

**U.S. Department of Health and Human Services  
18<sup>th</sup> Annual Tribal Budget and Policy Consultation Meeting**

*March 3, 2016*

***EXECUTIVE SUMMARY***

The 18th Annual Tribal Budget and Policy Consultation Meeting was held on Thursday, March 3, 2016, in Washington, D.C. Sponsored by the U.S. Department of Health and Human Services (HHS), the day-long meeting provided an opportunity for tribal leaders and representatives to share their views and concerns regarding HHS policy and funding priorities for Fiscal Year (FY) 2018, and to hear from federal officials. Plenary sessions on the agenda addressed the HHS budget; human services, public health, behavioral health, and Indian Health Service (IHS) priorities; HHS program and division updates; and formulation of the IHS budget. The agenda also included a roundtable discussion, featuring remarks from HHS Acting Deputy Secretary Mary Wakefield. Facilitated by Chester Antone, Chair, Secretary's Tribal Advisory Committee (STAC), and Council Representative, Tohono O'odham Nation; and Lillian Sparks Robinson, Commissioner, Administration for Native Americans (ANA), the meeting was convened in the Great Hall of the Hubert H. Humphrey Building. Leaders and representatives from tribes, Indian organization, and HHS attended the meeting. On the previous day, one-on-one meetings between tribes and HHS divisions were held to discuss specific health and human service issues.

The consultation meeting opened with Chairman Antone welcoming the group during the *Tribal Opening Remarks* session and inviting Gil Vigil, President, National Indian Child Welfare Association, and Governor, Pueblo of Tesuque, to deliver the opening prayer. After the invocation, Chairman Antone asked Emily Barson, Office of Intergovernmental and External Affairs (IEA), to give remarks for the *Welcoming and Opening Remarks from HHS* session. She too welcomed the attendees and noted the influence tribal leaders have concerning the HHS budget. After acknowledging the IEA team that assisted with coordination of the consultation meeting, as well as asking members of the Intradepartmental Council on Native American Affairs (ICNAA) to stand to be recognized for their contributions to the meeting, Ms. Barson provided an overview of the day's agenda.

After having all of the tribal leaders and representatives introduce themselves, Chairman Antone introduced the speaker for the *HHS Budget Overview and Update* session, Ms. Jillian Curtis, Public Health and Social Services Branch Chief, Office of Budget. Ms. Curtis first reiterated the sentiment that tribal input is essential to the formulation of the President's budget each year; then she proceeded to provide an overview of the FY 2016 appropriations bill that was passed last December, followed by an overview of the funding that is included in the FY 2017 President's budget, and a status update on the FY 2017 appropriations process. She said the FY 2016 appropriations bill included \$4.8 billion in budget authority for the IHS, an increase of \$165 million above FY 2015 (but \$295 million below the President's budget request

for that year). Congress also provided an indefinite appropriation for contract support costs (CSC), allowing HHS to fully fund CSC, as needed, without directing funds away from direct services. Also of note, Ms. Curtis said the FY 2016 appropriation did not include an increase in Purchased/Referred Care (PRC), but it included substantial increases for facilities construction, sanitation facilities construction and maintenance and improvement, as well as new resources for behavioral health services and supports for Native youth. Regarding the latter, \$10 million in new funding was added to the IHS budget and \$25 million to the SAMHSA budget for a partnership across the two agencies to increase the number of adolescent behavioral health professionals serving in Indian Country, and to increase the availability of behavioral health programs for Native adolescents and youth. Finally, regarding the FY 2016 appropriations bill, Ms. Curtis said it included passage of the Medicare Access and CHIP Reauthorization Act (MACRA) with a 2-year extension of the Special Diabetes Program for Indians (SDPI) at \$150 million (the current funding level).

Turning to the FY 2017 President's budget, Ms. Curtis indicated that a set of proposals were given to Congress early last month. She said the IHS budget includes a total of \$6.6 billion (a \$400 million increase above FY 2016), of which \$5.2 billion is budget authority. To lend perspective on the administration's continued commitment to services and supports for tribal communities, she added that the entire HHS discretionary budget was reduced by \$653 million below FY 2016. FY 2017's key tribal priorities include medical inflation and population growth; CSC; facilities and staffing; as well as behavioral health services, which has an increase of \$67 million in discretionary budget authority. Concerning CSC, Ms. Curtis said in FY 2018, CSC is slated to move to the mandatory side of the ledger with a 3-year capped appropriation, with funding increasing each year. If the FY 2017 budget passes, Indian Country will see \$4 million in support of pilots for the implementation of Zero Suicide, a comprehensive and system-wide strategy to implement the recommendations of the National Strategy on Suicide Prevention; a \$15 million increase for Generation Indigenous, to increase the number of child and adolescent behavioral health professionals in Indian Country and expand youth and adolescent programming for behavioral health; and \$2 million for a pilot that will provide aftercare services for Native youth who have completed treatment at youth regional treatment centers. On the mandatory side of the ledger, she said there is an HHS-wide mental health initiative that is \$500 million (split over 2 years). Specifically for IHS there is a \$30 million proposal to create a new Tribal Crisis Response Fund to allow IHS to provide needed short-, medium-, and long-term supports for tribes that are experiencing behavioral health crises. There is also \$20 million for IHS to focus on increasing the number of American Indian and Alaska Native (AI/AN) behavioral health professionals serving in Indian Country. Ms. Curtis also noted that the FY 2017 President's budget includes the permanent reauthorization of the SDPI at \$150 million and proposes legislation to unify the definition of an Indian across health eligibility programs.

Ms. Curtis acknowledged that most of the funding for Indian Country is in the IHS budget, but she said HHS is also looking to other agencies to see what they can bring to the table to support Indian Country and improve its health outcomes. To that end, she noted the following for FY 2017:

- Within the ACF budget, funding for tribes increases by \$192 million in total. That funding will be used both to support tribal communities in building capacity to run and administer their own child welfare systems; and it also reflects the administration's continuing commitment to achieving a guarantee for child care assistance for all low- and moderate-income families with children under the age of four.
- In the Centers for Disease Control and Prevention (CDC), there is a new \$15 million investment to expand the Good Health and Wellness in Indian Country program. This program currently focuses on chronic diseases, but the new dollars will build in a behavioral health component focusing on suicide, substance abuse, and vehicular deaths related to alcohol.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) budget includes a series of increases that will help to address the disproportionate burden of behavioral health issues for tribal communities.

In closing, Ms. Curtis said she and the administration were hopeful that Congress will continue to provide significant funding increases for tribal communities in the HHS budget; and she commented that the FY 2017 President's budget request represents a 58 percent increase in funding for the IHS since 2008. Noting that it is an election year and that there will be a Presidential transition in January, Ms. Curtis welcomed tribes' recommendations and input on FY 2018 budget priorities.

Following Ms. Curtis' presentation, the floor was opened for comments and questions. Support was expressed for moving CSC to the mandatory ledger and having a unified definition of Indian. Regarding the latter, concern was expressed about how the figure of \$520 million was derived in relation to expanding the definition of Indian, as the National Indian Health Board (NIHB) and tribes' review of the issue estimates the number at \$50 million over a 10 year period. It was noted that this issue has been raised to the STAC for follow-up. Also during the *Question and Answer* period, the following items were noted:

- Disappointment was expressed that PRC didn't receive an increase.
- There was a suggestion to have small ambulatory grants to allow small tribes to build smaller health care facilities, rather than only building a few large hospitals per year.
- There was also concern over tribal health care facilities losing funding and the need for continued support for long-term care service options.
- Tribes expressed a need for funding for the implementation of best practices concerning prevention.
- Appreciation for cross-agency collaborations was offered.
- A request was made that consideration be given to IHS facilities not having to deal with state regulations for encounter rates, but rather have regulations based on a government to government basis.
- Support was offered for direct funding to tribes, rather than going through a state.

- A request was made from the Navajo Nation for start-up funding to become its own Medicaid agency and recommendations were provided on how to proceed to request Congressional appropriations for this.

As appropriate, Ms. Curtis responded to the issues. Notably, she stated that the FY 2017 President's budget does include an increased funding request for small ambulatory grants; and she stressed that the Affordable Care Act (ACA), although certainly a positive step for tribal communities, is in no way perceived as a supplement for the needs of a PRC program. A full record of tribal participants' questions and comments, and applicable responses from federal officials, on this and other agenda topics is available via the comprehensive meeting transcript (under separate cover).

The next session, *Human Services Priorities*, featured representatives from SAMHSA, ACF, and the Administration for Children, Youth and Families (ACYF). Mirtha Beadle, Director, Office of Tribal Affairs and Policy, Office of Policy, Planning and Innovation, SAMHSA, was the first to present. Director Beadle said the issue around the human services budget is an important one, adding that for SAMHSA the connection between trauma and substance abuse and mental health issues is a very clear and well documented connection. SAMHSA, she said, has developed very specific documentation that it believes will be helpful to communities around improving trauma-informed care. Director Beadle also noted that SAMHSA has grants that focus on trauma, two that specifically target tribal communities. She said the Tribal Behavioral Health Grant program is funded at \$30 million for FY 2016; and the expectation is to fund another 100 tribal grants this year. SAMHSA also has the Circles of Care program, which is more of a systems planning program that also infuses trauma and trauma-informed care as part of its work. After mentioning specific trauma activities at SAMHSA, she recommended that they think about how they integrate the work on trauma, suicide, mental health, and substance use issues, saying they are all connected.

Mark Greenberg, Acting Assistant Secretary, ACF, was the next presenter to speak. Mr. Greenberg highlighted important aspects of ACF's FY 2017 budget proposal. Notably, he said last year the ANA had its highest budget level in history and they are seeking to make it bigger this year with a proposal of \$3.1 million. He said \$2 million is slated for grants to support Native youth resilience and leadership development through Native youth center and youth driven programming; and \$1.1 million would be for a specialized training and technical assistance center on fostering Native youth resilience that would develop materials, a website and other technical assistance efforts. The budget proposal also includes a request to remove the 2 percent limit on tribal set-asides for the Child Care Development Block Grant (CCDBG) on the mandatory budget side and increase the percentage to 2.75 on the discretionary side; and for the first time in 20 years, the proposal seeks an \$8 million increase in basic block grants for Temporary Assistance for Needy Families (TANF), as well as new grants and initiatives for which tribes would be eligible for along with states and counties.

Lastly, Rafael Lopez, Commissioner, ACYF, provided highlights of ACYF's FY 2017 budget proposal. Among the notable items he shared included a \$20 million increase in discretionary funds to support tribal child welfare systems; an additional \$3 million to expand the Tribal Court Improvement Program; upwards of \$40 million per year for 5 years to support cross-system collaboration and innovation in the needs of children and families via Regional Partnership Grants; proposed reauthorization of Family Connection Grant Program through FY 2021; and a proposed \$250 million to support a 5-year demonstration grant to address the over prescription of psychotropic medications. Other focus areas include expanding independent living to age 23, and investments in the child welfare workforce across the country. On the Family and Youth Services Bureau (FYSB) side of the house, Commissioner Lopez mentioned a proposed additional \$1 million for the Alaska Native Tribal Resource Center; and a proposal to re-authorize and modify the Family Violence and Prevention Services Act (FVPSA) to better respond to unmet need for domestic violence shelters and supported services, improve access for underserved populations, and promote adoption of emerging practices.

For the *Tribal Leader Testimony* portion of the presentation, the group heard from Governor Vigil. Governor Vigil focused his remarks on the Indian Child Welfare Act (ICWA), saying it has never been fully implemented or regularly enforced. Notwithstanding, he credited the Department of Justice (DOJ), HHS, and the Department of Interior (DOI) with coming together and working with tribes to improve ICWA enforcement. He also commended HHS for requesting new funding over the last 2 years to improve tribal access to programs and making policy changes to make programs more culturally appropriate. To this end, he said the changes will assist tribes as they seek to protect their children and families from questionable practices and advocate for better outcomes. Governor Vigil proceeded to give child welfare budget priorities for FY 2018. Those priorities included the following:

- Continue to request \$20 million in new funding under the title IV-B for the Promoting Safe and Stable Families program to assist with tribal capacity building.
- Increase the Tribal Court Improvement program funding to \$3.75 million.
- Continue the FY 2017 request to provide start-up funding for tribes who are approved to operate title IV-E Foster Care programs.
- Raise the allocation for the CCDBG and increase tribal allocations accordingly.

During the Q&A session, it was requested that Congress increase Low Income Energy Assistance Program (LIHEAP) funding to meet rising energy costs; a more significant commitment be made towards historical trauma and its resulting outcomes; more funding be given for substance abuse and mental health services, detoxification facilities, halfway houses, and wrap around services; and funding for SAMHSA be increased. Among other noted items included the need to break down the silos of the different sub-agencies within HHS to improve communication and better coordinate efforts; difficulty experienced by smaller tribes in trying to meet certain grant criteria without being in a consortium; concern about options for Natives 18 to 35 years old so they are not idle; the need for continued support of traditional practices such as equine therapy;

the need for increased grant flexibilities and direct funding to tribes; continued concern about ICWA enforcement; and the need for adequate funding to support tribes' needs.

In response to some of the comments, Director Beadle agreed that suicide in Indian Country is an epidemic and she reiterated SAMHSA's commitment to the problem. She also encouraged tribes to pursue available programs related to drug courts and tribal healing and wellness, and she welcomed feedback on how SAMHSA can further its ongoing efforts to streamline its grants to make them more accessible to tribes. Commissioner Lopez discussed the seven approved plans from tribes to implement tribal title IV-E; and he noted that five of them are currently in the implementation process. In response to various tribes' request for technical assistance concerning tribal title IV-E, he said ACYF will host another series of webinars to answer questions and provide guidance. He said ACYF is also contemplating how it can do meaningful pre-application engagement with tribes; and will institute monthly communications to dispel myths about tribal title IV-E. For his follow-up, Mr. Greenberg acknowledged the importance of focusing on ICWA; he said they are committed to getting through the process of the data reporting requirements for Adoption and Foster Care Analysis and Reporting; he noted that Congress has been asked to build in a contingency fund for LIHEAP; he acknowledged the importance of trauma and historical trauma; and he said some progress has been made, but ACF continues to seek ways to simplify the application process for tribes. Concerning the latter, Commissioner Sparks Robinson reminded the group of the STAC and ICNAA's work to identify and publicize all of HHS programs for which tribes are eligible to apply; and she said the next step is to increase the number of tribal applications and tribal awards for those programs. She also noted that ANA hopes to pilot a form to enable a more circular application process for tribes in the near future. Finally, Commissioner Lopez assured the group that the Department is desperately looking at how to more quickly and rapidly share information across systems and break down its silos.

The *Public Health Budget Priorities* session began with federal updates by Ursula Bauer, Director, National Center for Chronic Disease Prevention and Health Promotion, CDC; James Anderson, Deputy Director for the Division of Program Coordination, Planning and Strategic Initiatives, National Institutes of Health (NIH); and Leslie Kux, Associate Commissioner for Policy, Office of the Commissioner, Food and Drug Administration (FDA). Director Bauer was the first to present, sharing first an overview of CDC and its work focus. She said CDC invests \$140 million a year in Indian Country, with over \$100 million of that going towards contracts for services like information technology services and security services that they purchase. Approximately \$36 million goes to public health and prevention activities in Indian Country, with the largest grant, Good Health and Wellness in Indian Country, addressing the main risk factors for heart disease, cancer and diabetes. She said the program is currently funded at \$15 million a year, and the President's FY 2017 budget proposal includes another \$15 million for this program.

For his portion of the presentation, Dr. Anderson provided an update from NIH, the principal agency responsible for behavioral and biomedical research in the country and the largest in the

world. In brief, he said NIH does research to prevent disease and treat it, and invests in the special workforce and infrastructure required to do the research. Dr. Anderson relayed recent progress within NIH in setting up the infrastructure to enhance the way it does research, specifically focusing on areas relevant to AI/AN communities. Highlighted items included: NIH established its Tribal Consultation Advisory Committee (TCAC) last summer and held its first meeting in September; an “Indian Desk” was created within the NIH Tribal Health Research Office (THRO); a Director for the NIH Tribal Health Research Office (THRO) has been hired; and the NIH THRO will conduct an analysis of the NIH and federal AI/AN research and research training portfolio. Dr. Anderson also provided a brief update on topics discussed at the last TCAC meeting, including Institutional Review Board (IRB) training, peer review and reviewer training, and indigenous health research training.

Providing an update for the FDA, Ms. Kux said the agency has regulatory responsibility for protecting public health by ensuring the safety and efficacy of human and animal drugs, including biologics and medical devices. She said they also regulate the safety of the Nation’s food supply, cosmetics and radiation emitting products, and now also has jurisdiction over tobacco products. Ms. Kux spent the balance of her presentation time discussing FDA’s new Tribal Consultation Policy, which was recently issued in draft form. She informed the tribal leaders and representatives that FDA welcomes feedback on the policy and has set a deadline of May 31, 2016, for comments. She also indicated that a consultation session on the draft policy will be held on April 21, 2016. Ms. Kux ended her presentation by introducing Brian Kehoe, Acting Director of the Office of Intergovernmental Affairs, who will be the primary point person in FDA for all tribal matters.

Aaron Payment, STAC Vice Chairman; Secretary, National Congress of American Indian (NCAI); and Chairman, Sault Ste. Marie Tribe of Chippewa Indians, delivered the *Tribal Leader Testimony*. Specifically, he provided testimony on the FY 2018 budget directed to the Office of Minority Health (OMH). He also provided testimony on behalf of the American Indian and Alaskan Native Health Research Advisory Council (HRAC). Concerning OMH, in order to build a stronger, more sustainable foundation for the future of health care and public health in Indian Country, Chairperson Payment identified several areas targeted for improvement on behalf of the 567 federally recognized tribes. Among those items included: tribal set-asides for various OMH grant opportunities; dedicated funding to update the Annual Health Research Report; and leveraging available funds to increase the number of Navigators trained to serve the unique needs of tribal and urban Indian communities. He also noted a need for more specific technical expertise on American Indian health systems, among other areas for improvement. On behalf of the HRAC, Chairperson Payment offered various recommendations regarding research priorities for the various HHS operating and staff divisions. Among those priorities included development of an HHS-wide umbrella policy for conducting research in tribal communities; funding that supports AI/AN culturally-specific interventions; stronger focus on social determinants of health and public health research; increased initiatives to build local capacity to use research data to inform public health practice; creation of a searchable AI/AN health

research and reference collection; and creation of an AI/AN IRB point of contact list that is published annually in the Federal Register.

When the floor was opened for questions and comments, the following federal staff members were on-hand to respond: Nadine Gracia, Deputy Assistant Secretary for Minority Health, Office of the Assistant Secretary for Health; Carmen Clelland, Associate Director, Tribal Support Unit, CDC; Kathy Etz, Senior Advisor, NIH; Zahava Hurwitz, Policy Analyst, Office of Policy, Office of the Commissioner; and Mr. Kehoe. The following items were noted during the Q&A session:

- Dr. Etz said she has been in contact with NIH Principal Deputy Director Lawrence Tabak and they are working to develop a plan to address concerns about protecting human subjects in research. Per NIH policy regarding requests for consultation, she said they will respond within 15 days of the request.
- Ms. Kux indicated that the FDA has begun looking at de-regulation of tobacco for ceremonial use.
- Federal agencies need to collaborate and look outside of their boxes to help Indian Country find solutions to their problems, especially cross-cutting issues such as the suicide epidemic and climate change. [It was suggested that White House Council take up these two priorities.]
- Follow-up is needed regarding testing AI/ANs for Hepatitis C, including coordination with the U.S. Department of Veterans Affairs (VA) for AI/AN veterans, as it is a collateral piece related to substance abuse. [Mary Smith, Deputy Director of IHS, agreed to follow-up on this issue that was raised by Chairman Trudell.]
- The next generation of the Good Health and Wellness Program should look into supporting the gathering of traditional medicines.
- The Navajo Nation advocated for a continued increase in funding for injury prevention, funding for the prevention of infectious diseases, AI/AN representation on NIH peer reviews, and additional funding to address the effects of uranium exposure.
- Concern was expressed regarding tribal communities disproportionately bearing the brunt of many natural disasters and emerging biological threats; to that end it was recommended that a portion of the \$5.4 million proposed increase for preparedness and response capability be used to expand preparedness planning at the tribal level and increase coordination between tribal, local and state jurisdictions. For FY 2018, it was also recommended that funds be dedicated to evaluate coordinated tribal, local and state preparedness and response.
- NIHB is working with Mr. Clelland's office to set up a call with tribal leaders to discuss the Zika virus as well as being able to provide information not only to the tribal leaders, but also to health care practitioners that are working in Indian Country.
- Concern was expressed about VA services not being available at a local level.
- Those interested in being a grant reviewer for OMH can sign up on OMH's website at [minorityhealth.hhs.gov](http://minorityhealth.hhs.gov).
- The Office of Minority Health Resource Center will be awarding in the near future some



subcontracts to entities to work on social marketing campaigns towards improving outreach and education with regards to co-infection of HIV and Hepatitis C.

- Chairman Antone asked for a progress report on American Indian health equity efforts. [In response, Dr. Gracia (after clarifying that Chairman Antone was referencing specifically the auspices of the National Partnership for Action) agreed to take the issue back.]
- Dr. Etz agreed to share a 2-page fact sheet that NIH produced on recreational and medical marijuana use; she also noted that NIH is looking to develop a suicide surveillance system that does in fact consider unintentional injury and incorporates alcohol and drug use.

After returning from lunch the group reconvened for the *Behavioral Health Budget Priorities* session. Kana Enomoto, Acting Administrator, SAMHSA; and Beverly Cotton, Director, Division of Behavioral Health, IHS, served as the federal presenters. After reminding the tribal leaders and representatives about some of SAMHSA's investments in Indian Country cited by Director Beadle earlier in the day, Ms. Enomoto shared some of the other budget priorities that SAMHSA used in formulating its FY 2017 budget request. Four key priorities were 1) engaging people with serious mental illness in accessing care; 2) addressing the public health crises of opioids; 3) suicide prevention; and 4) maintaining the behavioral health safety net. Regarding the latter, she said SAMHSA's three-prong approach is to 1) reduce suicide attempts and completions through increased reporting and program investments; 2) improve knowledge and capacity to address behavioral health in tribal communities through comprehensive data analysis; and 3) establish a collaborative Native Tribal Behavioral Health Agenda (TBHA) to provide a clear national statement about the extent and need for prioritizing behavioral health in tribal communities. She said the TBHA will be updated based on feedback from the SAMHSA Tribal and Technical Advisory Committee (TTAC), and other stakeholders and federal collaborators. In the coming weeks, the product will be released again for national comment before it becomes final. With that, Ms. Enomoto welcomed thoughts on the FY 2018 budget.

For her portion of the presentation, Ms. Cotton provided an overview of the FY 2017 budget for IHS as it related to behavioral health issues. Highlights included a \$21.4 million request to initiate the Behavioral Health Integration initiative; a request to address after care services for youth who are discharged from the youth regional treatment centers; a focus on suicide prevention and addressing issues for Native youth; and the Zero Suicide initiative, which works in coordination with the SAMHSA request to ensure that direct service facilities have access to funding streams to implement Zero Suicide. Ms. Cotton said the budget also includes the Methamphetamine and Suicide Prevention Initiative (MSPI) increase for \$15 million; a \$4 million increase for the Domestic Violence Prevention Initiative; a \$10 million increase to address increasing the number of behavioral health professionals that are participating in the loan repayment program and SAMHSA's scholarship program for behavioral health related fields; and other initiatives that address behavioral health crises, including a request for an additional \$15 million to establish a mandatory program over 2 years so SAMHSA can provide

funding outside of grants for tribes that are facing behavioral health crises. Ms. Cotton said she too welcomed thoughts on the FY 2018 budget.

For the *Tribal Leader Testimony*, Mr. Vernon Miller, Chairman, Omaha Tribe of Nebraska, addressed the group. In response to the presenters' request for recommendations for FY 2018, Chairman Miller suggested that behavioral health grant funding be increased to \$50 million and that funds specifically be appropriated for pre-determined areas such as suicide intervention, expansion of mental health counseling capacity and infrastructure, and surveillance of and mediation of increasing levels of domestic violence. He also stressed the importance of getting funds directly to tribes. Finally, Chairman Miller commented that he looked forward to the release of the TBHA; and he suggested that tribal communities, especially rural communities, work to train and encourage its members to perform in professional behavioral health capacities so that service providers better reflect the tribal communities they serve.

The following points were noted during the Q&A session.

- Mental health services in Indian Country need to be accessible and culturally appropriate, especially for children and adolescents.
- A recommendation was made to increase the FY 2018 funding request for SAMHSA programs of regional and national significance to \$8.5 million, with \$6.5 million reserved for the Circles of Care program; as well as a continued request of \$50 million for the Tribal Behavioral Health Grant.
- There is a need to address the encounter rate issue for youth treatments centers, as many need to serve more than 16 people at a time, they provide 24-hour care, and they utilize culturally relevant best practices. [In response, Ms. Cotton stated that IHS has made the issue of reimbursement for the youth regional treatment centers a priority and she said an update is expected in the coming months.]
- There is concern that inaccurate or failed reporting by medical examiners in tribal areas unfairly hurts tribal applicants because medical examiner information and suicide rates are needed for certain SAMHSA grants.
- More of an effort should be made to compact funding for tribes.
- Tribes need assistance, guidance, and support for transition homes once a person finishes a treatment facility.
- Funding needs to be "local" because the solutions need to be "local"; and small tribes need to get together and work together and start taking over federal programs collectively.

Before moving to the next agenda session, Ms. Enomoto clarified that the original Tribal Behavioral Health Grant had a very clear statutory requirement to make the grants only to tribes with the highest rate of suicide; she said in FY 2016, the new grants that will be coming out will no longer require those specific data. She also stated that SAMHSA grants don't restrict or prohibit traditional practices, but noted that most lead off with requiring evidence-based

practices, while allowing flexibility for tribes to make the case for a culturally-based intervention for practice-based evidence and for traditional practices to be either blended with evidence-based practices or made as adaptations to other models. And in terms of the time a person spends at a treatment center, she said that it is becoming clear to her that the decision is oftentimes unfortunately based on finances and not a clinical decision between a provider and the individual and their family. To that end she said SAMHSA and CMS and IHS need to work together to ensure people get the pathway to recovery that is right for them—medically, clinically, personally, spiritually, and culturally.

Ms. Enomoto also noted that SAMHSA invests approximately \$10 million annually for programs aimed at increasing training for health professionals who are interested in focusing on minority communities. In FY 2017, she said SAMHSA's workforce priorities focus on peer services, i.e., partnerships with community colleges to implement peer credentialing programs and training and education programs. Ms. Cotton added that IHS' FY 2017 budget requests for \$10 million to increase the number of behavioral health professionals that would be participating either through the IHS scholarship program or the loan repayment program; and Health Resources and Services Administration's (HRSA) Mr. Jim Macrae said the FY 2017 President's budget for HRSA includes targeted money, approximately a \$45 million increase, to support a targeted initiative to expand HRSA's capacity to provide more loans and scholarships for behavioral health and then a second \$25 million to support providers that have medication-assisted treatment accreditation. He added that the President's budget request for FY 2017 includes a request for 2018, 2019, and 2020 for \$810 million, representing a significant increase for the National Health Service Corps (NHSC).

As a follow-up, on behalf of the Navajo Nation, Ms. Ramona Antone Nez requested that the various dollars slated for Indian Country from the various HHS agencies be consolidated by category into one summary sheet so tribes can see where the money is coming from and identify gaps as appropriate. [Commissioner Sparks Robinson agreed to forward the request to Ms. Jillian Curtis.]

The next session, *Centers for Medicare and Medicaid Services*, was delivered by Jessica Schubel, Senior Advisor, Centers for Medicaid and CHIP Services, CMS. First, Ms. Schubel gave an update on Medicaid expansion, noting that for Indian Country Medicaid expansion means more IHS funding particularly for PRC services to be freed up in states that have taken up the expansion. She said 30 states and the District of Columbia have expanded Medicaid. She added that IHS data show IHS facilities in states that have expanded Medicaid have been able to purchase services at the Priorities 3 and 4 level. Since Alaska expanded Medicaid in September 2015, she said they estimated that approximately 40,000 Alaska Natives have been enrolled; and with Montana's recent expansion, it is estimated that 19,500 American Indians will be eligible for Medicaid. She said CMS will continue to work with other states as they consider Medicaid expansion. Notwithstanding the good news about Medicaid expansion, Ms. Schubel said the highlight of her presentation was CMS' recent guidance on 100 percent federal medical assistance percentages (FMAP) for certain services that are provided through IHS and tribal

facilities. She gave the following high level points concerning that guidance:

- CMS expanded the scope of services that the enhanced match applies to, so now the 100 percent FMAP applies to any service the IHS or tribal facility is authorized to provide, as long as that service is also covered under the state's Medicaid plan. To that end, she noted two "big items," long-term services and supports; and transportation.
- Services must be requested by the IHS or tribal facility practitioner and that practitioner will maintain responsibility for the patient's care; services are then provided by the non-IHS or non-tribal facility practitioner, but that person also needs to be a Medicaid provider and has to sign a written care coordination document with the IHS or tribal facility.
- Billing flexibilities include an option that the non-IHS or non-tribal facility providers can bill the state Medicaid agency directly; and the second option is that the IHS or tribal facility would handle all of the billing, in which case the specific billing rates would vary by service.

Ms. Schubel said CMS will host an All Tribes Call on March 8, 2016, from 2-3pm EST to address questions. Before ending her presentation, Ms. Shuebel took a moment to speak about the Department's commitment to improving the health care quality and access for AI/ANs, particularly in the Great Plains Area. Specifically, she noted the development of an extensive work plan that helps identify ways within the IHS health care delivery system to improve telehealth capability and enhance South Dakota tribal members' enrollment in Medicaid.

Following Ms. Schubel's presentation, Roger Trudell, Chairman, Santee Sioux Tribe, provided the *Tribal Leader Testimony*. He thanked CMS for the directive regarding the 100 percent FMAP, as well as its efforts in South Dakota, Nebraska, and the entire Great Plains Area.

During the Q&A session, the following items were noted:

- It is important that states allow the tribes flexibility in managing the referrals to non-Indian providers for reimbursement.
- Some tribes are concerned that states get to determine what services they will allow and they have to also approve the rates for those encounters, while tribes incur the cost of billing staff and will have to figure out how to reimburse the non-Indian providers.
- A question was posed regarding if tribes can arrange a lower reimbursement to non-Indian providers and keep part of the \$350 to help cover their billing expenses? [In response, tribal leaders were told that billing arrangements are intended to be flexible for tribes, and it was not CMS' intention that the non-IHS providers would be able to bill at the all-inclusive rate (the encounter rate). It was reiterated that specifics would be provided during the March 8th All Tribes Call.]
- Tribes should be exempt from estate recovery in the American Reinvestment and Recovery Act of 2009 (ARRA), especially because now the states are reimbursed at a 100

percent FMAP. [In response, it was noted that “the Medicaid estate recovery rule does require the states to place a lien to recover services that are provided for long-term services to individuals over the age of 55; but under the ARRA, Indian trust income and land is protected from that recovery.”]

- The administration should treat tribes as a 51st state in order to implement the ACA. [In response, it was mentioned that through title 19 of the Social Security Act, the ACA is written as a state/federal partnership. It was noted however that Congress was given a report in 2014 about the feasibility of having the Navajo Nation operate as a state Medicaid agency.]

After a short break, it was time for the *Indian Health Service Budget Priorities Open Discussion* session. IHS’ Mary Smith introduced Ann Church, IHS Budget Office, to provide the *Federal Leadership Updates*. Ms. Church said IHS held a national budget formulation work session in early February which continued the trend of the FY 2017 budget by focusing heavily on behavioral health issues, quality of care, and recruitment of qualified health professionals. Without further ado, she yielded the floor to Andy Joseph Jr., Council Member, Confederated Tribes of the Colville Reservation, and Co-Chair, IHS Tribal Budget Formulation Workgroup, to give the *IHS Budget Formulation Team* presentation.

Noting that Tribal Budget Formulation Workgroup members are appointed by tribes from each of the 12 IHS service areas to develop the annual and national tribal budget recommendations for the IHS budget, Councilman Joseph Jr. proceeded to present the FY 2018 recommendations for the IHS. He said the workgroup strongly advocates for full funding for the IHS at \$30.8 billion; to begin a 12-year phase-in to full funding for IHS, a 37 percent increase (\$7.1 billion) is recommended. He cited the following as the top five priorities: increases to hospitals and clinics; PRC; mental health; alcohol and substance abuse; and dental services. Councilman Joseph Jr. also said the workgroup set priorities for the current year, namely ensuring funding for new provisions of the Indian Health Care Improvement Act (IHCA). Other top priorities are long-term care; behavior health treatment; diabetes prevention, treatment, and control; health care professionals; the Health Professional Chronic Shortage Demonstration Project; and mental health technicians. Over the next few weeks, he said the workgroup will develop the official recommendation document that will be subsequently presented to the administration and Congress.

After Councilman Joseph Jr.’s remarks, the floor was opened for tribal leaders and representatives to give their input on the workgroup’s work. Highlights from those comments are provided below:

- To-date, IHS increases do not cover the unmet needs of tribal people who suffer the greatest health disparities in the country.
- Incarcerated persons receive a larger amount, per capita, of dollars spent on them for health care than American Indians.

- Shortfalls, sequester, and government shut downs have drastically impacted tribal governments and caused tribal programs and services to close for a period; this has had the effect of erasing gains made in previous fiscal years.
- IHS and other programs for American Indians need to be exempt from sequestration; “support passage of S1497, exemption from sequestration for IHS.”
- IHS needs advance appropriations, passage of HR395 (IHS Advanced Appropriation Act 2015) is recommended.
- The SDPI has been phenomenally successful in reducing the A1C levels and achieving long- and short-term positive outcome measures; reauthorization is critical.
- Concern was expressed that the national budgeting process, because of the way it consolidates priorities from the various regions, often results in priorities from the Great Plains being left out; it was stated that “it is all a ‘priority.’”
- Indian Country asks top medical people to leave a secured area with top schools and top hospitals to come work in our area, with no funding for clinics, no funding for equipment, 150 year-old schools for their kids to attend, and we struggle to offer a competitive salary; the entire reservation system needs correction. [In response, Ms. Church said the FY 2018 budget process included experimenting with local priorities.]
- IHS providers should be able to be paid the same rate as VA providers.
- IHS funds need to be mandatory, not discretionary.
- Indian Country needs a long-term solution for its health care staff shortage, especially in the Great Plains Area.
- IHS should follow the Bureau of Indian Affairs (BIA) and do away with “prioritizing.”

It was noted that written testimonies were provided that address specific requests and recommendations related to elders and nutrition, child welfare, title IV, foster care, Head Start, and emergency preparedness, among other areas.

The final plenary session, *Tribal Leaders and HHS Secretary’s Budget Council Roundtable Discussion*, featured remarks from Acting Deputy Secretary Mary Wakefield, as well as comments from the Secretary’s Tribal Budget Council members. Dr. Wakefield first conveyed the administration’s deep commitment to improving the lives of AI/ANs, and expressed her appreciation to everyone for making the time to attend and contribute to the consultation session. She noted the importance of hearing from tribal leaders and representatives and sharing work that is underway. After sharing some personal remarks about her appreciation of the resilience and strength exhibited by Indian Country, particularly tribes in the Great Plains Area where she was raised, Dr. Wakefield communicated that an important change in leadership occurred earlier in the week at IHS. Specifically, she said Bob McSwain stepped down from his position and IHS’ Deputy Director Mary Smith, an enrolled member of the Cherokee Nation, assumed the position of Principal Deputy for IHS and has been delegated the responsibilities as Director. Additionally, to augment the leadership of IHS, she said Dorothy Dupree has been brought in to lead quality efforts. Next, Dr. Wakefield commented on the President’s budget. Noting that the FY 2017 President’s budget was recently released, she said

“it requests some key broad budget requests in some important areas...and also reflects the administration’s commitment to tribal self determination.” After recapping some of the budget highlights that had been shared during earlier presentations, Dr. Wakefield also reminded the group about CMS’ guidance that will expand the scope of Medicaid services received through IHS and tribal facilities that are eligible for a full 100 percent FMAP. In terms of IHS, she said, “At the top of our list right now is to make Indian Country and the work that IHS does on behalf of Indian Country even stronger through new resources and new ideas.” She added that HHS is working with IHS leadership and across HHS to introduce some cutting edge management practices and to look systematically at how they are doing their work in order to leverage every dollar as effectively as they can through the IHS. Finally, recognizing that the current administration’s tenure was drawing near a close, she thanked everyone for their work along the way and assured them that work would continue every hour, every minute, every day the administration is in office to drive the tribal agenda forward.

Following Dr. Wakefield’s remarks, Chairman Antone opened the floor for discussion. Highlights from tribal leaders and representatives’ comments included the following:

- Tribes appreciate the President’s request for full funding of CSC and his request for CSC to be a mandatory funding item.
- Tribes are supporting legislation that would exempt IHS and tribal programs from sequestration and are looking for advanced appropriations.
- Tribes are experiencing anomic outcomes as a result of historical trauma; more research is needed.
- The White House Council should look across agencies to address the outcomes and social indicators for which AI/ANs have the worst statistics.
- An update on the Quiet Crisis report is requested.
- A document should be prepared for the next administration to communicate the usefulness of the various committees that have been established to work with tribes, in hopes that the work will continue and progress.
- There is concern that tribes are regularly left out of statewide public health plans and federal funding decisions for public health programs.
- As independent sovereign nations, tribal governments do not operate within the state regulatory structure and often must compete with their own state governments for resources.
- Tribes were ignored during the formulation of the U.S. Public Health System and it is now time to reverse this wrong.
- Several comments and recommendations were given related to the CDC:
  - CDC should require states that receive CDC funding to declare and provide evidence of how they will include tribes in funding and resource distribution, in both non-competitive and competitive funding streams.

- The CDC needs to reinstate funding for education and research centers. Additionally, a portion of this funding needs to go to recruiting and retaining tribal members in occupational safety and health careers.
- The CDC should prioritize tribes by dedicating a percentage of grant funds that are needed mostly in Indian Country.
- The CDC needs to consider its recent investments in promoting tribal public health accreditation, which is a key strategy to strengthen tribal public health infrastructure.
- We recommend that the CDC work with other federal agencies to implement demonstration projects to create evidence-based or culturally-based substance use prevention programming and home-grown interventions in Indian Country.
- The CDC needs to examine opportunities to work with other federal operating divisions to implement the strategies named in the forthcoming TBHA.
- CDC's Good Health and Wellness in Indian Country initiative should be recognized as an important investment in community-based health and applauded as a model for other centers, institutes and offices at the CDC.
- CDC needs to continue its current efforts and continue to explore how its programs can be expanded to include direct funding to more tribes.
- Mary Smith's appointment is appreciated.
- The diversity of tribal narratives that were brought to the table are appreciated.
- The budget formation process should consider more of a needs-based format to ensure priorities of smaller tribes don't get lost.
- There is concern that the numerous Head Start rules and regulations are truly prohibiting programs from being better. [In response to concerns about Head Start regulations, Douglas Steiger, Counselor to the Secretary, Office of the Secretary, noted that Head Start is finalizing rules this year that should reduce the number of regulations by potentially as much as a third.]
- Delay of "Notice of Awards" and continuing resolutions have crippling effects for some Indian programs.
- The Navajo Nation continues its advocacy for becoming its own state Medicaid agency.
- The Navajo Nation continues to request technical assistance in many areas.
- Long-term care continues to be an issue important to tribes, as well as how to get encounter rates for various long-term care options.
- Tribes remain hopeful that the new budget will have some increases for title VI programs. [In response, Cynthia LaCounte, Director, Office for American, Alaskan Native and Native Hawaiian Programs, Administration for Community Living (ACL), stated that a \$6.5 million increase was granted for title VI; she also indicated that ACL is developing a guide to assist tribes with billing Medicaid for services provided under title VI and title II of the Older Americans Act.]

Before the consultation meeting came to a close, Ms. Barson addressed the group for the *HHS Wrap-Up* session. She echoed Dr. Wakefield's thanks to all the attendees for their participation



and for the issues and comments they offered, saying they will continue to work on them throughout the year.

The 18th Annual Tribal Budget and Policy Consultation Meeting ended with Councilman Joseph Jr. offering a closing prayer for the *Tribal Closing* session.