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17th Annual Tribal Budget and Policy Consultation

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

(11:10 a.m.)

Tribal Opening Remarks

by Rex Lee Jim, Chair, Secretary's Tribal Advisory Committee

and Vice President, Navajo Nation

MR. JIM: Good morning. Let's go ahead and get started. I would like to ask the tribal presidents, vice presidents to come to the table, and the chairpersons, vice chairpersons, governors, lieutenant governors. And if there is room, the other elected officials like the council delegates. You can also sit at the table.

We will go ahead and get started with our 17th Annual Tribal Budget and Policy Consultation for the U.S. Department of Health and Human Services. My name is Rex Lee Jim, vice president of the Navajo Nation. I am also chair of the Secretary's Tribal Advisory Committee. And for Navajos, (speaking Native language).

So we will go ahead and get started, but before we get started, I would like to say a few opening remarks. Basically going over the presentation protocol. We would like to remind everyone that under our tribal consultation policy, the presentation protocol has been defined. We will adhere to that policy.

And those of you who are not elected tribal officials but will be representing your respective tribe, you need to bring a letter of authorization to speak on behalf of your tribe. At this point, we only have three letters of designation. The excerpt from the tribal consultation policy can be found on page 13 of 22, and it reads, One: Presentation protocol

will ensure that the highest-ranking official from respective tribes is given the opportunity to address the session first, followed by other elected officials.

Those designated by their elected official to represent their respective Indian tribes and representatives of Indian tribal organizations — official letter from the Indian tribe designating a representative must be presented to IGA before the session begins.

In this open session, we will defer to the highest-ranking official from the respective tribes to address the consultation first. And the order in which we will follow is one, tribal president, chairpersons and governor. They will go first. So would you please raise your hand if you are a tribal president, governor —

(Show of hands)

MR. JIM: There is one, two. Chairpersons. Okay, next after those will be the tribal vice president, vice chairpersons and lieutenant governors. Any of those sitting at the table?

(Show of hands)

MR. JIM: Okay, there is one. And then after that, elected or appointed tribal officials, council delegates and so on. Any of those?

(Show of hands)

MR. JIM: One, two, three — okay. And then there are two — are they able to sit at the table? I think we have some room over there. And then finally the designated tribal official. So we have, is it Melanie Fourkiller? Who is that? And then Rick George? Okay, thank you. Michael Cook? Is that what it is? Okay, thank you.

So we will go in that order. And we also want to ensure that every tribal official who would like to express something, that they speak. So that means if you already

spoke, then we will let others speak first. And we are asking that you give a minimum of two minutes. Well, actually, I mean, two minutes. No more than two minutes.

So please get to the point. Don't give a speech. Get to the point. And then we also recommend not only do you identify problems but offer solutions as well because in the process we want to think about those solutions and integrate it into some of the solutions we will offer. And we ask you to do that.

As representatives of tribal nations, we are diplomats so please conduct yourselves accordingly. We would appreciate that. And because of the delay, we are two hours behind, so we are going to try to stick to the time as much as possible. So if you are becoming long-winded, I am going to put a stop to that and say, excuse me, you are over your time.

The other thing that we need to keep in mind is that we are all tribal leaders. We all have problems and situations back home. And we want to speak to that. So don't overdo that. Okay? And thank you. I will go ahead and take the privilege and call you Dr. Payment. He is close. He said in May. He just reminded me that we need to start with a prayer so I will go ahead and do that.

(Prayer)

MR. JIM: So we will go ahead and start with the next tribal leaders who will give the opening remarks as well. Mr. Payment will go first and then Mr. Vigil.

Comments

by Aaron Payment, Chair, Sault Ste. Marie Tribe of Chippewa Indians

and Representative, National Congress of American Indians

MR. PAYMENT: Okay, good morning. On behalf of NCAI, I welcome you all, and thank you for this opportunity to highlight our budget priorities for Indian Country.

NCAI appreciates the Administration's engagement with Indian tribes and listening to our concerns for FY2017 budget. We commend the Administration for honoring the government-to-government relationship between tribes and the United States and the budget formulation process.

The HHS Budget Consultation serves as an important opportunity for tribes to share their priorities with the Department's budget. Tribal leaders and administrators throughout Indian Country seek the same outcomes as any other nation's leaders; to protect the health, safety and prosperity of the communities in which we serve.

NCAI has several policy recommendations that could assist the tribes in meeting the needs of our people. I will just highlight a few. We must continue to care for our elders and those living in poverty. The requested support for the Older Americans Act and LIHEAP is a must.

Our children and youth struggle with often devastating behavioral health issues at higher rates than any other population. Our suicide rate remains at 2.5 times that of the national average. SAMHSA's Tribal Behavioral Health Program must be funded at a level to address this dire need.

Tribal Behavioral Health grants must be used for effective and promising strategies to address the problems of substance abuse, suicide and mental health promotion among our young people. To improve enrollment of our people in the Marketplace, the

Centers for Medicaid and Medicare — I said that wrong — Medicare and Medicaid Services American Indian/Alaska Native's Tribal Technical Advisory Group (TTAG) strategic plan must be fully funded and other TTAG concerns addressed.

Regarding IHS, NCAI supports the National IHS Tribal Budget Formulation Workgroup in their funding recommendations. Lastly, NCAI strongly supports President Obama's proposal to move contract support costs from discretionary to mandatory. We look forward to the discussion today and to hearing from other tribal leaders. (Speaking Native language) and thank you. And I am glad you are back, Rex Lee.

MR. JIM: Thank you. Mr. Vigil?

Comments
by Gil Vigil, National Indian Child Welfare Association
and Governor, Pueblo of Tesuque

MR. VIGIL: (Speaking Native language) Good morning. I too want to welcome all of the tribal leaders who are here this morning on behalf of their respective tribes to provide testimony on their needs.

Thank you, HHS, for conducting, what is this, the 17th Annual Tribal Budget and Policy Consultation hearings? And I too want to echo what Mr. Payment said about the needs of our communities. It is a big need. And we have people back home who are suffering right now.

And we come here to provide testimony and hope that our words will be heard by you as the people here at the federal level to assist us because our needs are great. And so our testimonies are just not words that we are bringing just to talk about, but they are real because our needs are real in our communities.

And so I hope that this session is going to be a fruitful session. And I know there still needs to be improvement in this consultation process. I am still — two minutes for me is not enough time to express all our needs. And to limit tribal leaders to two minutes is also I think not appropriate.

So we need to revisit this process and allow tribal leadership more time to have their testimony to be provided. And with that, thank you for all of you being here, and I hope that this session is going to be a fruitful session. Thank you.

MR. JIM: Thank you. We understand the need to have more time. I have the similar concern. But on the other hand, there are a lot of tribal leaders here. So if you listen to one another, perhaps you don't need to repeat what others are saying but to add on so that way we can express many of the concerns that we have. And we thank you for your understanding.

So next will be the welcome and opening remarks from HHS, Mr. Dioguardi?

Welcome and Opening Remarks from HHS
by Paul Dioguardi, Director, Office of Intergovernmental and External Affairs

MR. DIOGUARDI: Thank you, Vice President Jim, and I will make my remarks brief to allow for more time for hearing from tribal leaders. I just want to do a couple of acknowledgements and announcements.

I appreciate everybody bearing with us with the change in the agenda today. I know most of you come from parts of the country where a couple of inches of snow is nothing and not worth screwing up the whole day but welcome to Washington, DC.

But at least we are here and are able to hold the session, and we look forward to a very fruitful discussion. I wanted to acknowledge the people who are responsible for

pulling today together. It couldn't have been done without them. I think everybody knows Stacey Ecoffey.

(Applause)

MR. DIOGUARDI: She is the leader of our team and certainly the key person for the Department for these consultations every year. But I also want to acknowledge the hard work of her team, Liz and Ashley as well. Liz Carr, those of you who don't know Liz Carr, you should know — there she is back there — Liz Carr is the one who —

(Applause)

MR. DIOGUARDI: — really did all the legwork in putting this session together, been spending a lot of time really over months to make sure that we have a successful session today. I also want to acknowledge the members of our internal group, the Intradepartmental group on — I don't know if we have any members of the ICNAA, as we call it, here today. Intradepartmental — I can never say this right — Council on Native American Affairs.

So if you folks want to stand up and acknowledge yourselves, any members of the ICNAA here today. There we go.

(Applause)

MR. DIOGUARDI: I want you to know that the work and what is said here today goes to the ICNAA for our internal work, and that is how we make sure that we get to next steps and actually follow through on some of the recommendations and comments that are raised during the consultations.

Just as it relates to the agenda, in addition to being compressed a little bit, we did make some changes this year based on your feedback. We are always looking to improve the process, improve the flow of the agenda.

You will see for each session we have listed a couple of tribal leaders who have volunteered to offer some comments up front. That doesn't mean that other leaders are not welcome to provide their commentary under each section. But we thought it would be helpful just to have some folks who are prepared to provide some upfront commentary to sort of set the stage for the discussion.

You will see those folks listed on the program, and so they will be called upon to speak at the beginning of each session. And then we will, of course, have other folks from the federal side who will be here to listen to those remarks and then also staff-level teams will be available to follow up and answer questions.

In addition, the IHS budget formulation team is going to provide a brief update on their budget priorities and solicit feedback from you in case you have not been a part of that process. And this will help them finalize their budget request for the FY17 IHS budget.

And of course Secretary Burwell will be here later today. While she has participated in several Secretary's Tribal Advisory Committee meetings, this will be her first Annual Tribal Budget Consultation, and I know she is very much looking forward to providing some remarks, but more importantly, to hearing from each of you.

So again thank you very much for being here. We look forward to the discussion and I will turn it back over to Vice President Jim, who as we acknowledged earlier, is also the chair of the Secretary's Tribal Advisory Committee. So we are very pleased that he is here today to preside over this conversation.

MR. JIM: Thank you. We are going to the tribal leaders introductions now. Just please provide your name, title and whom you represent. And we will just go around the table.

(Tribal introductions)

MR. JIM: Thank you. Back on time. Thank you. We are going to — I will be the tribal moderator. And along with me federal moderator will be Dr. Roubideaux. So I will go ahead and have her start it off. Dr. Roubideaux?

DR. ROUBIDEAUX: Well, thank you and good morning, everybody. I am Dr. Yvette Roubideaux. I am senior advisor to the Secretary for American Indians and Alaska Natives. Really great to see you all today.

So it looks like on the agenda next is the HHS budget overview and update. And we will see if Norris Cochran is here yet?

DR. ROUBIDEAUX: So we have Kevin Bumatay, director for the Division of Budget Policy Execution and Review. And Jillian Curtis, branch chief of the Public Health and Social Services Branch. Thank you for being here today.

MR. BUMATAY: Thank you so much.

HHS Budget Overview and Update

by Kevin Bumatay, Director, Division of Budget Policy, Execution and Review

MR. BUMATAY: Good morning. Thank you for having me. I am really honored to be here. I am accompanied by Jillian Curtis, who is our branch chief who oversees the discretionary human services budget as well as Elizabeth Fisher Laurie who is the analyst who oversees the same for IHS.

Norris Cochran, the HHS budget director, sends his sincere regrets for not being able to attend. Every year he makes it a priority to be at these meetings. Unfortunately the Secretary is having an energy and commerce hearing on the Hill, which he had to attend.

So I would like to just provide you with a brief overview of the FY15 omnibus bill, budget bill, as a reference point and then we can talk about the 2016 President's budget.

I will then turn it over to Jillian who can provide more details on the tribal aspects of the FY16 budget.

So last December, Congress passed an omnibus bill, budget bill, funding most of the government through the end of the fiscal year. The bill provided just shy of $79 billion in discretionary funding for HHS, which is about $800 million above the FY14 enacted level.

I used the term most of the government in my last statement because the Department of Homeland Security was not funded and instead they are operating currently under a continuing resolution. Within the FY15 bill, Congress funded IHS at $4.6 billion in discretionary funds. This is an increase of $208 million over fiscal year 2014.

The increases were provided primarily for staffing and operating costs at new and replacement health facilities, contract support costs, and the Purchased and Referred Care program. The increase for IHS demonstrates Congress' continued commitment to the tribal community.

In FY16, the President's budget was released in early February. The HHS request included $678 million in additional funding for Indian Country, the bulk of that being within the IHS budget. The budget also proposes replacing the discretionary and mandatory sequester by offering up reasonable spending cuts, program integrity measures, and closing other tax loopholes.

The FY16 budget proposes $6.4 billion for IHS. That is an 8 percent increase above the FY15 level. And it is also above the overall increase for HHS of 6 percent. Further this amount represents an increase of 49 percent over the FY2008 funding level for IHS.

Hearings on the FY16 budget are currently under way, and thus far the appropriations process has been very positive. We had a very good hearing with the House

Interior on IHS, where Dr. Roubideaux testified. The hearing was encouraging for several reasons.

First of all, the chairman and members expressed clear support for the work that you do on behalf of the tribes and for improving the health of the tribes. The subcommittee also expressed clear support for Dr. Roubideaux as the leader of IHS.

Even as the request proposes to remove contract support costs from their jurisdiction, from the Appropriations Subcommittee's jurisdiction because we are proposing to move it from discretionary to mandatory beginning in 2017, they still express support for that proposal. So that is a positive indication.

While encouraging, some members did express concerns that their ultimate subcommittee funding allocations might not be sufficient to fund the full request. However, they did express appreciation for the robustness of the proposals we identified.

The Senate hearing is scheduled for March 11. That is the Interior. And we hope to hear similar statements of support. There are a few unknowns that we should be mindful of as we proceed in the FY16 appropriations process, particularly as it relates to the fiscal climate and various budget procedures on the Hill.

First of all, we don't know how the budget resolution between the House and Senate will play out and what kind of allocations each subcommittee will get. We also don't know how budget reconciliation, a procedure that has been used in the past to expedite the passage of tax and mandatory spending proposals, will play a role.

We are hopeful in particular that the contract support costs proposal — again, to move it from discretionary to mandatory, is successful. And we think we have positioned ourselves well in that the Secretary has made it clear that our budget proposal more than pays for that policy through Medicare and other mandatory savings.

And it is critical that we work with Congress to really secure this long-term solution for the tribes. And finally we don't know the timing for getting an appropriations bill. As with every year, it is always — it seems to always get delayed.

The chairs of both the House Interior and the Labor H Interior subcommittees have expressed strong interest in tribal matters. In addition to that, they are very experienced members of Congress and clearly understand the process. And they are very professional and their staff is very engaged on the substance of tribal issues.

I think these are all very positive indications of what is to come in terms of FY2016. With that, I am going to turn it over to Jillian, who will get into more of the details.

Comments

by Jillian Curtis, Branch Chief, Public Health and Social Services Branch

MS. CURTIS: Good morning, everyone. Thank you very much for having me. I am honored to be here and to hear from all of you today.

I am going to share some specific information about the 2016 budget request for IHS, SAMHSA and ACF. And I will start by addressing IHS' FY16 President's budget. So within IHS, the budget increases significantly, and those increases include an additional $147 million for current services to fully fund medical inflation, pay raises for medical providers and to partially fund population growth across Indian Country.

An additional $70 million for the Purchased and Referred Care program, which is a 70 percent increase over fiscal year 2008. It also includes $18 million for staffing and operating costs at two newly constructed health care facilities and one youth regional treatment center.

An additional $10 million to help improve the ability of IHS, tribal and urban facilities to collect funds from third party payers. As well as $10 million to enhance the Resource Patient and Management System, electronic health records, to comply with Meaningful Use Stage 3.

In addition, an additional $35 million is provided for maintenance and improvement to address the critical maintenance backlog at IHS facilities, tribal facilities and urban facilities. An additional $35 million for sanitation facilities construction across Indian Country. And an additional $100 million to construct additional facilities from the health care facilities construction priority list in 2016.

In the mental health and substance abuse space, the budget requests an additional $50 million for a tribal behavioral health initiative for Native youth, which is part of the governmentwide Generation Indigenous Initiative, which also includes investments in DOJ, the Department of Education and the Department of Housing and Urban Development. And this is designed to address barriers to success for Native youth.

Within that $50 million, IHS will use $25 million in new funding to expand the successful Methamphetamine and Suicide Prevention Initiative, which will increase the number of child and adolescent behavioral health professionals who provide direct services, and to implement youth-based programming at IHS tribal and urban Indian health programs, school-based health centers or youth-based program.

And SAMHSA will collaborate with IHS, building off of this provider network with $25 million in new funding to develop community or system-level infrastructure and service linkages, providing support for suicide and substance abuse prevention activities for youth.

The budget also requests reauthorization of the Special Diabetes Program for Indians for three years, and it includes an additional $55 million for contract support costs, with the goal to fully fund the estimated need for new and expanded contracts and compacts.

And also, as Kevin has already mentioned, proposes reclassifying contract support costs as mandatory in FY2017, proposing significant out-year funding growth to accommodate increased anticipated need.

Shifting gears a little bit, I will share a few key budget items within the Administration for Children and Families that will impact Indian Country in FY2016. The budget overall requests an additional $156 million for a number of programs impacting American Indians and Alaska Natives.

The budget requests an increase $1.5 billion in total for the Head Start program. This includes over $1 billion in increased funding to ensure that all children served by Head Start, including in tribal Head Start programs, receive services for a full day and a full school year.

The FY2016 President's budget also includes an increase of $80 million for a total of $199 million in child care funding for tribes. It supports a $20 million increase for tribal child welfare under the Promoting Safe and Stable Families Program to enable tribes to build the capacity they need to fully exercise their tribal sovereignty and fulfill the intent of the Indian Child Welfare Act, further building their child welfare programs in capacity.

Additionally the request includes an increase of $35 million for tribal title IV-E programs to allow tribes, tribal organizations or consortia that are approved to operate title IV-E foster care programs to apply for start-up funding to assist with the implementation of program requirements.

And finally within ACF, the budget includes an additional $3 million to improve Native American language instruction across the educational continuum.

Tribal programs remain a top priority for the Administration, as evidenced by the increases provided in the FY2016 President's budget. And recommendations from tribal leaders provided at the annual tribal budget consultation, like today, and other such events over the course of the fiscal year will be critical as we develop the FY2017 budget.

We are happy to answer any questions that you have and to hear your input today. Thank you again for having us.

MR. JIM: Thank you. Mr. Hayes, if you join us at the table, there is a name plate for you by Mr. Payment. So we have about 20 minutes for questions and constructive comments. We will open the floor to the presidents, chairmen and governors. Anyone? Mr. Payment?

MR. PAYMENT: I will go.

MR. JIM: Go ahead.

Questions and Answers

MR. PAYMENT: So I did this the first time I came here. I did my presentation and I forgot a few things so I presented again later. I am not sure when we are supposed to present when the Secretary is coming later but what I will say is on behalf of the Contract Support Cost Workgroup, we worked really hard for the last —.

Before the Congress voted to mandate the consultation, and we worked as a tribal-federal partnership to identify solutions, and one of the things we did was we came up with, labored through and came up with a calculator to make contract support costs very predictable.

One of our drivers was to be predictable but to also allow for flexibility so that tribes could make sure all these exclusions and the buy-ins later, that they get fully what they are eligible for.

So the big part though was to make it predictable, and that is what the calculator does. And we are very proud of that. That was born out of an area director who does that as a normal course along with some very smart people in our technical workgroup who helped us to put together that calculator.

It is automated, it is predictable. The other day at NCAI, we had a tribal leader who was a little skeptical about it, but we went through it. We put it up on the wall, and by the end of that session he was very confident and actually spoke on behalf of it by the end of the day.

So the only thing I would say for this is that I support immediate implementation because we spent a whole year in consultation. And we are giving the Congress what they want. And I am very proud of the President for stepping up and making one of our trust obligations truly mandatory. I think it is a first step in that direction. And so I am grateful for that.

I am grateful for the tribal and federal partnership and the problem solving that I was a part of. And I am very proud of that. Thank you.

MR. JOSEPH: Aaron is right on the Contract Support Cost Workgroup. I chair that, and I would say that it was kind of a bumpy start when we first got started. You know, one of the issues that we deal with is dealing with the FACA compliance and the workgroups that form.

I know, you know, as a tribal leader, we are not all experts in every line of government authority. We have to be education. We have to be law and justice. We have to

be health. We have to be natural resources. And we hire technical experts who know the language that is being produced and it just seems like — when we ask our technical workgroup to help us with the work, we had to interrupt some of those meetings and stuff.

But the end product that Aaron was talking about is really a good product. I really commend the Administration for their technical people who actually helped build that program. So they got to do some input.

And then our technical people and our advisory committee, we all pretty much liked that system but there is one thing that is in the formula that our whole technical workgroup was unanimous in, and that is in the formula of using the medical inflation rate.

I mean, the IHS does medical work. It is not doing anything really else. My tribe, we contract our mental health programs, and our mental health providers save the lives of our people just like a surgeon would, and it is a medical necessity to send them to treatment or do whatever they have to do to heal our people, and it is saving lives.

I really want the Administration to remember that medical part needs to be a part of the formula so that we are not kind of taking back steps. It just seems like every time we brought it up, it was kind of pushed to the side, and to me I think we need to make sure the medical inflation rate is in the formula. That is all. Thank you.

MR. JIM: Thank you, Mr. Joseph. Ms. Crotty and then Mr. Antone and then Mr. Shippentower.

MR. SHIPPENTOWER: Thank you, Mr. Chairman. Bob Shippentower, the Umatilla Confederated Tribes. I am on the tribal council and the health commission also. I have a question about the contract support claims. We had our experts, you know, work on it for some time, and we did put in a claim for about $5 million, which we felt was fair and appropriate.

Yet when it was presented to us, it was reduced down to about $3.1 million. And we were just wondering what were the factors involved for that reduction that we did accept, and we appreciate that amount, but we just kind of were wondering what was used to reduce it from our original claim costs?

MR. JIM: We will go ahead and —

DR. ROUBIDEAUX: In general we can't talk about litigation for your specific situation but we would be happy to talk with you about that offline. And I don't have your numbers in front of me. I think in general, what has occurred with contract support costs claims is trying to find a place where the tribal and federal sides can find a number that they can live with.

And the reason is in the past, there was variation in how people calculated contract support costs. The good thing about this tool that was developed by the federal-tribal workgroup is it will make it consistent among all of the areas. And so the goal in the past claims is to find a number to settle those and put them in the past. And moving forward, the work of the CSC Workgroup will make sure everybody is on a level playing field and everybody gets their fair share.

So we appreciate the ability to settle those claims, and we have been able to settle over 60 percent of them. We have actually settled $679 million overall. And we are almost done, so we really appreciate your willingness to settle.

But I think there was an issue. Contract support costs are so complicated, and so the good thing is that we have this tool now that can make it fair moving forward. And make it consistent among all the areas. So thanks for the question. And if you want to talk about your specific situation, we can have staff work with you on that.

MR. SHIPPENTOWER: Thank you.

MR. JIM: Ms. Crotty?

MS. CROTTY: (Speaking Native language) I would like to give some feedback. The Navajo Nation continues to advocate to receive direct funding from the Department, DHHS, to expedite the implementation of funds rather than establishing a contract with the state.

It is very important to our nation that we receive direct funding to assist the Navajo Nation to exercise our tribal sovereignty and to address our maybe unique status as a multi-state jurisdiction. For example, the Public Health Emergency Preparedness has had to coordinate a tri-state emergency response.

However, we would be able to address emergencies without these particular restrictions. In addition, I would like to thank the Administration for the support in the funding for our child welfare systems, and also for the increase in all of the ICWA program. We certainly appreciate it.

MR. JIM: Thank you. Mr. Antone?

MR. ANTONE: Under the ACF, the increases, it did not include the Community Services Block Grant Rural Community Development Funding program, CSBG-RF. That is concerning being that it is a basic necessity, clean water, and this program really certifies tribal water workers at different levels, Class 1, Class 2, Class 3, and that is for the operation of water systems.

And those are usually built by Indian Health Service. I would request that we take a look at that again. The other issue, of course, the support of contract support costs being mandatory. That is the optimal result that we would want.

The other thing that I want to relay here is flexibility. Flexibility within the budget, within the authorities of the directors who run these agencies. How far do they

extend over the budget and how far do they extend over the waivers of certain regulations? And that is really key for all agencies, and all agencies should be flexible.

Yesterday I presented the mental health agenda, which I had spoken of in December, and flexibility is required for that within the different agencies to be flexible enough to come together for one cause. And Chairman, that is all I have to say this morning.

MR. BATT: Thank you, Mr. Chairman. I didn't want to take too much time. I kind of ditto what your representative from Navajo Nation said. But also I wanted to add, tribes, we have seen a lot of funding move toward grants, which we kind of don't like for our funding. We would rather have it direct to the tribes. And it is frustrating that we are seeing a lot of competitive grants, when we have to compete with other agencies or other states, which is not very effective for us. So I just want to make those remarks. Thank you.

MR. JIM: Anyone else at the table? Mr. George?

MR. GEORGE: Thank you. I just wanted to say thank you for the support for tribes. I wanted to especially say thank you for increase in the Purchased and Referred Care costs, and the Northwest Portland Area region, where we have no IHS hospitals, we have — for instance, the Grand Ronde Tribe runs about a $4 million deficit to make up for that on an annual basis. So I just want to say thank you.

MR. JIM: Thank you. Any other remarks? Mr. Hayes?

MR. HAYES: Good morning, everybody. Thank you.

As we move forward, and we really appreciate the Administration, what they have done for Indian Country as far as increasing health care for — with this Administration, as we move forward and we think about the tribal budget, and we probably look at this early with the Tribal Budget Formulation Workgroup, but this has to be brought up as far as we look at the 53 percent increase that this Administration has done for IHS.

It is incredible, but as Andy Joseph mentioned about the inflation of medical costs, which averages between 8 and 10, if you take that and times it by the number of years this Administration has provided those increases, then overall it is probably between a 2 or 4 percent increase overall for our programs in health care improvements.

That was one of the key concerns that we have had, that we cannot include in the medical inflation costs for these services. So when we testify, those who testify, tribal leaders and federal officials, be mindful of that because in the climate that we are in, it is important as we mention these increases.

Some of the Congressmen or Senators may think, well, you guys are getting enough money, which is totally not true and is unacceptable because of the conditions in our communities regarding to health care services.

We know that is not true, that we still have to put that big target up there, which is around about $29 billion that is needed to improve, just to have partial parity with the general population in health care services in our community. Thank you.

MR. JIM: Thank you. Any response from the federal side? If not, thank you. We are interested in direct funding. We are interested in increases in funding simply because of inflation and other increases in costs. We think we are getting an increase but it is very little when it comes down to it.

Again, thank you. And I would also like to remind you that in your packages, there is an evaluation form. Please do them at the end of the day but think about it as we go along. So we will go ahead and start with the next — we will let you get back to work and find us more funding. Thank you.

Next will be the human services budget priorities. The purpose is in your handout, so please read that. The federal leadership update has two minutes, Mark Greenberg and Pam Hyde, Susan Karol. Is that how you say it?

You have two minutes to update and then we will have tribal leader testimony after that. So go ahead. Mr. Greenberg. Anyone representing Mr. Greenberg? Well, while they are doing that, let's have Ms. Hyde. Ms. Beadle.

Human Services Budget Priorities

by Mirtha Beadle, Director, Office of Tribal Affairs and Policy

Office of Policy, Planning and Innovation

Substance Abuse and Mental Health Services Administration

MS BEADLE: Thank you very much, Mr. Chairman. Ms. Hyde is on her way, but while she is on her way, I will go ahead and begin her remarks.

First, thank you all very much for the opportunity to be here with you today. SAMHSA is truly committed to addressing behavioral health for American Indians and Alaska Natives, and it is an honor for us to be here.

I want to talk quickly about some of the things that SAMHSA has been engaged in for the past year. Some of you who are on the Secretary's Tribal Advisory Committee do have this information but we believe it is important for all tribal leaders and representatives to know the kind of work we have been doing with you to try to help in your communities.

SAMHSA has been part of an effort throughout the Department of Health and Human Services to address improving access to our funds by tribal communities. And over the past year we have made tremendous strides. SAMHSA's grant portfolio increased by 50

percent between fiscal year 2013 and 2014. That means that there was a $27 million just in SAMHSA grants to tribal communities.

That also means we increased the number of grants, individual grants, to tribes as well. There was almost up to $100 million across all of the SAMHSA tribal-specific programs. We do have quite a few programs that tribes have been able to access funding from. For those of you who want a list, we do have a list available of all of our programs.

We believe that we have done, I think, a better job at trying to support your behavioral health needs. About a year and a half ago, the administrator, Pamela Hyde, established what is called the SAMHSA American Indian/Alaska Native Team, and this has really been a very important part of SAMHSA's efforts to try to bring together work that supports the issues that you have asked us to address.

For example, one of the things that we have done is we have streamlined SAMHSA's grant program for tribes. We have heard very loud and clear that we don't have enough time with our grants so that you don't have enough time to apply. So we have streamlined our grant program so that there is, for example, more time. The specific requirements for applying are simpler and we are working on a couple of other things to help with that process as well.

We have recently established what we are calling a communications strategy for working and sharing information with tribal communities. We received a lot of feedback from the SAMHSA Tribal Technical Advisory Committee around the way that we communicate with tribal governments.

And so we have developed a strategy with their guidance on how we are going to improve on sharing information about the work that we are doing at SAMHSA.

We have also tried to ensure that our discretionary programs are really including tribes in the way that they develop their competitions and also awards. And as you heard just a few minutes ago, we have increased our awards to tribes substantially.

For those of you who don't know, we do have a Tribal Technical Advisory Center. They provide specific support for any type of behavioral health need that you have. Any consultations, so we encourage you to seek SAMHSA support through the Tribal TA Center.

And we also have a Native American Addiction Technology Transfer Center that does provide support on workforce issues, so if you have workforce-related questions, need technical assistance, this particular TA center can help with that. And on Friday this TA center is having — tomorrow actually this TA center is having a session on historical trauma.

We believe that this is a critical area for us to begin to work more closely with you on in addressing some of the needs that we are seeing in Indian Country. So for those of you who can make it, it is in Arizona and it is tomorrow.

Administrator Hyde also established the office that I lead, which is called the Office of Tribal Affairs and Policy. This is really an effort to establish a point of contact within SAMHSA around American Indian/Alaska Native issues.

In the past, if there was a question, if there was support that was needed by tribes, you had to go to very different sources. Now you can come to what is called OTAP. Every single component of government has an acronym, and so OTAP is the place that we would like for you to come to, to ask questions, get support, address your needs.

And I should just say very briefly that in November, SAMHSA held its first all-tribal grantee meeting. It was a cross-agency meeting where we had about 240 people

attend. What was really critical about this particular conference was that it was focused on behavioral health issues for Native American youth.

And we actually had about 100, over 100 youth who participated. They were phenomenal. We gave them an opportunity to tell us what they thought their needs were, and they were right there and they told us their needs. We will be coming out with a report on that conference and the kinds of issues that they would like to be able to have all of us — tribal leaders, government officials, and other programs work together on to help them in their future.

As has already been said by the folks who talked about the budget, the FY16 budget is very positive for tribal communities. You heard about the Tribal Behavioral Health initiative. From that initiative, SAMHSA's request includes an increase of $25 million to address the needs of Native American youth. And so we are really pleased about that.

It specifically responds to your request for additional funds to address those issues. I have gone over my two minutes. I am trying to be respectful so thank you for your time. And Administrator Hyde is here with you as well.

MR. JIM: Thank you. Mr. Greenberg? In two minutes, highlight the —

Comments

by Mark Greenberg, Acting Assistant Secretary, Administration for Children and Families

MR. GREENBERG: Thanks very much. I am pleased to be here. I am Mark Greenberg. I am acting assistant secretary at the Administration for Children and Families, and a number of my ACF colleagues are here with me today.

We appreciate being able to be here to talk and to hear testimony and to listen to tribal leaders in today's conversation. I want to start with just a few words about ACF's grants generally. And then I will mainly focus on our budget proposals for fiscal 2016.

As I think you all know, ACF has the responsibility for a wide range of programs principally affecting low-income children, families and communities. In 2014, we awarded nearly $50 billion in total across all our grants, and of that amount, $729 million went to tribes.

Tribes were eligible to receive funding in a number of programs in Head Start; child care; child welfare; low income; energy assistance; the Community Services Block Grant; Tribal TANF; the Tribal PREP program; family violence; the Tribal Maternal and Child Home Visiting Program; ANA funding for social and economic development and language immersion, preservation and maintenance; and environmental and regulatory grants.

Some of our grants are formula grants; some are discretionary grants. We are currently involved in a very active process of looking at ways to improve tribal access to discretionary grants that are potentially available to tribes.

We are exploring ways to increase outreach efforts to recruit more Native American grant reviewers, to encourage the use of standing funding announcements. We have started to collect data to expand on the grants matrix that had been created by the Intradepartmental Council on Native American Affairs to include 2011 to '14 award data.

The grants matrix allows tribal communities to easily identify all the HHS funding that tribes and tribal entities are eligible for. As you know, most of ACF's funding goes directly to states in formula grants. Those services typically provided by the states. That makes partnerships between states and tribes crucial in relation to those grants.

We want to be supportive of your efforts in those relationships. We encourage you to reach out to us when you feel that ACF programs and services aren't reaching your communities in the ways that you feel that they should be.

So let me turn to our fiscal 2016 budget. First thing to note is to say we are very proud that in fiscal '16, the budget for ANA, the proposed budget for ANA, is $50 million. It is the largest budget request in ANA's history.

That includes an additional $3 million that we are proposing this year in funding to improve Native American language instruction across the educational continuum.

Second the budget includes funding to allow tribes and tribal organizations and consortia to operate title IV-E programs, to be able to apply for start-up funding to assist with the early implementation of IV-E programs. The budget also includes a $20 million increase for tribal child welfare under the Promoting Safe and Stable Families Program.

And then in the early childhood area, we want to flag that the budget is making a couple of proposals that would have significant positive impacts for tribes and others. A proposal that there be a guarantee of child care to all low-income working families with young children, with a strong focus on high-quality care and proposes funding to make Head Start programs full school day, full school year.

Two last things just quickly to flag. I want to note to you all that Congress has asked us to submit a report to Congress about the future directions and effectiveness of the child support program. As part of legislation that passed last year, the Preventing Sex Trafficking and Strengthening Families Act.

We would like your input and advice about what to say to Congress in that report. Our Office of Child Support has sent out a consultation letter in reference to it. We

greatly encourage your comments and your advice to us on ways to improve the child support program.

And then the last thing to note is that the next ACF Annual Tribal Consultation session will be occurring May 21 here in DC. We will be sharing logistics and details about it in the next few weeks but we ask that you save the date if you plan to participate. Thanks very much.

MR. JIM: Thank you. Ms. Karol?

Comments

by Dr. Susan Karol, Chief Medical Officer, Indian Health Service

MS. KAROL: Thank you. Thank you, Rex Lee. Good morning, everyone. I am Dr. Susan Karol, the chief medical officer for the Indian Health Service. It is my honor to be here today to talk with you about the behavioral health IHS budget.

It is my pleasure to tell you that the 2016 Presidential Budget does have increases, and the behavioral health component of that hopefully will see some improvements. There was a budget formulation work session recently for 2017, and we did note that the majority of the tribes spoke very significantly about behavioral health services as one of their top priorities.

And I have to agree with that 100 percent. Over and over again, as I do my position, I see that as a significant area where we need improvement. The behavioral health division serves to help with national advocacy, policy development, management of behavioral health programs, which is done in partnership with tribes, tribal organizations and the urban Indian health organizations.

Our priorities are to provide the highest-quality care with services through the alcohol and substance abuse programs, and of note, that is the MSPI or Methamphetamine and Suicide Prevention Initiative.

We have 10 regional youth treatment centers that we are working with, and the Domestic Violence Prevention Initiative is also an important program that we are presently working on. I look forward to hearing your comments to help us with the work that we need to accomplish this year. And it is an opportunity for me to listen directly. So thank you.

MR. JIM: Thank you very much. Next we will go to the tribal leader testimony. Again, two minutes and then submit your written comments as well. And then after your comments we will allow the federal representatives to respond. And then we will also open up the floor to the others as well.

So we will go ahead and get started with Mr. Vigil. And then after him will be Ms. Morillo and then Ms. Fourkiller, Mr. Brown and Mr. Joseph. Mr. Vigil?

Tribal Leader Testimony

by Gil Vigil, Governor, Pueblo of Tesuque

MR. VIGIL: Thank you, Mr. Vice President Jim. I will try and be brief and be within two minutes but I do have a 100-page testimony here I am going to read. No, I am just kidding.

Again, thank you. Good morning. My name is Gil Vigil, and I am from the Pueblo of Tesuque. And today my testimony is on behalf of the National Indian Child Welfare Association. Thank you for the opportunity to share our 2017 child welfare and children's mental health budget recommendation.

The President's fiscal year 2016 budget put forward several initiatives that recognize our Native children are strengthened by their communities, families and culture. If these proposals are funded by Congress, they will empower tribal self-determination and improve outcomes for our children and families.

Based on this important work, I want to highlight NICWA's 2017 recommendation. The President's 2016 budget recognizes the need to increase support for tribal child welfare programs. This includes a $20 million increase to promoting the Safe and Stable Families Program for tribal child welfare capacity building. NICWA recommends that this initiative be funded and continued in 2017.

The President's 2016 budget includes an additional $27 million to the payments for adoption and permanency program that will allow tribes to have approved title IV-E plans to access start-up funding. In addition, HHS recommends time limited, enhanced federal financial participation for program administration and a temporary waiver of cost allocation requirements for title IV-E tribes.

Many of you may remember that states received these benefits during the recession. NICWA recommends that the President's request be funded, the policy adjustment be made, and these be continued in 2017.

As part of the Gen I Initiative, the President's 2016 budget expands the new behavioral health treatment prevention grants to $50 million, 50 million new dollars in the substance abuse appropriations for a total of $30 million. This additional funding is still not enough to provide the programs with enough support to make it available to all the tribes.

To make the grant more widely available, NICWA recommends that the program be funded at $50 million total. We appreciate the 2016 budget and the important

policy changes recently made by ACF. We are still concerned with the processes some of these agencies are using to engage and educate tribes about policy changes.

Tribal consultation and engagement requires a close working relationship with frequent dialogue that happens before policy decisions are made. This is not happening uniformly with ACF. We strongly recommend that each ACF agency work, closely examine its processes, and with input from tribes, establish more effective consultation engagement strategies.

Again thank you for allowing us to make our presentation. And also, I am an advocate for Head Start, and I have some people from behind me, they are asking if I am going to ask some hard questions. But I am not. I am just going to make a statement in that — this is how I talk about Head Start. Head Start works.

The problem is when Head Start works, our people go through the educational process, and now they are professional people. Yet now their children are not eligible for Head Start because they are over income. We need to change the philosophy and concept of Head Start.

I think it should be more of early child development program, and that it be funded that way so that it allows tribes to have those educational programs we talk about — cultural, traditional — at an early age, which Head Start does afford that opportunity.

But we are not in a poverty area. Many tribes have progressed, and they have programs that I think are ready to move forward. So in order for them to develop these kinds of programs, we need to make some changes in Head Start regulations and standards.

While I agree those are necessary to be accountable, I think changes need to be made to accommodate tribes in their efforts in developing child care programs. Thank you.

MR. JIM: Thank you very much for those last remarks. I appreciate that. Ms. Morillo? Go ahead.

MS. MORILLO: I am going to speak on behavioral health. The federal government, in meeting its treaty and trust obligations, plays a key role in Indian Country. If the federal government shrinks away from its commitments, the ensuing shortfalls lead to great impacts to the harmony of tribal communities.

But when the federal government honors its commitments based on the trust responsibility, while promoting tribal self-determination, Native people and leaders can solve longstanding social, economic dilemmas. Many tribes recognize historical trauma as the root of disproportionate rates of depression, suicide and reoccurring trauma from domestic violence and sexual assault.

Historical trauma is the result of historical policies of genocide — boarding schools, relocation and child welfare practices.

These experiences and subsequent loss of traditional kinship, systems, traditional language, spiritual practices and culture values impact the core of self-worth and identify and has left a legacy of familial and community grief and a cycle of economic conditions that continue to contribute to extraordinary mental health needs.

The issue illustrates the impact of unmet treaty and trust obligations in Indian Country as well as the rippling effects of shortfalls in one area on others.

Unaddressed behavioral health problems in tribal communities lead to decreased productivity in the workplace, loss of earnings, early termination of schooling,

which leads to lifelong reductions in economic and social functioning, as well as poor health associated with low-incomes status.

Behavioral health covers just one aspect of how important fulfilling the federal trust responsibility is to overall wellness and balance in Indian Country. Native children in communities grapple with complex behavioral health issues at higher rates than any other population.

Historically destructive federal-Indian policies and unresponsive or harmful human service systems have left American Indians/Alaska Native communities with unresolved historical and generational trauma. The most assured way to transform these broken systems is to support tribal children's mental and behavioral health programs with funding that reflects the need.

Funding must also count for the understanding that effective mental and behavioral health care requires the entire tribal system dedicated to treatment. NCAI appreciates increases proposed to SAMHSA to address behavioral health in FY2016.

NCAI recommends that tribal behavioral health funding for the FY2017 be increased to $50 million to help to meet the tremendous need in Indian Country. Thank you.

MR. JIM: Thank you. Ms. Fourkiller, and then Mr. Brown, get ready.

MS FOURKILLER: Thank you, Mr. Vice President. Melanie Fourkiller. I am here this morning representing Chief Lynn Malerba, who is chairwoman of the Tribal Self-Governance Advisory Committee. And we have submitted our written testimony for the record. I will just summarize it here.

First of all, just a bit about self-governance. Self-governance is certainly a tribal option that has been in place now for several years, and tribes are choosing it with greater frequency. Over 62 percent now of tribes have chosen the option to go into self-governance

to manage their Indian Health Service programs, and that represents $1.8 billion of the IHS budget at this point in time. So it has been a highly successful federal policy.

Each year Self-Governance Tribes convene, and we develop a strategic plan, and from that strategic plan come our highest priorities for the budget as well as for legislation during the year. And I would like to share those with you today.

First of all, the top budget priority for Self-Governance Tribes, is maintaining current IHS services. We all know that population growth, inflation and other costs that are fixed degrade our budget, and so unless current services are addressed, that budget erodes over time.

We have experienced increases in the last four years of 17 percent of the Indian Health Service budget. Unfortunately population growth and inflation also represent in 17 percent of our budget so even though we have experienced some increases, we have got some way to go.

Secondly, the tribes continue to remind us to protect the budget from sequestration. The experience we had in 2013 was a set-back that Indian health did not need to experience, and so that remains high on our priorities to continue to protect the budget from sequestration.

Thirdly, Self-Governance Tribes have enthusiastically supported the President's request to make contract support costs a mandatory appropriation within the Indian Health Service budget.

What we experienced in 2014 would require the agency to reprogram from the services appropriation to make contract support costs available, and we felt that was unacceptable, and transferring that to a mandatory appropriation would address that.

Finally, in our budget priorities, the tribes have highly recommended to fully fund the authorities in the Indian Health Care Improvement Act as well as continuing to fund implementation of the Affordable Care Act.

Outreach and education continues to be an issue that needs to be addressed in Indian Country as well as funding those authorities that have not yet been funded like for long-term care services and supports, behavioral health facilities and all kinds of additional authorities that are not funded in the Indian Health Service budget.

So that brings me to legislative priorities. We continue to support expansion of the self-governance initiative within the Health and Human Services outside of the Indian Health Service. A feasibility report was done that determined that was feasible. Tribes have worked with the agency to identify any barriers that need to be overcome to make that a reality, and we continue to support work to advance that initiative.

Next we continue to support Medicare-like rates for non-hospital based services for contract health services, now called Purchased and Referred Care. We continue to advance the idea that legislation would make enforcement easier for Medicare-like rates and that we continue to support that.

Next, Self-Governance Tribes have unanimously supported advanced appropriations for the Indian Health Service. Like VA, IHS should be similarly treated to make sure that we are not subject to any CRs that come along, any federal government shutdowns that come along that disrupt our health care services. So advanced appropriations would deal with that.

Finally, on legislative priorities is continue to support SDPI reauthorization. We have had to reauthorize SDPI annually, which means we have to make a considerable effort to do that. It should become a permanent authority, and tribes, we join other tribes in

continuing to support for a $200 million appropriation for a five-year term or at best permanent authority for that. So with that, Mr. Vice President, thank you.

MR. JIM: Thank you. Mr. Brown, and then Mr. Joseph, get ready.

MR. BROWN: (Speaking Native language) Okay, I will be talking on the behavioral health budget priorities. First, the Navajo people with co-occurring disorders are over four times the national average. The Navajo Nation requests Substance Abuse and Mental Health Service Administration, Indian Health Service and other federal agents to provide adequate staff training in treating co-occurring disorders that impact an extra burden in costs.

Secondly, the Methamphetamine and the Suicide Prevention Initiative, the MSPI, is a critical initiative Congressionally funded in response to public health needs. It is important to maintain or increase this level of funding.

We recommend there be interagency discussion and coordination among CDC, SAMHSA and IHS to set priorities for the budget. For example, on the health concern of alcohol abuse and misuse.

MR. JIM: Thank you. Mr. Joseph?

MR. JOSEPH: (Speaking Native language) Badger is my name. Good afternoon. I am pleased to provide this testimony for the Substance Abuse and Mental Health Services Administration and to provide recommendations regarding the needs of Indian Country.

First, I would like to commend SAMHSA for their work with tribes. We are grateful for the commitment to address the needs of tribal communities through the tribal behavioral health grants. We are also excited to see the agency's commitment to increase the behavioral health workforce.

Indian Country has a shortage of health care providers at all levels. Behavioral health care providers are no exception. We hope to see the same development in Indian Country, including funding for tribal colleges to participate in the Peer Professional Workforce Development program.

I also have several recommendations for consideration. Collaborate with other federal agencies to create a mental health agenda for American Indians and Alaska Natives. The health disparities in the communities are large, especially pertaining to mental health and substance abuse.

Please collaborate with other federal agencies and tribes to develop an agenda outlining specific mental health issues and strategies for turning the issues into winnable battles.

Create a white paper on historical trauma. We are interested in understanding how forced relocations and cultural assimilation have affected the mental health and well-being of American Indians and Alaska Natives. Please devote resources to research historical trauma and create a formal report.

Increase funding for Fetal Alcohol Syndrome Disorders. The rates of FASD in American Indian and Alaska Native communities are disproportionately high. Please make FASD a priority issue by investing in more current, usable data and providing direct funding to tribes for programs.

Continue to Access to Recovery program. Proposed elimination of the ATR program takes away vital funding for tribes to provide services related to recovery support. The program allows tribes the opportunity to assist clients with services including transportation, housing and job support.

Fund tribes directly with grants or offered through states. Tribes miss out on valuable opportunities. For example the proposed increase to grants to prevent prescription drugs and opiate overdose related deaths would make funds available to states but not tribes.

The best way to ensure tribes receive funding is to provide it directly to them. SAMHSA has made great strides in its work with Indian Country. We look forward to a future collaboration that will improve the livelihood of our people. Thank you.

MR. JIM: Thank you. So what we are going to do now is open it to the rest of the tribal leaders here. In addition to Mr. Greenberg, Ms. Hyde and Ms. Karol, we have other federal representatives here who will be responding to your questions. Ms. Robinson? Please raise your hand when I call your name. And if I mispronounce it, it is because of a Navajo accent. Ms. Robinson? Ms. LaCounte? Way back there hiding.

Ms. Beadle? Ms. Cooper? Way at the end back there. Mr. —. Back there. Mr. Balk. Could you come up front? They may have a question for you. Mr. Bentley? Not here. Ms. Shoemaker? She is on that side. Ms. Shaffin? She is not here. Ms. Tourestski? She is over there.

Ms. Pattel? She is on the side. And Ms. Linehan? She is right there. Thank you. So we will go ahead and open it up to tribal leaders. Again the order, presidents, chairpersons, governors and then vice and so on. Mr. Payment?

Open Discussion

MR. PAYMENT: Okay so, you know, we have talked about this a lot at STAC with regard to historical trauma and so I just want to emphasize that a little bit.

So the suicide rate for Native American youth is 2 1/2 times that of the general population. And we throw that stat out but it is really a heart-wrenching statistic because we

are talking about our young people who are committing suicide at a rate of 2 1/2 times that of the general population. And that is really a serious thing.

We also have a prevalence of substance abuse at all ages, and I want to just — I am finishing up, as Rex Lee mentioned, my doctorate degree, and so the hardest part of my degree is writing about the boarding school experience but I hope I can get through this.

The official policy of the United States, as emphasized in Lt. Pratt's — and some of you will recognize this — is kill the Indian; save the child. That was the policy of the United States government, is to strip us of our culture and our identity, to assimilate us and in some cases, because they believed that we would be better off but in some cases it was really to get out of the treaty obligation.

And that is well-documented. That forced assimilation effort to strip us of our language, one of the techniques was to get Native youth to stop speaking their language was to put a wooden block in their mouths so they couldn't speak at all. It was illegal to practice our religious practices until 1978. That law was passed within our lifetimes.

Some of the people testifying earlier, maybe not their lifetime because they are really young, but in most of our lifetimes. In 1879, when the boarding schools were created, there was 350,000 Native Americans. And that is tragic in and of itself because prior to intervention there were 5 million Native Americans.

But in 1879, 250,000 or two-thirds of our population were in boarding schools so within one generation the tactics of forced assimilation and brainwashing really were devastating to our people. So the legacy of historical trauma through the boarding school experience is what we are experiencing now. We know this. It is social anomie, if you want to go back to the sociology.

But the federal reports, and I am almost done, 1928 Mirriam Report, 1934 Johnson O'Malley Education Support, 1969 Kennedy Report, 1991 Indian Nations at Risk report, 1992 White House Conference on Indian Education, and recently the 2014 BIA/BIE and Department of Education all recognized the travesty of the forced assimilation policy.

The federal government created this situation that we are living out today. But I want to remind you that for all of that devastation, the reason why we have a federal trust responsibility to Indian Country is because in the treaties we ceded millions of acres of land to provide for the health, education and social welfare for as long as the grass grows the rivers flow and the winds blow.

So we will take the sympathy that comes along with it but it is an obligation that the federal government has to American Indian people to provide for our people. Thank you.

MR. JIM: Thank you. Anyone else? Mr. Cook?

MR. COOK: Again, Michael Cook, Saint Regis Mohawk Tribe. I just want to follow up on a discussion. Mirtha, you had made a presentation to our group, the USET group two weeks ago, on the development of a behavioral health agenda. We look forward to participating in that effort.

The prevalence of alcohol substance abuse, and specifically the opiates, are an epidemic in our communities as well as in the nation as a whole but it is impacting our communities, and we look forward to having that as a priority.

Domestic violence, child assaults are two items that we do need resources in. And in terms of the child assault, there is the lack of resources to help in the treatment. We lack — in the outside of the community with our PRC funds, we work with local hospitals but they lack the resources as well as the sensitivity to deal with our community.

And that is where we need to emphasize and really encourage SAMHSA and IHS to work together in helping us out. Thank you.

MR. JIM: Mr. Antone?

MR. ANTONE: I too want to put on the table discussion on the behavioral health agenda of last month or December.

Yesterday I met with six agencies and told them and asked them to come together to help us out — either facilitate meetings, find something in your budget where we can get tribal members together and discuss the common themes that run throughout us, one of them being creation stories, stories of origin, teachings of value, morality.

Also, the celebration of birth. The role of the female, the role of the male. Worship, how we worship. There are certain elements that are common among us, one being fire. One being tobacco. Everything that we use — sage. So if we can put something like this together that really just defines us. It is not telling any tribe what to do. It is just defining the Native practices.

And as we move forward, if we can make this adopted by this Administration or the next, that will provide a road map for us when we seek grants and we bring forth a concept that hopefully the federal agencies will be able to understand why we are saying that. And that we have an overarching plan or definition that we can plug into to be able to make those possible, those proposals.

So without being too long on it, I hope we will hear more of that. Hopefully some of the agencies will support this idea. SAMHSA listened very intently and so has HRSA. Actually almost everyone. But it took a lot of explanation because they didn't really understand what I was trying to say.

But after awhile we began to reach some common ground even there. So I just wanted to bring that to your attention. There is another thing for the Administration for Children and Families that I wanted to ask a question on. Earlier I had mentioned the water systems grant on the Community Services Block Grant Rural Community Development Funding Program.

I just wanted to ask if that was even considered. I know it is zeroed out under the President's budget, but when you are talking about child development, then water becomes a basic necessity, particularly safe drinking water.

So I was wondering, because when we talk about Head Start, we are talking about economic development. I heard that last year. And so that is an essential part of economic development, clean water.

And so I wanted to ask if there had been any consideration given that because that program, at least with ITCA, really certifies tribal water workers, tribal water systems operators in different levels at the third level with arsenic training and how to deal with that. So it becomes very important.

I just wanted to know if that had been given any kind of consideration or if that will be considered in the future or what are our plans on that? Can we connect to EPA, et cetera? That is all I wanted to ask. Thank you.

MR. JIM: Thank you, Mr. Antone. And talking about water, we don't have construction funding for our Head Start program so how can we make that a part of it because they need a place to study and feel safe and so on. Mr. Joseph?

MR. JOSEPH: I want to talk about the historical trauma a little bit more. My tribe — I went to a Catholic boarding school on my reservation, and in my 8th grade year the

tribe took it over. It was — a lot of my friends that I went to school with were sexually molested and abused in the school system that was there.

And kind of like what Aaron was talking about, how some of the kids were treated and, you know, that historical trauma is really serious. And at the same school we had some contracted mental health providers, and the children worked better, our children worked better being in groups.

They don't like going into rooms with one individual person. To me, you know, our providers were dinged for bringing kids into these groups. I did mention this in the White House call on the President. I wanted to make a call a couple weeks ago.

There is a real need for the ceremonies that Chester was talking about, to bring those back. And it is proven in like the Healing Lodge of Seven Nations, a youth treatment facility, that some of our traditional practices, we have a better success rate, and it will save the government a whole lot more money down the road.

I believe we would have less suicides. We would have more people starting to walk the right way. There are a lot of these ceremonies that they could be taught. But there has got to be some way for the Department of Health and SAMHSA to work together and work with tribes in coming up with a traditional approach to providing the services that our people are really lacking.

Some of these people who went to those schools didn't get their — they didn't get to live at home to learn how to be parents and — so there needs to be more parenting classes as well. And, you know, I am grateful for the President wanting to work with the youth but I always look at home and see who is taking care of these youth.

Most of them are their grandmothers or their grandpas. And there needs to be some kind of way to support them as well because, you know, they will save up their pennies and dimes to buy birthday gifts and stuff.

What is really sad is one of my elders at home, 80 something years old, said that she got an increase in Social Security. Well, the low-income housing she was in, they found out she got a raise and they took that raise so it wasn't even an increase to her benefit.

And then I said, how is the food program? And she says, I get $93 a month. You know, that is not enough money to — when I retire I sure hope that I get more than $93 a month to eat on.

Some of these elders are having to deal with that and raise their grandchildren. And they are not really getting paid as much if you do relative care versus — if you either take somebody else's kid on, I think there is a higher rate in pay that goes with the non-relative versus these other ones.

But at the Healing Lodge, there is a group of children — I mentioned this last year, who have never used drugs in their life but their parents did, so they have these mental issues. And they have some kind of a treatment program for them that is a higher risk and higher need of care than what the youth treatment facility — that Healing Lodge runs.

So those children are really at high risk, and they could snap a little grandmother's bones without realizing it because it is not in their mind to. They are really just disabled because they grew up in that. But they don't qualify for the Healing Lodge because they never used before. Thank you.

MR. JIM: Thank you. Let's have some quick federal responses to the five tribal leader testimonies and then additional four, and then we will go back to the tribal leadership. Any responses from federal representatives?

MR. GREENBERG: First, thank you for your testimonies and for your comments. I want to just highlight a couple things in response. So on the child welfare proposals in our budget, again, we are very happy that we were able to put them forward. They very much came from discussions and listening and hearing of needs.

So we are hopeful that Congress is going to be responsive to them. I should say on these and frankly on others, not long after we submit the ’16 budget, we start thinking about the ’17 budget, so we would welcome additional thoughts for what else we should be considering for next year while we continue to hope that Congress will act on what we have proposed.

I did want to note on consultation, we take our consultation responsibilities very seriously. You know, we are very proud of the fact that with the leadership and encouragement of Lillian Sparks Robinson and ANA, that ACF has developed its own consultation policy in addition to, and building on the Department’s policy.

Our offices do take it very seriously. If there are concerns about any specific instance where a program or an office hasn’t consulted in an appropriate way, we would welcome hearing it and following up on it.

On the Head Start issue, you know, it is a difficult one. I mean, for a child who is in Head Start, I mean their eligibility should be continuing even if their parent gets a job, moves to a higher income level — their eligibility for that individual child can continue.

But we are very mindful that federal law is pretty specific about the eligibility limitations and how much room there is to go beyond them. And choices about doing something different from that really are up to Congress.

And then just the last thing, sir, on the issue about Rural Community Development funding, you know, this is an area where we have, for a number of years

actually, proposed the elimination of funding. It is never an easy decision. It is always in the context of limited discretionary funding and having to make hard decisions on it.

I would say, as you, I know, are aware, Congress hasn't acted on this proposal. And we don't know if or when they will. So we continue to operate the program and greatly appreciate the work that is being done under it. If you have guidance or advice for us about the current operations of the program, we welcome that, and I will certainly share with my colleagues your comments as we enter into our fiscal '17 discussions.

MR. JIM: Ms. Hyde?

MS. HYDE: Thank you, and I apologize for being late but as you can see, we have great leaders who are working on tribal issues. We are very proud of having created the Office of Tribal Affairs and Policy and appreciate that Mirtha has really stepped into that role and we have got increasing great staff who are here to help you and work with you.

Just a couple things I want to just acknowledge. I want to really thank Chester Antone. He has been very consistent in his messages to us. And I think sometimes it takes us a little while to take it in but I think we finally have heard in a different way than I think we started out.

When we started to tell you we were developing a behavioral health tribal agenda, frankly we just kind of meant we were doing that for SAMHSA, for our work. And as we began to talk to you we realized that you are really asking us for a bigger and different kind of approach.

And Chester met with us yesterday and really helped us think a little bit about what that might be, and we are going to continue to work on that, and we will definitely need your help to think about what that means going forward. We have heard that and I really do appreciate your continuing to tell us about that.

On the issue of historical trauma, I just want to tell you that we are preparing to do a session on this topic at the next STAC.

So at the next Secretary's Tribal Advisory Committee in March — we are actually also going to talk to our SAMHSA's STAC about in April but we will be at the Secretary's meeting first in March — so I appreciate Aaron's comments about this and Andy's and others, and Andy has served on our national advisory councils.

If any of you have further thoughts about what you would like to hear or how you would like us to be prepared to do that, we are going to bring our principal deputy who is sort of an expert in the issue of trauma and testified recently before the Senate Indian Affairs Committee about historical trauma and community trauma.

So we are really interested in making sure that session works for you and that we get some really good dialogue going about how we can be helpful about it. The final thing I want to say is the — as many of you know, I have been fighting, and Yvette has been very good about continuing to remind you as well, that we have been fighting for some additional money for tribal grants for some time now.

We finally got a small amount in fiscal year '15 — '14 and '15? '14, forget the years, and '15, and we have proposed literally a five times increase in that, from $5 million to $25 million in '16 but it is not a done deal. Congress has to act.

Congress has to give us that 25, and then we will continue to look at what we can do beyond that. So we really appreciate your help on that because we know it is a big issue, and continuing to work with IHS on those suicide and substance abuse issues. Thanks.

MR. JIM: Ms. LaCounte?

MS. LACOUNTE: Thank you, sir. Cynthia LaCounte with the Administration on Aging, Administration for Community Living. Thank you very much for bringing up historical

trauma. As many of you know, not only am I the fastest talker in the federal government, but I am also the person who works with our tribal elders, and historical trauma is certainly in our world.

And one of the big issues that we are working on now and that we are starting to talk more and more about in Indian Country is elder abuse/neglect. And certainly the elders tell me that is definitely a result of historical trauma and that break in our families.

So please just keep elders in mind as we are talking about these new initiatives and new tasks and new directions. I am going to be going around the room very quickly and handing out a couple of pieces of paper for you that I wanted — one is a grant announcement through the community, the National Center for Community and — what is it? Thank you. Those guys.

The National Center for Community and National Service. They are the ones who fund VISTA's Foster Grannies/Senior Companions. They have an announcement open just for tribes for the foster grandparent program and senior companions. So I will hand this out. Get your grant writers working. Have your title VI-E directors or your senior companion programs call me for additional information.

And then the other piece of paper I am going to be giving all of you is about a program, a new program, called REACH that we are bringing in for caregivers for our elders.

We worked with Veterans Administration and got some funds through the University of Tennessee from the RX Foundation to begin training our caregivers to provide care for our elders with dementia and Alzheimer's. So I will pass both of these around so you can get more information. I will be here all afternoon. I am the elders queen, so let me know if there are any issues. Thank you.

MR. JIM: Thank you very much. I think it is important for all of us to understand that we would like to use and make the most of the wisdom that our elders have but in some cases, like with Head Start, they have to go through background checks and because of certain requirements they are told they have to be credentialed.

And we would like to review that and see what else we can do to ensure that. As indicated earlier, our grandparents are the ones who are raising the kids. And they are also the ones who are fluent culturally and linguistically so they can pass that on to the children.

And so we need to find a way to have our kids and our elders come together without having to go through the bureaucratic process of credentialing and background checks and so on.

So I just wanted to put that on the table too. Other questions or comments? Mr. Micklin, Mr. Andrews, go ahead.

MR. MICKLIN: Thank you, Vice President Jim. So Ms. Sparks Robinson and Dr. Roubideaux, it is a pleasure to be here. Tribal leaders.

I am Will Micklin, first vice president, Central Council, in the Tlingit and Haida Tribes of Alaska. We are 30,000 tribal citizens in 43,000 square miles of territory. It is about the size of the state of Indiana. We have written comments that we will submit to the record. I will just be referring briefly to a couple of priority issues of ours.

The number of Alaska Native children in the Alaska state child welfare system is 60 percent of those in out-of-home custody. That is out of 25 percent of children under the age of 18 who are Alaska Native, so we are disproportionately represented in the child welfare system in the state.

We do all we can with the resources provided to advocate for our children and additional child welfare resource needs for the prevention and intervention activities and services that we feel are necessitated by the need. And we advocate for a shift to prevention and intervention activities for these programs.

We have a number of specific recommendations. One is the child set-aside percentage at 2 percent that the amendment of the statutory authority lifted the cap on that and provides the opportunity for the President's budget to propose a higher percentage of the total funds allocated for that purpose.

And we would recommend for the President's budget in the next offering to increase that well above the current percentage. We recommend that title IV-E waivers and the title IV-E applications be combined to make developing the tribal programs under these authorities to be made easier.

And I am going to refer to some issues that involve the Congress, but we find that our petitioning of the Congress, even with a strong delegation with the state of Alaska, really needs the leadership of the Administration, of the President and of the Secretary to make these types of legislative changes possible.

So some of the issues and areas that we think are important are the statutory caps. CCDF is a 15 percent limit on recovery of indirect rate, TANF is 25 percent. That causes us with a higher ID, indirect rate, to have under-recoveries and that affects our financial balances that we have to accommodate in the two-year cycle for these indirect rate formulas and contract support costs.

We, by necessity, had to separate out our CCDF program and our TANF program out of our other self-governance programs. That relieved some of the under-

recovery burden for those two programs but it caused our pool for BIA self-governance programs to shrink. Our indirect rate went from 32 percent to 49 percent.

That causes us to offer fewer programs and fewer dollars in those programs and inhibits our overall capacity of our governance. So we would sincerely like the efforts of the Administration to be directed toward lifting the statutory caps or at least accommodating these to the rates that tribes have.

Our rate has gone up not because of mismanagement but because of the effects of sequestration and rescission, which funds were not supplemented in subsequent budgets, and also because of our having to shift significant dollars out of our pool because of the statutory caps on CCDF and TANF.

As well the TANF rate set at $923 for the cash distribution was $923 in 1996, and in 2015 it is $923. That is a — represents a loss of value against inflation of 32.7 percent on average in southeast Alaska. Rent in 2000 was $1,000 for an apartment that could accommodate a small family and up to a family of four for that $923 rate.

That rent is on average $1,500 today. So offering services, cash services, is much appreciated but offering only a fraction of the amount needed for someone to actually have a roof over their head is insufficient.

So we need the help of this administration in focusing the Congress on increasing those rates to something that matches at least the minimum rate of affordability. That represents really in total disbursements less than half of the poverty rate.

And the poverty rate, as you know, is pretty low as a standard. The financial assistance at less than half of that rate is remarkably insufficient and causes significant problems in continuing to keep our folks in these programs.

So — and finally I will just refer to ICWA compliance. As you know, we have had a troubled history with the state acknowledging tribes, Alaska Native tribes.

We know we have a change in administration and we were fortunate to elect one of our people as lieutenant governor. But we still have some issues and we would petition the Department to apply the Child & Family Services Review Process to state compliance with ICWA regulation and statutory mandates.

We know it is a difficult process in bringing the state into compliance but it is, after all, federal law. We comply by it and we are — our expectation that others for whom you have enforcement compliance authority under IV-B and IV-E to apply the same standard to the state partners as you do the tribal partners.

So again we will follow up with specific written testimony and further remarks, and I appreciate the opportunity to comment. Thank you very much.

MR. JIM: Thank you. Mr. Andrews?

MR. ANDREWS: Thank you, Chairman Jim. My questions or comments were specific to the Head Start program. The Tohono O'odham Nation currently receives enough funding for 215 slots, although we have over 14,000 members who reside on the reservation within its boundaries.

I was curious, one, if there could be a possibility or if there is a possibility of change on the horizon for the allocation formula for the funding to be considered. The reason I bring that point up is for the second point I wanted to bring up or make was the accommodation for our children with disability.

Every year the Tohono O'odham Nation has been able to fill its 11 percent slots, and we have a waiting list so we have internally made children with disabilities our priority to get off the waiting list and onto — to receive services. But the limited amount of

slots does actually hinder our ability to provide service to a greater number of children who are in need on the nation.

Several years ago I asked for an account of how many children or how many live births actually happen on the reservation. At that time it was about 700 per year are born and come and live within the boundaries of the nation. So just consider that 215 slots are all we are allowed — that is the amount that we can provide service for. Thank you for the opportunity to make these comments. Thank you.

MR. JIM: Thank you. Federal response to the last two comments and concerns, and then we will go into the next session.

MR. GREENBERG: Mr. Chairman, can I ask Ann Linehan the acting director or our Office of Head Start, to respond on that and start discussion?

MS. LINEHAN: Good afternoon. I think we certainly agree the issue of the availability of funds across the nation certainly at this point does not fulfill the needs, and we have many, many programs that have significant waiting lists.

I think the allocation formulas are pretty well set relative to the population numbers so I am not sure that we have the discretion or the authority to make those changes at this point. I do think it is commendable that through the selection criteria you have made the needs of special needs children such a high priority. And we certainly commend you on that.

I don't know beyond that, Mark, because we really are certainly tied to certain allocation formulas. We did have a recent opportunity, which is really very good news, and we will soon — we are in the process of awarding approximately $14 million to our tribal programs for the new Early Head Start-Child Care Partnership, which is going to bring services for infants and toddlers who are currently in child care.

So we are happy to be able to share that with you today.

DR. KAROL: I just have one last closing reminder. Our Methamphetamine/Suicide Prevention Initiative Dear Tribal Leader letter is out to all of you. If you don’t have it, it is on our Website. But it is due, comments are due back March 6, which is coming right up, so please, please, please look at the MSPI Dear Tribal Leader letter. Thank you.

MR. JIM: Thank you. We will go on to the next session, but before that I would like to remind all tribal leaders that you are welcome to submit your written testimonies in detail. And I would also like to remind the federal representatives that these consultations need to be meaningful, meaning that we want you to take our recommendations seriously and make it part of your program. And we would appreciate that.

We just don’t want to submit consultation papers and for you to read it and then not do anything with it. So thank you very much. So we will go on to the next session. Centers for Medicaid and Medicare Services and Public Health Budget Priorities. Again the purpose is written on your agenda.

The federal leadership update, you have got two minutes each to highlight. Ms. Wakefield and then Ms. Cohen. Following that will be the tribal leader testimony. Again, two minutes, Mr. Allen, Mr. Payment, Mr. Antone.

Centers for Medicare & Medicaid Services and Public Health Budget Priorities by Mary Wakefield, Administrator, Health Resources and Services Administration

MS. WAKEFIELD: Thank you very much, Mr. Chairman. I am Mary Wakefield with the Health Resources and Services Administration. All of you should have had an opportunity to access a set of PowerPoint slides that we made available. I am hopeful that

you did, but if you didn't, I would certainly encourage you to pick them up at some point. I believe they were out on a front table.

Just a few comments about the information that is presented there. First of all, if you do have the slides, you will find on the second slide a description of the mission of this operating division of HHS. And basically HRSA's programs focus on ensuring accessing to primary health care services for underserved populations, and also strengthening access to the primary care workforce for underserved primarily. Not just but primarily for underserved populations.

On the slides, on the third slide, you will see the header HRSA programs serving American Indians/Alaska Natives. And what you will see there are some examples of some of the bureaus that we have within this particular operating division, and some examples of our investments that impact populations from the American Indian and Alaska Native communities.

And so you see investments listed. I won't read all of this. For example, our Ryan White HIV/AIDS program to examples from our rural, Office of Rural Health Policy, and some of the resources that flow specifically to American Indian/Alaska Native populations.

If you move on to the next slide, you will see a discussion of some of our priorities within the agency, specifically consistent with the President's fiscal year '16 budget.

Next slide, the fifth slide, that is titled providing access to high quality, affordable primary care, are just some data points that will show you — that describe a little bit about the investments in the community health centers program that serves American Indian/Alaska Native populations in addition to other populations as well.

This is a program that is markedly increased in the President's fiscal year '16 budget, so this was one of the priorities in the President's budget that HRSA has responsibility for, and that touch health care services to thousands of American Indians and Alaska Natives.

If you skip to the next slide, you will start to see a series of slides that focus on strengthening the health care workforce. I had mentioned to you earlier that that is one of the agency's priorities.

Here too across these slides, you will see a footprint in the President's fiscal year '16 budget where there are very specific resources that are designed to strengthen our workforce training programs by providing, for example, scholarships and loan repayment to students who are interested in pursuing health careers.

And also in this context you will see a slide that is labeled diversity programs. That particular slide, in the context of workforce, the first listed program there, a new program that is included in the President's '16 budget, is a program that focuses on health workforce diversity.

And this is making scholarships. This would make scholarships available to disadvantaged students who have financial need and who are enrolled in or accepted into health professions programs.

So that is a new program in addition to those that we have had, we are responsible for operating historically. I also wanted to show you some of our investments in oral health. You will see a slide there. In behavioral mental health. Those resources that we make available in partnership with SAMHSA because those are also high-priority disciplines, if you will, that HRSA has responsibility for strengthening in terms of the workforce.

And finally you see — or actually I should say on the workforce front, you also see a slide titled National Health Service Corps Tribal Collaboration. The National Health

Service Corps is a workforce distribution program that in exchange for scholarships and loan repayment, puts students in underserved rural and urban areas.

And this is one that we have had some really good uptake from tribal communities, for example, to be able to access those health care providers. There are other slides throughout this set, I know I only have two minutes, so I will just go straight to two I would like to highlight.

One, the Ryan White HIV/AIDS program, this program does touch our American Indians and Alaska Natives. If you think, for example, about youth between the ages of 13 and 24, in fiscal year ’14, for example, we were providing services to about 240 American Indian/Alaska Native youth through this program.

I don’t have the most current data for 2014 across the entire population, but when we get that, we will share it through the Secretary’s Tribal Advisory Committee. We should have that in about a month. And then lastly I wanted to point out the very last slide, the Home Visiting Program. This is another high priority in the President’s fiscal year ’16 budget.

We have responsibility for this program along with the Administration for Children and Families. This slide, as the slide notes, we have awarded through ACF about $44.6 million to Tribal Home Visiting Program grantees. That part of this program, ACF has responsibility for. But as I said, we operate this program together.

So bottom line, HRSA’s budget for fiscal year ’16, resource is up, the infrastructure to access primary care services through community health centers, it’s resources up. Health care workforce investments in, for example, the National Health Service Corps especially and also the new diversity program the President is proposing.

And then you see some of our investments that are reflected in the fiscal year ’16 budget across oral health, behavioral health and so on. And then the final big boost in resources that the President is requesting from Congress is in this home visiting program. That is a fairly significant footprint for American Indian/Alaska Native communities. I will stop there.

DR. ROUBIDEAUX: Our next speaker is Mandy Cohen, deputy center policy director of CCIIO, which is Center for Consumer Information and Insurance Oversight.

Comments

by Mandy Cohen, Deputy Center Policy Director

Center for Consumer Information and Insurance Oversight

MS. COHEN: Great. Hello, everyone. Thanks for having me here today. So I just wanted to talk briefly about some things related to the Marketplace.

As you know, just a week ago we closed our open enrollment session for the Marketplace, enrolling 11.4 million consumers through the Marketplace. Either they were new to us or returning from last year.

But the good news is, and I agree we have more work to do in Indian Country, but the good news is that open enrollment doesn’t close in Indian Country so we have time for continued enrollment through the rest of this year and I look forward to dialogue on how we can continue our joint efforts for continued enrollment throughout the year.

I do want to touch on a couple of things that are new for the Marketplace. Even though we are in year two of our open enrollment cycle, we are about to enter, for the first time, tax season. And tax season and the Marketplace are linked, as you know.

When folks get financial assistance, we need to reconcile those on your taxes, so for the first time, folks are going to be getting tax forms from the Marketplaces. There are forms 1095A. So they are going to get those tax forms and will need to use that to help fill out their taxes for the first time.

And so, you know, we do anything for the first time we always have a few glitches. We are sending out some corrected forms as we speak. But generally all those folks who have those forms are going to need to use them to submit things to the IRS, and they will have to reconcile on their taxes.

So that is another new thing coming for this year. Again, we are here to help. Marketplace has been trained and staffed up in order to provide help to consumers to navigate this process for the first time.

And then as we look forward to this coming year, we know that there are more improvements we need to make in the Marketplace. And so that is what we are focusing on. Really three goals for us is again more focus on the consumer, making the system a lot easier to use, giving folks more tools to be able to help make better decisions on what product to choose.

The Secretary has charged us in particular to look at — sometimes there are too many choices and it is hard for folks to understand what is the best choice in this Marketplace for them and their family, and how can we help them do that? So that is one of our charges.

We also always want to make sure that whatever folks are shopping for is good value for them, that there are affordable prices and it is covering the services that they want. And then lastly, stabilization of our operations. We made great strides. We were not in the newspaper this year, which is a success.

No one wants to cover the good news of things going well but we know we need to continue to stabilize those operations and will continue to do that. One note before I close just on exemptions. Because we are in tax season now, really the fastest and easiest way for anyone who needs to file in Indian Country for an exemption is through the tax form process.

It is really just checking the box. We will continue to process things through the Marketplace, and I have numbers here. We have processed about 110,000 of them. There are about 10,000 that we are still going back and forth with folks to get additional documentation.

We will continue to do that but again the fastest, easiest way to do this is really through the tax forms themselves, to have folks get an exemption.

So again we really just want to work with you on some of our mutual goals of making sure that the folks who are eligible for the Marketplace and financial assistance are taking advantage of that because we know there is a gap between who is eligible and who is already enrolled in the Marketplace, and whatever we can do to continue to improve our operations to make sure we are being responsive. Thank you.

MR. JIM: Thank you. We will go to the tribal leadership. Mr. Allen, then Mr. Payment, and then Mr. Antone. Mr. Allen, go ahead.

Tribal Leader Testimony

by Ron Allen, Chair, Jamestown S'Klallam Tribe

MR. ALLEN: Well, thank you, Mr. Chairman. It is always an honor to be able to come and make a case for the budgetary needs for Indian Country as it applies to health care.

My testimony, my written testimony, has been submitted, and in summary, you know, we are testifying on behalf of our TTAG group, which is the tribal leadership and our technicians who oversee all of our many clinics and hospitals throughout Indian Country.

And as ACA gets implemented and the CCIIO program is off and running, there are a myriad of issues that we have raised regularly as it applies to Indian Country, whether it is the Indian Health Service, the tribes to the direct service, or through 638 or self-governance.

Implementation of these programs as they affect our citizens, wherever they might be, is a very complicated matter. Last week we were in town discussing many of the issues, and we were delighted to hear from the director and chief data officer from I guess the Office of Enterprise Data and Analysis that 24,000 Native Americans were enrolled.

But the fact is, that is still only 2 percent of the 8 million Americans who are enrolled through the FFM. And so we have got a long ways to go. There is a great deal of need and we want to continue to remind the Administration that IHS alone only receives about — what we calculate as about 50 percent of what the true health care needs are for Indian Country.

And so ACA is going to provide us a lot of opportunity but the work is still yet to be done. We appreciate opening the enrollment again to assist us but that begs the question of our work. Our TTAG group has put together a strategic plan that outlines what our many issues are with regard to ACA, Medicaid expansion and CCIIO operations, and that plan has identified the many issues and responsibilities that and we need to implement it.

We have estimated that our need probably is in the neighborhood of $7.2 or $7.3 million. To date, the Administration has been stepping up but the resources they made available as of this year is about $4.26 million.

So the bottom line is in terms of providing the tribes the assistance, the education for enrollment assistance and changing the rules for Alaska Natives and American Indians in the family plans, improvements to the call centers with regard to tribal citizens who are reaching out, looking for assistance, is a big deal.

And the Navigator programs expanding into Indian Country as well and making them more affordable and more practical and more effective in their use. CMS enforcement of rules related to Indian health for the QHPs is a big deal.

So the outreach is ongoing. We have a lot to do when you are dealing with 566 Indian nations, and as complex as they are in our respective communities. So we have made a lot of progress but we have a long way to go and need the resources to achieve that.

One of the objectives that we are looking for is waiving the employer mandate for tribes, for people who qualify for the Indian exemption to the individual mandates as well. In addition, we have a need for funding to assist the tribes in complying with meaningful use health records as well as the Medicaid payment incentives and penalties.

It has always been a delight for me, as a tribal leader, to work with the TTAG group and the senior leadership of CMS/CCIIO and the various agencies who implement ACA. But the bottom line is that it is challenging. And we seem to be constantly racing to make sure that any new regulations are sensitive to tribal needs and that they work effectively for tribal operations, clinics and hospitals.

I will close there, and we will continue to work with the Administration in terms of making this thing work. We know it is expensive. And we know there are reasons why not, but Indian Country believes that ACA is going to make a difference to improve — to start bridging that gap of providing quality health care in our communities.

MR. JIM: Thank you. Mr. Payment?

Comments

by Aaron Payment, Chair, Sault Ste. Marie Tribe of Chippewa Indians

and Representative, National Congress of American Indians

MR. PAYMENT: Okay, my testimony is as the co-chair for the Health Research Advisory Council, HRAC, or the group of nerds as some people have dubbed us as. It is my pleasure to out myself as a nerd.

So HRAC carries out the three primary functions: obtaining input from tribal leaders on health research priorities; providing a forum through which HHS can better communicate and coordinate Native health research activities; and provide a conduit for disseminating information to tribes about research findings from studies focusing on health of Native populations.

In my limited time today, I would like to share some HRAC recommendations concerning general research. The HRAC is acutely aware of the high and disproportionate rates of morbidity and mortality experienced by Natives. Therefore, many of the recommendations focus on addressing the health disparities that continue to plague Indian Country.

In order to address the health concerns identified by HRAC, research should focus on data quality and accuracy to address under-representation of Natives in population health data.

The lack of access of health care services for Natives in both rural and urban settings, lack of incorporation of traditional health care practices and traditional diets, efficacy of health promotion/disease prevention activities, and the lack of health insurance coverage for Natives.

HRAC has identified and recommends several research priorities including the following. Intentional and unintentional injuries, suicide prevention, causality and incident rates, meth prevalence and prevention, utilization of health services like prenatal and emergency room use, autoimmune disorders, environmental justice, Alzheimer's disease and dementia, historical trauma and autism.

We support research to understand exposure to risk and vulnerability over the Native life span due to social determinants such as social exclusion, marginalization, inequalities and historical trauma. Research is needed to address the complex interactions between health determinants and long-term exposure to risks unique to Natives, resulting from misguided federal Indian policy.

All research conducted should be evidence-based and should be, to the extent possible, community-based and participatory. As the rightful owners of their respective data, all efforts should be undertaken to ensure tribes are consulted before such data is shared with any entity.

Many barriers exist regarding research activities in Indian Country. These barriers could be addressed by increasing cultural sensitivity among researchers, increasing the number of Native researchers, improving the accuracy of data related to Natives and the inoperability of data among HHS operating and staff divisions.

Increasing the amount of available comparative data, improving infrastructure among tribal governments to increase tribal capacity to carry out research, increasing the amount of community-driven research, provide IHS with research funding, a research funding line item to support research by and for Natives.

Holding a consultation with tribes for the purpose of developing a department-wide policy on data management in Indian Country, and establishing a single data source, a

single integrated, internet-accessible website with data available to calculate simple statistics such as incident and prevalence rates. This would greatly benefit us.

HRAC recommends that grant requirements for research projects include demonstrated cooperation and collaboration with tribal governments, such as with the submission of a tribal resolution.

We also recommend that agencies allow more time between funding announcements and application deadlines. We have an idea of how to do that. A Dear Tribal Leader letter sent out as early as possible, and even before the funding announcement, so that we can start preparing for it.

Finally HRAC would like to emphasize how important it is to have grant reviewers who have demonstrated an experience with tribal governments and who are culturally sensitive and again who are Native.

Such reviewers can ensure that grant applications adequately include collaboration and cooperation components. In closing, as the co-chair of HRAC, we look forward to continued collaboration with HHS to improve research activities affecting Indian Country. I believe we make a great team.

MR. JIM: Thank you. Mr. Antone?

Comments

by Chester Antone, Council Member, Tohono O'odham Nation

MR. ANTONE: Good afternoon. First of all, I want to thank the Centers for Medicare and Medicaid Services for the reauthorization of the uncompensated care costs. You don't know how much that helps us out. And I would also ask that you leave yourself open to reimbursements of traditional healers.

Many tribes have always had an understanding of public health in a way that it is a part of their traditions. Ceremonies that include prayers for all of Mother Earth and for all people and creatures, plants, animals, rain and wind and so forth are our way of public health. Our Native way of knowing.

Today we still keep these among us but we also live in another world. Therefore, public health as we have come to understand it in the western way requires us to seek accreditation to become public health authorities so that we may act in the best interest of our respective tribes.

We have to be accredited by a much larger government in order to be considered for acceptance of our data. It would be prudent for the Secretary to embrace the language in the Indian Health Care Improvement Act, which recognizes the Tribal Epidemiology Centers as public health authorities.

It would also be in her ability to write to the departments of health and states with Indian tribes to encourage them to also recognize this fact. It would also be good to support the Centers for Disease Control and Prevention through its technical assistance to tribes by way of field officers to help tribes with technical expertise toward their goals to be accredited. This does not affect the budget.

Public health as it is now, Indian Country needs a push and a pull if we are to become users of the same funds, data and the capabilities that states have but that the tribal nations have difficulty obtaining. For some tribes, this may not be possible. But for those that can, it should be given the attention that it requires to maintain public health in their communities.

I will provide additional testimony within the additional 30 days after this consultation. I would also provide some recommendations, and this is from the National

Indian Health Board, and I feel that I am making a lot of work for myself as well as the tribal advisory committee but we all have to move the same way.

We request that CDC request that Congress establish a budgetary line item that would dedicate funds to the Tribal Epidemiology Centers to administer, store, analyze and transmit surveillance data for tribes in their area.

Under this Congressional line item, corresponding moneys should be directed to each of the Tribal Epidemiology Centers to conduct the same activity. The CDC needs to require states who receive CDC funding to declare and provide evidence of how they will include tribes in funding and resource distribution in both noncompetitive and competitive funding streams.

The CDC needs to continue to fund the Racial and Ethnic Approaches to Community Health and the Partnerships in Community Health programs as they have been successful in engaging tribes in more holistic approaches to community health.

The CDC needs to dedicate funding for both HIV and Hep C awareness, capacity building and screening efforts that specifically target tribal communities. The CDC needs to restore the National Public Health Infrastructure Improvement grant program. The restoration of the funding stream program will allow tribes to access capacity and infrastructure building moneys.

The CDC should fund a national organization to coordinate a national assessment of the capacity of tribes to deliver the 10 essential public health services and identify the designated public health authorities operating at the tribal and area levels.

Public health accreditation has been a driving force in recent years to stabilize and informally regulate public health department functionality. No tribe to date has been

accredited. The CDC needs to continue its recent investments in promoting tribal public health accreditation as a key strategy to strengthen tribal public health infrastructure.

Public health infrastructure, which includes stability and ability to plan for personnel facilities and departmental structure, allows tribes to develop a workforce, support growth, design programs, conduct surveillance, assess needs, and deliver services to align with those needs. And that concludes my testimony.

MR. JIM: Thank you. In addition to the federal leadership, who presented, Ms. Marx, where are you? There she is. Ms. Wilson? She is out. Mr. Maloney? He is way back there. And Ms. Etz. Is that how you pronounce it? There she is.

They will be responding to the tribal leader testimonies as well as — we will go to the floor for three or four comments or questions. Then we will have the federal responses. So the floor is open to the tribal leadership. Mr. Joseph?

Open Discussion

MR. JOSEPH: The Indian Health Care Improvement Act was a part of the Affordable Health Care Act, and in that — I worked really hard to put long-term care language into that act, and it is in there and is permanently authorized.

The reason why I really wanted to push on that was my tribe, the Colville Tribe, has a rest home facility and, you know, when it got approved, I asked our area director, — at the time, so can I hand you the keys now? And she said, we would have to shut it down because they don't have any funding to fund that long-term care facility.

So I have asked in the last couple years, coming back here to this meeting, is that IHS and CMS work together to figure out, you know, what the encounter rate would be to provide those services for our rest home facilities.

And also an encounter rate to provide hospice care, in-home care, to our elders. When our people do mental health, they have an encounter rate that they can bill with. That is an IHS encounter rate. And, you know, hospitals that IHS runs have an in-patient encounter rate that tribes that have hospitals can use to bill with.

Well, our elders need this encounter rate so that we can provide the service. It has been over the last four years or so, I believe my tribe has almost put in close to $1 million a year of tribal dollars to offset the budget just to keep our elder home operating.

So I really — you know, being a veteran, I know the Veterans Affairs do long-term care services. They have rest homes for veterans who are bedridden. And I believe it is like a big brother to the IHS system. If you can figure out how much it costs them to operate their facility per patient, that could probably be a starting point on the negotiation with tribes to come up with an encounter rate for our long-term care service needs.

So that is really important to me, and our tribe will probably continue having to help fund our elders because they are our priority. But that money could be going to other programs like our youth and education and — there are also needs in those facilities for maintenance improvement, and those special needs, medical equipment that they use to provide the services with. Thank you.

MR. JIM: Anyone else? Mr. Shippentower?

MR. SHIPPENTOWER: Thank you, Mr. Chairman. Bob Shippentower, Umatilla Confederated Tribes. We recently — we would like to thank the Indian Health Service personnel for helping us complete an MOU with the Veterans Affairs, in which our tribal health clinic gets reimbursed when they serve our veterans, provide services to our veterans.

So I just wanted to say that we really appreciate that. Thank you.

MR. JIM: Thank you. Ms. Crotty?

MS. CROTTY: (Speaking Native Language) In terms of Navajo Nation, when we talk about Medicaid and Medicare services, our concern and our testimony is as third-party reimbursements is increasingly utilized to bill for qualifying services to supplement the health care needs on Navajo Nation, especially among our PL 638 facilities, the ACA Indian Health Care Improvement Act authorized and included the Navajo Medicaid Feasibility Study, deemed the Navajo Nation has the capacity to establish the Medicaid infrastructure.

The Navajo Nation passed a resolution, C0-50-14, to conduct due diligence toward the potential establishment of the Navajo Nation Medicaid agency funding. And technical assistance is the next step to establish this tribal agency.

The Navajo Nation also supports the Medicare-like rates, also known as Purchased and Referred Care. That is our testimony. Thank you.

MR. JIM: Thank you. Anyone else? Mr. Micklin?

MR. MICKLIN: Thank you, Mr. Chair. Will Micklin, Central Council of the Tlingit and Haida Indian Tribes of Alaska. Just too again raise the issue that RPMS, the data management system, the IT system for IHS, which was formally for maintenance and improvement funded out of year-end funds, and I know I have discussed this with Dr. Roubideaux, and she was very forthcoming and informative about the initiatives to find a means for regular and permanent funding for RPMS.

And I would just encourage that discussion to continue. Year-end funding, as we know, has somewhat evaporated. That the importance of maintaining that not as a legacy system but as a mainstream system that can provide for things such as interconnectivity with hospitals and other third parties, including implementation of our obligations under ACA.

That instead of seeking exemptions for this and paying fines or penalties, that we really ought to be coming into full compliance. It is going to take some dollars, so there

need be a capital funding strategy to accommodate these needs long term. So I look forward to that further discussion. Thank you.

MR. JIM: Federal response? Let's hear from Mr. Antone first.

MR. ANTONE: I just wanted to ask Mary on the oral health slide that you presented, when you are talking about new and emerging models of care, would the DHAT be one of them?

MS. WAKEFIELD: I am sorry. Would the —

MR. ANTONE: The Dental Health Aide Therapist?

MS. WAKEFIELD: Yes. So the Dental Health Aide Therapist is a new program that is being implemented I think in about three states. We are using our resources to try and encourage the deployment of new models of care using different health care provider categories.

We had a little bit of a limitation put on us by Congress about a year ago where we were told very directly that we could not fund certain new oral health provider types. We were actually told we couldn't do that. That was a couple of years ago.

We are trying to be as creative as we can with the resources that we have. But yes, we are going to have a study that we are going to be releasing probably within the next month that is going to show the problems we have got with supply of dentists across the United States and the health profession shortage area of dentists.

And part of what you will see in that study is a nod to whether or not we could address those shortages of access to oral health care resources by considering the full complement of oral health care providers, with a little bit of a nod to that provider category.

So it is an area of concern for us, yes, and we are trying to make our resources in oral health as flexible as possible.

MR. ANTONE: Okay because the statewide executive committee of the Arizona American Indian Health Care Initiative will be putting on a symposium to highlight that model, to disseminate that model to the Arizona tribes just in case we — some tribes might want to consider that due to the remote areas in the state of Arizona where the tribes are located.

And the other one is the behavioral health slide, which is for SAMHSA and HRSA collaboration. It is to expand the behavioral health workforce. Now is that going to be training new workforce people or is it going to be training existing personnel within tribal behavioral 638 clinics?

MS. WAKEFIELD: So most of that training is for new health care providers. We have some resources that are allowing us to support the training of peer professionals so unlicensed health care providers as well as training of additional, licensed health care providers like psychologists, for example.

So it is mostly on the supply side to produce more providers with behavioral health expertise.

MR. ANTONE: And the final thing I want to do is to just say that diabetes on the Tohono O'odham Nation is, I believe, at 20.1 prevalence. It is an increase but a small increase. We need to figure out how to measure how that occurred, that kept it at the lower level.

We need that information, and then I believe it is a part of public health, at least in our area, and it has really affected us and I just wanted to say that because I think it is public health, at least in the numbers that have occurred over time. Thank you, that is all.

MR. JIM: Thank you, Mr. Antone. I was down there for the diabetes marathon run. I looked for you but you weren't around. I wanted to race you. Mr. Allen?

MR. ALLEN: Thank you, Mr. Chairman. I want to, since we have a little bit of time, to underscore one of the requests for resources. During our last meeting, we raised the issue of the concern that tribes have that, one, the fact that they should be identified as providers.

And the question of the day is whether or not that they are being recognized as providers, and if they are being recognized as providers, you know, are they being responsive in terms of timely reimbursements?

So there are a couple of areas in there that, when we were talking to Mr. Conohan about this topic, that, you know, it didn't sound to us like CCIIO has the data to monitor how effective those various plans are being implemented with respect to all of our providers of the tribes.

And that is a big deal to us. One, are we being recognized? And if we are not, or if we are just on paper, and actually not being utilized, then that is a huge problem for us.

And then number two, if we are being recognized that the reimbursements that we should be receiving for services provided is being recovered in a timely manner. And we need to be able to document that. We have great concerns all over the place and there are mixed results throughout the country.

So the point was, if CCIIO can't do it within its system, then we need to have the resources to be able to go out there and monitor it ourselves and report it back to you through our TTAG forum.

MS. COHEN: Understood, and thank you, and I would be —

MR. JIM: Let's go ahead and have the federal responses to the tribal leaders' testimonies and some of the comments and concerns raised.

MS. COHEN: Sorry. I jumped in too soon. So Mr. Allen, thank you very much. And I have been sitting here reading the full testimony, which is very helpful, and I hoping to get this electronically so I can share it with the rest of the team.

Specifically about the network adequacy piece that you were talking about and the fact that all qualified health plans are supposed to be offering contracts, it doesn't mean you have to ultimately sign those but at least offer contracts to tribal health care facilities.

When we look at that, they only need to tell us they have done it, in an attestation way. You know, we are in an infancy of sorts of the program in that respect. And so it is an attestation and you are right, that doesn't allow for a lot of great understanding of the deeper details within CCIIO.

So the other part of this is that in the first few years we also have a good faith compliance, and so we are not yet at the point where we are doing enforcement or auditing, to your point, which is where we are going. But we have not yet done that just again because we have been just at the beginning of trying to put the program together. But that is certainly where we are headed.

And in the meantime we can talk about ways in which to ensure that this work is under way, that these contracts are being offered. I would have to get more information about the second piece, which is the timely payment because that is really more on the private insurance side but we still want to know about those so we can work with the department insurance at the state level because it is really more their jurisdiction.

But we can definitely be helpful there in making sure those bridges are connected.

MR. ALLEN: Just in response, Mr. Chair, yes, we can certainly work with you on that topic. We are getting reports that it is not timely at all, and you can well imagine within

any operation that if you are not receiving the timely reimbursements for services, that it is harmful to the operation's fiscal capacity.

So that is a big deal to us. And just a matter of how do we gather that information? We have a pretty good network in Indian Country and I think that if CCIIO would work with us, we might be able to work out a way, maybe it is a contractual way, maybe through the National Indian Health Board et cetera, that we can accomplish these objectives.

MS. MARX: And Mandy maybe I can add to that. As a response to this issue that was raised at the TTAG meeting last week, members of the CCIIO staff who oversee the QHP contracting had a conference call with Indian Health Service, and I think that what we want to do is at least have a webinar with the QHPs, with the issuers, to let them know about the model QHP addendum, and to also let them know about Section 206 of the Indian Health Care Improvement Act.

So even if the QHPs don't have an actual contract with an ITU, under 206, there is a right of recovery. So I think that is the first step that we want to take, is to have that webinar to educate the issuers. And if we can provide written guidance, we will try to do that. So at least educate them and work from there.

MR. JIM: Other federal responses? Go ahead.

MS. ETZ: Good afternoon. I am Kathy Etz from the National Institutes of Health. And I want to thank you very much for the opportunity to hear your testimony.

In response to Chairman Payment's testimony representing the HRAC, I wanted to offer just a few points. You indicated one research focus that is a priority of disease prevention and health promotion. And I wanted to make sure that people were aware that we do have a funding opportunity out on the streets right now entitled Interventions for Health Promotion and Disease Prevention in Native American Populations.

And I think one of the things that is exciting about that is we have certainly heard from Indian communities, American Indian/Alaska Native communities, that they would like a focus on strengths and on health promotion as opposed to just disease outcomes.

And this FOA is a response to that in part. That FOA also does require a community-based, participatory research approach and further requires that there are tribal letters and resolutions included in the application.

And then I wanted to share one other bit of language from the FOA, which states that in recognizing that tribal governments are legal, sovereign nations, potential research partners should be informed that tribes may seek ownership or control of all data and all biological samples.

Therefore universities and other partners should be prepared to negotiate data sharing and biological sample sharing agreements with tribes and tribal governments. So we are excited to have that out.

The other thing in response to the request that the Indian Health Service have a line item for increasing research for and by Natives, obviously NIH can't respond to that, but I did want to highlight the NARCH research program, Native American Research Centers for Health, which is a partnership that we have with the Indian Health Service that does require that the grantee organization be a tribe or tribal organization to ensure that the funds go there and then go to the research partner as a subcontractor.

And then the only other thing, not in response to your testimony, but I did just want to highlight that the NIH is in the process of setting up our inaugural Tribal Consultation Advisory Committee. And we have just extended our nomination deadline to March 18, so it is a very quick turnaround.

And we are specifically seeking nominations only for four different areas because we have sufficient nominations in the others. So if I could highlight those, they are Alaska, Albuquerque, Billings and Phoenix. And then we are also seeking additional nominations for National At-Large Members. So thank you very much.

MR. JIM: Other federal response? Mr. Payment, go ahead.

MR. PAYMENT: All right. So at the risk of getting very nerdy, I just want to also emphasize the importance of oversampling in research. So — and I am experiencing this myself because I chose to do an archival study rather than primary research, which broke my heart, because I wanted to do my own direct research.

But I am using a university that has a high population of Natives but the reason for that is because whenever you do research on populations, you use a couple of different methods. One is a chi-square and ANOVA and logistical regression. So there are three different ones.

And in order for those to be effective, you have to have a minimum number of populations in each cell. And so that gets very nerdy right there but normally what happens is those people who are studying Natives or different populations just basically ignore us.

They put us in other or they just — a little asterisk that says insignificant population. And so the way to get around that is to plan for that and to do oversampling. And I mentioned this yesterday to the U.S. Census because that is an important thing for them too.

So a lot of our funding is dependent on the data that comes forward — what is happening in Indian Country? So if we want to be accurate, we have to do oversampling. It is just what you have to do in order to study American Indians. So thanks.

MR. JIM: Thank you. Let's go to the federal and then Mr. Allen. And don't get nerdy on us. Use language we understand.

(Laughter)

MR. MALONEY: I look nerdy enough probably. Hi, everybody. My name is Joe Maloney. I am the acting director for the Tribal Support Unit for the Centers for Disease Control and Prevention. And I just wanted to acknowledge Councilman Antone's nice list of CDC actions. So duly noted, literally, and it is also helpful that Councilman Antone is our chair of the CDC Tribal Advisory Committee. So that is helpful.

Just a couple quick things from what was mentioned. So the Tribal EpiCenters as public health authorities, that is a fairly new development, and our public health law department at CDC, they have an issues brief around that issue, so that is going to be out in a week or two.

And just to mention that it very much is a priority at CDC for the tribal public health accreditation and we have some money available through the National Indian Health Board for some seed money for tribes to just begin to prepare themselves for accreditation. I just wanted to mention those two items specifically.

MR. JIM: Mr. Allen?

MR. ALLEN: Thanks, Mr. Chair. So on the advisory committee, we all appreciate the extra steps with regards to regions that are not submitting nominations. So I guess I am curious what the timing is to bring the committee together regardless of whether or not everybody has submitted nominations from their respective area.

We don't necessarily want to wait, and they can always come back on, get on later, but there is work to be done with regard to the opportunities that should be made available for research and some initiatives that tribes would like to see NIH advance.

MS. ETZ: Thank you so much for that comment. And I think we appreciate — let me just put it this way. No one is more eager than I am to stand this up and have our first meeting. And so we are just trying to balance that desire to move forward with our desire to make sure we have appropriate representation.

Our plan is whatever we have on March 18, we will move forward with. And as soon as we are able to notify all of the committee members, I think we will try to hold a meeting within about two months of that date. You know, we were hoping — our original plan was to have it March 2015 so we are definitely a little bit behind.

But we are not too far behind yet, and so we will — I can assure you that nobody is fighting for this — to, to roll this out more than I am. So thank you.

MS. MARX: This is Kitty Marx with CMS. I just wanted to respond, I guess, to some of the Medicaid issues that were raised by Mr. Joseph in regarding the reimbursements for nursing facilities and home and community-based services.

CMS does have several programs that can help reimbursement for services for long-term support services under Medicaid.

Of course the reimbursement rates vary from state to state but on the CMS.gov, American Indian/Alaska Native outreach page, we have a long-term support services roadmap that we have developed with our contractor and with the assistance of ACL and IHS that showcases ways that tribes can implement programs for the elderly and disabled in their communities.

And there are a lot of good examples and best practices there. In addition, CMS last year released a grant program called the Tribal Money Follows the Person grant funding that went to five states; Washington, Oklahoma, Wisconsin, Minnesota and North Dakota.

And this grant funding is in the process of — the states are in the process of developing proposals, working with the tribes in their states. And the purpose of this funding is to bring home elders who might be in institutions, maybe located off reservation, and bring them back to their home communities, and with the funding, provide them with the infrastructure with the tribes, with the infrastructure to provide care to these elders and disabled.

And then through what we call our 1915(c) Home & Community-Based Waivers program, sustain those services through reimbursement to Medicaid. So I wanted to let you know about that program. And then just in response to the Navajo Nation feasibility study, a report to Congress was submitted June 2014, and that report to Congress did indicate that it would be feasible for the Navajo Nation to operate as a state Medicaid agency.

The report was sent to Congress to the Finance Committee, Indian Affairs, and the House Energy and Commerce and Resources. So at this point, it will require authorization from Congress and probably appropriations but that would be up to Congress to decide but I want to let everybody know that the report to Congress has been submitted.

I think those are all the questions from CMS. Thank you.

MR. JIM: Mr. Joseph?

MR. JOSEPH: What I have been asking for is in IHS, a tribal encounter rate specifically for long-term care services in our facility and at homes. There is a big difference between — if you see what the state gets for an encounter rate for mental health services compared to what a tribal encounter rate is — and it was adjusted that way for a reason.

Because a lot of times we are in those hard-to-serve areas, and the costs could vary. I appreciate the money follows the person but a lot of our elders, actually they are in

our facility and they are given the cultural practices and treatments that actually — they feel more at home.

And some of the people who do go to their homes actually get abused, and that is why we keep them, some of them, in our rest homes because they need that extra care. Thank you.

MR. JIM: Thank you. Other federal responses?

(No response)

MR. JIM: If not, we will go and take a break. Be back on time. We only have 30 minutes to go over the budget and then the Secretary will be here.

(Whereupon, a brief recess was taken.)

MR. JIM: Good afternoon. It is 2:30 p.m., so let's go ahead and get started. We need to stick to the time, and thank you. In the next session we will have — Ms. Lillian Sparks Robinson will be the federal moderator. So we will go ahead and get started with the Indian Health Service Budget Priorities Open Discussion.

The IHS Budget Formulation Team will be presented by the tribal leadership Mr. Gary Hayes and Mr. Andy Joseph. The federal leadership will be by Robert McSwain and Dr. Roubideaux. And Elizabeth Fowler and Elizabeth Laurie will be federal representatives for questions and answers if needed.

So let's go ahead and get started. Mr. Hayes, you have the floor.

Indian Health Service Budget Priorities

IHS Budget Formulation Team

by Gary Hayes, Council Representative, Ute Mountain Ute Tribe

MR. HAYES: Good afternoon. I am Gary Hayes. I am tribal council, former chairman, vice chairman, of the Ute Mountain Ute tribe located in Towaoc, Colorado, God's country. And prior to that, politics, I served 25 years in the Navy and I retired. So I have been doing tribal politics for nine years, and being part of STAC and the IHS Budget Formulation Team.

So it is a great opportunity for us to discuss these issues, and my partner was supposed to take over now after I had done my introductions but I am going to go ahead and push on and persevere. The Navy says you have got to be flexible, so here I go.

Those who aren't familiar with, what we are part of is co-chair of the Tribal Budget Formulation Workgroup that was held a couple weeks ago here in DC, and thank you for allowing us this opportunity to present the fiscal 2017 budget recommendations for the Indian Health Service.

The Tribal Budget Formulation Workgroup members are appointed by tribes from each of the 12 IHS service area regions to develop an annual tribal budget recommendation for the IHS budget. In this annual process, tribes within each area meet directly with the IHS area office during the fall to establish the budget priority recommendations in their area.

The areas each send two delegates to Washington, DC, to participate in a national tribal budget formulation, which we held a couple weeks ago. This group negotiates specific national tribal budget priorities for the next budget formulation cycle, which is two years in the future.

This year, the workgroup once again strongly recommends full funding for IHS, and we have a handout here that was presented to you, and so you might want to review that. Overall we ask for a 22 percent increase. During the national work session, tribal leaders shared difficult stories from their communities to reinforce the importance of full funding for health services.

It is a trust responsibility that was created in treaties with our forefathers and reinforced by law. These promises must be honored. It is only too clear from the stories we continue to hear from our tribal communities that our people continue to suffer needlessly because of the lack of resources.

This year in particular, many tribal leaders expressed how frustrating it is for tribal leaders to try to put one health priority over another. The truth of the matter is that tribes feel strongly that all budget priorities are urgently needed and should be considered to be top priority within the IHS budget request.

So at this time I am going to go ahead and turn it over to Andy Joseph so he can continue on.

Comments

by Andy Joseph, Council Representative, Colville Business Council

MR. JOSEPH: To begin a 12-year phase-in of full funding of IHS, the workgroup recommends a 22 percent increase for the IHS — or $6.2 billion. The top five priorities include increases to hospitals and clinics, Purchased and Referred Care, alcohol and substance abuse, mental health and dental services.

Tribes believe this will provide an important start to give the IHS funding that we need and deserve. The Obama Administration has done a remarkable job in requesting

IHS increases for the last several years. We are excited to build on the work as we look to the FY2017 budget.

However, the majority of these increases have largely been targeted to backstop inflation for current services and provide funding for staffing for new facilities, payment on contract support costs obligations, population growth and facilities. This leaves very little funding, if any, to begin to fight the alarming disparities facing Indian communities.

At the national session, the tribal leaders reported that they are forced to cut basic programs such as Purchased and Referred Care, specialties in dental services, and are forced to defer much needed facilities maintenance and repairs, deny a patient travel and ignore upgrades needed to ensure safe patient care through meaningful use of electronic health records.

They also express how difficult it was to prioritize between budget needs. Many expressed the concern that all these unmet needs are top priorities. We also discussed the importance of ending sequestration for Indian Country, supporting mandatory appropriations for IHS and additional funding to fully fund the Indian Health Care Improvement Act, new provisions.

Over the next few weeks, our technical workgroup will develop the official recommendation document that will be subsequently presented to the Administration and Congress on the tribal budget priorities. During this session today, we would like to receive your input on the work that we have done so far and hear what needs and priorities are important to your communities.

With that we can open up the session to remarks from other tribal leaders. Thank you.

Open Discussion

MR. JIM: Mr. Hayes?

MR. HAYES: What has been handed out is a snapshot, a summary of what we — of the outcome of that meeting a couple weeks ago. As you look at the FY2017, the request that we are asking again is 22 percent increase. That is about a $2.1 billion increase for our programs.

And again the challenges that we felt and needed again were the priorities, and how can we choose one program over another? Let me give you an example. The Great Plains, in their submission, in their tribal leadership, did not provide figures to support the 5 percent cut or 5 percent or even the 17 percent increase that was requested by IHS.

And their position is, it is the position of the Great Plains leadership that the figures proposed do not accurately reflect the unmet needs in the Great Plains region nor do these options provide adequate funding for the provisions of health care authorized under the Indian Health Care Improvement Act.

So that was basically — the message was loud and clear. As we look at coming together and asking those questions, what is a priority? And what we would like to say is the initiatives. And part of that process we look at as we identify what is the truly actual need in our communities.

We understand that it is about $29 billion but let's really go back and identify and see how many social service workers you really need. How many mental professional workers do you really need in your communities?

And we talked with some of the tribal leaders about the issue that is ongoing when we talk about mental and substance abuse, about this issue of marijuana now. The smoke coming from the reservations is not the old-time smoke signals. It is something

different now. So that is something that we need to be mindful of, and the direction that we are looking at as far as the support that we get. It was already mentioned about behavioral health.

And how are we going to require those programs or resources to help our communities? And with the lack of funding that we receive, and the report, as I mentioned earlier, IHS has received significant increases from this Administration of 53 percent from Obama's Administration.

And we talked about medical inflation. And when you look at the overall, it is like between 2 and 4 percent really in increases for our programs. And so in order for us to continue to, as we meet with our federal officials, and we are grateful for this opportunity again, but I would first like to thank those who participated in the workgroup. If you can stand just to — some of the tech advisors.

(Standing)

MR. HAYES: We appreciate your help and assistance in putting this together. I am hoping that we have a meaningful discussion here and, again, for tribal leaders this is a very sensitive issue when you talk about priorities. How do you rank one program over another? As you can see the list there, we had 19. The initial was to look at 5.

And we wanted to make sure that we list all the programs and to include each one of them. With that, vice president.

MR. JOSEPH: One more thing. Just looking at the math, we got a report earlier from HHS staff that talked about the increases that we got. Those are increases off of only about — not even 16 percent of what the real need for IHS' budget is.

You know, last year's budget was at 4.6, and I believe the total need was 28.8. If you do the math, we are only receiving about 1/16 percent of total need for IHS. And that needs to be reflected in our report. Thank you.

MR. JIM: Thank you. Mr. McSwain? Or Ms. Fowler, go ahead.

MS. FOWLER: Good afternoon everyone. I am representing Mr. McSwain. I am Elizabeth Fowler, Deputy Director for Management Operations for IHS.

I just wanted to acknowledge the comments, and thank you for your remarks. I do understand that you are asking for input from tribal leaders at this point in time, for input or comments on the recommendations that you have presented and we are willing to listen to those comments and respond.

MR. JIM: Dr. Roubideaux.

DR. ROUBIDEAUX: Well, thank you. And I want to thank the IHS Budget Formulation Workgroup for their great work. It is really hard, and I know that sometimes those meetings are pleasant and sometimes they are challenging. And the bottom line is nobody wants to prioritize the budget. We all want the $29 billion. That is the absolute truth.

But we are unfortunately in a situation where Congress is trying to cut the budget. But the good thing is that this President, this Secretary, they have been able to prioritize the Indian Health Service to get the 53 percent increase. We recognize it is not enough. But based on, you know, all the other agency budgets, we have been proposed for increases every single year.

And it is the strength of the recommendations that budget formulation makes to us. When I first got here there was a process of you could only present a 2 percent or 5

percent budget. And we did away with that because I wanted you to have the opportunity to present the budget you wanted.

And I know that even 22 percent isn't enough but I appreciate that because the hard work of the Administration is, given the reality of the budget, they do have to prioritize. And if you leave it up to the Administration to do it themselves, they might not get it right.

And so even though it is hard, it does help when tribes do prioritize because the Administration will make better decisions in partnership rather than alone. And, you know, the '16 budget is an example of your priorities getting through. And lots of priorities getting through at lots of agencies, so your consultation is making a big difference.

So I appreciate the work that you have done. The Department will, of course, take a good look at it. Our practice with the Indian Health Service was to say, when we went to meet with the Department and OMB, the first thing we said was, here are the tribal recommendations. This is what the tribes want.

And so the Department and OMB know that is the first thing we are going to say. And so we appreciate having it in a form that helps, but we really look forward to your final budget recommendations after you have received input, and all of us in the Department of Health and Human Services will work hard to get the biggest increases possible.

MR. JIM: Thank you. I understand too that in April we will present the budget to the HHS, including the Secretary? Will she be there? Somebody was telling me that. Mr. Hayes?

MR. HAYES: There is a proposal, you know, trying to get the Secretary there. Because normally what we do at this, right — today, normally, historically — we would actually be doing a Powerpoint presentation on these priorities. But because of the timeliness and because of getting this together, we are proposing that we do it — it is going

to be a separate session, I believe, that we are asking to present it to you once we complete our —

So this is a new process. Okay, there we go. We are adjusting and trying to do what we can. But I want to just go back really quick to what we mentioned about the discussion we had. And it was a challenge for us because when we — and the majority of the regions went to the 17 percent. Some went to 25 percent.

And to look at — oh, recommendation was 22. So when you put that up, and you are saying which is the priority, so we tried to do it fairly and equitably in all the programs, increasing them.

And I just want to commend and thank the tribal leaders for the last couple years since I have been part of this process, initially the contract health service, as it was formerly called, wasn't considered like a program.

But we knew that throughout our communities that was key to providing services because of the priority system that it wasn't a program but we as tribal leaders ensure that now that is a high priority, one of the high priorities, in funding and ensuring that PRC now is on the table for that discussion.

DR. ROUBIDEAUX: I have a question. In the last few years, there is always the struggle about area-specific needs versus increases that benefit all. And I know there had been some talk about trying to get a more general increase, and then areas could decide how to allocate those funds. Did you have that discussion at budget formulation?

MR. JOSEPH: Yes, we did. A lot of the area — the way the process is, for any of our new tribal leaders who are here, each area sends in their priority list and then the Department takes that and they run averages. And then we come up with what the national average is and the national priorities.

So you might get a budget that might be, let's say, mental health strong. Some areas might not need that much mental health but they would like to spend it more into prevention or some other line item. So the areas we are looking at, okay, when we get our part of the budget back home, why don't we spend the money in what our priorities that we submitted would be because each area is different. Thank you.

MR. HAYES: And Dr. Roubideaux, there was some discussion about that also being more flexible and trying, especially in a specific area, to have hospitals and clinics. On the handout there, it was No. 6.

It was to try to be more flexible with that line item because we want more — again I use the word flexibility — for it to be tribally driven, to be able to let the tribal government make those decisions on where — just give us the funds and we will ensure that we take care of our hospitals and clinics and the programs they provide. So that was part of, one of the recommendations.

MR. JIM: Any comments, recommendations from tribal leadership? Mr. Vigil?

MR. VIGIL: First of all, thank you, Chairman Hayes and Mr. Joseph and the members of the workgroup who put that budget together. I know it is a challenging job but we still have the same problems in our areas because when we were asked to put our priorities together, we are doing the same thing you are doing except in our local areas, and that is the problem.

When you are trying to prioritize at the local — everybody has a different need and different areas, and it is hard to come up with that priority list.

And, you know, while you look at the amount, and they are asking for 22 percent, and like you are saying, it is not enough. Well, it looks like there is a lot of money

being generated. By the time the federal government takes their share, and the regional get their share, and by the time it gets to us, it is just a drop in the bucket.

And so it doesn't address all the needs that we have, all the things that we need to accomplish, especially like in my area. We have a service unit that is just a clinic now. It is not even a hospital anymore. And so one of the things we need to do is to try to encourage our people to enroll in some kind of health care so that they at least have some kind of coverage. But we don't hit everybody.

And so the ones who don't get the coverage are the ones who are going to be left out in the cold when it comes to some major medical issue that they are confronted with. And if they don't have health insurance, they are going to be in hard shape.

And so I think that is what we need to look at. We need to look at — the funding needs to be developed from the bottom up, and give the majority of the money, like Mr. Joseph or Mr. Hayes said, give us the money. And then we will spend it the way we feel it is necessary.

And I am agreeable to accountability but I think tribes are more accountable with their funds than some in the federal government themselves. So my recommendation would be that we look at that seriously. Thank you.

MR. JIM: Mr. Allen?

MR. ALLEN: Thank you, Mr. Chair. I too want to compliment Andy and Gary with regard to the outline that captures the depth of the need in Indian Country.

And I think that this Administration has known it. This has been a consistent report that has been provided to it now for a number of years so this team has continued to scrub these numbers and come up with what I consider legitimate justification for the need, and we are well aware of the challenges of the budget and the wrestling match between the

Administration's proposal versus what Congress decides is in their will to appropriate for Indian Country.

I do want to note that the $460 million add-to for '16, which I equate to 9 percent. Is that what I saw? And I am assuming that within that $460 is some CSC because the mandatory is proposed to be in '17 so it is not in '16. So you are saying yes, there is inclusive of it.

Some of us have been advocating to OMB to get them to be supportive as we try to champion to move that mandatory up into '16, so not '17, because sooner is better in terms of getting the federal government to recognize that these treaty obligations are historical, moral obligations to the Indian communities is something that really needs to, you know, be honored.

So how do you get to what our budget committee is recommending, and that certainly is a positive step. So, you know, their recommendation of 22 percent versus the 9 percent, and then reflecting back on — the backdrop of the last 6 years where the increase has been more in the 3 percent range, give or take.

So it hasn't been a lot. It has been something. And one thing that has always frustrated me is the inflationary rate that IHS uses is lower than what you would see over in HHS. And I don't know what the statutory restrictions are or what the conditions are, why we don't get the same inflationary rate that the other similar entities receive in HHS.

So I am curious about that adjustment that usually happens on an annual basis. But it is a positive step, so I just want to say I am hopeful the Administration, when you begin this wrestling match between you and Congress, and Congress decides what they think that they want to appropriate, that you do hang onto that 460 because that 9 percent is a big deal. It does solve some problems.

I think that is going to be really important. And then if we are so fortunate to get the CSC off the table and into mandatory, that is going to be a huge — not just a relief in terms of securing those resources from that pot of money, if you will. But to help us, you know, not compete for contractual obligations versus programmatic service obligations to our Indian communities. So I will stop there.

MR. JIM: Thank you. We will go ahead and stop here because the Secretary will be here at 3:00 p.m. I understand.

MR. DIOGUARDI: She is on her way down so we might have time for one more comment.

MR. JIM: Mr. Antone? Make it quick.

MR. ANTONE: I just wanted to ask on the budget recommendations on number 11 and 19, they are both at one but one is up further on the chain than the other one area. How did that come about?

MR. JIM: Response?

MR. HAYES: As you can see, on the recommendation in front, because contract support costs, when you really look at it, it was across the board. And we took that and said, well, part of our recommendation, number 5, if it is reclassified, then for FY17, that wouldn't be part of that, so as our deliberations were occurring, that was one thing that we always had to be mindful of. If it happens, this is what it is going to be in the future for FY17.

If not, then we are going to have to revisit this again.

MR. ANTONE: Yes, I was just concerned about or curious about all the other that says seven areas, five areas, three areas, three areas, one area. That is why I asked about it.

MR. JIM: Thank you. Dr. Roubideaux?

DR. ROUBIDEAUX: Yes, and in the spirit of us all fighting for the biggest increases possible, please help us advocate to Congress for the fiscal year 2016 budget, the $460 million. That is the one thing I can tell you to say to Congress. Please help us support the President's budget, not just for the Indian Health Service but all of the initiatives that benefit Indian Country.

They are going to be doing hearings and they are going to be deciding what they are going to be doing soon so it is of the utmost importance. And on the contract support costs thing, as soon as you can find champions in Congress to help move it forward, we want to work with you.

We have been working on this, as you well know, self-governance and contract support costs. We have been working on this for a couple years now and have been fighting for it. But we have got to find those Congressional champions who are going to move it across the finish line for us. So thanks for your help.

MR. JIM: Thank you. Do you have further questions of those two, Mr. Hayes and Mr. Joseph?

(No response)

MR. JIM: And when the Secretary gets here, I would like for you to again — we represent our nations so let's exhibit diplomacy and let's get to the point. And we can be assertive. And I would also like to ask you to — if your nation's representative already spoke, to give others time as well. We need to make sure that as many nations' representatives speak to some of these critical issues.

So having said that, try to keep it to two minutes because if we all — everybody around the table speaks, we are looking at 40, 50 minutes. And with the Secretary's remarks,

we won't have any time for discussion. And I thank you for your commitment to the time and for your understanding.

MR. : Why are you looking at me?

(Laughter)

MR. JIM: I just wanted to see your reaction. Here is the Secretary.

(Pause)

Tribal Leaders and HHS Secretary's Budget Council Roundtable Discussion

MR. JIM: Madam Secretary, thank you so much for your presence, and we appreciate your time. All these people around the table there represent tribal nations, elected leaders. And we would like to give you a few minutes to make your remarks and then we will give them the floor to make comments and offer questions.

But one of the first things we really emphasize is we are tribal, sovereign nations, and we are here to have government-to-government conversations. We are here to ask for your support. For example, we have a $29.7 billion need. That is just to cover the basics, the foundation that we are asking for. And we will let the tribal leadership speak to the more specific issues.

And we thank you for your time, so we will give the floor to you.

Secretary's Remarks

HHS Secretary Sylvia Burwell

MS. BURWELL: Thank you, thank you very much. And I have had the chance to meet with a few of you all before, and I see some new faces that I will look forward to hearing from as well.

I want to thank our moderator and our person who, I think, is going to keep us all together. This is the first time we have had the chance to meet, in terms of our other two meetings, so it is a privilege. And thank you very much.

I also want to make sure that I recognize Lillian, who is part of our team; Paul, as part of our team; as well as I think you all have met — Mary is there, and we have Doug. Is Doug — yes, Doug is right there. I want to recognize members of our team and Stacey as well.

And also especially want to thank and recognize Yvette, for her leadership because we are going to be talking about budget issues a lot. And I just want to recognize that the budget we are going to talk a little bit — I will just briefly touch on the ’16 budget because I want to hear your input for the next budget. That is the purpose of our conversation.

But I want to thank Yvette for her strong leadership and pressing for what we feel is a quality budget. But hearing, listening, making sure we are all listening on a regular basis. I have the opportunity to do that a number of times a year but Yvette is there every day as that voice. And so I want to thank her as well.

As you said, I am going to be very brief because I — some have heard me say this — there is the ratio of two ears to one mouth for a reason so I will try to use it in that form in terms of more listening than talking in terms of this session.

I think you all know that we are deeply committed to improving the lives of this community and working with you to do that. And I have been fortunate to meet with the Secretary’s Tribal Advisory Committee twice since I have been here, and I have only been here eight months.

I have also had the opportunity to actually have a visit to tribes in Washington state, which was great. And I am excited to be here today to have the opportunity to hear from you all. I think probably folks have touched on our budget for ’16 but I think it bears repeating because I think we think it is an important reflection of the commitment, an important part of what we need to try to achieve this year.

Having just come from two hours and 45 minutes of budget testimony today and two hours and 30 minutes on budget testimony yesterday, it is very important that what we have put forth in the ’16 budget, that we all work very hard to make it a reality, which was part of what those hearings and testimony are about.

I think you all know there is an 8 percent increase in our funding at HHS for these issues, for IHS. And I should also reflect that for the Department as a whole there is only a 6 percent increase.

So the increase in the funding here is disproportionate and more in terms of how we look and think about that funding, and that is something we feel is the right thing, and we are excited, and I have been up on the Hill having discussions and have mentioned it in all of my oral testimonies, of course in my written testimonies, but have made sure to mention this issue is part of what we want to highlight in our budget. So an important issue.

And I think you all probably have had some conversations. It does reflect our all of government approach. We are trying to make sure that we work together with our other departments on a series and number of issues.

While the health issue is firmly rooted and centered with us, there are a number of other issues, and whether that is our Generation Indigenous effort, which cuts across a number of departments, as well as some of the other issues in terms of — while

mental health and some of the substances issues are with us, we also share those with other parts of the government, and we will continue to work on those.

So I think with that, the only other thing I wanted to touch on before I listen is the Affordable Care Act. And I just think it is an essential part of resolving the health disparities that we see in this nation, and I think some of the topics today we are going to talk about are some of those health disparities.

And it is important because of the access that it can provide to quality care, and quality care that has prevention. Essential health benefits require that behavioral health, mental health, substance issues, be required in the plans.

And so while our open enrollment has closed, and you may have heard a little bit about that, it has not for this community. And so I just want to make sure that is on your radar screen. I think it is both important from the perspective of the individuals and the care and coverage they can receive.

But it is also important as one thinks about, in your communities, the payment mechanisms in terms of people being insured and how payment comes through in different ways. So I just wanted to make sure I touch on that because the enrollment period is not closed. There is a special enrollment period.

That we want to make sure that information continues to move to the community so that they can benefit from it. With that, I am looking forward to listening and hearing your thoughts. That is what this session is about so we get that input and do that listening. We think we incorporated it hopefully well as part of our ’16 budget, and we want to do that again.

So thank you all for time. It is your expertise and advice that will make us better at what we do. And so we greatly appreciate your willingness to be a part of these conversations and to give us your good counsel. Thank you.

Tribal Leaders Discussion

MR. JIM: Thank you, Madam Secretary. Mr. Allen?

MR. ALLEN: Thank you. I am surprised he called on me that quickly. Madam Secretary, it is good to see you again, as always, and we definitely appreciate your sensitivity and understanding of Indian Country's agenda.

Without a doubt that in HHS, throughout its system, and its operations, many of your programs — well, all your programs — affect us one way or another. And I did want to point out that OMB has identified $19 billion that goes out into Indian Country. The question is, a great deal of that $19 billion is in this Department. And it is a matter of how tribes can access those moneys.

So a big ticket item here is always IHS, advocating for the IHS budget. You know, the proposed $460 million increase. We deeply appreciate it. We deeply appreciate the Administration advancing, moving CSC into mandatory. You are going to see us advocate to move it up.

I saw that little article about the dock bill, you know, $174 billion. You know, our little $500 million could slip right into that little bill nice and easy. You wouldn't even see us, quite frankly.

We Indians like to disappear every now and then. But most of the time we like to be known. But it is a big deal. It is a contractual obligation. And you know that. When you

were over at OMB, we made that case, and now you are here and you see how it affects us here within IHS as well as the other department, DOI.

So I will leave it at that. I am on the TTAG with regard to CMS, and needing the resources to make sure that our programs and our systems being acknowledged as providers. Outreach, getting our people enrolled, et cetera. That requires some resources to get that done, and so we are looking for additional resources to make sure that ACA works the way it should be working.

MS. BURWELL: Thank you. And we will look forward to your support with regard to that issue of the move to mandatory. Having been through two hearings in the last two days, I am — there is pushback in terms of that because it will require pay fors and offsets.

And so just making sure everyone understands that I think we believe it is the right way with regard to speed. If the Congress would choose to do this faster — we put the time in for consultation. We wanted the Congress to have the opportunity for the consultation as appropriate.

But, you know, with regard to the question of speed but I think there is the overall question, so I look forward to working with you all. As I have said, the last two days I have pushed — and even when it wasn't raised, I have raised it because it is an important issue that we think should be taken care of that way.

As I said, I received a lot of questions about how that could occur but know that we can all work together on this one.

MR. JIM: Mr. Dixon?

MR. DIXON: Thank you, Vice President Jim. Good afternoon, Secretary Burwell. My name is Stacy Dixon, the tribal chairman for the Susanville Indian Rancheria in

California. As for me, I am the delegate for the budget formulation and alternate for the STAC representative.

Formally I haven't met you yet but eventually I will get to that point. But as of our delegate, Elaine Fink, our chairperson from North Fork Rancheria, she is our delegate for California. I just got a brief statement. We just want to make sure — California is under the radar so — because as for us, there are 104 federally recognized tribes, recognized in California.

The California tribal leaders voted on the top five California budget priorities, the first one of which is diabetes. Diabetes is no longer just affecting our adults but it is also affecting our younger kids age 2 to 5 years.

22.6 percent of these kids have BMI that are above the 95 percentile at California tribal health programs.

Number 2 is the Purchased and Referred Care, formerly contract health service. There are no federally operated health care clinics or hospitals in California. The tribal contract did a compacted health care but clinics rely heavily on Purchased and Referred Care.

Behavioral health; Because of the lack of funding for depression screening, domestic violence, intimate partner violence screening and fetal alcohol syndrome screening and prevention, patients go undetected.

Maintenance improvement for health facilities; The current backlog on deferred maintenance in California is over $16 million.

Methamphetamine/suicide prevention; These funds are critical to help reimburse prevention activities within the Native communities and assist with psychiatry services so needed for many of our people.

In California there are eight urban Indian health care programs ranging from community health to comprehensive primary health care service, providing care to 10,000 American Indian/Alaska Native active users. The urban programs play a role in overall health care of all American Indian/Alaska Natives. The tribal leaders in California support funding to increase for the urban and health care programs.

The Tejon Tribe in California has recently added tribal members, which has doubled their size, resulting in a request of additional $1,022,940 in funding to serve their new population. A funding request for Smith River Rancheria for $490,340 is also being requested.

January finished as one of our driest Januarys in California on historical record, and very little meaningful participation throughout the state. Some of our tribal communities this past year had to have water brought into their community.

With the drought conditions continue is a — on what effect the lack of the water will have on California tribal communities. This coming summer and fall, your support of activities that help Native communities deal with the strain of the drought is being sought and appreciated.

California is requesting continued support for full staffing of the Southern and Northern YRTC in the fiscal year 2017 budget request. Full staffing is considered in the 2016 budget, President's budget, but staffing for the northern YRTC is still outstanding.

I appreciate having the time for representing the California tribes.

MS. BURWELL: Thank you. And the maintenance issue, just as we are tying across the forward and the current, I just want to make sure everyone knows we have funds in the current budget about that and so it would be important because of the backlog you are mentioning specifically in California — they exist across the board.

And so any — we want to get started and get to work. That is what those funds are about, those maintenance backlogs and so we are hopeful that we will get support for that funding. It is part of our additional funding ask that we have asked the Congress for, and so I just want to highlight that.

So in your conversations, you know that is a place where we align and we are trying to move that ball. If we can move it this year, it will help us next year.

MR. JIM: Ms. Morillo? Oh, she is not here. Okay, Mr. Payment?

MR. PAYMENT: Good afternoon, Madam Secretary. As you know, my name is Aaron Payment. I am the chairperson of the Sault Tribe. The federal trust and treaty obligation for my tribe currently funds about 56 percent of our identified need. And I bring this up every time but I have to keep doing it.

44 percent of our negotiated need is just not met. For the 2/3 of my members who do not reside in our service delivery area — it is no longer CHISDA so I am not sure what to call it — who don't live in our service area, and who are not covered by Medicaid expansion, those who don't live in Michigan, there is 1/3 of our members who just are not covered.

And so we are concerned about that. But I believe we are at the precipice in history with the President's budget request to make mandatory portion of the treaty and trust obligation. I proudly serve on your Secretary's Advisory Council and also on the IHS Contract Support Costs Workgroup, which strongly supports President Obama's request to make mandatory our CSC funding.

Our federal trust partnership worked hard to create our CSC calculator that is predictable but flexible. This should aid in creating comfort level in Congress, as they look for

accountability, with moving our contract support costs funding to the mandatory side of the ledger.

Our workgroup strongly urges Congress to recognize the yearlong consultation that has already happened plus the expedited consultation we are currently doing. I would be remiss — today is my Auntie's birthday, my Aunt —. She would be 68 years old today except we lost her 18 years ago when she died at 50 of a heart attack.

That is all too often in our family. My life expectancy, my family's, is 62 years old. And before she died she had a limb amputated and she was only 44 years old due to diabetes. So the budgets that we are talking about are a matter of life and death in our Indian community.

All funding should honor the trust and treaty obligations and should be mandatory, but we are pleased and grateful to the President for taking this historical first step. I want to also recognize, because a little bird whispered in my ear to give me an idea of how much your strategic and stealth advocacy helped us to move this to an actual request.

So I want to personally thank you for that. A year ago we were nervous about you coming here but now we are grateful so thank you very much.

I also want to say that for the Generation Indigenous, which they call Gen I or — it sounds a lot like Jedi but it is not — my tribe has joined as one — the challenge, we have accepted the challenge and we are doing a viral video, of which I am putting forward a personal contribution of $1,000 to get my youth council to put together a video to urge other youth to understand, first of all, they are not invulnerable.

And number 2, to talk about a very serious issue, and that is suicide that is happening in our community to give them some resiliency and to know whom they can

contact. And so my youth council is excited about doing it. They are going to write, produce and edit the whole thing. And so we are grateful for that.

And so finally I want to say that my tribe strongly supports reappointment of Dr. Roubideaux, and we stand ready to testify and talk to anybody and everybody who needs to hear it. Thank you.

MS. BURWELL: Thank you, thank you, thank you. And the video, that is great, making sure that young people hear from young people about these issues and how they can get access. And that is one of the things this funding will do, funding that is particular in terms of this community but across the board getting young people that access they need when they are having these issues and that they can know where to turn.

MR. JIM: Thank you, Madam Secretary. Those were chairmen, presidents and governors. We will go to the vice presidents now and the vice chairs. So since I am facilitating this, in my place I want to ask Ms. Crotty to speak on behalf of the Navajo Nation. Ms. Crotty?

MS. CROTTY: (Speaking Native language) Thank you very much for this opportunity. Honorable tribal leaders, distinguished federal officials and guests. It is an honor and a great responsibility to represent the Navajo Nation at this official tribal consultation session to share testimony on critical budget priorities concerning things that specifically pertain to the U.S. Department of Health and Human Services.

I am accompanied by members of the 23rd Navajo Nation Council delegates, our executive directors and staff. The Navajo Nation's government-to-government relationship with the U.S. is essential to access federal funds and technical assistance to prevent disease and strengthen our health, education and human services to benefit members and residents of the Navajo Nation.

The Navajo Nation is pleased to provide support and recommendations to the U.S. President's executive branch budget for congressional justification. The Navajo Nation continues to advocate and to receive direct funding from DHHS. We recommend that there be an interagency discussion and coordination among DHHS to set priorities for the budget.

The Navajo Nation recommends an increase of $2.1 million to total $11 million to fund American Indian and Alaska Native unintentional injury/prevention programs. As you may be aware, this is the cause of many of our mortality rates on Navajo Nation and in Indian Country as a whole.

The Methamphetamine and Suicide Prevention Initiative is a critical initiative congressionally funded in response to public health needs, and it is important to maintain or increase this level of funding.

The Navajo Nation passed our tribal resolution, C0-5014, to conduct due diligence toward the potential establishment of a Navajo Nation Medicaid agency. Funding and technical assistance are the next steps to establish this tribal agency. The Navajo Nation also continues to advocate for health care facilities to be constructed on Navajo Nation.

The Navajo Nation supports the FY16 budget proposal to an increase of $12.6 million for additional activities, projects of HIV/AIDS. However, it is important that CDC allocate portions to improve HIV and AIDS programs' effectiveness to tribes for prevention, care and treatment.

We also advocate for the hospital and health clinics. Tribal EpiCenter to increase base funding. Thank you for the SDPI three-year funding reauthorization. And the flexibility in the TANF programs for our children and welfare funding.

Navajo Nation supports the current IHS priority listing and requests that the federal government and other tribal entities continue to support the construction priority

listing and mandatory funding. Navajo Nation also deeply supports the Head Start and the child care funding partnership.

In the end I want to say I commend you for your time here to speak to all of the tribal leaders. We look forward to becoming a team player with you, and we support you in your vision for this great department. Thank you very much.

MS. BURWELL: Thank you, thank you. I look forward to working on those. That is a range of the issues, and I think you covered a lot, again the maintenance issue and some of these issues we are talking about in terms of behavioral health, and I think we are going to continue to emphasize those.

MR. JIM: Thank you. Ms. —.

(Pause)

MR. JIM: All right, thank you. Mr. Micklin?

MR. MICKLIN: Thank you, Vice President Jim. Madam Secretary, Dr. Roubideaux, Ms. Sparks Robinson, tribal leaders. Thank you for the opportunity to address you, Madam Secretary. I am Will Micklin. I am first vice president, Central Council of the Tlingit and Haida Indian Tribes of Alaska. We represent 30,000 tribal citizens in 43,000 square miles of southeast Alaska. It is about the size of the state of Indiana.

We occupy predominantly majority Native, Alaska Native villages as well as the urban areas of Juneau and Ketchikan, urban for southeast Alaska at least. I want to, first of all, say that we support the budget priorities established by the tribal leaders on the Tribal Budget Formulation Workgroup.

And we are grateful for the budgets and the funding that we do get through the advocacy of — through the efforts of you, Madam Secretary, and your staff at the Department. I just wish to speak briefly to the story behind the top-line numbers.

We know that there are challenges with the statutory caps that we live with, the 15 percent on CCDF, the 25 percent on Temporary Aid for Needy Families. This causes us — has caused us for many years to accept shortfalls in our indirect cost rate budget formulations.

We moved those programs out of our overall rate, but that has consequences. It reduced the pool for our BIA programs. It caused our indirect rate to escalate from 32 percent to 49 percent. That causes us to manage fewer programs with fewer dollars actually going to the programs.

We also have as a matter of reality that the temporary aid for needy families cash distribution is capped at $923. That is the same rate that was established in 1996. It exists as the same rate today.

That means that is a 32.7 percent decrease to value for the dollar. The rents in Juneau for those needy families — a family of four can get an apartment for an average cost of $1,000 a month in 2000. It is now $1,500 a month. That $923 is really insufficient for the needs that these families have.

And they are in our instance, in our region, predominantly families relocating from the villages to the urban areas in looking for employment.

Unemployment of 50 to 80 percent in the villages causes them to seek economic opportunity in the urban centers, and we are — frankly don't have the ability to provide them with a sufficient amount to make do while we are trying to keep them on the plans that we need to keep them on to successfully work through these programs.

Those cause real consequences. One of the solutions that we have found that we have asked for greater implementation, greater use of, is the 477 program.

We visited the Hill and our Alaska delegation and others, and are fairly confident that we can have a 477 bill passed in this session that will reaffirm the Congressional intent on one of our most successful programs, which is the 477 program that allows us to bring together funds from different sources, allows us to have a one-stop shop where a tribal citizen can come in who has no idea whether they qualify for TANF or vo-tech or Head Start or any of our myriad of programs.

And instead of sending them to a different person, a different receptionist to fill out a different form, we are able to have a one-stop shop. Well, that was challenged. We think that the Congress will iron out those issues but it is one of those things that we think we can apply more broadly to even greater efficiencies.

The last thing I will leave you with is really the underlying message, and one of our biggest challenges is suicide prevention. Now suicide prevention can be addressed in any number of subject matter specific programs where this is the cause so we will have a program for that or this may be another cause for it.

You know, we find that the strength of our society is our preservation of our culture and our indigenous institutions. Much like Navajo and Vice President Jim, whom you sit next to. They have preserved their languages, their cultures, their ceremonies, their stories and their ways of life.

So have we. We are a people of the land and the waters. We are the tides people. We are the Tlingits and the Haidas of southeast Alaska.

We find that when we are separated from our subsistence, our Native foods, which we are very challenged by in southeast Alaska, that when we are challenged by high unemployment, when we are challenged by health care problems that are not addressed

because there are limitations on the funding that can address these, that people resort to domestic violence.

They are driven to child abuse, they are driven to substance abuse, they are driven to basically — I don't want to say criminal but bad behavioral activities. And, you know, those can't be addressed by any one specific program. It is really bringing together a number of approaches.

And we find that our ability to reallocate our funding for different villages, for different problems, would be a much more efficient approach, and our ability to emphasize our aboriginal Native systems and ways of life make it ever-more productive in addressing these problems.

We need to better address our suicide among our youth. We need to better educate them. We need to give them greater opportunity. And so I would really thank you if we could continue our conversations. We think, in this area, we think that the Congress will give us a pathway with the adoption of the 477 bill in this session that Senator Murkowski is sponsoring.

And I think — I am hoping that will lead us to a renewed conversation about what more we can do under these authorities to reallocate programs while still reporting, still being responsible for the funds, still adhering to the requirements on use of funds but being more effective and efficient. So I thank you for your time and your attention and I am grateful for the opportunity to speak to you today.

MS. BURWELL: Thank you. In the interest of time I am only going to touch on one thing and go back to the beginning because I think it is an extremely important point.

You mentioned the caps. And I mention it because even champions of these issues — and fortunately the chairman of our committee is a champion in terms of

Congressman Cole from Oklahoma. We are fortunate to have a great champion in someone I have known and worked with.

But even the context for him of the caps. And I want to give you a sense of the caps so we understand what that means. It is sequester. It is the levels. The levels are the levels that are the sequester levels.

And so you have a sense of what that would mean for the government in its entirety, we would be funded at levels that would be funding things at 2006 in real dollars for some of our programs.

For our research programs at NIH, it would be at a 2002 level in real dollars to give you a sense of the question about — I just want to mention it because it is a very extreme situation if we are not able to get out of sequester.

Our budget reflects doing that. We pay for that. We have suggested ways to pay for that but this is a very important point because, you know, we think our budget is a good, sound one. But, you know, the questions I was asked dead on arrival because the caps are the law.

And so I just want to emphasize that point so we all understand what we need to make sure we get done in order to get the levels of funding that we are talking about in this budget, in the ’16 budget before us. And, you know, hopefully one can get a deal that would do two years, as we did with Ryan Murray. That would be ideal.

MR. JIM: Thank you. Mr. Pratt, do you have anything?

MR. PRATT: My name is Bruce Pratt, and I represent the Pawnee Nation. I am the vice president there. And I am very new at this but very thankful for your presence here and the presence of all of you. You know, we support the President’s budget.

The mandatory contract support costs are — my president, Marshall Gover, has always advocated for holding harmless the Direct Service Tribes in the things there. He is always mindful of reminding the government of their trust responsibility. And so I want to say that too.

You know, I can't imagine what you all think about at the high level even though you are talking about billions and we are down here at the lower level. We are just trying to help our own people. We see the faces. I have a daughter whose friend has so many troubles and comes from a very difficult home situation.

When she comes and she sees my daughter, and then she talks to me about things, and you know, as a parent, as a tribal leader, all I can do is cry with her and try to find help for her, and it is difficult because it seems like there are so many services that the doors are closed. There is not money, there is not room, there is not — the facilities aren't open.

And that is the level that we see, that we see. And even though we are looking at this budget and it is huge and it is still not enough, we see it at a somewhat lower level. We see the faces. We deal with the people. We know the names. We are members of those families and things.

So I would just say — remind you all that, you know, we are first Americans but we are all Americans. And I would be hopeful that we as tribal leaders continue to pray for you all, continue to pray for what you do and how you do because we need your help. We need you.

And so I am thankful to be here and support all the efforts that you all do, and I know it is mind-boggling to me trying to learn all of this stuff. Even the acronyms still trip me up. So I am thankful to be here. Appreciate you all. God bless you.

MS. BURWELL: Thank you, and we welcome the prayers and we also welcome the stories and the reminder of keeping it real because the numbers are one thing but what those numbers translate to. It is people every day, and their lives and what their lives are really like.

And so we welcome those reminders. That is an important part. I have spent the last months out with consumers on the health care issues and have met the folks that this means a difference to with regard to their health security and their financial security.

But in all the programs of HHS, we always welcome that reminder because that is who we are here to serve, and it is on an individual basis. It aggregates in numbers but what it means around everybody's kitchen table is really — I sometimes refer to us as the department of the kitchen table because we need to be focused on those things that are happening in people's lives and families every day.

MR. JIM: Thank you. We will go next to the council. Mr. Vigil and then Mr. Joseph and then Mr. Antone.

MR. VIGIL: Thank you, Vice Chairman Jim. Madam Secretary, thank you for being here to listen to our concerns.

This is the 17th Annual Tribal Budget and Policy Consultation, and I have been here — I don't want to age myself because I am only 29, but I have been coming to these consultation session where we are allowed a half an hour presentations, it went to 15 minutes, it went to 5 minutes. Now it is down to 2 minutes. So it has gotten shorter but the concerns, the needs are the same.

The 17th time where we come here, we make the same presentation. I also represent the National Indian Child Welfare Association. I am the president of the

association, so on behalf of NICWA, I gave my testimony earlier and I hope that will be shared with you also.

But also I want to thank you for your efforts and certainly the workgroup's effort in putting together the budget that they have been working on, on our behalf.

And I want to echo what Chairman Payment said. And I like his name, Payment. Because I think that is why we are here. We just want payment for our people to be served in a good way because all those things you heard of the testimony that has already been given, the need of our people. The people whom we see on a daily basis.

One of the comments I made in the past is we come to Washington, and we come in front of the leaders and we ask for funds. But we have to go back home. Well, you are going to go back home to — probably your nice home across the river into Virginia or wherever you are living at, your comfortable homes. We have to go back to our communities and tell our people, we are not coming home with any money because we were not given any money.

So our conditions are going to be the same, like I think the gentleman from Oklahoma was saying. Those are our people and we have to look out for them. And that is why we come here. And so my recommendation is basically that I know your predecessor is Secretary Sebelius has spent a day with us where she sat there with us and spent the whole day with tribal leaders discussing these issues.

In the future I recommend that we spend more time on this consultation on a government-to-government basis. Like you, we are busy. When we come to Washington, we try to cover all the bases. So we have set up our meetings with our Congressional representative. We go up on the Hill. We meet different agencies, Bureau of Indian Affairs, IHS.

So we are busy also. And I know you have a busy schedule, but if we planned it out in a way that we all come one day and we all sit together and talk about this on a true government-to-government consultation session.

And thank you for being here, and welcome, and I wish you well in your position. And of the people who are sitting with you, I have worked with them. You have got good people. If you work with them, I think we can accomplish a lot, including the leadership.

MS. BURWELL: Thank you, thank you.

MR. JIM: Mr. Joseph?

MR. JOSEPH: (Speaking Native language) Badger is my name. I am Andy Joseph Jr. I chair the Health and Human Services Committee for the Confederated Tribes of Colville, and also the chair of the Northwest Portland Area Indian Health Board. I sit on NIHB. I serve on several different work committees — the budget, the CSC for IHS, CDC and SAMHSA.

On the budget, I have heard this twice today from you and your staff about the 8 percent increase. And that is 8 percent of only close to 16 percent of actual need. And if you — I would hope that when you testify on our behalf, that that message gets out to Congress.

We need your help. You need our help, and like Gil said, we go on the Hill and we do our part as well. You look at this paper here and you will see we are on the bottom percentile of the whole nation's health care. I believe if the federal penitentiary is on there too, they would be getting served higher per person, and to me that is an inhumane way that the government is allowing our health care needs to be moved up.

I would hope that it would be the 8 percent of the $29 billion — that is the actual need — versus 8 percent of the 16 percent of last year's need. On the CSC Workgroup,

our workgroup unanimously — and we had both the, I really think that our IHS director pulled a pretty good workgroup together.

We had good people working from the Department and then we had tribal leaders there and we had our technical staff there. One of the things that we were pretty — we were unanimous on — was on the medical inflation rate. It needs to be put in that formula. If it is not in there — I imagine you probably use the medical inflation rate in all the rest of your departments. But for some reason they were not willing to look at that.

It just seems like we were getting pushback on that item. So I have been going on the Hill asking for that to be written into language to make sure that we are not going to be I guess looking substandard like what is in this paper. To me, it is really important that, that medical inflation rate is looked into.

Last summer I was never so grateful to have a staff person from your office and the IHS headquarters and OMB — they came to my reservation and they saw, you know, our health care facilities. Some of the ones that we built ourselves. There was an opportunity for joint venture to apply for, you know, a clinic in our biggest populated area, and with that, we would have gotten 110 new staff who would have been able to help.

One of the four districts that we were applying for — right now our tribe is only staffed at 34 federal paid positions for districts. It has been that way since, I believe, 1950 when IHS took over. You know what? I wish my tribe could be like some of the other tribes that have been waiting for so long for a facility, and the ones that do get it, it is like winning the lottery.

The rate of facilities — the Portland Area will not see a facility in over 30 years. So we were willing to pay for a facility ourselves, pay the extra medical equipment.

But the way that it was scored, because there is a non-tribal hospital across the river that we can't go into unless it is a priority one issue, and actually those doctors in that hospital, because it is a rural hospital, they send our people to Spokane or Seattle because they don't have the expertise. It is like the 1 1/2 doctors that we have in that district.

And that 1 1/2 doctor is actually taken from my district. We have five medical providers who are there. We declared a state of emergency on providers. The federal system on getting security clearance to hire doctors was a part of the problem in not being able to get someone who is licensed to provide medicine to come to Colville.

You know, the area office was actually rotating two doctors in, but one of them retired. And I got word that we have another one of our doctors retiring in May. So we are still in that state of emergency. We still need staffing. We would love to be like Cheyenne River Sioux who got a full staffing package. They can really take advantage of the Affordable Health Care Act.

You talk about telling people to sign up for insurance. You know, five doctors can only see so many of our people. And our user population is going downhill because you can't — you can only funnel so many people through those five providers.

My tribe is over 10,000, close to 10,000 members. And you know, we don't marry our own so we have — like my spouse is from a different tribe. Well, you can count on about 10,000 more that — anyway, those children our President saw, we have just as many children who need the health care. And to me that is really important.

Somehow you should look at the staffing needs of all of IHS. And let Congress know what the shortage is. I think the Affordable Health Care Act is a good thing but we can't take advantage of it. Thank you.

MS. BURWELL: The issue of providers is one that crosses a lot of communities that are underserved as well as this community. And one of the things is there is a major investment in the public health service corps, which is a very important part of serving underserved communities.

And we are hopeful that investment will occur. When we look at the minority participation also, in terms of that, in terms of trying to make sure there is a diverse population that is serving, it is at 30 percent. And then the population generally, it is only 10.

But the most important concept, I think, is making sure that there are health care providers, and that we are increasing the number of those providers that will go to underserved areas. So it is something that we are focused on not just in this community but more broadly and basically rural communities. Not all, but rural communities across the country. But it will serve your population as well.

MR. JIM: Thank you. Mr. Antone?

MR. ANTONE: Madam Secretary, I am Chester Antone, the representative of Tucson Area. I just want to thank the Department for the continuance of the uncompensated care costs in Arizona.

Yesterday, I wanted to let you know, I invited Mirtha Beadle and Pam Hyde to the Tohono O'odham Nation so we can begin discussing the mental health agenda, which I spoke to in December. And I know that you are aware of this issue as you had discussed that at the White House Conference as well.

And so — I talked to them about the development of some overarching common themes that run through all tribes. And that we put this together so that way we can basically identify who we are, define our well-being in our way and be able to work with federal agencies, especially if we can get that adopted by some Administration.

So without really going into the whole thing — you can ask Pam or Mirtha because I think they pretty much understand what I am saying. Or Sheila Cooper. And because of the time I just wanted to also let you know that we support the Special Diabetes Program for Indians. We will forward testimony on that because at present our tribe has the highest rate of diabetes across the country.

The dental health in IHS, 2017. I want to thank the workgroup for putting the dental health number — it is up there now — because it is a big issue. And not to put Dr. Roubideaux on the spot but we had been requesting that report for three years. We finally got it.

And we would ask that you would ask Mr. Frieden to be a little flexible on his budget. Two weeks ago we held our consultation with CDC, and all the responses were, it has to be this way. It has to be this way. It can't be that way. So I don't know if it has anything to do with scientific method but people are ingrained in over there.

And so the contract support costs mandatory we also support because if you look at the Bureau of Indian Affairs, Bureau of Indian Education reform, and you look at the Indian Health Service and the tribes over 300 have some self-governance.

So to me it kind of looks like IHS will probably become a technical resource center in the future. And that really prioritizes contract support costs for all tribes. Now I already asked SAMHSA, HRSA, NIH, CDC — about six agencies — if they could come together and support this mental health agenda that I am speaking of. And they will inform me of that.

Lastly I was told that ACF did not include the water systems program in their budget. It was a hard decision to make, they said. But I would ask for assistance in that we could — if we could find some way to keep that going whether here or whether somewhere else. Thank you.

MS. BURWELL: Thank you.

MR. JIM: Mr. Hayes?

MR. HAYES: Madam Secretary, thank you for this opportunity, and thank you for being here. And we look forward to this partnership that is part of the workgroup and our recommendations for fiscal year 2017.

The 2017 — we are not done with ’16 so it does have impact on what is going to happen with ’17 but as with this Administration, it has been a great opportunity, a landmark opportunity to turn that corner for Indian health care in our communities.

The theme for FY17 was turning the corner for Indian health; treaty and trust obligations, writing a new future for American Indians and Alaska Natives. As Chairman Payment talked about life expectancy, listen to me just give you some numbers regarding my tribe, and I am asking tribal leaders throughout Indian Country to also analyze their data also.

Since 1990, the average death of our tribal members is, for females, 54. For males, it is 50. So the average since 1990 has been 52. This is reconfirmed how our median age with this last 2010 census, when you look at our community, the two towns that are near us, their median age is 45. On my reservation, it is 27.

And if I also look and I say, well, let me look at Pine Ridge and Rosebud. Respectively 23 and 22. So there is an epidemic that is happening in our communities, whether it is mental health — we talked about historical trauma. But this is all dealing with the inadequacy, the injustice that has been occurring for decades before we were here.

And during your time here with this Administration, with the FY17 budget, it can leave a legacy, a footprint, that will continue what we have been — this 52 percent increase that has been occurring through IHS and Indian programs across the board.

And I am hoping that the President will support, and with the tribal leaders, today as we talked in workgroup, as Dr. Roubideaux mentioned, tribal leaders, we have to be a part of this participation, ensuring that the President's proposed budget is going through Congress, that it gets passed, and the recommendations of this Administration — because it is upon us.

We can come here and talk about this but we also share that burden and that responsibility. So that is what we will continue to advocate as the workgroup in this partnership.

And so those — I concur with many of the suggestions of contract support, the Special Diabetes Program for Indians, all these increases across the board because many of our communities mirror the stats I gave you off of my reservation. So thank you, Madam Secretary, appreciate it.

MS. BURWELL: If I asked the heads of your State House of Representatives and your State Senates in your state about those statistics, would they know?

(Chorus of No)

MS. BURWELL: We don't have time, so I am not going to get — because I want to hear from everyone. In the next STAC we will hopefully — Paul, can we make sure we have time? I want to discuss this issue because we need to figure it out.

I am not sure that — I have to be honest and say that state legislatures right now in this country, I am not sure that they would listen to me, having had a deal with Medicaid in terms of Tennessee and we saw what happened last night. Utah, for those of you who are from Utah, I think you saw what is happening —

So I am not sure but we need to think about this because it is just how I am seeing everything bleed through in terms of policy making and trying to get things. There is a

lack of knowledge that is happening around the country with regard to the substance of these issues, and how that impacts our ability — these facts, they are facts.

There is not — and so I will not take any more time but we will have that on our, an issue for us to discuss in the next time that we convene because I would love to understand how it works from your perspective so then I can think about ideas because I am not sure I am the answer or that the Obama Administration in any form will be the answer.

But let's understand it and see if we can figure it out because people need to understand because that is the way we are going to make progress on these issues, when more people understand the substance of what we are talking about, the numbers. Sorry, didn't mean to take us off.

MR. JIM: Thank you. We have time for one more comment from someone whose nation hasn't been represented. Anyone? Go ahead.

MS. SWITCH: Hi, my name is Lisa Switch. I am the tribal treasurer for the Iowa Tribe of Oklahoma. We are a very small tribe in Oklahoma, and we are — our administrative offices are in Perkins, Oklahoma. And we do have a clinic there, a small clinic.

And we are very appreciative for our funding we do receive, and just like Vice President Pratt here said, we see the people who come in. And so I am very thankful for the opportunity to be here today and say I am appreciative of the funding, and we also stand behind the National Tribal Budget Workgroup's recommendation.

Specifically, being exempted from the sequestration, because we were impacted by that the last time. The nation went ahead and put in dollars to keep those programs going. Also I want to say that we are in support of the President's proposal to reclassify the CSC from the discretionary to the mandatory. And the request for a higher percentage on the budget increase in the hospitals and clinics.

We hope to expand our clinic since we do provide medical services to the local area, non-Natives and Natives. So really, it really does impact us, the dollars that we do get, or that we don't get. So I just wanted to say thank you for your time today. And thank you for allowing me to express myself.

MS. BURWELL: Thank you.

MR. JIM: Madam Secretary, any closing remarks?

MS. BURWELL: I just want to express appreciation. It is important. These conversations are important. They are important for us to understand the priorities.

They are important for us to work in partnership in terms of — as I have just kind of come upon here at the end, we need to work on all these specifics but there is a broader general point, which is the knowledge that our nation has about the tribal nations in terms of what is happening, how that works, how that feels, and the stories.

It is about those numbers and stories. And so thinking through how we educate and communicate about that as we try and work toward making the numbers that are on the table right now in terms of this current budget a reality.

And building the kind of support where people believe and support the choices, because that is what, you know, the budget conversation is about. Which choices the nation, the U.S. part of this, you know, and the federal government here in Washington, are going to make and how it impacts.

So I appreciate your time. I appreciate — you know, so many of you serve on multiple committees, and we know that is hard, and we are very appreciative and know that you — whether it is the different pieces because there are a lot of pieces of HHS.

And so I do want to express appreciation for your time today for this conversation, and I will look forward to our next conversation. But even more I look forward

to hopefully getting some progress on the numbers that are in front of us now. We want to be informed in the next budget but I think deep focus on this '16 is important too.

And I think we have kind of gone back and forth in this conversation and I think that is very important and we are going to focus on it and we look forward to working in partnership with you all as we try and achieve what we have put forward so then we can work to build on it some more.

So thank you all very much. And I will look forward to seeing you again. Thank you.

(Applause)

MR. JIM: Thank you very much. That was a — try to be fair to everyone so they can put in their piece, but thank you very much. Mr. Dioguardi?

HHS Wrap-Up

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

MR. DIOGUARDI: I don't have much more to add by way of wrap-up. I want to again echo what the Secretary said about our appreciation for all of the conversation today but also all of the work that goes into this during the year in our regular communications with you. We need to keep that up. We need to keep moving that forward.

In terms of today's proceedings, as I said at the outset, we are always interested in improving it. I think this was a very good session, and it seemed like we were very focused on specific issues, specific budget items, specific programs. And that is incredibly helpful to us as we look to deliver results. But we are always looking to improve the process, so we will continue to engage all of you in improving that.

We want to note for everybody the regional consultations, which are ongoing throughout the spring across the country in all service areas. So I know many of you participate in those, and particularly for members of your tribes or others in your community or other tribes in your area who are not able to come to Washington, I really encourage you to attend, participate in those regional consultations.

All of what is said there also comes up to leadership here just as what is shared around this table does as well. So I want to encourage participation in that process as well. So thanks again. Apologies for the agenda and the snow today but we here in DC will learn how to deal with inclement weather one of these days. Thank you.

Tribal Closing

MR. JIM: Our elders in Indian Country deal more with it, snow. And thank you so much, tribal leaders for all your hard work. I appreciate it. And federal representatives, we appreciate your presence as well. And as normal, we would like to end this with a prayer. Mr. Antone, if you would honor us?

MR. ANTONE: Thank you all for today. Now we thank the Creator for today and for the days ahead, and for the days that are behind us.

(Closing prayer)

MR. JIM: Thank you. Safe travels home. This consultation session is now closed.

(Whereupon, the meeting adjourned at 4:06 p.m.)