to have half of the feeling that was given. So, I just commend you for that.

MS. SEBELIUS: Well, thank you. I know and I hear this loudly and clearly, I know we never have enough time. And I know it is always feeling very — abrupt and I apologize for that.

I do think though, you know, one of the things that we have tried to do, not only is make sure that the senior leaders are here in addition to me personally, but as been said, Cathy said it and several people, we do have the Secretary's Tribal Advisory Council. And I come to those in person each time they meet.

So, this is not the one-time shot. I know that all of you aren't on that council but your representatives are on that council and again, it's an opportunity for me to get direct input more than once a year at the Budget Consultation, which I take very seriously and then, you know, I do try to visit Indian Country personally. And I have a standing set of invitations and I — I want to make as many as I possibly can. But again, I take that very seriously.

And I always learn incredible — not, I still have not learned quite all the dance moves but I --

(Laughter)

MS. SEBELIUS: But it is very, very helpful to see, because all tribes, as you all know better than I, are clearly not the same. Different issues, different parts of the

county, different facilities, different challenges and that is enormously helpful for me to get those personal snapshots. But some very common issues and some very common themes.

MR. JIM: Thank you. One more. Mr. Two Bears.

MR. TWO BEARS: I would say good afternoon, Secretary Sebelius. I am going to say it's an honor. I have been attending these consultations for a number of years. And I want to say thank you for coming down and listening to us. I know that time is valuable to you and I want to thank you for actually coming down and listening to us.

I think — my name is Robert Two Bears, I am from Ho-Chunk, Ho-Chunk is in Wisconsin. Our issues are always the same as the last two years. We normally have the — Administration there. I am going to just keep it really short.

You know we have state issues going on as far as consultations. The issues are always the same as the previous three years with the Administration. You know the tribes come up with solutions or alternatives to maximize Medicaid. We talk about the 1115 Waiver. We are just stonewalled by the current Administration and the cabinet members. Before it was Secretary Smith and now it is Secretary Rhodes.

So, I guess it is that there are solutions that tribes model after, you know, Minnesota has a model. Fond du Lac is leading the way in Minnesota. So, I guess is that — tribes have solutions. They are not listened to at consultations with governments, state-to-state. So, I guess, just that — if there is any way that the Administration could put pressure on states to help tribes be sustainable. I want to thank you.

MS. SEBELIUS: Well, you raise an interesting point. Because while we have, I think, made some progress when a state applies to us for various things insisting that if they have not gone through a consultation process we need them to go back and make that part of the process.

We have, I would say, some additional challenges in states like Wisconsin where they really do not want to deal with us at all. So, there is not the kind of lever that is a — a waiver coming in that has not been fully consulted.

But here is what I think we can certainly commit to doing. Is going back and looking at all the levers that we have. Because whether or not the state acknowledges a partnership with Health and Human Services, they actually receive a lot of funding from us. And I think there may be ways to get their attention and again remind them of the sort of statutory obligation that we take very seriously. That they do consultation on the variety of programs.

And I would be happy to commit myself to revisiting that with governors across the country. But it is particularly a challenge with some states like Wisconsin where they are really not coming forward to say how can we partner, and we say well, you have left an important partner out at the local level so you need that government-to-government consultation first and then come to us. If they are not coming to us at all it makes it a little more challenging.

But I think there are ways that we can be more creative than we are.

MR. JIM: Thank you. Mr. Batt.

MR. BATT: Sorry, this is going to be real quick. I know I got to fly out, too.

I would like to thank you for your time as well, but I would ask that you ask your regional as well. We did consultation in Region 10 and our tribal leaders were very upset on the allocation of time, as well. So, it needs to be expressed through all the regions that they need to give ample time for all tribal leaders to speak.

One of our issues right now that I wanted to wait for our elders to speak was, I know there are $200 million that is allocated for construction for new facilities. We are asking that we put some money set aside for maintenance, because we do have a nice

facility and our staff has maintained that facility for a good amount of time since the ninety-twos. So, we would like to thank you and express the — spread that money out for everyone else as well.

But we know there is a need out there for Indian Country and then as well as the Sioux have taught you to dance and — these guys want to teach you to eat.

(Laughter)

MR. BATT: The Shoshone are good at our bead work and so we will bead you an outfit, if you want, you can go out there.

(Laughter)

MR. BATT: But I would just like to thank you for this time. And again, thank you.

MS. SEBELIUS: Thank you.

MR. JIM: Very good. Thank you. Concluding remarks, Madam Secretary?

MS. SEBELIUS: Well, again I apologize. I know you have come a long distance and your jobs are demanding and busy and — I apologize for not having more time to spend with all of you.

And I can assure you the issues that you deal with every day are a priority within this Department and certainly a priority for me, personally. And I intend to continue to do everything we can, not just to be advocates on the funding level, but to look at ways that we can be more helpful and strategic about your challenges managing the priorities that you have with the stream of funding that you have.

And I hear you loudly and clearly that the health care is part of the treaty obligations that has never been fully realized. And we are a long way from fully realizing that as well as other treaty obligations.

In the meantime I just would urge you to look at, you know, what we have and where we are because I want to try to maximize all of our possible resources. And one of the things that having actually other streams of revenue, certainly Medicaid is a piece of it, coming in to the tribe, is that that frees up what are, I know, overly limited resources, but frees them up to do other things with. So, it is a way to drive additional funding for health services and other services, mental service, substance abuse service, prescription drugs that are vitally essentially.

So, I know it is not the ideal way to live up to those treaty obligations but I want to make sure that we are just not leaving resources on the table. That we cannot direct to you unless we have some help in getting folks enrolled.

So, again, thank you for what you are doing every day. And thank you for letting me join you, at least for a brief period of time.

MR. JIM: Thank you very much. Have a wonderful day.

MS. SEBELIUS: Yes, you, too.

(All stand as Secretary Sebelius exits the room.)

MR. JIM: Thank you very much. We go ahead and continue with our agenda. We will go back to the Indian Health Service Budget Formulation Team Testimony. So, we will let Ms. Abramson run the show from here.

(Pause)

MR. JIM: Thank you. From here on Ms. Sparks will take over.

MS. SPARKS-ROBINSON: Well, we know folks have to leave and that there are flights heading out, and people don't want to spend the weekend in D.C. And I don't blame you. But we are going to make sure that we take care of the IHS Budget Formulation Team. I am always impressed by level of detail and the information that they provide.

As you heard Linda Smith say earlier, it would be great if we could get needs-based budget across all of HHS programs because it would really help us in terms of our budget formulation as well.

But I am going to take this time now to turn it over to Doug Steiger, who is our counselor to the secretary, Doctor Yvette Roubideaux, who is our Acting Director of IHS and I believe — and Liz Fowler, who is the CFO and Director for Office of Finance and Accounting for IHS. And then we will have our tribal testimony and then we will — and then we will open it up for comments across the table.

MR. STEIGER: Hi, I am Doug Steiger; I am the Secretary's Counselor for Human Services. So that includes the Administration for Children and Families as well as IHS. So, I help the Secretary on a lot of the Indian programs in the Department.

But I would like to spend as much time as hearing from you all as opposed to you listening to me. So, I will pass it over to Doctor Roubideaux.

DR. ROUBIDEAUX: I think what we will do since time is short is we will turn over to our tribal representative, Vice President Rex Lee Jim, one of the Co-Chairs of the IHS Budget Formulation Committee. And let him present the budget and we will comment after that.

Tribal Health Service Budget Formulation Presentation

By Rex Lee Jim, Vice President and Co-Chair

MR. JIM: Thank you. Good afternoon. I am Rex Lee Jim, Vice President of the Navajo Nation. And I serve as the Co-Chair of the National Tribal Budget Formulation Workgroup.

Presenting with me today is President Bryan Brewer, President of the Oglala Sioux Tribe. President Brewer also serves as a Co-Chair of the National Tribal Budget Formulation Workgroup representing the Great Plains Area.

On behalf of the National Tribal Budget Formulation Workgroup, we are pleased to present our budget recommendations for fiscal year 2016.

(Slide)

By way of background, we would like to start this presentation by restating that the United States government, from its very inception, continued the English and colonial strategy of dealing with the Indian tribal nations through treaty-making on a government-to-government basis.

The federal government entered into more than 400 treaties with various Indian Tribes from 1778 to 1871. In these treaties, the United States negotiated cessions of land, recognized other areas of land called “reservations” which the tribes reserved to themselves, and respected the self-governing powers of tribes. Even though Congress ended treaty-making with tribes in 1871, the preexisting treaties are still in effect and contain promises which bind the United States today. In fact, under our Constitution, treaties are “the supreme Law of the Land.”

(Slide)

The United States has a legal and political responsibility to provide health care services to our people.

The findings of the Indian Health Care Improvement Act include 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.”

As with any contract, both parties must fulfill the promised terms or suffer the legal consequences. The United States, then, must fulfill the treaty promises it made to Indian Tribes. As one Supreme Court Justice stated in regard to Indian treaties: "Great Nations, like great men, should keep their word."

(Slide)

American Indians and Alaska Natives suffer disproportionately from a variety of health issues. Our people endure unnecessarily high rates of preventable chronic conditions like Type II diabetes, heart disease and stroke. We lose too many lives to suicide and alcoholism and curable cancers.

For example, the Navajo Area has a suicide rate that is four times greater than the U.S. all races rate for youth aged 5 to 14. In 2010, in one town with a population of only 8,000 there were 15 suicides. Sadly, many communities throughout Indian Country also experience this tragic story.

Meanwhile, we have seen health get better and better on the rest of American. This disturbing trend leaves our tribal members asking our leaders, why not us?

As our president's second term draws to a close, this Administration has the historic opportunity to not only reduce, but also eliminate this growing gap between the unequal health conditions of our people and other Americans. We have an opportunity now to develop a joint strategy to achieve our target Indian Health funding level of $28.7 billion over 12 years which will offer a path forward and a clear direction for future Administrations, and defy those who argue this cannot be done.

(Slide)

For Fiscal Year 2016 our national Tribal Budget Formulation Team unanimously proposed five main budget recommendations.

First, phase in full funding of IHS over the next 12 years. The total Tribal Needs Based Budget is calculated to be $28.7 billion, which is made up of both services and facility and infrastructure development like sewer and water to improve health in our communities.

Second, put forward a fiscal year 2016 budget which includes a minimum 17.58 percent increase from the fiscal year 2014 Enacted Budget request planning base. This represents a minimum amount as it includes only a placeholder estimate for the legal obligation to pay contract support costs, and for staffing for new facilities and for funding for newly recognized tribes. This anticipated binding obligations are difficult to predict today, but will be known as the appropriations process gets closer to 2016.

Third, restore cuts and shortfalls realized in fiscal year 2014 and 2015 which were the result of Congress appropriating inadequate increases to cover current contract support cost obligations, and new staffing obligations for new facilities.

Fourth, the Administration must advocate with Congress that tribes/tribal programs be permanently held harmless if sequestration occurs in fiscal year 2016 and beyond.

Finally, provide an additional $300 million to implement the provisions authorized in the Indian Health Care Improvement Act so that our tribal communicates can move beyond just providing for medical treatment and can begin to address much needed provision of chronic diseases, unintentional injuries and behavioral health crisis.

(Slide)

Our first recommendation is that this Administration commit to finding a viable pathway to get to full sustainable funding of our total tribal needs base budget of $28.7 billion over a 12 year period. In 2003, the U.S. Commission on Civil Rights released a report titled, "*A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country*."

Sadly, despite increases in federal spending little has changed over the last decade. In 2003, IHS was 0.5 percent of the Department of Health and Human Services budget. Today, IHS spending is only 0.4 percent of the HHS budget.

IHS is still one of the most historically underfunded agencies in the federal government, at only 59 percent of total need funded. Our facilities are the oldest in the country with an average age of over 100 years old. Many communities still lack adequate water and sanitation. There are not enough funds to raise prevention of illnesses and disease to the top of the priority list due to the urgent demand for basic primary and urgent medical care. Many tribes still run out of funds to access basic medical care under the purchased and referred care program as early as July of each other. Others still can only provide Priority One care, which only covers life or limb services.

We urge the Administration to make a serious and meaningful commitment in its FYI 2016 budget to provide full funding for IHS. As the last budget that will be enacted during President Obama's term, now is the opportunity to make a historic commitment to the First Peoples of our nation.

(Slide)

Our second recommendation is an increase of 17.58 percent or $779 million over the fiscal year 2014 President's proposed IHS Budget. This includes $189 million for current services, $194 million for binding agreements with tribes and $337 million in program increases expansion.

All pay-cost increases for IHS and tribal employees should be exempted from any freezes or decreases to prevent additional burden in recruiting and retaining health care providers.

The Indian Health Discretionary Budget has always been underfunded, increase if any, have been too small to make a significant impact on building this base to a level necessary to bring parity for our programs and services.

Instead, we have had historical and continued funding disparities compounded by diminished purchasing power related to, underfunded medical and non-medical inflation, and underfunded assessments and fiscal requirements which has placed an additional financial burden on the IHS budget.

(Slide)

With the 17.58 percent increase we have prioritized specific program expansion increases totaling $352 million needed to address the ever-widening American Indian and Alaska Native health disparity and funding gap.

These top tribal budget priorities are to, one, increase funding for Purchased/Referred Care by $145 million, two, increase funding for hospitals and clinics by $98 million, three, increase funding for mental health by $42 million, four, increase funding for alcohol and substance services by $34.5 million and five, increase funding for new health care facilities and other authorities by $16 million.

We must place priorities on these key areas if we are to end the suffering of our people. We must do this for our people so that they can stop living sicker and dying younger than other American citizens.

And now I will turn it over to President Brewer to address the remaining budget recommendations.

By Bryan Brewer, President Oglala Sioux Tribe

MR. BREWER: Good afternoon again. I am Bryan Brewer President of the Oglala Sioux Tribe. I mean --.

(Slide)

Our third budget recommendation focuses on the fiscal year 2013 sequestration cuts, and the cuts or shortfalls which resulted from inadequate funding to cover congressional mandates in fiscal years 2014 and 2015 above and beyond what is needed to keep up with the inflation and population growth.

The IHS suffered a 5.1 percent reduction due to sequestration in fiscal year 2013. This cut devastated tribes from across the country. All other federal programs that serve the nation's populations with the highest need, such as Social Security, Medicare, Medicaid, CHIP and the VA, were exempted from these funding reductions. But, not the HIS Service.

For many, this meant shutting down facilities, furloughing employees and denying access. Others have shifted funds from other tribal services, meaning that they are forced to subsidize the federal trust responsibility.

On my reservation, this meant more people sick, fewer people educated, few people getting general assistance, more domestic violence, more alcoholism. That's all correlated to the cuts from the sequestration.

Although we appreciate that the fiscal year 2014 enacted budget did restore the 2013 sequester for facilities, it regrettably did not restore sequestration for the entire 2013 services budget line. These real cuts must be restored or we will continue to make one step forward and two steps back.

(Slide)

And while we applaud Congress acting to fulfill its legal obligations to pay contract support costs and new facility staffing commitments in 2014 and 2015, these congressional mandates, when compared with actual appropriations amounts, left no funds for national tribal budget priorities, much less for normal medical inflations. Again,

despite receiving these urgently needed increases, we are once again losing ground and addressing health disparities suffered by our people.

(Slide)

As you can see from the chart above, sequestration caused the IHS budget to lose critical gains made over the last several years. The red bar on this graph represents the IHS budget adjusted after sequestrations and recessions.

These reductions effectively wiped out all the hard work that has been done by Congress and the Administration to fund IHS increases.

(Slide)

Our fourth budget recommendation is to hold us harmless from sequestration permanently.

For fiscal years 2014 and 2015, Congress has found a way out of sequestration for discretionary programs. Indian health simply cannot take any more sequestration cuts.

Section 256 of the Budget Control Act explicitly holds IHS to two percent for any year other than fiscal year 2013. However, with IHS only funded at 59 percent, even two percent is too much. Tribes should not be held responsible for the inability of the federal government to balance its books.

The Administration must advocate for tribal health to be exempted permanently from sequestration and the 2015 budget should reflect that commitment.

The former Senate Indian Affairs Committee Chairwoman, Marie Cantwell, stated this well. "Our country's financial troubles are not really stemming from our obligations to Indian Country, and frankly we are not doing a good job in fulfilling those obligations."

(Slide)

Our last recommendation is to fully fund the implementation of the Indian Health Care Improvement Act. The law provides new authorities for Indian health care. However, additional funding is needed to fully implement the Act. Authorizing these expanded authorizations means nothing if funds are not identified to carry them out.

The law improves health delivery services like cancer screening, home and community based services, and long- term care. It also establishes a continuum of care through integrated behavioral health programs, to reduce the devastatingly high suicide rates and other behavioral health issues.

All provisions of the Act are important to improve the health care of our people and must be implemented now.

(Slide)

The workgroup also proposes other policy recommendations.

First, we request that the fiscal year 2016 budget support advance appropriations for the Indian Health Service. An advance appropriation is funding that is available after the year of the Appropriations Act in which it is contained.

This fiscal year's two week long government shutdown illustrates the need for this provision for IHS. During the shutdown, tribes, including our own, were forced to lay off employees and deny much needed services. Advance appropriations would allow Indian health programs to effectively and efficiently manage budgets, and to avoid costly disruptions in patient care. This means we will be able to plan ahead, and more effectively, manage our health system.

(Slide)

Second, the Administration must support legislation to require that non-hospital purchased/referred care is paid at Medicare like rates.

Neither the VA nor the Department of Defense pay full billed charges for health care from outside providers. Nor do insurance companies.

In April 2013, the government accountability office issued a report that concluded quote "Congress should consider imposing a cap on payments for physician and other non-hospital services made through IHS's programs that is consistent with the rate paid by other federal agencies."

This one small change would have very little effect on physicians but would allow IHS and tribal facilities to save millions of precious PRC dollars.

(Slide)

Tribal leaders understand that the promise of wellness for our Native American children and the seven generations to come, depend on your deliberations and actions today. As we look at the turmoil in the Ukraine and Venezuela and other countries around the world, the world looks to the United States as the stronghold of protecting and promoting human rights. It is what this country stands for.

Now is the time to protect and promote the human rights for Native Americans and Alaskan Natives. Now is the time to live up to the promise embedded in the very law of our land. Now is the time to fund necessary health care for our people.

(Slide)

In closing we want to remind you that the plight of all American Indians and Alaska Natives is solidly in the hands of this Administration. This president has a unique opportunity to remarkably change the course of history for federal/tribal government-to-government relations.

The trust responsibility accepted by the U.S. Government in treaties and agreements with our forefathers must be taken seriously. This president must leave his legacy by acting now to provide a meaningful increase of at least 17.58 percent for the IHS

in 2016 and to go create the necessary pathway for future Administrations to continue until 100 percent of our Tribal Needs budget is achieved.

To allow the existing funding gap to continue for both IHS services and facilities budget lines is to disregard the health and lives of all Native Americans. This country has a track record of looking out for the rights of other citizens, our elders ask, why not us. It is time to end the unnecessary death and suffering occurring every day in Indian communities. Centuries of neglect is now an urgent humanitarian cry for justice for our people.

We urge our president and you as Secretary of HHS, to find the courage to take action now to leave a legacy of justice and dignity for all Native Americans. You have the power to make measurable improvements in the health status and quality of life for American's First Peoples.

The amount of funding to do is only three percent, $28.7 billion of the overall 2014 HHS budget. In this constrained environment, Congress relies on the Administration to exercise its duty to responsibly carve out the necessary funds for tribal health care within the overall President's budget. Tribes no longer rely solely on Congress to right-size to our budget needs. We must work as partners on this. This is why this opportunity — today.

It is time for President Obama to keep this nation's promise, to honor the trust obligations to American Indians and Alaska Natives and invest in our future. As previously noted, "Great nations, like great men, should keep their word." (Indian word)

MS. SPARKS-ROBINSON: So, at this time if the federal partners have any response to the testimony they have just heard.

Indian Health Service Budget Formulation Response

by Dr. Yvette Roubideaux, Director of Indian Health Service

DR. ROUBIDEAUX: First I would like to thank our presenters and the entire IHS National Tribal Budget Formulation Workgroup and the co-chairs for their very thoughtful presentation today about the budget.

I know this is important for you for lots of reasons and I appreciate your hard work. They only got together last week to do the national budget formulations. So, to have put together such a very thoughtful and well developed budget is really a testimony to your commitment to your communities. And I want to thank you all so much for doing this.

I will review this with great detail and wait for the full document that you usually give us as well. We will start our budget formulation process probably in May and a — and will — will be submitting a budget to HHS probably May to June. And then HHS will formulate its budget and submit a budget to OMB in about August or September. And then final President's budget will be the following February or so.

So, thank you Vice President Jim and Chairman Brewer for your — for your work and help today with presenting the budget.

I also want you to know that we take this very seriously. When I present on the budget I look at these priorities and do everything I can to get these priories in there. And also I lead with your full needs budget. Which is you have calculated as $28.7 billion, which I appreciate.

I also want to thank Carolyn Crowder, she is another one of the co-chairs for the IHS Budget Formulation Workgroup.

Fully see why you want the biggest increase possible, we are always fighting for that. Have heard very loud and clear the impact of the cuts and shortfalls

lately and wanting to restore that. We are all fighting for no sequester, so we will keep fighting together.

And the Indian Health Care Improvement Fund, you are right, there is so much in there that could benefit our communities, it is just a matter of getting funding for that.

Advanced appropriations, we are doing a review. We are going to talk with the VA as was mentioned before about — through their experience, lessons learned, do they have any suggestions and those sorts of things. And Medicare like rates, we are ready to go, we want to get that done. That is one of our top priorities and we are working to try to get that done.

The quote at the end, "Now is the time to fund the health care for our people." I wrote it down because that absolutely characterizes what we need to do. The Administration has less than three years left. We want to make the biggest impact that we can and do as much as we can. And I think you heard our Secretary and her commitment. You have heard the President's commitment. I have heard him say IHS is a priority. And I know this Department and all the Department leaders are willing to try to help us get as much funding for the budget as possible.

You are welcome at any time to submit more additional information. You are welcome to submit additional testimony. Consultation@IHS.gov is our e-mail address if you need to submit any more information. And I also want you to know that these documents that you give, that you give us every year, we have used it to save parts of our budget, and it has worked. And so, we are really grateful, your words matter. And this does make a difference.

And so thank you to the great work that you have done. We will pour over every detail. We will work as hard as we can to try and get as much of it as we can as possible. And I also want to thank Norris Cochran, he's a great advocate for us, as well.

And I do want to give Doug Steiger a chance to say a few words if he would work. He is the — a counselor to the Secretary. There is only like five or six counselors and he has her ear every single day. So, I want to see his impressions on the budget and any comments he has had. He has worked on Indian Country issues for many years. And I appreciate his counsel.

Comments

by Doug Steiger, Counselor to the Secretary

Department of Health and Human Services

MR. STEIGER: First I want to echo what Doctor Roubideaux said, this is an impressive set of recommendations, very thoughtful. I actually wanted to ask for a little more discussion with the tribal leaders and those who worked on this about advanced appropriations.

I would think that the challenge has been Congress does not get the budget done at the beginning of the fiscal year. And sometimes it is well into the federal fiscal year. So, we have continuing resolutions that go for a few weeks or a few months, and then it is three or four months into the fiscal year and we get a final budget.

And that advanced appropriations would end that uncertainty for the first few months of the federal fiscal year. Is that the challenge or are there other issues that you are trying to address with advanced appropriations?

(Pause)

MR. STEIGER: Sorry, I guess that was too much Washington-speak. Ordinarily, we are supposed to have our congressional budget done by September 30th, for the fiscal year that starts on October 1. That almost never happens anymore.

So, when they — usually have continuing resolutions to keep the government open. Occasionally we fail like last year and the government shuts down. But ordinarily then they fund the government for a few weeks or a few months at the time and it takes a while to finalize the budget for the rest of the fiscal year.

So, to me an advanced appropriation would mean you would not have that trouble this coming October 1 because you would have already gotten your money, you would already know what your number is so it would be easier to manage.

I just wanted to double check if that is what you are trying to fix with advanced appropriations because it seems like our budget process is pretty messed up in Washington and it seems like every year we are going to be stuck with continuing resolutions.

Roundtable Discussion

Moderated by Dr. Yvette Roubideaux

MR. PAYMENT: So, all right, so let me give you a picture of what it looks like in — back home. So, with the shutdown and with sequestration and, you know, what our IHS budget, most of our programs and services are on a calendar budget, but IHS is on an October.

So, what happens is — what happened was we did not know right until the end a couple of things were affected, whether they were intended to be or not, Special Diabetes was not intended to be effected, but it was effected by the shutdown. It is not necessarily affected by the budget.

But, you know, in our community what happened with Special Diabetes is a lot of our staff did not know that they were funded under Special Diabetes because when the funds came in, you know, when it matched the service that they were providing, it provided funding for that service, and additional outreach for diabetics and the normal delivery system that we had.

So, anyway the funding got interrupted and now the staff know that they were being funded by this. They did not know that necessarily, but they know now. And what happened was they are like, you know, for doctors they are like well, we are not sticking around, we are not working — we did not know we were working under a grant program and our practitioners and they left.

And then so — the interruption of funding is the main thing. So, we have gaming revenue. One hundred percent of our revenue goes for — to basically — somebody said it once before — to help the federal government fulfill their trust obligation to us. Because we backfill the stuff that the federal government is not doing.

And but there are tribes that do not have gaming revenue at all. I mean — and I have said this before for Alaska Natives, I don't know what they did. I don't know how they survived the sequestration or the shutdown. We did the best that we could do but it still adversely affected us.

Head Start is another example. Head Start — their cycle is even a little bit earlier, like a month earlier. When we had to go in front of my council, when I came back to office it start focusing on sequestration. I hit the Hill and everybody is like, oh, it's not going to happen, it's not going to happen. I am like — no, as long as the Tea Party is here it is probably going to happen and it happened. And our Head Start program came in front of our budget cycle, they did a modification, they reduced the services and slots and

the — earlier I mentioned in the furloughs. And so that really affected our ability to deliver our services.

In many cases the programs that we offer are hanging on by a string. Independent on the federal government to fulfill their obligation. Advanced appropriations would help because it would give a little bit of a cushion. One year in advance that we know that funding is coming and then we would not be in such a crisis.

You know again I think about the tribes that don't have gaming and how in the heck did they survive this situation. You know, when you hear the frustration in our voices, with not having enough time, it is because we just went through hell. And I know the federal government knows that but the impact in Indian Country when life or death decisions are made and people are dying then it is really critical.

This would be one step towards that. A bigger thing would be to make it non-discretionary. Our funding should not be discretionary funding. It is an obligation that we fulfilled by trading our land, the federal government should fulfill by keeping up their promise.

MS. SPARKS-ROBINSON: Do we have any other tribal comments?

(Pause)

DR. ROUBIDEAUX: While you are thinking, I want to introduce Liz Fowler. She is our Chief Financial Officer and is over the IHS Budget and works really hard every year with tribal partners with National Indian Health Board on the budget formulation. And she is the one that crunches the numbers and helps make the argument for the budget every year. So, she is a real important part of this and you are welcome to give her input or questions or —

DR. ROUBIDEAUX: Ms. Metcalf.

MS. METCALF: I kept having to go out so I do not know if you covered contract support costs topics.

DR. ROUBIDEAUX: We actually have not had much of a chance to talk about it at all today so then do you --

MS. METCALFE: Oh, yes, then I have some comments.

DR. ROUBIDEAUX: Okay, great.

MS. METCALF: So, I am a little bit bothered when they are talking about fully funded contract support costs. Now, I am understanding that the President said that contract support costs is going to be fully funded.

But here is the problem. If IHS does not recognize the need to obligate contract support costs to a tribe, then how can that be fully funded? I just — I have a big problem with that.

My tribe was forced, which again was 638 contracting rolls, to take our medical without startup costs and without contract support costs. Now, my tribe has continuously, year after year, since 2008 — 2007, tried to have a remedy to this and it is not going anywhere.

So, if you guys do not recognize a tribe's — not having contract support costs then how can we truly say that it is fully funded?

DR. ROUBIDEAUX: Thank you for the question. You know, the President said at the White House Tribal Nations Conference that the Administration hears the frustration of the tribes about — contract support costs and he committed to working on solutions.

And so it was that commitment that led to the, you know, Congress for 2014 told the Administration we want you to fully support contract support costs but they did not give us any amounts or any information and they wanted us to develop an

operating plan. And so for the first time ever in 2014 both the BIA and IHS — had in their operating plans to fully fund contract support costs.

It is a huge change in federal policy. And — it was based on the great advocacy of the tribes in this issue. It was not in particular based on some very good diplomacy by some tribes who were able to help sway some minds and a lot of all of us trying to work on this issue.

The federal government is committed to — you know, making sure that we can follow the Ramah Decision, which is that the federal government owes contract support costs to tribes. That is expressed in this new policy in 2014 to actively fund — fully fund contract support costs.

So, that — the $140 million that we committed towards contract support costs for the Indian Health Service paid that old outstanding shortfall that was carried on the books, it paid for the new and expanded — from the new staffing and paid for another amount of estimated new staffing this year.

I think that we still have a little bit of a challenge on it though. And Congress recognized that, which is how do you determine the exact amount. And that is what we are hoping to work with tribes on the long-term solution. We are having a listening session at NCAI next week.

That is the first of we hope are multiple forums where we can talk about contract support costs because it is a complicated thing and it is — it is an estimate, when we negotiate the contracts it is an estimate during the appropriation process. It is an estimate during the appropriation year and it is an estimate even after that, all the way — it is almost until — it is not even until we got to the claims process where we started to really see the firm numbers.

And so, it is not that that is a bad thing, it is just a challenging thing. And so we really are going to rely on tribal leaders to work with us to find a solution to better be able to know those numbers to be able to budget them and get them in the budget and make sure we full fund them all the time.

For 2015 the Administration again made the commitment to fully fund the estimated amount of contract support costs for 2015. This is really like completely new policy for the federal government. So I understand your frustration about what has occurred in the past, but this commitment by the Administration for 2014 and 2015 represents a new — a new willingness to work with tribes and a new willingness to move forward in a good way.

And I think that is has been a long hard fought battle but I think we are ready to move forward to try and make sure we hit that mark every year in the budget and fully support contract support costs.

The issue of the past claim, we are working on that as well. We know that in the past contract support costs was not fully funded because of appropriations not being sufficient. And so, tribes have claims for past contract support costs. We have been working very hard to get those paid. We actually have recently, hearing on tribes want us to speed it up, have put more resources and staff on it. And we have already tripled the number of claims analysis and doubled the number of claims settlement.

And even today, while I am sitting here, I am getting my lawyers asking me to approve settlement offers for tribes. And so, we are ramping up and our goal is to get offers out to all the tribes this year. And we really do think we can actually do that. So, we are trying to deal with the past. And we want to put that to — we want to get those settlement offers done and put that in the past.

And with this Administration's policy of fully funding contract support costs moving forward, we still have to solve that issue of the exact numbers and estimates and how to make it more precise. Congress recognized that was an issue and that is why they pushed it back to us. So, we are really looking forward to working with all of you. So, I hear your frustration about how it was in the past.

For next year, for any new and expanded, we are trying to estimate the best amount we can to fully fund it in the budget, and working with tribes to figure out a better way to know that number in advance. And there are a number of ways that we can do that. We just need to hear from tribes through this consultation process how to get that done. And we do not have any preconceived notions of how that will work, we just want to work with tribes on getting it to move forward.

And we have to think about that. This Administration is committed to fully funding contract support costs. And the Congress is committed to that. But in less than three years we may — well, actually in about six months, we might have a different Congress. And then in less than three years we might have a different Administration. So, it is up to us to come up with a solution that we can — that will stand the test of time.

And so that is why we really need your engagement on the — and your partnership on thinking through, how do we make sure that this will stand the test of time. The Obama Administration now has a goal of fully funding contract support costs and moving forward. And so — but we have only got less than three years left. So, let us figure out a solution that stands the test of time, figure this out once and for all, so we do not have to worry about it and be frustrated like you were in the past.

And so, I appreciate you bringing it up. We did not get a chance to talk about it today, but our whole team and the Administration is committed to trying to solve this and get it done.

And so, for those of you wondering, we just received our approval of our OMB apportionment for the agency, for the 2014 funding. Which means now that we are going to allot the funding out to the areas, we start with the recurring base funds, and then anything else that goes out by formula or other determination will get out as soon as we can. We are working with our CSC Workgroup on how to do the distribution of that $140 million in CSC and we are going to try and get that out as quickly as we can.

But it turns out it is complicated and the workgroup understands that we are dealing with — estimates and numbers that have to be updated and we want to get that done as quickly as possible.

So, I want to — try to reassure you or try to — let you know that we heard your frustration and now the Administration is moving forward in a more positive way in trying to find the solution to resolve this once and for all.

MS. WESTING: So, I do have one more thing and this is in regards to the RPMS system, which we all really love.

So, ours does not work. And it continues to not work because the Portland Area is not doing their patches and sometimes they say we are not cooperating but we really do try to.

I have asked continuously if we can't get our RPMS working how do we get our numbers because they are so quick to drop our user account — and not want to provide us with any extra dollars or give us what we really are doing. And they still do not provide me with the remedy in order to get our actual numbers of service — services provided to them. Instead they just go by whatever the RPMS says, which is basically nothing, because we can't get anything to transmit and it is a continual battle.

I mean — working with Indian Health Service should not be a battle for the tribes, we should be in partnership. And we should be able to do services. I mean, Indian

Health Service, and we provide services. But it is not that way. It is always an argument to try to work with Indian Health Service. And I believe — and I'm pretty frank — that it is at every level.

And so, how do we — how do we create what the Chairman was saying earlier about teamwork. But that is what it is going to take. And I have been fighting this RPMS battle since 2005. And it is still not going anywhere. And we are still losing money because we are not getting those number captured.

DR. ROUBIDEAUX: Thank you for bringing that up. I will talk to the Portland Area Director about the concern you have about not updating the patches. And I will also talk with the OIT Director, Doctor Hayes, about that frustration and — I --.

I am glad to hear you all talk about teamwork, because that is what I am trying to do within the Indian Health Service, is change it from a service — I think — that word service, has led to some — I don't know — it doesn't promote teamwork.

And so we really are trying to change the whole culture of the organization. I am requiring all my area directors to meet more regularly with tribes and share more information. And I am also requiring the CEOs to do the same. It is a big organization with a lot of people and change sometimes is never fast enough. But I want you to know we have the same goal and I will continue to push for more of our staff to be more in — that is our first priority is partnership with tribes — to understand it is a partnership of equals. It is not us doing for you or it is not — you know, it is us together and we need to do more of that.

And I think our organization has been used to doing things certain way. And we are fighting every day and putting in place things that — you know, will help us move towards that more partnership model. And it helps me when you give me the input about our staff that maybe aren't along with that model because now I have — a

performance evaluation system where it is in there that they have to partner with tribes. And if they don't then what I can do is hold them accountable. So, it helps us to get that feedback. So, I am really glad you are honest and frank about it because we can go back and, you know, push for more progress and hold people accountable if we need to.

And, you know, this whole thing — IT, electronic health record, RPMS, a huge with the Affordable Care Act and the changing health care delivery system. And I understand your frustration and we want to try to find solutions to make it work better moving forward.

Because, you know, it is another budget issue. We would buy a fancier package if we had the money but we don't. And so we are constantly patching what we have and — at some point it is probably not the best strategy, it is just us figuring out what our next steps are, so appreciate your feedback today. Thank you.

MS. SPARKS-ROBINSON: Do we have any other questions or comments from the tribal leaders' representatives?

MR. BEAR SHIELD: Doctor Roubideaux, I think it was real important that you said that about the teamwork amongst the tribes. But also we are looking forward to the teamwork between the tribes and your area office, especially the Great Plains Area office. And it trickles down to, I know — I can't speak for Mr. Brewer, but — I can speak for Rosebud and the Sioux San facility in Rapid City.

And we will get together with you concerning those issues. And we know the bottom line of everything is we want things to run in the best interest of the facilities and the people that they serve, you know.

And I know the area office has been making some changes. And they are trying to address some issues. And it just needs to continue. And I think it can be all worked out. And a lot of it isn't — I mean a lot of it is cost effective. It is just dealing with

personnel and some issues there but — I'm sure we will get together on it in the future pretty quick. Thank you.

DR. ROUBIDEAUX: I look forward to that. And also — help remind my staff of the things I am telling to do, so if they are not partnering well with you, say well, Doctor Roubideaux said that — the agency now is supposed to partner with tribes.

I would like you to use those words, because we have to work together on this. And we are trying to change the environment in a big, giant health care system that has been dysfunctional for a long time.

So, if you have heard me say something and they are not acting in the same way, then say well, Doctor Roubideaux told us that you were going to partner with us and you were going to give us more information and you were going to meet and you were going to work with us. So, you know, they don't want me to get on them because they have seen what I can do.

So, you know, use that as a way we all pressure change in this organization. Changing a big organization is tough. It can't happen overnight. But I think that is something you can help me with, continue to remind them, these are the agency priorities, this is what we are moving forward towards.

And I had a TDM with a tribe who said they've changed the clinic and then the service unit said, oh, yeah, we have implemented the IPC. And the tribes are like, but we can't get into the clinic. And the service unit director was like, well, we have implemented improving patient care. And then like, wait a minute, it doesn't matter what you have implemented if the patients don't like it, you know. So, let us just continue to — continue to remind them that their efforts have to be in service of you and your patient — your members and our patients. And — we are just going to have to continue to help make that change happen because it is hard to do that.

We have put in the system now where I can hold them accountable. So, I need your help to kind of continue to remind them. And they'll get nervous if they think I'm going to get on them, because I do get on them and they don't like it. So, we just need to work together on all this.

MS. SPARKS-ROBINS: Great. Ms. Homer and then Governor Quetawki.

MS. HOMER: I am glad to hear you say that because I've been to the service unit, I've been to the area director and we finally came here two years ago. And we spoke with your staff. We had the service unit director and the area director on the line and they were caught in a couple of falsehood statements. And your staff finally excused them from the call and we went on to bring forward some of our frustrations with them.

It is still the same. I've gone and I have told them well, the last meeting Director Roubideaux said you guys are supposed to be, you know, looking at the wasteful spending, looking at this, you know. You are implemented — you say you are implementing, you say you are meeting with the tribes, that is not true because you have not come down and met with us, even though we have asked you to come down to our council meetings several times. So, I think what she thinks is her consultation with us is with the Health Board and that is not — that is not it. Okay.

And so, with Dorothy — it is the same thing, you know. I don't know if she just thinks that we like listening to ourselves talk. Or that I like listening to myself talk because I am usually that is very forward. And, you know, but — we do — I do tell them those things because we do have meetings where our tribal leadership is around the table. And they are asking us for our input, what are you needs, what are your — and then we don't see anything.

We are at the meeting. We discuss the same things every time. And it was like at the one meeting I said — when I came in 1995 I came to one of these meetings with a different area director but it was exactly the same issues and exactly the same frustrations that we had. And here we are ten years later and I'm back and it's the exact same thing. And we are not getting anything from you except lip-service. You tell us what we want to hear. And then you go back to doing whatever you want to do.

And it just seems — and that is the frustration that I've had with Ms. Hutchinson and Ms. Dupree. You know, because things are going on — tribes don't know about it, you know, and then they are having meetings. But yeah, we can't always attend those meetings because we have numerous other issues that we're dealing with and we can't always be at those meetings. But they are never available to come and talk to us.

It seems like every time we call up there to Ms. Hutchinson she's gone. She's gone or she's on leave or whatever. So, we can't seem to get her to get down there and listen to the things that we need to say to her.

So, I'm glad that you said that about teamwork because this is one of the weak links in the chain that we have is that our service unit portion --.

DR. ROUBIDEAUX: Well, let's get back on the phone with them again. Let's schedule another tribal delegation meeting.

MR. QUETAWKI: Arlen Quetawki, governor for the Pueblo of Zuni again. Thank you for those comments, Doctor Roubideaux.

I think a courtesy letter, cc to the tribal council regarding to again working as a team to our area agencies and our CEOs of our IHS facilities so that again when we get those cc letters that we can provide to him saying that — this is what we have been saying. And we are very fortunate as consultation occurs, the tribal leaders, that we are

all saying what we want to do as far as moving forward in teamwork, so that in our respective areas they also get that letter. And so that we can have that communication going.

So, I think that this is one recommendation to do that and cc that to the tribal leaders so when we actually meet with our IHS people, the CEOs, the directors and the area directors to actually sit down and saying this is from Washington, DC, that these are what the recommendations and to move forward in a positive direction.

And so that we all move positively because again, in our area, too, is that well, we want to talk about our health issues within our community, our constituents. Because if they are having problems with IHS and they are not getting anywhere, guess where they come to? To tribal leadership. And they talk about it, so what are you going to do about it.

And so, we address that and they say well, you know, it's area. They're telling us what to do. No, no, no. Area is over here but the facility is located on our — in our reservations, we are working for our people. And the people are coming to us. And that is why we want to sit down and we want to develop a plan to address our concerns and issues within our community, that they are bringing up.

You know, we see these problems, we hear the problems, but what are you doing about it or what can we do about it to address these, because they are our constituents. You are — because of them, you are working there.

So, I think as we move along and — you sending a letter to them and cc us, so that when they say, no, it's not going to be like this, well, here is a letter that you received, which we got cc on as that Doctor Roubideaux says let's work as a team and this is what we are going to be doing.

And second of all, is on the contract support costs it is great to hear that it is going to be fully funded but I think, I'm pretty sure that the Tribal Leaders Advisory and those that have been at the table working on this, it's long — I mean coming on this one, I mean very fortunate.

But one of my concerns is that when we talk about fully funded is that hopefully there will be new dollars to address that one instead of taking those — saying that you are going to fully fund it, but take it out of the programs and saying, well, we are told to full fund it, so I'm going to take portion out of these programs and then put it here on contract support costs. We don't want that. I'm pretty sure the advisory committee has been saying that, taking a look at new dollars to really address that issue of fully funding contract support costs.

I have been involved with the attorneys on that contract support costs and it's very tedious about having to sit down with the federal agency that is coming up, and I have look at the request. Look at the amount that's been there and that's on the BIA side. Now, just imagine IHS.

So, as you mentioned, how do we come up with a figure that addresses all of those that are part of this issue on funding our contract support costs and I've seen it — and so — but my concern is hopefully that when we say fully funded we don't take it out of the other programs and fund the contract support costs and not having these programs being deleted because of the fact that there is no more dollars. And I don't think we want to go there. I think our Tribal Advisory Committee Group members have been saying that to us. Don't take it out of the programs. Let's find new monies to do fund the contract support costs. Thank you.

DR. ROUBIDEAUX: It is a great point. That is the whole reason we got to look at a long-term solution, because this Administration, this Congress is giving us

increases and we can cover it. But if we can't cover it for an Administration or Congress that does not give us the increases, you are right, it is going to dig into the rest of the budget.

So, we need your help finding that long-term solution. Absolutely. So, thank you for bringing that up. And I like the idea of the letter. Thank you. I will write that.

But what you can use in the interim is there is a letter out on the table that is now seeing — that I am going to be doing 12 in person listening sessions this year. One in each area. I will be there in person. I will have the area director right there and that is your chance to bring up some of these issues. And the letter that is out here has the four agency priorities, and the first one is to renew and strengthen our partnership with tribes. You can use that letter until you get the letter from me. And say, she's coming to town so we need to get working on this.

MS. SPARKS-ROBINSON: Any last comments or questions from our tribal leaders' representatives?

(No response)

MS. SPARKS-ROBINSON: Any closing comment from our tribal leader moderator? Any closing comments?

(No response)

MS. SPARKS-ROBINSON: If we do not have any more closing comments, I do — want to — do the wrap-up on behalf of Paul Dioguardi's — one more, Chester Antone.

MR. ANTONE: Real quickly. I believe I addressed with you, Doctor Roubideaux, what — Marshall address to you here earlier about the moving between line

items at the area level. So, I just wanted to say that part. I believe we had that discussion but we had something to do with the regulations that won't allow it.

But I understand that at least in the Tribal Consultation Policy for the Department, that if there are question on the waiver — waivers of certain things, that that will be addressed, I think, as a priority. So, I just wanted to add that before you go.

DR. ROUBIDEAUX: Thank you.

MS. SPARKS-ROBINSON: Okay, I am going to turn the chair back over to Vice Chair, Rex Lee Jim.

MR. JIM: Thank you very much, Ms. Sparks for taking over for a while. Now, according to our agenda we are going to do the HHS Wrap-up. So, since Mr. Dioguardi is not here, we will let Ms. Sparks do that. Go ahead.

HHS WRAP-UP

By Lillian Sparks-Robinson,

Commissioner for the Administration for Native Americans.

MS. SPARKS-ROBINSON: Great, thank you. So, today has been, I think, incredibly helpful for those of us who have been able to sit at the table and listen to the comments, the testimony, the recommendations, the challenges. It allows us to go back — and it really does, as Doctor Roubideaux said earlier, and Norris said earlier, allows us to really begin having the conversations internally that we need to have to shape our FY '16 budget.

Your testimony does not fall on deaf ears. We spend an incredible amount of time discussing the recommendations and we will actually take the tribal testimony that was presented today, as well as the testimony that can be submitted up for the next 30 days and take this to our Secretary's Tribal Leaders Advisory Committee. And they will

review and provide recommendations as well based off of what has been put forward today and over the next 30 days during their meeting in June. And so, you can look forward to hearing updates after June, after our Secretary's Tribal Advisory Committee Meeting takes place here in D.C.

I also want to thank all of those who had opportunity to participate in our planning calls. As you know, the agenda is not set just by folks here in Washington, D.C. We spend an incredible amount of time doing outreach to tribes and national organizations to help us come up with the agenda, to help us identify speakers and to help us promote this day.

And so, we want to thank all of you for doing that and in particular we want to thank the National Congress of American Indians, the National Indian Health Board, National Indian Child Welfare Association, National Indian Education Association, United South and Eastern — United South and Eastern Tribes, as well as the numerous regional and area Indian Health Boards for helping us put together today's agenda.

We also make sure that everyone knows that we heard loud and clear a lot of the comments and the feedback about the format of the session for today and for yesterday. And that we do have evaluation sheets. And again, we take the information that you provide on the evaluation sheets very seriously, as well as that helps us shape the format for the next year's agenda. So, please take the time to fill that out, as well.

I can tell you I have been participating in these Tribal Leaders Consultations for HHS now 12 years. And it is only for the last five years that it has been here on this side as a federal representative. Prior to this I was able to write a lot of the talking points of testimonies for the tribal leaders that came in and spoke and was part of the planning calls, and so it is great to see how long this has been sustained by the Department.

But it is also great to know that we are all still thinking of ways to improve this format in this session and that — really there are open ears, open minds and open hearts when we come to the table. So, I look forward to again hearing the feedback from all of you.

And so, before I hand it back over to Vice President Rex Lee Jim, I just again want to thank you all for coming. Thank my colleagues, Liz Fowler, Doug Steiger, Doctor Roubideaux and Norris Cochran for staying longer than we had originally planned. Thank you all for pushing back your flights or changing your flights or just taking the time again to make sure that you are here to present this incredibly important information.

And that we ask you all to kindly please take your glasses, your cups, your bottles with you when you leave because otherwise IEA staff will have to come up here and to this and sweep the room for you. So, if you could do that quick favor as well. So, again thank you to our tribal leader moderator, Vice President Rex Lee Jim, and I will turn this back over to you.

MR. JIM: Thank you very much. Just like to say thank you to the federal representatives for your time and your patience, and the tribal leaders, thank you very much for being here with us.

We will continue to look for ways to give more time. But we have also heard before, at least — and some tribal leaders say we are too busy, we consulted out too much and — we don't have time, and we heard both sides, so we are trying to accommodate everybody. But we do understand the need to speak to our issues and get more time with the Secretary. Well, she heard us, so we will see what happens out of that. We will follow through.

And again, thank you very much for your time. And we will go ahead and close this up as we normally do with an offering of prayer, so let us all stand and do that.

(Whereupon, a prayer was spoken by Vice President Rex Lee Jim in Navajo.)

MR. JIM: Thank you. Safe travels.

(Whereupon, the meeting adjourned at 3:45 p.m.)