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I N D E X

Tribal Opening Remarks	5
by Chester Antone, Chair, Secretary’s Tribal Advisory Committee	5
Welcoming and Opening Remarks from HHS	6
by Emily Barson, Director, Office of Intergovernmental and External Affairs	6
HHS Budget Overview and Update	9
by Jillian Curtis, Branch Chief, Office of Budget, Assistant Secretary for Financial Resources	9
Questions and Answers	15
Human Services Budget Priorities	28
by Mirtha Beadle, Director, Office of Tribal Affairs and Policy Substance Abuse and Mental Health Services Administration	28
Comments	31
by Mark Greenberg, Acting Assistant Secretary, Administration for Children and Families	31
by Rafael Lopez, Commissioner, Administration on Children, Youth and Families	32
Tribal Leader Testimony	35
by Gil Vigil, Council Member, Pueblo of Tesuque	35
Questions and Answers	37
Public Health Budget Priorities	57
Federal Leadership Updates	57
by Ursula Bauer, Director, National Center for Chronic Disease Prevention and Health Promotion, CDC	57
Comments	59
by James Anderson, Deputy Director, Division of Program Coordination, Planning and Strategic Initiatives, NIH	59
by Leslie Kux, Associate Commissioner for Policy, Office of the Commissioner, FDA	61

	3
Tribal Leader Testimony	62
by Aaron Payment, Chairperson, Sault Ste. Marie Tribe of Chippewa Indians	62
Questions and Answers	66
Behavioral Health Budget Priorities	84
Federal Leadership Updates	84
by Kana Enomoto, Acting Administrator, Substance Abuse and Mental Health Services Administration	84
Comments	88
by Beverly Cotton, Director, Division of Behavioral Health, Indian Health Service	88
Tribal Leader Testimony	90
by Vernon Miller, Chairman, Omaha Tribe of Nebraska	90
Questions and Answers	92
Centers for Medicare and Medicaid Services	114
Federal Leadership Updates	114
by Jessica Schubel, Senior Advisor, Centers for Medicaid and CHIP Services, CMS	114
Tribal Leader Testimony	118
by Roger Trudell, Chairman, Santee Sioux Tribe	118
Questions and Answers	119
Indian Health Service Budget Priorities Open Discussion	128
Federal Leadership Updates	128
by Ann Church and Mary Smith, IHS Team	128
IHS Budget Formulation Team	129
by Andy Joseph, Jr., Council Member, Confederated Tribes of the Colville Reservation	129
Question and Answers	132

	4
Tribal Leaders and HHS Secretary’s Budget Council Roundtable Discussion	147
Deputy Secretary’s Remarks	147
by Mary Wakefield, HHS Deputy Secretary	147
Tribal Leaders Discussion	153
HHS Wrap-Up	172
by Emily Barson, Director, Office of Intergovernmental and External Affairs	172
Tribal Closing	173

KEYNOTE: "—" indicates inaudible in the transcript.

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

(9:05 a.m.)

Tribal Opening Remarks

*by Chester Antone, Chair,
Secretary's Tribal Advisory Committee*

MR. ANTONE: 18th Annual Tribal Budget and Policy Consultation will begin this morning with a prayer that will be offered by Mr. Vigil, of Owingeh Mexico. If we could all stand.

(Prayer)

MR. ANTONE: Thank you, Mr. Vigil.

MR. VIGIL: Thank you.

MR. ANTONE: Just to open up with a few remarks, I know a lot of you all have traveled quite a distance to be here. And we hope that your testimony and the information that you gain from here will be very helpful. This time I just wanted to (speaking Native language) my name is Chester Antone, chairman of the Secretary's Tribal Advisory Committee since Tuesday. And vice chairman, Aaron Payment over here. Lillian Sparks will be co-moderating with me today and we have Emily Barson, the Office of Intergovernmental and External Affairs and then we will have Jillian Curtis, branch chief, Office of Budget.

So before I turn it over to Emily, I would like to ask for the — all the tribal — if you are a tribal chairman, president, governor or chief, you are welcome to the table. We go in a certain order here, so I would like to invite chairman's, presidents, chiefs and — to come to the table. Second we would like to invite the vice-chairs, lieutenant

governors, the vice presidents to the table. Thirdly, if there are any councilmen, councilwomen here, they are invited to the table as well.

And lastly all authorized representatives, those who have a letter indicating that they are authorized to speak, we would like to have them here too at the table. And so moving right along, I am going to go ahead and give it to — MR. : Don't be shy, come on up here. Otherwise you are going to hear me talk a lot.

MR. ANTONE: That is going to be a chore trying to keep him from doing that. I am going to turn it over to Ms. Emily Barson from the Office of Intergovernmental and External Affairs.

Welcoming and Opening Remarks from HHS
by Emily Barson, Director,
Office of Intergovernmental and External Affairs

MS. BARSON: Thank you and good morning everyone. I will be brief to make sure we have enough time to hear from the tribal leaders and have a good discussion today. Just a few acknowledgments and announcements up top. I appreciate the opportunity to attend our 18th Annual Tribal Budget Consultation. As you know, these sessions do make a difference and for those of you attending over the years, you have seen first hand the influence that you have had into the HHS budget and will hear more about that.

We value the input you — we receive from you at this session every year. I also want to acknowledge the people who are responsible for pulling this together. It couldn't have been done without them. First, the members in my team in IEA who pulled this consultation off. Elizabeth Carr who might be out in the hallway, is our lead for this annual consultation. And those of you who don't know Liz, you should. She is the one who

leads all of the work behind the scenes in putting this consultation together and has been spending a lot of time over the past several months to make sure that we have a successful session today.

And assisting Liz is Ashley Martin who is on our team and also interacts with a lot of you on a regular basis. If you don't know them, please take the time to get to know them. And of course, thanks to Stacey Ecoffey, our principal advisor for tribal affairs, who most of you have worked with over the years and is a great advocate for Indian Country and the Department.

I also want to acknowledge the members of our internal HHS group who contribute greatly to this session. I don't know if we have any members of the Intradepartmental Council on Native American Affairs or ICNAA here with us today. If we do, can members please stand? Might be still early. I think we will have folks joining us throughout the day but I want you to know that the work — what I said here today goes directly to the ICNAA for our internal work group and that is how we make sure that we get to our next steps and follow through on the recommendations and comments that are raised during the consultation.

And as it relates to the agenda. We did make some changes this year based on the feedback from previous years. We are always looking to improve the process, improve the flow of the agenda and make this a successful session. We have done this over the years, not only to be responsive to you but also so that we have a strong consultation process so the next administration will have a concrete foundation for consulting with you after this administration is gone.

Today you will see for each session, we have listed a couple of tribal leaders who have volunteered to offer some comments up front. This certainly does not

mean that other tribal leaders are not welcome to provide their commentary under each session. But it is helpful to have leaders who are setting the stage up front for this specific discussion at hand.

And then we also will of course, have other folks from the federal side who will be here to listen to those remarks and staff level teams will be available to follow up and answer questions. The Indian Health Service Budget Formulation Team is going to provide an update on their budget priorities and solicit feedback from you in case you have not been a part of that process previously and this will help to finalize the budget request for the FY 2018 IHS Budget.

And later today, we will be joined by our Deputy Secretary Mary Wakefield. Many of you know Mary, she was previously the HRSA administrator for many years during this administration and she spent every year in that role here with us during this consultation. She is really a champion at the Department on tribal issues and we couldn't be luckier to have her as our deputy secretary leading cross departmental work on tribal issues.

I know she is very much looking forward to joining you today to provide some remarks and more importantly to hear from the tribal leaders here. So again thank you very much for being here and for traveling far to Washington for some of you. We look forward to the discussion and I will turn it back over to Chester, our new chairman of the Secretary's Tribal Advisory Committee and we are so pleased that he will preside over today's conversation.

MR. ANTONE: Okay, good morning. I am going to have the tribal leaders introduce themselves. Their name, title and who you represent. If we could do that beginning on this side and go around.

(Tribal Introductions)

MR. ANTONE: Thank you. And moving right along, we are going to turn you over to Jillian Curtis of the Health and Human Services Budget Overview and Update.

HHS Budget Overview and Update

***by Jillian Curtis, Branch Chief, Office of Budget,
Assistant Secretary for Financial Resources***

MS. CURTIS: Thank you. Good morning everyone. I am Jillian Curtis and I am the public health and social services branch chief in the HHS Office of Budget and I am responsible for the Indian Health Service — the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration and the discretionary portions of the Administration for Children and Families budget, so many areas that touch on tribal communities across the Department.

I am really grateful for the opportunity to speak with you all today and I will try to keep my remarks short to allow time for questions at the end. I want to start by thanking you all for joining us here and just emphasize that your input is essential to the work that we do in formulating the President's budget each year. And I am looking forward to hearing from all of you throughout the day.

I am going to start by giving a short overview of the FY 2016 Appropriations bill that was passed in December. And then I will provide an overview of the funding that is included in the FY 2017 President's budget as well as a short status update of where we are in the FY 2017 appropriations process. And again, leave time for any questions or input that you all would like to share with us today.

As many of you may know, the FY 2016 Appropriations bill included \$4.8 billion in budget authority for the Indian Health Service. That is an increase of \$165 million

above FY 2015. But it is \$295 million below the President's budget request for that year. Contract support costs is a major highlight in the FY 2016 bill. As many of you are already aware, the Congress provided an indefinite appropriation for contract support costs which essentially means that they included an estimate in their bill that the administration can go above if we need to.

So it allows HHS to fully fund contract support costs without directing funds away from direct services. So it really — it meets both of our policy goals from that respect both fully funding contract support costs and also protecting the rest of the IHS budget in order to do so. We did not receive the funding the President's budget requested for Purchased/Referred Care. We did not receive that increase but the Congress did support our substantial increases for facilities construction, Sanitation Facilities Construction and Maintenance and Improvement.

And they also included new resources for behavioral health services and supports for Native youth. \$10 million in the IHS budget and \$25 million in the SAMHSA budget for a partnership across the two agencies to both increase the number and adolescent behavioral health professionals serving in Indian Country but also to increase the availability of behavioral health programs for adolescents and youth.

Another important development in FY 2016 was the passage of the Medicare and CHIP — the Medicare Access and CHIP Reauthorization Act. Excuse me, MACRA. And that included a two year extension of the Special Diabetes Program for Indians at \$150 million the current funding level. So we did — we were able to secure some pretty significant increases for tribal communities in the FY 2016 budget although certainly not as much as we had hoped.

Turning to the FY 2017 President's budget, we delivered that set of proposals to Congress early last month. The IHS budget includes a total of \$6.6 billion and of that, \$5.2 is budget authority. That represents about a \$400 million increase above where we are right now in FY 2016. IHS in total is well above other agencies at the Department. And to give you some context on the increase provided for IHS, I think it is important to note that as a whole, the HHS discretionary budget is reduced by \$653 million below FY 2016, so despite the fact that in total, our budget is well below FY 2016, this administration continues to put significant priority on increasing services and supports for tribal communities as evidence by that \$400 million increase for that IHS budget.

Those dollars for IHS in FY 2017 will support key tribal priorities including medical inflation and population growth, contract support costs, facilities and staffing as well as behavioral health services. And I am just going to highlight a few of these to try to keep my remarks on the shorter side but happy to respond to any questions for additional detail at the end.

Contract support costs in FY 2017, the President's budget continues the Congress' approach of fully funding contract support costs with that estimate in the bill, the indefinite appropriation to protect the other funding in the IHS budget. And then in FY 2018, it moves contract support costs funding to the mandatory side of the ledger with a three year capped appropriation with funding increasing each year to make sure that we are again meeting our commitment to fully fund contract support costs while still protecting direct service funding.

The budget also more than doubles behavioral health programming for the Indian Health Service with an increase of \$67 million in discretionary budget authority. So these dollars will support a variety of new and expanded initiatives at the Indian Health

Service. \$21 million will support the integration of medical care, behavioral health services and tribal community organizations to really build out a continuum of behavioral health services and make sure that we are achieving the best health outcomes in Native communities that we can.

\$4 million of that funding will support pilots for the implementation of Zero Suicide which is a comprehensive and system wide strategy to implement the recommendations of the National Strategy on Suicide Prevention. There is a complementary effort in the SAMHSA budget and this is also some work that the Indian Health Service is undertaking right now but these dollars will allow them to expand those pilots.

There is a \$15 million increase for Generation Indigenous and that is again to expand on the progress that we were able to make in the FY 2016 Appropriation to increase the number of child and adolescent behavioral health professionals in Indian Country. And also to build out that youth and adolescent programming for behavioral health, continuing that partnership with IHS and SAMHSA.

There is a new \$2 million pilot that will provide aftercare services for Native youth who have completed treatment at youth regional treatment centers. Again, emphasizing the focus on building the continuum of services to best support health — positive health outcomes and recovery, even once youth have completed their treatment. On the mandatory side of the ledger, there is an HHS wide mental health initiative that is \$500 million split over two years. Specifically for the Indian Health Service, there is a \$30 million proposal to create a new tribal crisis response fund. To allow for the Indian Health Service to provide needed short, medium and long-term supports for tribes that are experiencing behavioral health crisis.

And there is also \$20 million for IHS to focus on increasing the number of American Indian and Alaska Native behavioral health professionals serving in Indian Country. So, trying to come out of behavioral health challenges both by increasing access to services and by building out the health professions workforce.

I will also note that the budget includes the permanent reauthorization of the Special Diabetes Program for Indians at \$150 million so that Congress would not have to act to continue that program into the future. And it also proposes legislation to unify the definition of an Indian across health eligibility programs.

While most of our funding for Indian Country is certainly in the IHS budget, we are also looking to other agencies to see what they can bring to the table and in recognizing that they have some significant expertise that can help to build out a full range of appropriate services for Indian Country and also improve health outcomes. So I will just touch on a few of those as well.

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 is reflected in 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, there is a new \$15 million investment to expand the Good Health and Wellness in Indian Country Program. This is a program that 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.

And finally for the FY 2017, I will note that SAMHSA also includes a series of increases that will help to address the disproportionate burden of behavioral health issues for tribal communities. As I mentioned at the beginning of my remarks, we did just deliver the President's budget to Congress last month. We are currently in the process of Congressional hearings, so the Secretary and agency leaders are completing a series of hearings on the hill. The Secretary will be testifying in front of the Senate Labor, Health and Human Services and Education Appropriations Committee in about 30 minutes.

We don't yet have an outlook for the FY 2017 Appropriation but we are of course, hopeful that Congress will continue to provide significant funding increases for tribal communities in the HHS budget. If Congress is able to reach agreement on a budget resolution for FY 2017, that might give us an indicator of the direction of the HHS budget overall. That will help us to know whether Congress is setting an overall funding level for the federal government that is either increased from FY 2016, decreased from FY 2016 or sort of the same level as FY 2016.

So that might be an indicator that will help us to speculate as to what the HHS budget might look like overall moving — in FY 2017. But today, we are to get critical recommendations and input from you for 2018. 2018 will be a somewhat different year than sort of the last seven because it is both an election year and there will be a Presidential transition in January.

Whatever course that transition takes, we will of course, want to maintain the progress for Indian Country that this administration has made over the last seven years, to give you a sense of where we are today compared to where we were when this administration started. The FY 2017 President's budget request represents a 58 percent increase in funding for the Indian Health Service since 2008.

So tribal communities continue to be a very high priority for this administration. Your input and recommendations are essential and will be seriously considered as we move through the FY 2017 budget formulation process. And I am really grateful for the opportunity to speak with you today and I look forward to your questions. Thank you. I will also note, I am sorry, that Doug Steiger, the secretary's counselor has also just joined and he will assist with questions as needed. Thank you very much. Thank you.

MR. ANTONE: For the questions and answers, we have about a half hour but we are going to go in the same order as we have in the past. Which will be tribal chairman's, presidents, governors and chiefs. They will be the first who will be called on. Please state your name and your title and who you represent and be sure to us the microphone. Thank you. Aaron?

Questions and Answers

MR. PAYMENT: I will kick it off. So this is our opportunity to be able to share with the administration what our concerns are either with what she addressed or any of the concerns that we brought. We have limited time for testimony so if you have anything you want to pull and advance forward, you are welcome to do that as it relates to the budget.

So, one of the things that I said yesterday to the Secretary is that we are grateful and appreciative of the full funding for contract support costs and also moving it over to the mandatory ledger. You know, we have often argued that our funding — we prepaid for the funding that we get, through the millions and millions of acres of land that we seeded that made this great country. So that includes a trust and treaty obligation. Trust, responsibility and treaty obligation and you know, we have to — unfortunately we have to fight for to remind Congress to fulfill that obligation.

And so, we are grateful that the President requested it and we are grateful that the Secretary took the step to help us to figure out how to do that. And it is not lost on us that she worked in OMB and knew the language to speak to get this across the finish line. For me, this is a huge step in the direction of our funding becoming mandatory rather than discretionary and in fulfillment of the trust responsibilities. So we are grateful for that. So hopefully that stimulated something so that we could get some conversation.

MR. ANTONE: Next? Arlan?

MR. MELENDEZ: Yes. Thank you, Ms. Curtis. I have a question. This is disappointing in a way that Purchased/Referred Care didn't really receive an increase and it is — there is only so many services that are offered in our health centers and most of the time we have to send people out to specialty care. So it is just disappointing that there is no increase at all. You can pass that along to the President or whoever.

But I think you know, with inflation, we just fall further behind when we don't really do that. Is the rationale behind not the increase because of the Affordable Care Act and that they are thinking that the Affordable Care Act replaces Purchased/Referred Care? That whole line item? I guess that would be one question.

And my second question is, the facilities, I know there are increases and as you look at the list, you know most of those are — you know, we only do so many facilities per year and some of those are only partial and those are high costs. There are some tribes and in California, there is about a 100 tribes and in Nevada, there is a number of small tribes and the small ambulatory grant which could be useful to those tribes to build smaller facilities at \$5 million or even less, you could get a lot more done than a cure list that has a certain amount of appropriated money but it only builds really large hospitals. And then there is only two or three built a year.

And so I am just disappointed that there is no money in that for small tribes to do anything with small ambulatory grants or even the one where the program where they build a facility and IHS funds it. So those would be alternatives that would really help to alleviate facilities in general. So I just want to point out those two issues. Thank you.

MS. CURTIS: Thank you. If I could address the two items that you raised. I think that — we don't have a lot of insight as to why Congress did not include an increase for Purchased/Referred Care in FY 2016 unfortunately. We had been successful in achieving those increases in prior years and we are not sure what the difference was in FY 2016. But it is something that we are making sure we are paying close attention to so that we can achieve the President's budget level for FY 2017.

We do request a current services increase that will help to address medical inflation population growth as you pointed out for Purchased/Referred Care. But I can tell you that although the administration's perspective is that the expansion of health insurance coverage under the Affordable Care Act is certainly a positive step in the direction for tribal communities. It does not perceive that to be a supplement in any way for the needs of a Purchased/Referred Care.

The second item that you raised was regarding facilities. And I neglected to discuss the funding that is requested in the FY 2017 President's budget for facilities. In particular we do request a funding increase specifically for small ambulatory grants. So I unfortunately don't have that number off of the top of my head, we would be happy to follow up with it, but I want to make sure that I appropriately presented that fact to this group today. So thank you very much for your comments.

MR. ANTONE: Any other tribal chairman?

MR. DEVERS: Yes, Chris Devers, vice chairman of the Pauma Band in California, can you expand a little bit on the pilot projects that you are talking about for aftercare? California within the next couple of years is going to be opening up two substance abuse facilities for youth. And

the — how is this pilot project going to work? They are IHS run facilities is that monies — how is that money to be used or — and in the future because we have — we always understand that aftercare is a critical step after a youth completes the treatment process and you know to keep them on that Red Road so they can — they don't relapse and go back to the facility.

MS. CURTIS: Thank you very much for your observations and question. What I can say is that we certainly recognized the importance of aftercare services and in maintaining recovery. Achieving and maintaining recovery after completion of a formal treatment program. The \$2 million that we requested in the FY 2017 President's budget is to test strategies for delivering that care to find out what works best. So that we can take that learning and ideally then expand it more broadly across the Indian health care system.

I know that you will have the opportunity to speak with the Indian Health Service leader today about their budget priorities and your budget priorities as well and I would encourage you to share any feedback or input recommendations that you have on the best approaches for providing that aftercare. And to also raise these questions then as to what the plan might be for moving forward.

Unfortunately, we don't — we don't have — we don't have insight as to where we will be in FY 2018 and beyond just yet, but I do think that our goal really is to find out what works best, build a little bit of understanding, best practices and maybe some

evidence around those services and then ultimately use that knowledge to expand that service more broadly.

MR. DEVERS: Thank you.

MS. CURTIS: Thank you.

MR. ANTONE: Vernon and before you start, I want to let you know — let you all know when we are running up on time. Thank you.

MR. MILLER: Good morning, so on behalf of the Great Plains Area, one concern I wanted to bring up that was pretty — had a significant impact within the four state area was we have a treatment facility on the Rosebud Reservation and unfortunately what happened was it was providing rehabilitation services for individuals that were recovering and dealing with the meth epidemic that is going on.

And unfortunately it lost its funding and had to shut down. And so the — and that was the only facility within our area. As a result of that, we had no facility that was accessible by our area — it is North Dakota, South Dakota, Nebraska and Iowa. And so as a result, that was a few months of a time span that was unable to be utilized. And so I was hoping that we can in forecasting for the budget cycle and coming up that there is an earmark for specifically some of those services to be maintained, continued and increased. So that we don't have that situation arise again.

It has since re-opened this fiscal year but I know that was an impact that was felt greatly within my area with a lot of tribal members from the 18 areas that we service in that specific region. Also I wanted to bring up long-term care services. I know that it is something that has been prioritized as mandatory but we — I am not aware if the funding has been provided to substantiate that concept yet and so I can specifically tell you within my own tribe — within the Omaha Tribe, we do have our own nursing home facility

that we have had for decades. And we also have unfortunately a dialysis center which has two cycles of patients that go through and looking at possibly a third.

And for our tribes such as mine, which is as small as it is, to have those long-term services that we have, we are relying on Medicaid and Medicare for the tribal members that do have that to be able to utilize that service. And so I know that that would be something that would be greatly received within my community as well as tribes that are looking at enhancing or even creating and providing that service as a nursing home and hospice as well as the dialysis.

And so those are unfortunately with diabetes and the next step that comes along with that in dealing with dialysis, you know, that would be something that we really support and I hope to see something like that included if it hasn't been already. I know we do prioritize but seeing something with some financial backing would really be appreciated by the tribes within Indian Country. Thank you.

MS. CURTIS: Thank you very much.

MR. ANTONE: Any other tribal chairmen? Mr. Trudell?

MR. TRUDELL: Yes, good morning. I might have missed a part on what is going to be available for prevention? But you know there has been like thousands of best practices developed now but no way to implement them. And best practices you know would be essential I think in reducing overall health care costs for tribal members. But unless there is some — actually some funding put up for implementation of best practices and prevention, greater prevention I should say because it is very minute part of everything. But probably one of the most critical important parts of anything is prevention, so I might have missed what you had said about that, so if you could maybe bring me up to date a little bit? Thank you.

MR. ANTONI: Any other chairmen? Gil?

MR. VIGIL: Thank you, Mr. Chairman. My concern also is on the aftercare program you talked about. Well, aftercare is needed. The main problems are the communities that some of our youth go back into and we need a lot more prevention stuff in that area because even with aftercare, if they go back in their communities and the same environment exists, it doesn't help. Because they are then thrust back into that same environment that they came from.

So I think like Chairman Trudell was talking about, preventative portioning(sic) communities is really important and that needs to be I think funded also. I know SAMHSA is doing some of those things but I think we need additional funding. On the IHS — I am also the executive director of the Eight Northern Indian Pueblos Council, consorts of eight Pueblos in Northern New Mexico and we do have a treatment center. And we don't call it a treatment center, we call it a healing center. Because that is what we want to do with our kids. It is called the Butterfly Healing Center.

And of course, there we also need additional funding to provide more funding and that we are really the only center in our area — there is no other centers in the area. So, that kind of funding is needed for the southern communities also. I am also part of the Santa Fe Service Unit. Again while you are appropriating dollars, sometimes don't dollars reach the local levels? Like the service unit. Right now the Santa Fe Service Unit, I think services about 10 of the 19 Pueblos and the problem is, one of the tribes took their own — their share of those monies and one of the bigger Pueblos and it really impacted the rest of the Pueblos with services.

So now the Santa Fe Service Unit is more of a triage than a hospital and if you don't have health care insurance, a lot of people don't get those kind of services. So I

think they — the hospitals like that need to be fully funded so that they operate as a hospital and not a service — not a triage.

MS. CURTIS: Thank you.

MR. ANTONE: Thank you, Gil. Chairman from Alaska?

MR. KEITH: One thing I wanted to — you know if you don't deal with mental health issues, and they become a medical issue later on, it can be a lot more expensive to deal with. And you know I think this would be a good long-term investment. I like what you said about the — a lot of these grants sometimes are one year, sometimes they are three year but if they would be — it would be better if some of these things may be up to five year grants cycles.

So — or three to five years, so you have time to find other funds and that is another issue. I really like what I am seeing across the different agencies or departments is more collaboration. Because sometimes it is kind of difficult to go after one grant and there is other grants out there. And to put them all together to make a more holistic program, you know, can go a lot further.

There is a limited pot of money out there, but if you can get cooperation or cooperation between tribes or cooperation between departments and agencies, you can probably put together a much better program on the local level. That is much more effective and efficient. Thank you.

MR. ANTONE: Mr. Joseph?

MR. JOSEPH: (Speaking in Native language) Good morning. My name is Badger Andy Joseph Jr. I chaired my tribal council's Health and Human Services Committee. I also sit on the Healing Lodge of Seven Nations and it is a youth treatment center for our youth. There are seven tribes, pool our resources together for our youth treatment center.

They have a new policy that is kind of being run through the state and it is going to be kind of you know, going to make things harder for the Healing Lodge of Seven Nations to be as successful as they are.

And it is — I have heard from Pam Hyde that it is one of the best treatment centers in the nation and not only is it successful but our non-tribal people could probably learn from the same practices that are going on there. This new system that the state is running, BMO's I think it is called. They are going to require them to be regulated more and have to go I think every 14 days and do — re-assess each case.

So you know, it is good that they are being accountable but they are worried that some of these young children are going to be told that they are going to have to go home because how they rate on this system. Well, they might have — our worry is that they might be just through getting their detox and not really able to get the counseling services that help make us successful and they will — our worry as tribes is that they are going to relapse.

And — one of the things that have been wanting to look at is if — to see if the Healing Lodge or if there is going to be a couple of treatment centers in California for youth, if there could be somehow worked out with CMS and inpatient encounter rate that they would qualify for — to provide the services. And that because it is an IHS facility that you know, they would be given an IHS encounter, versus having to deal with the state's regulations.

I believe our federal government should be able to regulate that on a government to government basis. The same thing I would say for Colville is we have a long-term care facility and if we could work with CMS to get an encounter rate. I heard that the Crow Tribe has negotiated a rate so that they could provide those services. My tribe pays

anywhere between \$400,000 to \$900,000 a year to — of tribal dollars to keep that facility running for our elders that need that 24 hour care.

So you know, we would much rather be spending that money on educating our youth and doing more prevention so that maybe when I hit that age, I am not having to be in that facility myself. And you know, I have heard about the money follows a person and that is a good thing too. But if we just had a basic encounter rate that would keep those patients there — I think that would be a simpler solution to providing care — they are — both of these facilities are really culturally run.

And at our rest home, we have our little pow wows, we have our root fees — they get to take part in some of the spiritual things that they are used to that you would never see in an outside long-term care facility but I am all for thinking outside of the box. A lot of our people do qualify for some kind of insurance to — so that you know things are going to be covered. But I just want to hope that we can do more to kind of work together as programs and tribes to figure out to get more direct funding.

I sit on the SAMHSA Tribal Technical Workgroup and I really appreciate the work that they do and the grants that they have. One of the things that I would recommend is more direct funding and that the programs use their funding and distribute it out similar to what IHS has funded. You know, our tribes are funded kind of based on our size and they have a formula that they use to distribute out funding. If the funds can be divided up that way and every tribe then be able to get I would say their fair share and I would hope that it wouldn't have to go through the state.

Sometimes there are states if you live on Colville, I believe I mentioned this last year, there was a Robert Wood Johnson study and two of the poorest health funded counties in the nation are in the Colville Indian Reservation. And that is right where I am

from. So they are not really that anxious to help our tribes out when we have our needs.

But thank you.

MR. ANTONE: I have time for probably about one more. Is there anybody here at the table that wants to — Ramona?

MS. ANTONE-NEZ: Good morning, thank you Mr. Chairman Antone and dear tribal leaders. It is a privilege to be here with you today. And Ms. Curtis, I am Ramona Antone-Nez and I am from the Navajo Nation. And I would like to put for the record, that the Navajo Nation has been advocating for its own Medicaid agency for years and for the record, we have had the Medicaid feasibility study that was conducted and provided a report to Congress in 2014.

With that it is a cost estimate for a start up at \$134 million to \$234 million. Excuse me, \$243 million. So over time what we have been doing is our tribal leader in this administration, President Begaye and Vice President Nez and our council has been advocating for start up funding. So I would like to request a moment with your — time to just provide additional recommendations about how we might proceed to request for Congressional appropriations to this start up cost. And I just wanted to provide that for the record. Thank you, Mr. Antone.

MR. ANTONE: Thank you. We actually have time for another one. Anyone here at the table want to address — Mr. Devers?

MR. DEVERS: Yes, Chris Devers, vice chairman of the Pauma Band and you made a comment about definition of Indian. You know I was — had the opportunity to be chairman for my tribe from 2000 to 2010 and that was a topic of discussion then in the late 1990s. When is that ever going to get completed?

MS. CURTIS: The President's budget does formally put forward a proposal and a strategy to Congress for unifying the definition and we are hopeful that we will be able to achieve that in the coming fiscal year.

MR. STEIGER: Just to add, this is not a broad discussion. This is about the Affordable Care Act where there are a multiple definitions for the benefits for Native Americans. In an ordinary piece of legislation, it would have been fixed right away as a technical problem. But because the Affordable Care Act was so controversial, people refused to even make technical fixes. So we have put forward a proposal and we are hopeful that Congress will finally move on something.

MR. ANTONE: Mr. Payment?

MR. PAYMENT: On that issue, we do appreciate the President requesting to get the clarification. We have been asking for that. We believe that the President has the authority administratively to do the corrections, so we disagree about that part. But the one thing that we have a concern with is the number that has been used to complete the definition. The definition of Indian is to adopt the Medicare definition which is two — three generations. So grandma and the grandchild will all have — potentially have coverage even if they are not enrolled.

So the estimated cost for that though, according to the administration is like \$520 million. We have calculated through the National Indian Health Board and tribal review that it is approximately about \$50 million over that ten year time period. So we are trying to get to how did that number \$520,000 come into behind because we are really concerned about going in front of Congress and saying, you know expand the definition because there is a cost associated with that.

And if that projected number is 10 times what the intel from Indian Country is saying it is, then it is an over statement and I think then it threatens its very passage. So we have asked during STAC for a refinement of that number and to work with NIHB in Indian Country to find out what that number actually is. We think the problem is that the number was estimated prior to when we started down enrollment and once we started enrollment, the actual number of enrollment is much, much smaller. We do push and we want to get — and we gave recommendations for improving the enrollment process because we are on board with that.

Anything IHS can't cover, we want Medicaid expansion in the states to be able to try to pick up. But we want to make sure that the number that we are requesting isn't ten times what the actual number is. Because I think that might kill it. So.

MS. CURTIS: Thank you for raising that. I did hear a report out that you also raised it at the STAC and that we are going to take a look at what the assumptions are behind that scoring and get back in touch. Thank you.

MR. STEIGER: The one thing that I would say for purposes of — you probably know this, for purposes of Congressional action, our number does not matter. It is the Congressional budget office estimate that matters. So if you persuade them that it is a much smaller number, that is even more important than persuading our budget folks.

MR. ANTONE: Okay, we are ready to go into the next presentation and I want to thank Jillian for your part in this and Mr. —

MS. CURTIS: Thank you all very much for the opportunity to be with you today. Thank you.

MR. ANTONE: May I call on Mark Greenberg, Rafael Lopez and Kana Enomoto for the next presentation. Until Mr. Greenberg arrives, we are going to go ahead and start with SAMHSA and I believe Mirtha Beadle is representing Kana.

Human Services Budget Priorities

*by Mirtha Beadle, Director, Office of Tribal Affairs and Policy
Substance Abuse and Mental Health Services Administration*

MS. BEADLE: Good morning and thank you for the opportunity to be here with you. I do want to share Administrator Enomoto's regrets. She was definitely planning on being here. She got called away but she will be here later today for the 1:00 session.

So this is — this whole issue around the human services budget is a very important one. And it is very important because of the subject that we are talking about this morning. In particular, we are talking about the whole issue of trauma and the impact of trauma and tribal communities. I can say that in response, I am not sure how many tribal leaders were here yesterday but we did have a discussion about a response to a letter from Senator Heitkamp and several other senators around trauma.

And for those of you who were here, I am sure that Commissioner Sparks Robinson may add some comments around the approach to addressing those concerns in the Senator's letter. But I have to say that for SAMHSA the connection between trauma and substance abuse and mental health issues, it is a very clear and well documented connection. For SAMHSA, whose mission is around reducing or improving the communities' response to substance use issues.

We take trauma very seriously and trauma is something that we deal with everyday. It is not a specific or a special topic that we parse out but specifically we work on trauma in every way, every single day. We have developed very specific documentation

that we believe will be helpful to communities around improving trauma-informed care. And I will mention two in particular. One is the concept of trauma in guidance for trauma-informed approach that was developed in 2014.

It specifically really looks across various sectors. Not human services alone but health and other sectors to ensure that we have a trauma-informed approach all the way across the needs of individuals. There was also a document called Treatment Protocols for Trauma-Informed Care and Behavior Health Services that was also published in 2014 and this is really a companion document. One sets kind of the guidance around how to have a more trauma-informed system. And the other one provides very specific guidance for behavior health providers on how to support trauma-informed work.

We have several grant programs. I will name just a couple that really focuses on trauma. I think the broader notion is there has been I think movement in some places where folks want to have more just trauma specific programs. But kind of the message is that SAMHSA has taken a dual approach. One approach is to have some very targeted trauma activities. But the other approach is to integrate trauma support and trauma-informed care across multiple programs. An example is the — we have two specific grants that are targeted only to tribal communities.

One is the Tribal Behavioral Health Grant Program and in that program there is a specific reference, specific information and specific opportunity for tribes and tribal organizations to address trauma as part of the broader network and part of this broad work, to address suicides, improve mental health and address substance use. And that grant program we will talk a little bit more about that later, but this is probably SAMHSA's largest program.

For fiscal year 16, it is funded at \$30 million. Our expectation is that we will fund another 100 tribal grants this year. With that increase for FY 2017, the budget continues that program at that level. Which we believe is substantial. Currently we have 20 tribal grants that were funded in 2014, so to go from 20 to 120 is really substantial for us. We also have the Circles of Care program that is more of a system planning program that also infuses trauma and trauma-informed care as part of its work.

I mentioned earlier that there are specific trauma activities at SAMHSA. One example is the National Child Traumatic Stress Initiative, which it is a broader consolation of organizations that are working together and also very specific grants that come under this broader umbrella that are looking at trauma. For Native communities, we have one center that is called the National Native Children's Trauma Center and most of you may know that it is in Montana.

SAMHSA also has a full council. We are meeting very deliberately with the Intradepartmental Council of Native American Affairs as one way of supporting a broader HHS connection with trauma. Just a couple of more bullets and then I will just stop so that we can have the other panel members provide their thoughts. The last comment I will make is that I think that we really need to think about how we integrate the work on trauma, the work on suicide and the work on mental health and the work on specific substance use issues.

I think we talk about them separately and distinctly as if they are individual separate issues but they are not. They are really connected. And so as we have conversations about how we can support and improve our work, I think we need to remember that integration, that connection that is really required to do the best work for tribal communities. Thank you.

MR. ANTONI: Thank you, Mirtha. I forgot to remind the presenters that we wanted a brief update in order to allow some questions and we are at two minutes per Mr. Greenberg?

Comments

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

MR. GREENBERG: Thank you and good morning everybody. The — I am Mark Greenberg and I am acting assistant secretary at the Administration for Children and Families. And I am going to talk about important aspects of our 2017 budget proposals. As soon as I am done, Rafael Lopez, the Commissioner for ACYF will talk about the ACYF portions. So I won't talk about the ACYF portions, Rafael will do that. But as you will hear from Rafael, some of our most exciting proposals are on the ACYF side.

But in our 2017 budget proposals, the first thing I would want to note is that for ANA last year we reached the highest budget level in history for ANA and this year we are seeking to make it bigger. So, we have made proposals for an initial \$3.1 million in funding for ANA, \$2 million of that would go to grants to support Native youth resilience and leadership development through Native youth center and youth driven programming.

And then along with that \$2 million, \$1.1 million would be for a specialized training and technical assistance center on fostering Native youth resilience that would develop materials and a website and other technical assistance efforts and this would be a unique first of a kind technical assistance center. So as I know everybody can appreciate this connects closely to the Generation Indigenous discussion and Lillian as you might appreciate, this has been a strong priority that in Lillian's work and the work of ANA and we are very happy that that is put forward as a budget proposal.

Apart from that, I wanted to highlight a few other areas. One is, in child care — in child care as everybody may know, the law used to say not more than 2 percent of child care funds could go as tribal set aside(sic). It was changed on the discretionary side but not on the mandatory side. So we have made a budget proposal to provide room on the mandatory side so that it would no longer be limited to two percent and then on the discretionary side, where the tribal set aside had been two percent and we had the authority then to increase it. We increased it to 2.5 in 2015 and we will be increasing it to 2.75 this year.

Last thing that I highlight is for TANF. We have heard many of the concerns about the TANF program and its responsiveness in recent years and I am very pleased this year, for the first time in the 20 year history of the program, we are proposing to Congress an overall \$8 million increase in basic block grants for TANF and as the basic block grants went up, they would be going up for both states and tribes.

We are also proposing in TANF that there be dedicated funding for subsidized employment competitive grants, dedicated funding for true generation strategies and for both of those tribes would be eligible. And then finally we are proposing overall a \$2 billion initiative called Emergency Aid and Service Grants, which would be seeking to address the increase in extreme poverty in the United States, instead of demonstration grants to address that. And tribes would be eligible for those along with states and counties. And I will stop there and turn things over to Rafael.

*by Rafael Lopez, Commissioner,
Administration on Children, Youth and Families*

MR. LOPEZ: Thank you, Mark. Good morning, once again it is an honor to be here again with you today. For the second time, my name is Rafael Lopez and I am the

commissioner of the Administration on Children, Youth and Families. Much like my colleague Mark did, I will give you some overarching framing of ACYF's budget as proposed by the President to Congress and we are like Mark, so thrilled and very proud of where we have landed in this budget and would encourage you to visit the justifications — the Congressional justifications. They go into far more detail on each of the kinds of proposals that I will be lifting up today and then we will allow for some times for questions as well.

So first off, overall, I will focus on the areas where we are proposing growth in programs so that we are clear about where things are moving or intend to move. One we are promoting safe and stable families. There is a proposed increase for tribal communities of \$20 million in discretionary funds. To provide additional support for tribal child welfare systems. I lifted this up a couple of days ago, which is the importance of making sure that tribes are able to run a comprehensive and fully engaged independent child welfare system.

An additional \$3 million to expand Tribal Court Improvement Program. We lifted up in your STAC report, some of the data from the last couple of years and I also lifted that up at our presentation the other day. Those are increases moving forward as proposed. Second Regional Partnership Grants. Upwards of \$40 million per year for five years to support cross system collaboration and innovation in the needs of children and families. And it is one of my most flexible federal funding sources to meet local needs.

Particularly when it comes to substance abuse and family struggling with substance abuse issues and trying to respond more proactively to the opioids crisis. We are additionally proposing re-authorizing Family Connection Grants through fiscal year 2021. We are also proposing and this came up several times yesterday in the conversations with

consultations around the importance of looking at both substance abuse and also psychotropic medications for children in care.

So we are proposing a demonstration to address over prescription of psychotropic medications for children in foster care and proposing a \$250 million to support a 5 year demonstration to address the over prescription of psychotropic medication and working closely with Medicaid on this. There are a series of other re-proposals that are significant for tribal children, youth, and families. Particularly as it pertains to expanding the time frame which we can continue to have young people as they transition to adulthood and it is important to lift up some of those re-proposals which I will sort of focus on in a couple of ways.

One, expanding independent living to age 23 to allow for the development of evidence-based for serving older youth. As you can imagine, there is no magic age to 18 or 21 or 23 necessarily. But the more we can expand the way in which we support our young people as they transition from youth to adulthood serves all of our communities better. We are also investing in the child welfare workforce across the country.

Because we have seen through a variety of research studies that outcomes for young people who are in foster care or their families or — systems have been results and better outcomes over times if it reduces the case workers that are involved in their lives. And that are ultimately connected in the services that they need and deserve when they need to be there.

Again I am lifting up sort of major items and increases and you can take a look more closely online to the budget. I wanted to make sure that I lifted up one other piece of work on the Family and Youth Services Bureau side of our house, and specifically focus in on two components that are tribal specific and specific to the country as well. One,

under our Family Violence Prevention and Services area of work specifically around battered women's shelters we have proposed an additional \$1 million for Alaska Native Tribal Resource Center and language to re-authorize and modify the Family Violence and Prevention Services Act or FVPSA as it is called for five years to better respond to unmet need for domestic violence shelters and supported services.

Improve access for under served populations and promote adoption of emerging practices. This of course, builds on the strong work over the last couple of years of culturally specific kinds of centers and services. In addition, expanding the domestic services hotline which is available across the country. So that sort of captures in sort of broad terms the major budget items that we wanted to lift up for you this morning. And are open to questions.

MR. ANTONE: To lead off the discussion, I am going to call on Gil Vigil to provide a testimony.

Tribal Leader Testimony

*by Gil Vigil, Council Member,
Pueblo of Tesuque*

MR. VIGIL: Thank you, Chairman and again thank you for giving us the opportunity to provide testimony on behalf of ICWA. We have written testimony that has been provided for the record. So my testimony — top priorities for the administration for the 2018 budget. The Indian Child Welfare Act was instrumental in — the removal of Native children from their families and communities by public agencies. Public and private agencies. It also provided based upon the in — the Tribal Child Welfare Programs to serve Native children and families both on and off tribal lands.

Well, ICWA has largely been a success. It has never been fully implemented or regularly enforced. Today, Native children are still two times more likely to be placed in — out of home care and in some states removal is as high as 12 times their rate in population. In addition, public and private adoptions of Native Americans have resulted in over 52 percent of our Native children being placed in non-Native — non-Indian homes often far away from communities and families.

And to this, it takes away their identity as Native children. In response, DOJ, DHHS and DOI have come together with tribes to improve an enforcement of ICWA. This includes intervening in troubling court cases. Improving data collection and developing revised guidelines and regulations. We also commend DHHS for requesting new funding over the last two years to improve tribal access to tribal programs and making policy changes to make these programs more culturally appropriate.

These changes will assist tribes as they seek to protect their children and families from questionable practices and advocate for better outcomes. Our FY 2018 child welfare budget priorities are as follows. One, continue to request from FY 2017 to provide \$20 million in new funding under the title IV-B. Promote safe and stable families program for tribal capacity building.

If these funds were appropriate, that would allow more tribes to participate in this program. Continue the request from 2017 — increase the Tribal Court Improvement Program funding to \$3.75 million. This would allow 18 more tribes each year the ability to engage in projects to enhance their juvenile court systems. Continued FY 2017 request to provide start up funding for tribes who are approved to operate title IV-E Foster Care programs. The request includes \$37 million in new funding as — tribes who are being operational of this program.

Again we also want to thank the leadership for their heart in advocating for our people and pursuing the implementation of the Indian Child Welfare Act. On the Child Care Block Grant, we are — we would like administration to raise the allocation for the Child Care Block Grant and also when appropriations rises as it did in 2016, the Secretary of DHHS can increase the tribal allocations. Thank you.

MR. ANTONE: Thank you, Mr. Vigil. Are there any tribal chairmen, presidents, governors that want to address? Aaron Payment and then Mr. Trudell.

Questions and Answers

MR. PAYMENT: Okay, first I want to thank you for the information about TANF and Child Care Development Block Grant and LIHEAP, those are on my check lists. So, I would like to just call your attention to my testimony for some really strong justifications for that, that you can use. We also for LIHEAP we are asking Congress to increase LIHEAP funding to meet the rising energy costs. There is a pattern of deregulation happening across some states and that is going to mean significant costs for utilities for tribal members.

Adequate heating and cooling of the home is a health necessity especially among the very old and young. A 10 percent increase in FY 2016 travel set aside budget will keep us — that should be 18, will keep the LIHEAP effective. I also wanted to just take a moment to talk about behavioral health and SAMHSA. As vice chair, co chair and chair of the HHS STAC, Health Research Advisory Council and NIH Tribal Consultation Advisory Committee, I have amplified our voices to understand historical trauma and the resulting outcomes of high rates of suicide, alcoholism and accidents and normlessness.

These enormous outcomes have reached epidemic proportions in Indian Country and deserve a much more significant commitment both in terms of an emergency

response triage approach as well as scientific epidemiological explorations of the root cause and possible solutions to impacting individual independent variables. More funding is needed for substance abuse, behavior health and mental health services and to meet needs of drug court, detox facilities, halfway houses and wrap around services. To meet the needs of all federally recognized tribes including newly recognized tribes, we recommend restoration of the proposed cuts as well as additional funding.

I am appreciative of the new initiatives of the triage for this crisis, but again a much larger commitment and systemic solutions are needed. And then I just got an e-mail from a tribal chairman back home, Homer Mandoka, from the Huron Band of Potawatomi. And he asked me to bring up to support the request for increased funding for SAMHSA. SAMHSA is one of the greatest successes that we have under HHS but unfortunately it is not keeping pace with the need that is actually out there. The President's visit to Standing Rock, the focus of the Secretary on suicides and really this is epidemic in our community.

And so SAMHSA really provides — and their behavior health agenda in cooperation with the National Indian Health Board and NCAI provides the pathway to our resolution to these issues but the funding doesn't seem to keep pace with it. So we are asking for a much larger funding. And then also Homer asked me to share what we need to break down the silos of the different sub-agencies within HHS so that we can communicate better and coordinate efforts better. Thank you.

MR. ANTONE: Chairman Trudell?

MR. TRUDELL: Good morning. Thank you for the presentations and it is very interesting on the increases. My name is Roger Trudell and I am representing the Great Plains. And part of the problem is the — making the qualifications to you know, to be

accepted in some of the grant programs and stuff, you know, some of the smaller tribes are — have a really difficult time trying to meet the criteria I should say.

And it is very prohibitive to some of us. You know and some of us are not in positions to be in consortiums because of distance between tribes and stuff. That is one thing in the future that I hope that will be taken into consideration. The other thing is just generally listen. I don't know where our population of 18 to 35 fit in. Most places that is one of the more productive sections of the population but on a lot of the reservations, that is the most idle. And the most prone to be into things that they shouldn't be into.

So, you know, I don't know where that can be taken into consideration. I like the fact that you can consider a youth up to 23 or so and that is good. I did — these are just things for consideration. I know you don't have any answers. The other thing is, you know, I have seen what is real practice use and practical successes equine therapy. And you know we are starting to develop that on our reservation and it has been very successful.

A lot of the traditional practices are based around the horse halter and everything, you know, some of the youth really take a lot of pride in associating themselves with the horses and stuff. That is all very good. I guess there was one other thing — it is trying to escape my mind right now. But as we progress, or try to process especially with our youth, our tribe, we actually did a proclamation declaring 2016 the Youth and the Child. And we did this without any funding or anything of that nature.

And have tried to incorporate in existing programs and into the community that our children need an alternative to what they live in every day. And that somehow, they need breaks from that. So you know, just trying to develop activities and that type of stuff where they can compete with each other and have some intergenerational mixture and we had one back here in February — February 20 actually.

We had a winter carnival. And we had you know, good representation from three generations of people — well maybe four, I guess. So it was a good mixture and then I know that it should be sustained in the years to come but I don't now how we can do that. We just kind of did this shot in the dark.

They didn't think it would cost a lot of money but everything costs money nowadays. But you know we are not going to give up. And I just you know, some things I just think you know the rules of criteria to be eligible for things need to be relaxed. So that more tribes can get in and get to where they need to be. Thank you.

MR. ANTONE: Any responses to both Mr. Payment and Chairman Trudell? Mirtha?

MS. BEADLE: So thank you, Chairman Payment very much and thank you Chairman Trudell for your comments. And Mr. Vigil as well for your comments. I have got like half my page written over here in terms of some thoughts. We absolutely agree with you that suicide in tribal communities is in crisis. It is an epidemic. It is just an issue that we need to be able to figure out how we are going to address it.

I really respect your approach for trying to address some of the deeper root causes and we will have to think about that. I think as the Secretary said yesterday, I think we have to think about two different baskets. And in the first basket, meaning how do we to do the best we can in saving lives now while we get more information about those root causes.

One of the things that I have failed to mention is that in the 2017 budget, and we need to think about how that progresses to 2018, is that SAMHSA has requested funds for what is called Zero Suicide. And the request is for a larger pool of money but what we are trying to do is to make sure that we are mindful of the impact in tribal communities.

So there is a set aside in 2017 proposal requests which is about \$5 million. So if you think about \$26 million for the broader nation and \$5 million for tribes, we really tried to do this right.

So I think that that is a good proportion to start with. And that goes with some of the other funding around suicide but I think the points that you made around being able to figure out how to do this in a more deliberate way. How to do this in a way where there is definite funding for it, I think has been a challenge. The budget can only grow so much and in certain ways.

So I think if there are ideas or thoughts about how we might do that created differently, we really are open to that. Because we are just really concerned about suicides. We have done some additional work. There are a couple of reports that are going to be released this month on some assessments that we have done in a tribe in the lower 48 and Alaska. But then also Alaska in terms of clusters.

And that is just our way of trying to figure out what do we know right now? How do we put that together and how do we use that as a way for developing policy? And policy is not just programs, it is also budgeting. And how do we figure out how to do that. And so there are recommendations on how we might do that better given the scope. The range of SAMHSA's programs, we really are open to that. So I want to thank you for that.

In terms of drug courts, we have a drug court program that is available for tribes now in 2016. It is part of a broader Drug Court/Tribal Healing to Wellness program. But what we haven't seen is the level of interest from tribes on that. We have tried this before and it hasn't produced much. But we are trying it again this year. And so to the extent that we can have a successful 2016 drug court — Healing and Drug Court, I think that

might help some of the future work in driving that particular funding stream for tribes in that area.

I am going to stop by saying one more thing because I have like 15 things written here. I think Chairman Trudell, I think your points around access and grants is really important and we do want you to share with us if we are doing better. A couple of years ago based on the Secretary's Tribal Advisory Committee discussions, we actually took a look at our grant programs and took a look at how difficult they were. And we tried to streamline them, we tried to make them more simple. We have had good tribal applications and we don't know that we are there yet.

And so as we are trying to improve our welcoming, I am going to call it that. Our openness to tribes and in applying for these funds, let us know if we are doing better. I think we are trying that but if there are other ways that we can streamline it and make it more accessible to tribes, we are also very welcome to receiving that. So thank you.

MR. ANTONE: Mr. Lopez?

MR. LOPEZ: Yes, thank you. I wanted to not repeat what my colleague Mirtha was just saying. I wanted to build on Council Member Vigil's points. Which are not only extraordinarily important but we stand with you in the analysis. Clearly you know, our American Indian and Alaska Native children being two times the average rate and often ten times. That rate in population is unacceptable in the country. So let's just be clear about that.

Number 2, I misspoke the other day when I was asked a question about title IV-E and I wanted to correct that for the record. I said that there were 8 tribes who were either implementing or improving plans and there were actually only 7. And I wanted to sort of both correct the record and lift that up as another way that we can continue

working together to improve this because some of the issues that you lifted up squarely rest on tribes being able to actively and proactively create systems that are responsive to the community.

So, there are actually 7 approved plans. I wanted to walk you through those very quickly to kind of — we also have some new STAC members. We have five programs that are currently implementing across the country. The Port Gamble S'klallam, the Navajo Nation, Keweenaw Bay, the Eastern Band of Cherokee Indians and Chickasaw Nation are all implementing as we speak. And in fact, yesterday, we had the honor of sitting down with Navajo Nation talking about some of the struggles with what it takes to actually implement tribal title IV-E because of its complicated nature.

We have two approved plans that are not yet implemented but are moving forward. The Confederated Salish and Kootenai and South Puget Sounds. So those are the 7 and I said 8 and I misspoke on that one. There are 20 plans with a series of no cost extensions. But beyond the specifics of what you raised sir, are much larger issues around the importance of making sure that we are being responsive and proactive to the need for additional technical assistance.

So one, we huddled immediately after the meeting where I presented to the other day. We brought staff together who all are working some of which are here today, who are here to also answer additional questions from the ACYF team who spend every day working on tribal title IV-E issues. Two, we are going to be hosting another series of webinars and outreach to encourage tribes who are interested in tribal title IV-E or are stuck in a variety of stages, to answer very proactive questions.

And we are contemplating figuring out what we can do around pre-application kinds of engagement. We know with our partners and — they are already doing

that. And how can we model the precedent that has already been set at ACF and use some of those tools to better communicate. Third and finally, both of the response to what we have been hearing recently at the STAC meeting and in the hallway right after we presented, there seems to be a disconnect between what is happening and being heard on the ground with sort of front line staff and what is happening on title tribal IV-E.

So we are going to do a much better job of communicating monthly, directly through our list serves to staff who are actually doing this work on the ground to dispel myths about what is and is not possible and I am grateful to the Navajo Nation yesterday when we sat down and they brought up a series of really important but completely and imminently solvable problems. With people — to whom they have to give data or actually work with at our regional level or even some of our contractors.

Those kinds of things, we don't want any tribes to feel that they have to wait for the STAC meeting to bring up. We are willing to work with you quickly and responsively through and between STAC meetings because these things should not stand in the way of any tribe being able to lift up their work through tribal title IV-E.

So thank you for lifting up those issues. We want to show you that we are being responsive and again, whether it is with us directly here in the room between STAC meetings, we continue to welcome your feedback so that we can continue to improve our services.

MR. VIGIL: Thank you for those comments but along the same lines as Chairman Trudell's comments about sometimes these programs are too restrictive and I think that is the reason there are not a lot more tribes that have TANF programs. Because of some of the requirements that are restrictive. And so maybe relaxing some of those

requirements so that more tribes can become eligible because there is a need in all of our communities for these kinds of services.

MR. GREENBERG: So I just want to build on a couple of the comments and then add a few more. First as Rafael has emphasized for us, we very much share the concerns that have been raised both in this meeting and prior meetings about the importance of work around ICWA. And I hope that every one here can see the ways in which over the last several years, we have significantly ratcheted up our attention and our work around ICWA.

And under Rafael's leadership and ACYF, that has accelerated and we think that is fundamentally important. I would also note as I know Rafael talked about it, I think a couple of days ago that our supplemental notice of proposed rulemaking around the data reporting requirements for AFCARS is working its way through the process but we are absolutely committed to getting that done this year.

So a couple of other things just quickly to highlight Chairperson Payment, thank you for your comments about TANF and CCDBG and the child care. We are for LIHEAP and we are not proposing an increase but we are proposing that Congress build in a contingency fund that would make the program more responsive to changes in eligible populations and changes in fuel price costs.

So our dollar amount is actually less than the prior year and it was something that we had to do based upon the overall budget constraints but we are strongly emphasizing to Congress the importance of the contingency fund. Last thing that I just want to quickly note, we — well two last things to quickly note. One is strongly agree about the importance of trauma and historical trauma and I know Lillian has talked about that work and we are deeply committed around it.

On the issue of the grants structure, we struggle with this. And I will say that I personally struggle with it because you know, the funding announcements when they have come to me and they are both on the issues relating to tribes and the issues relating to everybody else, I think they are horrendously complicated and overwhelming. And you know when I have had to read funding announcements and they go on for a very large number of pages and bounce back and forth between topics and unless you have got professionals helping you work them through, we totally get how difficult that is.

And within ACF overall, we put together a working group a couple of years ago to ask what can we do to streamline and simplify and whereas every place where we can bring a more logical sequence to it, cut the number of pages, make them more accessible, figure out what kind of training and technical assistance opportunities there can be to help applicants work their way through the process.

So we have made some improvements. I don't think we are there yet. But it is a really strong area of emphasis overall within ACF. And then as I know Lillian has talked about, within ANA, they have made it an expressed priority to try to figure out how to make that process better. So there is still work to be done but we absolutely agree about how important that is.

MR. ANTONE: Ms. Robinson?

MS. ROBINSON: I just wanted to piggyback on what Mark was saying is that you know certainly I think for ACF but across the Department, we have really looked at what are the challenges to accessing grants. And the Secretary's Tribal Advisory Committee did charge the — Intradepartmental Council on Native American Affairs in taking a look at okay how many of our grant programs are tribes actually eligible for?

And when we started this process, it was somewhere in the 30s, about 30 percent, 35 percent. It looked like tribes were eligible for about 35 percent of HHS programs. But by the time we finished digging deeper and figuring out well is it because of statutory prohibitions or is it policy or is it regulatory, by the time we finished the matrix, we found out that tribes were actually eligible upwards of 70 percent of the programs at HHS.

But that doesn't necessarily mean that tribes are accessing those programs right? It just means that we now know that tribes are eligible to receive. So the next step is how do we actually increase the number of tribes applying and receiving those grants. And so at ANA, we do do — we do provide extensive training and technical assistance that we hope builds the capacity for any Native community to be competitive. And these trainings are free. They happen throughout the region. They happen several times a year and so we would be happy to share that information once that schedule is developed for FY 2016.

And on top of that, as Mark mentioned, at ANA, we pilot and test a lot of things at ANA and then our goal is to be able to scale it through ACF and through the Department. But we are looking at creating a process and a form that will allow anybody — anybody to come in, small, large, experienced, non-experienced and really fill out and respond to the FOA in a way that makes sense and a in a way that is circular, it is not lineal. In a way that allows the tribe to say this is what our need is, this is how we want to respond and this is what our budget looks like.

But at the same time, it is still responsive to all of the federal requirements of the FOA. And so we hope to be able to test this pilot, this — not this — clearly not this current competition or fiscal year but in the next round of competitions for FY 2017. And

that is going to put us of course on a fast track but that is why we need to hear this information to help invigorate and ignite some of these processes again.

We appreciate your feedback. And this is a result of these tribal consultations. What we have heard from you saying, you know, we would love to be able to apply for some of these grants. We would love to get some of these dollars but it is too competitive or it is too burdensome or it just doesn't seem like we meet the eligibility or the criteria. And so we are hoping to simplify this process while still maintaining all of the requirements required by our grant process.

And we are also hoping to increase the number of applications you receive from tribes across the Department for the grant programs that tribes are eligible to receive.

MR. ANTONE: Thank you. Then we will go over to Andy Joseph and then Nevil(sic) at the corner.

MR. JOSEPH: (Speaking in Native language) Badger Andy Joseph Jr. I appreciate the increases in the grants, you know they really are needed. They don't always meet our treaty or fiduciary obligations for tribes. Infrastructure, some tribes don't even have the infrastructure to have access to some of the grant — if they are being submitted through internet or even to be faxed, you come to my reservation, our internet is down almost weekly.

AT&T and Quest, they did their merger but they left out the reservation. They built high speed clear around us. We still — we are still stuck with old copper, you know, so and that goes down and so we try to go from mountaintop to mountaintop and we got dumped on with a lot of snow this year. So our internet was down three or four times a week. So just trying to be able to have access to submitting grants.

My worry is also some tribes, they might not have a grant writer or somebody that could you know, understand how to fill out the forms and so I would hope that the grants wouldn't be so competitive. Like I said earlier, if the Departments could look at how the Indian Health Service distributes out their funding to tribes by their size, their location and were — how many people they serve, I believe that maybe every one could get their fair share of the pie.

And I am always — I was always hoping that somehow the Department of HHS could look at tribes as doing a culture training on some of our best practices. I heard mentioned of the horses and you know there is other practices out there that work just as good and if they were looked at and understood better on why they work, it would probably save the government a lot more money down the road and doing —it would be more prevention. And when you — I would call it breaking the cycle.

You know a lot of our people got addicted at a young age and I could use my family as an example. My children, they don't use or abuse the alcohol and drugs. And that is because they were brought up in our traditional — more in our traditional way than I guess when I was a kid. I was a boarding school kid and they kind of kept that stuff away from us, so, you know as I grew up and learned into my tradition, I put it into my children and that was you know, that many more people that is going to be saved versus having to spend government money on trying to correct an illness. Thank you.

MR. ANTONE: Navajo Nation?

MS. MASSEY: Good morning, thank you for indulging me, tribal leaders and health and human services officials. Again my name is Terralene Massey and I am the division director for the Navajo Division of Social Services. I just wanted to briefly remind folks here that Navajo Nation is surrounded by three states, Arizona, New Mexico, and

Utah. We have the largest Native American population in the U.S. and many of our tribal members are living off reservation and in urban communities such as Phoenix, Albuquerque, Los Angeles and so forth.

So one thing that I wanted to talk about today here is regarding the ICWA, Indian Child Welfare Act. The Navajo Nation president submitted a letter to Secretary Burwell where stating that he supports the DHHS doing more work to support the new 25 CFR Part 23, which are the BIA guidelines for state courts and agencies. Right now — currently as of August of 2015, Navajo Nation had a total case load of 668 ICWA cases.

That is about 1,342 children who are in the state systems. In that, we have about — we have children in about 30 states that we are aware of. And the largest are you know, the three states that surround us but the other ones are also California and Colorado. That is what it looks like. We do support the commissioner's effort which we are appreciative of and the health and human services efforts to try to — to have the state submit their ICWA data — that is something that we really hope that you can implement before this administration leaves office, that is something that we are looking forward to and I think that would be really helpful because then how many more will be in the system that we don't know of.

That is what it will be. And as the commissioner did say, we did meet yesterday and most of these issues we discussed regarding the title IV-E, but for the record, I would like to say on behalf of the Navajo Nation, that we — that the Navajo Nation was approved for direct funding to administer the title IV-E program back in October 2014.

We request that ACF continues to support tribes who are implementing title IV-E specifically in the area of information technology that is a large cost to the Navajo

Nation that we are experiencing. And it is going to be ongoing. So we request that on behalf of the tribes and the nations — the Pueblos.

In addition, we did talk about the request for one rate for the Navajo Nation for — in determining IV-E edibility and that was discussed yesterday as well. Lastly in terms of the IV-E, technically — we do — the tribes do need technical assistance to implement this so that we can be successful. So we can continue to request for that now that we know who those key players are so we are happy about that.

And then not related to IV-E but we do also have previous — previously we have stated that we wanted more assistance for LIHEAP and also for the family violence, I heard that was mentioned earlier. So those are the two areas and we are also really glad to hear about the changes that are being made for child care. So. Thank you.

MR. ANTONE: Mr. Lopez?

MR. LOPEZ: Yes, thank you so much again for lifting this up and again so that we can all share what we are learning. Thank you so much for your leadership in the title IV-E work. The Navajo Nation has done some extraordinary work early on to try to sort of tackle some of these very real implementation challenges as you have lifted up. So as I said earlier, we are taking all of your feedback very seriously and trying to be very proactive and being agile and quick about that.

I did want to lift up one piece that you mentioned here that I didn't mention earlier on information technology because sometimes there is a perception that becomes reality around the use of title IV-E dollars on things like information systems. So first of all, you know, just to sort of be clear about this. Technology in general is broken around child welfare in the country. And the way in which we capture information in real

time and share that information across systems is one of our biggest challenges in child welfare at large.

We are trying desperately both at the ACF level across with interoperability work that under the leadership of Acting Assistant Secretary Mark Greenberg and Maria Cancian to figure out how we can more quickly and rapidly share information across systems, breaking down these silos. Number 1. 2, deeply within each of the operating divisions taking a look at and testing and experimenting how we can streamline capturing data and sharing it.

So yes, for all tribes, there is a way in which one can use title IV-E dollars around information and technology as we shared with Navajo Nation yesterday, it all depends on how it is structured but our staff is happy to work with you on that issue. So to dispel the myth, yes we can use it for information technology purposes, yes there are very specific rules about it and three, just work with our team at the regional and or central office level, happy to coordinate that at the national level if we need to but most of these issues around the challenges on information technology are truly solvable.

And we live in an era where the technology exists, it is just not applied for this work where it is most desperately needed. So I wanted to make sure that all of us got the same information at the same time and again back to responding on the issue of trying to connect more quickly and regularly with line staff so that we can help dispel some of those rumors with some very proactive communication on this front. And the information technology piece will be one of the pieces that we also convey very quickly across the country to the tribes, so thank you for bringing that up.

MR. ANTONE: Juanita?

MS. CHARLES: Thank you and again, thank you for taking the time to listen to us as much. My name is Frances Charles and I am the tribal chairwoman for Lower Elwha and I have been listening to a lot of the conversations, reminiscent of the issues that we are faced within our territory just as much. Jurisdiction issues is a concern with us because we are a checkboard reservation and we do have cross deposition that we had worked with on that part of it.

But on the Indian child welfare matters, it is a matter of timing. And our children are placed in unknown territories at times if we can't have families that are willing to take in our children. And not only that, it is the staffing. There is a lot of change in the state offices that don't understand the laws, that don't understand the act itself, that prohibit the negotiation and the processes of working for our kids and our families. So that is a concern. I really hope that you take into consideration not only from what you are hearing from all of the leaders and the tribes here today but look at the regions that we are coming from to help with the training.

We are more than happy in our territory to bring our staff in and to bring our elders in to help with the cultural sensitivities that we are faced with and our beliefs and our ways of our cultural livings and being able to utilize that for the prevention aspects of it as much.

The tribal court system, this is a wrap around program because it starts with the effect from our young to our elders of the needs that we have there, it affects our social services, it affects our elders, our social security funding because the majority of the time, our elders are taking in the grandkids and they don't turn them in in many ways and they will raise them themselves.

The family elders, the youth, the social services and the TANF programs. Let us utilize in how the uniqueness's of how we can better serve our communities. We have had our region come in and ask us how we are utilizing the prevention programs and providing services to our families in and with the uniqueness of the culture outreaches that we used they had prohibited us from using the canoe journey events for a prevention program for the drug and alcohol. Utilized the mental projects that we had started with our youth and taken some of these flexibilities away from us once we started sharing our technologies and how we were used and our culture ties.

The mental outreaches that we have from our kids because it affects them in a long-term and it is not a short term aspects of it. It goes up to our elders. The court systems. The Healing Court, we have been successful in that manner. We have had some failures but again it is the grand time frame of it because it is the shortness.

We just start getting them into the setting and getting them down that straight path and we have actually had a couple of them that we didn't personally see them coming out of the realm of their methadone of their drugs, their substance abuses, the alcohol, reasons that they were brought up in the changes of the generations and now we have them hired on as employees.

So there is success stories to that but we still have a long way to go and it is the shortness of the grants because we are just digging into it. And then the grants end and then we are trying to collaborate and subsidize in other grant aspects of it under the SAMHSA just as much. The court systems were short handed our endorsements. We start training our endorsements, we bring them on and then they go to other agencies or other tribes because we can't pay the salaries that are needed for our communities.

So we need some of those direct resource funding's that come directly to the tribes and not to the states to plea with them for the justifications of those policy and procedures that prohibit us under these grants. And it really gets back to the factor of having new staff and having employees that understand what the grants are about. Fortunately we have some of those employees but I know other smaller tribes and other areas, they do not — they don't have the technologies, they don't have the internet and they can't even get cell phone services on the reservations.

The indirect cost. We really take a look on how that is going to impact us in our funding sources on how that is going to subsidize of what we have to do to even apply for that grant. Is it worthwhile because it is only a year but the match or the indirect that is limited to what our percentages is — is something that we take into consideration.

The training abilities for not only our staff that are being hired under these grants but as a time and aspects of it because you just start getting them trained into that process and then that grant ends through that part. But really it gets back to our elders and our veterans who are taken care of our grandchildren. And it is long-term society that we are faced with and these are some of the avenues and the challenges we all have. But those are the things that I wanted to say today. Thank you.

MR. ANTONE: Thank you. I acknowledge Sarah Cromwell and then I will wrap up this session.

MS. CROMWELL: (Speaking in Native language). I am the secretary of health and human services for the St. Croix Chippewa Indians of Wisconsin. I do apologize, I was just notified that our leadership was unable to attend so I took the seat at the table. I would like to echo some of the comments from our leadership around the table.

Specifically when we talk about competitive grants, we appreciate the good start that you mentioned with finding funding and hearing us. We would hope that once you are made aware of issues, that you would take the steps to remedy them. What we find ourselves in as some of the leadership has mentioned, is that in rural settings, we lack the professionals and the infrastructure in order to provide the services.

20 grants and improving them to have a 120 grants, again is a good start. We have over 565 tribes and you are asking us to compete for those 120 grants. The funding is not there. The funding is not available to support our needs. We know what our needs are. We demonstrate that need. The funding is not available to support that need. When we talk about the reality of the numbers, split over 12 areas in the United States which I then split even more so among those tribes within those areas, it is a finite amount.

When we look at state and BIA funding or as stated earlier, the IHS funding, it is never there. We are currently functioning under continuing resolutions at 1.3 percent. 68 percent of the funding is considered reasonable. So I just wanted to echo that the needs are there but the finances are still not there. Although it is a good start. (Speaking in Native language.) Thank you.

MR. ANTONE: Thank you. And thank you Mr. Greenberg and Rafael and Mirtha. And we will go ahead and go into the Public Health Budget Priorities. I will call on Ursula Bauer, James Anderson and Leslie Kux.

(Pause)

MR. ANTONE: This session is entitled Public Health Budget Priorities. The federal leadership update is scheduled for two minutes each. And we will begin with Ursula Bauer and then go to James Anderson and then Leslie Kux. And we are ready to begin.

Public Health Budget Priorities

Federal Leadership Updates

*by Ursula Bauer, Director,
National Center for Chronic Disease Prevention and Health Promotion, CDC*

MS. BAUER: Thank you. Good morning everyone. It is an honor to be here with you. I am representing the Centers for Disease Control and Prevention and CDC is the Nation's public health agency. So we focus almost entirely on the prevention on diseases and risks behaviors and protecting health. And we do very little direct service which you have heard a lot about this morning.

Many of the other agencies support that. So we assist state, tribal, local and territorial health departments in fulfilling their public health mission and I really appreciate the call for a focus on prevention from your discussion earlier. We think of the population or the community as our patient as opposed to the individual, so we really seek to support healthy environments, healthy communities so that people can be supported in being healthy and choosing healthy behaviors.

CDC compared the colleagues that you have heard from today and over the last couple of days makes a relatively small investment in Indian Country on the order of \$140 million a year and most of that, over a \$100 million is in contracts for services like IT services and security services that we purchased. So we are pleased to support the economic development in Indian Country. But we really only have about \$36 million that goes to public health and prevention activities in Indian Country.

Our largest grant program with the Nations is Good Health and Wellness in Indian Country. And while we are specifically addressing the main risk factors for heart disease, cancer and diabetes with that grant, that program begins to build a partnership

network that we believe can be very effective in improving health overall in Indian Country. The Good Health and Wellness grantees include tribal nations that are funded directly. Up to 2 in each area, tribal organizations again up to 2 in each area that serve the remaining tribes in the area, often through small grants and then the tribal epidemiology centers and the Urban Indian Health Institute which support the essential public health services like surveillance, data, evaluation.

The Urban Indian Health Institute leads the national evaluation of the program. So in this way, we tried to support a connected, coordinated and mutually supportive network of nations and organizations focused on critical prevention and public health work. The program is currently funded at \$15 million a year and it is designed to grow and expand. And I will call your attention to the President's fiscal year 17 budget proposal which includes another \$15 million for this program.

The new fund would provide additional resources to tribal epidemiology centers which are critically underfunded as you know. The new funds would expand the number of tribal nations and tribal organizations in the program and also bring in the Urban Indian Health Center's funding up to 10 and critically expanding the work of the program to incorporate the culturally driven wellness practices that build resilience and strengthen social and emotional well being. So getting at the root causes of so much disease as we have been talking about in the past couple of days.

So we are thankful to CDC's Tribal Advisory Committee and especially to our TAC chair, Mr. Antone for guiding us in developing the existing program and ways to grow that program with additional resources and look forward funding to support that growth and expansion in 2017. Thank you.

Comments

*by James Anderson, Deputy Director,
Division of Program Coordination, Planning and Strategic Initiatives, NIH*

MR. ANDERSON: Good morning. Thanks for the opportunity to give you a brief update from the National Institutes of Health. The NIH is the principal agency responsible for behavioral and biomedical research in the country and the largest in the world. We do research to prevent disease and to treat it. We also invest in the very special workforce required to do research and the infrastructure that is used to do the research.

I would like to limit my comments today though to just recent progress within NIH in setting up the infrastructure to enhance the way we do research that is relevant to the Indian communities. First of all, we established our Tribal Consultation Advisory Committee last summer. Held the first meeting in September. And I would say that a key recommendation from our TCAC at that time was to create an Indian desk or essential point of contact where the tribes can go with requests and questions. Consequently we have done that and we have placed that within our NIH Tribal Health Research Office and the office was created within the division that I oversee in the Office of the Director so that it can reach out to our 27 Institutes and Centers and have a central focus for coordinating what they do.

Most of them do research that is relevant or specific for the Indian communities but we can do a better job in coordinating in how we do that. And that is the point of this re-organization. So among the functions of the office and this is a very short list, will be to coordinate tribal health research related activities across all of NIH. To serve as the liaison to the NIH representative to any tribal health related committees and working

groups. To coordinate the work of our TCAC. And to coordinate how our Institutes and Centers work together to develop new initiatives to support tribal health research.

And also to support our at least yearly tribal consultation sessions. That is a very short list. We have recently recruited for and hired a director for the office. His name is Dean Seneca. He has worked at CDC for almost two decades in support of tribal activities and he begins in April. He has a lot on his plate when he arrives. Some of the novel things that we will do that we haven't done before, we plan to conduct a portfolio analysis of the NIH and federal American Indian and Alaska Native research and research training portfolio.

When we see that, it is a good way to see what the opportunities and needs are whether there are synergies for people to work together that weren't and also where the gaps were for research activities. We will also initiate a planning process for the office and set priorities for the office for the next five years or so. I want to finish by saying that we held our second TCAC meeting last week. Dr. Collins, the director of NIH met with the group as did Larry Tabak who is our principal deputy director.

And I was able to attend the entire meeting and I will report that some of the important topics that were discussed were IRB training, peer review and reviewer training, traditional ecological knowledge and indigenous ways of knowing, health research training for Native scholars and we had a wonderful group of trainees who are in the intramural program who had lunch with the group.

And as a result of our discussions and yesterday, Dr. Tabak will also take the lead in following up on consultation by the issues of human subjects protection and research. Thank you.

MR. ANTONI: Thank you, James. By the way that was James Anderson, deputy director for a program called Division of Program Coordination, Planning, and Strategic Initiatives at the National Institute of Health. Now I will call on Leslie Kux, associate commissioner for policy, Office of the Commissioner at FDA.

*by Leslie Kux, Associate Commissioner for Policy,
Office of the Commissioner, FDA*

MS. KUX: Good morning everyone, I am very glad to be here. So I think unlike some of the other operating divisions that you have heard from today, we are a regulatory agency and so we are responsible for protecting public health by ensuring the safety and efficacy of human and animal drugs including biologics, also medical devices. We also regulate the safety of the Nation's food supply, cosmetics and then radiation emitting products. We also now have jurisdiction over tobacco products and a significant part of our portfolio is also ensuring that innovative products in all of those areas make it to the marketplace and to improve the safety and efficacy of drugs and foods.

So we have a different portfolio than I think most of the other people that you are hearing from today. I am here to talk about our new tribal consultation policy. We issued it in draft just recently and so it is really — this is a great opportunity for me to come talk to all of you about it and express our commitment to honoring the relationship between American Indian and Alaska Native tribal governments and the United States government.

Our consultation policy is based on the HHS consultation policy and the way we — because of our regulatory structure, we have issued it in draft for — to solicit comment and so we are obviously interested and would appreciate comments from the tribes or any concerns or suggestions that you have that can help improve the policy and

also suggestions on how we can improve communications and outreach and the deadline for comments is May 31, 2016.

We are holding a consultation on the policy, on the draft policy and the letter — the Dear Tribal letter that went out on Monday includes the details for that — that call that we have set up and that is April 21. So I would also like to take the opportunity to introduce Brian Kehoe who is the acting director of our Office of Intergovernmental Affairs which is in the Office of Policy, Planning, Legislation and Analysis which is the office that I am part of. And Brian is the primary point person in FDA for all tribal matters.

We do have folks in other parts of the agency that also work with the tribes but Brian is the — we have recognized the importance of having a central focal point in the Office of the Commissioner and so — that will be Brian's office. So again I am very glad to be able to announce the draft policy. And I know we are looking forward to comments on it and upcoming consultation. I am happy to take questions later.

MR. ANTONE: Okay. We are going to — we will go ahead and start off the discussion with Chairman Payment.

Tribal Leader Testimony

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

MR. PAYMENT: Thank you. I have testimony for both OMH and also HRAC and so I hope you don't cut me off at two minutes, Mr. Chairman. And then later after others get a chance to speak, as Sault Tribe leader, I will probably have a few things to say too. So first of all, I would like to provide some testimony from OMH. I would like to thank you for the opportunity to provide this testimony on the FY 2018 budget.

“I look forward to providing recommendations that will honor tribal interests and improve the provisions related to the health and wellness of Indian Country and the budget. On behalf of the 567 federally recognized tribes, we have targeted several areas in need of improvement to build a stronger, more sustainable foundation for the future of health care and public health in Indian Country. Before I address our priority recommendations, I would like to sincerely thank the administration for requesting an increase in the 2017 budget for OMH’s American Indian Alaska Native Partnership Program. Despite being flat funded for the past two years, this proposed increase honors past budget recommendations made by the tribes and if enacted will help improve health programs throughout Indian Country. We were also grateful to see that at an Administrative level within the agency, tribes were included to directly compete for OMH’s state partnership initiative to address health disparities program. This increased the availability of direct funding for two tribal organizations and past grant cycles including the Inter-Tribal Council of Michigan and the Nez Perce Tribe of Idaho. So under recommendations, the number 1 systems level of public health concern for Indian Country is of course the lack of direct funding available to tribes. Therefore, we recommend the following grant opportunities provided by OMH to have the tribal set asides that only tribes would be able to compete for. A portion of the \$3 million for the addressing childhood trauma grants. A portion of the National Workforce Diversity Pipeline Program and a portion of the \$2 million for the Re-entry Community Linkages Program. We also recommend that OMH dedicate funding to update the annual health research report. This is a product of HHS, American and Alaska Native Health Research Advisory Council for which I serve as co-chair and it is the agency’s way of sharing research topics, findings, and available federal programs

with the tribes. However, the report has not been updated since 2013. Tribes need updated information in order to continue moving forward in a good way for the health of our people. We know that the Indian health provisions and the Affordable Care Act are key to increasing access to affordable health care for American Indian and Alaska Natives, however there is a gap in a number of American Indian and Alaska Natives enrolling in the health insurance Marketplace. In order to close this gap, it is recommended that OMH leverage available funds to increase the number of Navigators trained to serve the unique needs of tribal and urban Indian communities.”

I also appreciate the mention at STAC just yesterday to consider more specific technical expertise on American Indian health systems. We had shared previously with Secretary Sebelius before the roll out of the Affordable Care Act, that NIHB did a brief little study and showed that the call centers didn't quite understand Indian health because they thought it was health insurance. And so if the people that you are calling don't understand our issues, it is going to confuse the issue even more. And we support getting people to sign up. So we want that to work as smoothly.

“As OMH continues supporting projects that enhance tribes and tribal organizational's capacity to carry out disease surveillance through the American Indian Alaska Native Health Equity Initiative, we recommend that OMH evaluate the initiative impact on the overall capacity of tribes to deliver all of the 10 essential services of public health. This assessment will provide information that can guide future initiatives aimed at building comprehensive capacity in tribal public health systems. Finally, we recommend that across all HHS agencies, when citing national population, health statistics by race, all racial classifications are accounted for. Too often we are relegated to other and key information is then not available for us. Explaining the reasons for not including

American Indian Alaska Native data should be clearly conveyed. This practice would serve to educate the users of the data on the challenges on accurately representing American Indian and Alaska Natives, and other populations and prevent assumptions that reasons for exclusions are due to intentional institutional bias.”

So that was my OMH. So I will switch hats. Or switch head dresses.

“As the co-chair of the American Indian and Alaska Native Health Research Advisory Council or HRAC, it is my pleasure to offer recommendations regarding research priorities for the various Department of Health and Human Services (HHS) operating and staff divisions. The HRAC carries out three primary functions. Obtaining input from tribal leaders on health research priorities. Providing a forum through which HHS can better communicate and coordinate with our communities, health research activities and providing a conduit for disseminating information to tribes about research findings that studies focusing on health of our populations. And in my limited time today, I would like to share with you what the HRAC has identified and recommends for research priorities including development of an HHS wide umbrella policy for conducting research in our community. HHS agencies and American Indian and Alaska Native culture specific modes of intervention and funding proposed requests. A stronger focus on social determinants of health among tribal and HHS policy makers and health practitioners and a stronger focus on social determinants and public health research. Advancing specific initiatives in Indian Country that are designed to build local capacity to use research data to inform public health practice, creation of a web based searchable American Indian Alaska Native health research and reference collection with links to university and governmental libraries that encourage voluntary submissions of scholarly articles and projects. And creation of American

Indian Alaska Native specific institutional review board point of contact list published annually in the federal registrar. In closing, the HRAC looks forward to continued collaboration with the various HHS operating and staff divisions to improve research activities affecting Indian Country. Thank you for the opportunity to offer these remarks.”

MR. ANTONE: Thank you, Mr. Payment. And our federal representatives for questions and answers if needed is Nadine Gracia, deputy assistant secretary for Minority Health of the Office of the Assistant Secretary for Health. Carmen Clelland, associate director, Tribal Support Unit, CDC. Kathy Etz, senior advisor, NIH. Brian Kehoe, acting director, Intergovernmental Affairs Office of the Commissioner, FDA and Zahava Hurwitz, policy analyst, Office of Policy, Office of the Commissioner. Are there any questions?

Questions and Answers

MR. ANTONE: So I will ask some questions. Yesterday, we had asked the Secretary regarding the protection of human subjects in research and she indicated that the task will be given to Mr. Tabak, so I am just asking if that has been filtered down. Any direction given for Mr. Tabak for that to occur? Ongoing consultation?

MS. ETZ: So I have a clarifying question. When we were in the TCAC meeting, the focus was on specifically on the single IRB policy that is being issued by the NIH and I wanted to clarify if we were to look solely at that policy or look more broadly at the protections of human subjects?

MR. ANTONE: I believe it was more broadly.

MS. ETZ: Okay, that is very helpful. Yes we —I have been in contact with Dr. Tabak about this and we are working to develop a plan. Our policy indicates that we

need to respond within 15 days, once our consultation has been requested so we will definitely be back with you in that time period.

MR. ANTONE: For the FDA, can you give us an update on the tobacco use for — quite a while ago I had heard that we — we were making some sort of effort to allow or not regulate tobacco that is used for ceremonial, is that still the case? Because it has been for awhile — I think three or four years now, so we definitely need to have a response to that.

MS. KUX: Yes, that began.

MR. ANTONE: Okay.

MR. PAYMENT: So I wanted to also address an issue and then I do have kind of like a cross agency sort of question, so if we can put that hat on. But in our community, our tradition is to provide traditional medicine and treatment to my people. During 2014, our healers had 1,515 patient visits and we dispensed \$4,732 traditional medicines and conducted 468 ceremonies that reached 1,329 of our members during our outreach events. So the very nature of our practice and traditional medicine is — we live much closer to our natural environment and pick our medicines. Part of our traditional healing is to teach or remind people of their way with being able to heal themselves through traditional medicine.

Our traditional medicine practitioners are on our medical records and they share all of the information so that they can look for interaction and drug effects and make sure that we don't have that problem and also, our western physicians concede the medicines so that we can train them and educate them about what they should be doing.

But with climate change and pollution we are noticing very starkly the change and the difference in our ability to harvest our traditional medicines. And so, so we

are looking for some solutions to that and that is a cross agency question because it gets to CDC, it gets to IHS and wellness and also behavioral health because a great deal of healing and wellness is covering your physical, spiritual emotional and mental health.

So I also wanted to pose a question and that was, so as we wrestle through these indicators and outcomes which is largely suicide that is going to take a cross agency approach. For me, even though I am on a couple of these committees now, I am still trying to figure out because we think okay we will go to the CDC and ask them for a solution or we will go to NIH and ask them for a solution, but in the federal government's unique way, we compartmentalize and we find in a compartmental way and we don't think in terms of cross-pollination of programs.

But I think there is something under each of those agencies that is going to be able to contribute to us trying to figure out this solution. And during the STAC I testified or not testified, but shared with the Secretary and she asked me and we got quite a bit of time to communicate this, is addressing both the triage and emergency crisis that is suicides and accidental overdose, because we see them on a continuum. We don't see them as separate.

But also being able to get to the systemic origin of these indicators and trying to find those solutions. That is going to take a cross agencies and being able to look outside of your box because federal government again has put you in the box and you are not allowed to look outside of the box. But it is going to take that in order for us to find these solutions. So if you have any suggestions or any ideas I would love to hear it.

MR. ANTONE: Mary?

MS. SMITH: Well, thanks Chairman Payment, those are excellent issues. I guess my one thought that pops to my mind is this might be an excellent two issues to work

on with the White House group and I think what you could say is I think it would be very powerful coming from tribal leaders to say that you know, in the remaining year of the Obama administration that maybe two priorities that group should work on cross cutting issues are the suicide epidemic in Indian Country and then climate change, I think it would be perfect two topics for that group.

To really get some deliverables before the end of the year, you know that is my thought. Because that is an existing cross cutting group that is already — we don't have to create a new one, you know.

MR. PAYMENT: I love that recommendation for two reasons. One reason is to get to the substance of it but the second reason is the process in order to solidify and get permanency on the White House Counsel. So.

MR. ANTONE: Call on Mr. Beaver.

MR. BEAVER: (Away from microphone) Chairman Trudell had his hand up, I don't know if you saw it or not.

MR. ANTONE: Okay, Chairman Trudell.

MR. TRUDELL: Thank you. I was just going to let it go but the question I guess is VA has this initiative on Hepatitis C to get all veterans tested from birth period to whatever. Is there that movement in Indian Health Service or any of the other agencies or anything of that nature? Then I guess my second part would be as the traditional healing and practices and medicines and stuff, a lot of those have been destroyed in our country by you know, crop farmers, spraying and that type stuff. So a lot of our stuff is gone. I know it has been talked about before about doing some initiatives to kind of restore some of that natural vegetation back to the — on the reservation grounds and stuff like that. So just food for thought, thank you.

MS. SMITH: Well, thank you Chairman Trudell, no you raised an important point obviously our veterans we have a duty to — for their health care along with all Native Americans and you know, I just started realizing myself that the — I think kind of increasing incidents of Hepatitis C as related to the substance abuse issues and things like that, that is kind of a collateral piece of it that I know I personally wasn't really thinking about. But I will definitely follow up with the folks at IHS and our chief medical officer, because I have heard from the past few days that this is increasingly becoming an issue. So, thank you so much for raising that and we will definitely follow up.

MR. ANTONE: Before I call on Dr. Bauer, Mary Smith, deputy director of the Indian Health Service. Dr. Bauer.

MS. BAUER: So just to comment on a couple of those points especially related to traditional medicines. At CDC we had a program for a number of years jointly funded with the Indian Health Service around traditional foods and reconnecting to traditional foods and rediscovering traditional foods and ensuring that those could be gathered and hunted and harvested and so on. We hadn't thought about including traditional medicines in that but when we lost the funding from Indian Health Service we rolled that traditional food component into Good Health and Wellness and so in the next generation of that program, we can certainly look at how we can support the gathering of traditional medicines.

I did want to make two other points related to we are so compartmentalized across the federal government but there is a little bit of a logic behind it and for something like suicide, very simplistically stating it, CDC would really focus on preventing suicides and NIH might focus on the research around the effective interventions,

SAMHSA would focus on delivering those interventions. What we need to try to do better is just keep everyone in the loop and coordinate a whole lot more.

And with the White House Counsel, I think that is a terrific idea but we will want to make sure that those discussions and those decisions actually trickle down to the agencies so that the people on the ground can know what is going on and how to work better across the agency, so thank you for those comments.

MR. ANTONE: Call on Ramona and then Vernon.

MS. ANTONE-NEZ: Thank you Councilman Antone and thank you for the presentation from our federal partners and dear tribal leaders. Thank you. I am Ramona Antone Nez from the Navajo Nation and I want to first start out by saying thank you to DHHS for your recent visit to the Navajo Nation in January 2016. We had visitation from CDC, ATSDR, SAMHSA and NIH.

From that, what we had done is we shared the 15 leading causes of mortality on Navajo Nation based on a report from 2006 to 2009 from data of Arizona and New Mexico Departments of Health. Of that, we want to say thank you to the CDC for the Good Health and Wellness Grant that is provided as a cooperative agreement to allow us to address the second, third and fourth top leading causes which is cancer, heart disease as well as chronic liver disease, and cirrhosis.

What I want to emphasize and we have advocated from the Navajo Nation that there is a need for continued increase for funding on injury prevention. Unintentional injuries is the leading cause of mortality on the Navajo Nation based on the time frame that I had stated. From that it is — a lot of it may be related to alcohol. But really we have years of potential lost lives that are off the charts if you will. It is a significant public health issue that we have and we look to your partnership to help us to address that.

The other is another part to the emerging infectious diseases that we have been facing. We continue to have incidents and then leading up to fatal — possible fatality to some of these infectious diseases and prevention is really what we have been working towards but there is also imminent threats that we have faced on Navajo. I just want to also emphasize that there is the public health authority of the tribal epidemiology centers. So we appreciate that recognition and working with our federal partners.

To NIH, we do want to thank you for your visit as well. I want to continue to emphasize the need for peer review and to have on the panels to have American Indian Alaska Native representatives to assist with the peer review because we bring a unique perspective to how perhaps our colleagues and our fellow tribes are submitting these grant awards for these applications.

And with that perspective and that lens in which we look through, then perhaps it will assist with a greater opportunity for grant awards and cooperative agreements to tribal nations. Because of actually having a representative of the American Indian Alaska Natives on your review. To SAMHSA, we just want to thank you for your recent visits as well and we fully cooperate and support the Zero Suicide that has been reported and the Navajo Nation has — I will provide more on testimony on that when we get to SAMHSA and into ATSDR.

The uranium effects continue to be a major public health issue on the Navajo Nation. We have the Navajo Birth Cohort Study as well as our long-term advocacy for a long-term affect and study on uranium issues. So we continue to advocate for that for additional funding. With that, I just want to say thank you for the opportunity to voice our continued recommendations on budget to the DHHS. Thank you.

MR. ANTONE: Vernon?

MR. MILLER: Good morning, some of my concerns and recommendations are kind of geared towards the CDC. I think a well known fact is that Indian Country is uniquely positioned to bear a disproportionate brunt of many natural disasters and emerging biological threats. I can tell a natural disaster perspective my tribal community experienced a U.S. government made flood in 2011. The Missouri River flooded and caused my community — it was a natural disaster but it caused my community to loose several homes, caused some viruses to be more well known(sic) in our agriculture base and as well as really hit us economically from a employment standpoint.

But then not even a year later, we had a tornado hit our community. A tornado hit down twice. And when disasters like that happen, you know there is diseases that are created and become airborne and kind of come with that. Another concern I had was you know, over the past couple of years with Ebola. My community is just an hour north of Omaha which is where Ebola was sent, the patient that had contained it. And I understand that the medical center that was utilized said it was well contained and you know, but that was all the buzz in my community. Because you know, it was on the news, they were showing the patient being flown in to Omaha Airport and then being transported from the airport to the facility.

And so my community was extremely nervous and very agitated and even, you know, what is going to happen now. If something happens and there is a leak because the facility that they utilized is where a lot of my tribal members go to receive some cancer care and services that are utilized to help them resolve that. And so now with Zika virus becoming something more prevalent, in terms of Indian Country and budget recommendation, definitely for FY 2017, I would recommend that a portion of the \$5.4 million proposed increase in terms of preparedness and response capability be used to

expand preparedness planning at the tribal level and increase coordination between tribal, local and state jurisdictions.

And as far as FY 2018, it is the recommendation that funds be dedicated to evaluate coordinated tribal, local and state preparedness and response as well. Hopefully these findings can be disseminated widely and from a leadership perspective at the tribal level, we think it is a national level of concern but when you — your community is an in urban area and that is where some of these patients and some of these concerns are.

Even in our hospital, you know it was still — one of the nurses just got back from where Ebola was and they were — we were told — and they went through the treatment process and made sure that that wasn't going to be transferred out in terms of like I said, the preparedness, just even knowledge based, that needs to be there to definitely reassure our community members that you know, we are safe but we can only trust it so far when it comes to diseases because of our past and what things that have happened to us. So I just wanted to make those recommendations for that portion of the budget.

MS. BAUER: Thank you very much for those recommendations. At our tribal advisory committee meeting in February at CDC, some of these concerns were raised as well and Rear Admiral Stephen Redd who directs our Office of Public Health Preparedness and Response did hear those concerns and is looking at ways to really engage tribes directly in building that preparedness response and certainly improving coordination. But not necessarily working through states, state health departments.

Dr. Friedman recently sent out a Dear Tribal letter on the Zika concerns and we are certainly looking to improve communications directly with tribes for Zika — improving our performance with Ebola where we recognize that we did fall short without

direct communications. And Zika will likely be an issue that is very relevant to rural areas and not just the urban areas. And especially in the lower half of the country where the mosquitos are more prevalent. So we will look forward to working with you on that. Thank you.

MR. CLELLAND: Just to follow up on that response with regards to the Zika virus, we are working with the National Indian Health Board to set up a call with tribal leaders and 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. So we are currently working through that process and we will be sending out information soon with regards to more information and more interaction from the CDC and where we are going with what is coming up on Zika and potential opportunities to work more with tribes.

I did real quickly want to at least address Chairman Trudell's request on the VA's response with regards to working with the Veterans Administration. We are starting to reach out to work with them, to be able to see how can we support veterans with public health measures including Hepatitis C. This was a really brief discussion that we had with them recently and we are working to be able to help address some more public health issues out of response to that, because we do realize that for those veterans — that were born between 1945 and 1965, 10 percent of those will have Hepatitis C so it is an area of concern that we really want to make sure that we start to address and we have activities that we can bring back and respond to Indian Country with regards to the CDC and the VA's cooperation of working with each other.

With regards to Chairman Payment, you know, we are — the CDC proposed is \$30 million increase in public health approach to prevent suicides so that is

something that we will be working with other agencies in order to utilize a method that is going to help suicide prevention from a public health approach and perspective that will be able to help address the ongoing concerns through a department wide approach on preventing suicide and what is going on overall not only within the country as a whole but also specifically with the Indian communities.

So that is an area that we are currently going towards. And then to address Ms. Antone Nez, we are working and we reached out some efforts to connect with IHS on some of the issues especially with the death you had recently in the Tuba City area with regards to the young lady. And that was very, very challenging especially with what is going on. So I know that our National Center for Environmental Zoonotic (sic) Infectious Diseases is reaching out to be able to help support that approach and trying to identify ways that we can get the epidemiological efforts and be able to work with IHS on those areas.

So we are working to be able to support a lot of those needs. And working with fundings that has been available to help support those types of efforts. As well as with birth cohort study. I know that is a strong support for our director and also with NCEH and in order to help support that too and it is on their radar as funding comes available to help continue that as a long-term solution in looking at how uranium affects our Navajo Nation. So thank you.

MR. ANTONE: Thank you. Mr. Joseph?

MR. JOSEPH: (Speaking in Native language), my name is Badger Andy Joseph, Jr. from the Colville Tribe. In Washington State, I believe I brought this up last year, they legalized marijuana and you know, there is some of our tribal members that actually use it for medical purposes and you know the children that need it for their seizures and

you know, my sister she has been dealing with cancer for over 10 years now and wouldn't be alive without it.

She gathers her traditional foods. There is no additives nothing bad in our traditional foods. And I believe that is what is keeping her alive is when we gather our foods, there is the ceremonies and prayers that go along with that. And I call it our best practices. We were brought up as children, you know gathering and so, but the problem with the state legalizing that is — has caused the heroin is now the number one drug that the people are getting at.

I heard that the dealers switched and was giving free samples to the children but I also sit on the Healing Lodge of Seven Nations and before they legalized it, marijuana was the number one drug that was coming in there. Now the — what they are coming in there addicted to is heroin and we are talking sixth grade children — aged children. And so it is really scary to think about the different diseases and illnesses that could come with the use of the heroin. So you know, I am not sure what the VA is doing with medical marijuana if it is — if they are using it for post traumatic disorder — stress disorders for our veterans. Some are suicidal and — but I would hope that — it is always my wish that if there could be studies from NIH or if they would look at you know what the VA is doing.

You know the MOU with IHS and the VA, might be a way to — I would much rather have the feds control that medicine than have our people having to get it through the other processes. It is not — they can't buy it on my reservation, it is still federal land so it is not allowed but our patients need it. So anyway, just wanted to bring that up as you know, somewhere — something to look into a little more. I sit on CDC's advisory committee and we did bring it up there as well and to me I think if it heals our people and

keeps them alive, I don't think — I truly believe my sister wouldn't still be with us if she didn't use that medicine. The other medicine probably would have killed her by now, that the doctor's prescribed. The legal stuff. But thank you.

MR. ANTONE: Thank you. Is there anyone — Gil?

MR. VIGIL: Thank you. My concern is VA and the IHS MOU, but more importantly while we have this MOU, the services that the VA needs at the local level doesn't get down that far. A lot of our veterans are still challenged with just going through the process of filling their paperwork, doing the necessary paperwork to get their benefits. And so in New Mexico, we are looking at VSO, Veterans Service Officers to be placed in the communities.

And like I said, I am the executive director of Eight Northern and one of our efforts to try to get a VSO under our behavioral health program. So that it can assist the veterans in accessing their benefits through the bureaucracy that is in place. The problem is there is not funding to fill that position at Eight Northern. So we are looking for funding. And I did talk to Stephanie Burwell last week at NCAI but I think we need some help then to fund positions like that to help access those services for our veterans.

MS. SMITH: Thank you so much for your question and it is actually very timely. I am scheduled to go to VA for a half day meeting on Monday, March 14 to talk about our MOU and I would ask all of you around the table if you have certain issues involving IHS and VA and veterans issues for health care, please send those along and I will raise them at the meeting because I know others have raised some issues too. So I would like to know what your concerns are and what things I should bring up at the meeting, I am happy to do so. So thank you so much.

MR. ANTONE: Nadine?

MS. GARCIA: Good morning everyone, I am Nadine Gracia, the deputy assistant secretary for the Office of Minority Health representing the Office of the Assistant Secretary for Health. And I wanted to respond and connect actually points that Chairman Payment and Ms. Antone Nez raised with regards to grants and certainly understanding the importance of having grant reviewers who understand the experience in the health disparities in particular that impact tribal communities.

One of the things that the Office of Minority Health has done and I know that other — certainly other agencies across HHS have also done is to post on our website that we are actually seeking grant reviewers so that we can make it more transparent and visible about how to actually sign up so that if you are interested in serving as a grant reviewer, you can do so. So in particular, Chairman Payment to your point with regards to the childhood trauma grant opportunity announcement, the re-entry grant opportunity announcement and others that are coming through the Office of Minority Health, certainly a way to encourage tribal members is to go to our website which is minorityhealth.hhs.gov. And you can actually — it is on the home page that you can enter your — go through and enter your information if you are interested or have tribal members who are interested in being grant reviewers.

I also wanted to address Chairman Trudell, you asked about Hepatitis C to let you know that 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 actually co-infection of HIV and Hepatitis C and in that we are going to be looking at each of the groups until we have specific subcontracts that are going to be awarded specifically looking at the American Indian Alaska Native population.

So I am happy to give updates as that project unfolds. I will certainly give updates during the Secretary's Tribal Advisory Committee meetings.

MR. ANTONE: Aaron?

MR. PAYMENT: Actually so this is something that we talked about at our NIH Tribal Consultant Advisory Committee, I keep saying it different every time. But so we have asked actually for a review of applications because we believe — we don't believe they are purposely being overlooked when we have methods that are traditional methods in the application but we think there is probably a western bias in the way people are reviewing these applications.

So while I do support and I think we need more Native reviewers, but if they are trained and academically trained to the western environment, then they are likely to have a bias and a western bias. And so, so we have asked for some kind of a review of that for the purpose of seeing if there is something we can do to either get more tribal reviewers or some kind of specific training and sensitivity training to understanding what you are looking at.

So if you have a traditional practice that is embedded within the application and the reviewers don't understand that or even maybe a Native reviewer who is far down the assimilation pipeline who doesn't understand what they are looking at then you are going to miss it and then we are not going to get the points and the scoring. If grants are awarded based on an extremely competitive process and you have to get like a 95 or 96 and you miss a couple of points because the reviewer doesn't understand what they are looking at with respect to traditional ways of knowing which is one of our priorities, then you are not going to get the grant.

So, so maybe that is something again systemically across agencies that we could look at because again and this might offend some people but just putting more Indian people as reviewers isn't necessarily the solution if they don't have a traditional perspective.

MR. ANTONE: Thank you. Mr. Anderson?

MR. ANDERSON: I just want reinforce what Chairman Payment has said. We had I thought a very good discussion last week with the director of our Center for Scientific Review. So this is the person who is responsible for almost 80,000 applications coming in every year and attempting to give them informed and fair review. And he recognizes the issue that reviewers must understand what is the point of this grant? Is this — are you researching the cultural context that might make the intervention more appropriate or is the reviewer thinking you are learning a lesson to apply across the entire planet?

You know what is the context for this? So it is something that we do think about and it is something Dr. Nakamura thinks about. And we are going to get back to you on the issues that you brought up. It is very important because we need to do valid research. So if our reviewers aren't getting that that is not going to work.

MR. ANTONE: Thank you. And we are coming up on lunch in a few minutes. I just want to let Mary before you go, there was a — there was a concern about the VA referring patients because they are covered by IHS but the concern was that perhaps IHS is simply quick to deal with those trauma from — from veterans that face suffering. So that is a question that I wanted to just to let you know that was a concern that came up. At least in our areas, so you are aware.

MS. SMITH: Yes, and I know that — thanks for asking that question and I know that we have a number of initiatives that we are working on in terms of trauma in base care. I see Dr. Cotton in the back of the room and if she can wave her hand. She is working on a number of initiatives that relate to that issue, so thank you so much for asking that.

MR. ANTONE: And the other issue that I wanted to bring up with Dr. Gracia, yesterday I had asked in consultation, although I did not have OMH on my list but since they were there, I asked for a progress report on the American Indian whether we have made any progress in health equity. And I know that health equity councils are within the OMH site. I ask that and so I hope you would give kind of a report if we are making any progress in the health equity arena.

MS. GRACIA: And just to clarify Chairman, do you mean specifically under the auspices of the National Partnership for Action, the tribal caucus that the councils have formed and the progress of that work specifically?

MR. ANTONE: Yes.

MS. GRACIA: Okay, certainly we can take that back.

MR. ANTONE: Okay and then we are — oh — after Kathy, we will go to lunch.

MS. ETZ: Sorry, thank you very much. I just wanted to quickly respond in terms of marijuana research, we did develop a two page fact sheet on this that we shared with NCAI last year and so I would be happy to share that with you. We do have quite a large portfolio of research at the NIH that looks at both recreational marijuana use and outcomes and then also at some medical marijuana use. And so I can get that to you. And then in terms of Chairman Payment's comments about suicide and it being on a continuum,

I wanted to point out that NIH in addition to some of the other options has supported work in a partnership between White Mountain Apache and the Johns Hopkins American Indian Center — Research Health Center.

Looking to develop a suicide surveillance system that does in fact conceptualize this on a continuum with unintentional injury and incorporating alcohol and drug use. And I know that Navajo is exploring using the same surveillance system, so that is something we could put you in touch with people at Hopkins to pursue that. So thank you very much.

MR. ANTONE: Thank you and now with that we will go to lunch and we will be back at 1:00 promptly.

(Whereupon, a luncheon break was taken.)

A F T E R N O O N S E S S I O N

(1:02 p.m.)

MR. ANTONE: If we can have everybody take their seats, we will begin this next part. I know some of the folks aren't here but hopefully they will be arriving. So if you are ready, kind of — we will call on you. Ms. Kana Enomoto, administrator for SAMHSA.

Behavioral Health Budget Priorities

Federal Leadership Updates

*by Kana Enomoto, Acting Administrator,
Substance Abuse and Mental Health Services Administration*

MS. ENOMOTO: Good afternoon. Thank you very much. I am very honored to be here with you this afternoon and I would like to acknowledge Chairman Vernon Miller and Councilman Andy Joseph who are members of the SAMHSA TCAC and glad to be with you here today. You heard Mirtha speak this morning about SAMHSA's Tribal Behavioral Health Grant Program at \$30 million we are thrilled to be able to award 100 new grants this year. I think we are going to see some wonderful work on substance abuse prevention and for our tribal youth as part of the Generation Indigenous effort.

Also the tribal set aside that is part of our Zero Suicide budget request for FY 2017 and I don't want to repeat all of that information but I want to share some of the other budget priorities that SAMHSA used in formulating our FY 2017 budget request and that is also to let you know that we would like your input as we consider important areas for investment in FY 2018. So in FY 2017, our budget includes 4 key priorities that align with efforts in the Department as well as Presidential initiatives. The first is engaging people with serious mental illness and care.

Here we have seen headlines. We know that people with serious mental illness have challenges in terms of accessing care. Often times an initial psychotic episode will occur and people don't get into the — the average time that it takes for a person experiencing psychosis, a young person generally to getting into care is 18 months.

So if you can imagine people are living for over a year with this very challenging conditions and not knowing where to go and that is hard for the individual and it is hard for the family. It leads to school failure, job loss and other really challenging things. There is a lot that we can do and we have some great things in our budget for that.

Addressing the public health crisis of opioids. I know that this is hurting tribal communities even greater than other communities and there is some good data coming from the CDC as — and that has been highlighted in the front line piece both on heroin and prescription drugs where we have seen a quadrupling of deaths in certain tribal communities due to opioid and heroin overdose. So that is really something that we need to look at.

Suicide prevention that is a topic that I know has been talked about at this group. We are looking at this more broadly across the country. And then maintaining the behavioral health safety net. There is the last two years, we have seen significant growth in our block grants as the country is moving delivery system reform and value based purchasing, it is still very important for us to ensure that our most vulnerable folks, people with mental illnesses and substance use disorders, people at risk for those conditions are ensured a secure and stable source of funding as we move as a nation to a new way of doing business.

So in our approach to behavioral health, we have had a three pronged — three pronged model of driving improvements in tribal communities. These prongs bring

together an array of current and proposed actions focused on making a real word difference. So the first one is to reduce suicide attempts and completions through increased reporting on what is known about AI/ANs and suicides and investments in the TBHG as you have discussed this morning.

Also investing through the Garrett Lee Smith State/Tribal Grants and the AI/AN Prevention Initiative as well as the AI/AN Zero Suicide. We are also looking forward to partnering with our colleagues at IHS on their suicide efforts that will be more focused on the IHS facilities themselves. Our second prong is improving knowledge and capacity to address behavioral health in tribal communities through comprehensive data analysis. So really looking at the scope of Indian alcohol and substance use problems and collaborations on tribal data reporting.

And the third prong is a favorite topic and what we held up as an example of great stakeholder and federal partnership is establishing a collaborative National Tribal Behavioral Health Agenda to provide a clear national statement about the extent and need for prioritizing behavioral health and tribal communities. We think that the behavioral health agenda can be a tool for improving collaboration among tribal federal agencies and others on common issues.

It will be a blue print that harmonizes our efforts and creates a unified approach for funding, programs and policy activities. So during last year annual tribal budget consultation, tribal leaders who previously engaged in discussion about establishing or — tribal leaders pushed for the development of the National Tribal Behavioral Health Agenda and so I definitely owe you a debt of gratitude for that initiative for serving as that catalyst to what has unfolded into a year of a lot of activity thanks to the great leadership of Mirtha Beadle and our staff. Sheila Cooper, Marci Ronyak and others.

We have really — at SAMHSA done quite a bit of work trying to engage both our federal partners, National Indian Health Board, other tribal organizations and I think we are handing out the side deck on the TBHA. And so we heard your voices. And we definitely acted and I think have talked with many, many, many tribal leaders, tribal staff and tribal community members on the content of the agenda. What do you think is most important thing to focus on? How can we collectively move forward to address the surge of substance use disorders and substance use problems in tribal communities? How do we address the tragedy that is suicide. We want people to know that help is available. And suicide really isn't the answer.

So last week, we met with our SAMHSA Tribal Technical Advisory Committee and walked through the contents of the TBHA and we received great advice from them as we also do and so we are in the process of updating the agenda based on their comments and we will add information from our federal collaborators and other comments that we receive from you today. I think we are very close to getting a product out but we want to make sure we really are hearing and reflecting what you want and what you see as priorities.

Over the coming weeks, SAMHSA in collaboration with IHS and NIHB will be finalizing that and we will get it back out to you for another national comment period before really making it final. So with that, I think I am happy to take your questions or get more into what our FY 2017 budget details are or your thoughts on FY 2018.

MR. ANTONE: We will go through the presentations and then we will open it up for discussions and questions. Beverly Cotton.

Comments

*by Beverly Cotton, Director,
Division of Behavioral Health, Indian Health Service*

MS. COTTON: Good afternoon, everyone. I am Beverly Cotton. I am a member of the Mississippi Band of Choctaw Indians. And it is my pleasure to serve as the director for Division of Behavioral Health at Indian Health Service headquarters. I just want to briefly provide an overview of the FY 2017 budget for Indian Health Service as it relates to behavioral health issues.

We have some really important requests in that budget aimed at improving access to behavioral health services. So the \$21.4 million request to initiate the behavioral health integration initiative really aimed at providing the behavioral health integration services with primary care is the crux of that budget request. There is also a request in there to address aftercare services for youth who are discharged from the youth regional treatment centers.

So implementing a pilot side to ensure that there are some wrap around services for Native youth after their leaving the treatment service centers around the country. There is also requests in that budget that are focused on suicide prevention as well as addressing issues for Native youth. The Zero Suicide initiative works in coordination with the SAMHSA request to ensure that direct service facilities have access to funding streams to implement Zero Suicide as well.

And then the MSPI increase for \$15 million addresses purpose area 4 or what we refer to as purpose area 4 which is really aimed at improving and programming for Native youth ages 8 to 24 or around positive youth development, increasing self sufficiency behaviors and promoting family engagement.

And we also see in that request, a \$4 million increase for the Domestic Violence Prevention Initiative aimed at addressing and increasing services for trauma-informed care. And then you will see that there — addressing behavioral health crisis. So issues related to suicide clusters, alcohol related deaths, mass shootings. Some of those current topics that have been facing many tribes across the nation where IHS has been asked to provide some additional resources. You will see that request in there for an additional \$15 million to establish a mandatory program over two years where we would be able to provide funding outside of grants for tribes that are facing behavioral health crisis.

And then a focus on the recruitment and hiring for behavioral health providers. There is a \$10 million increase to address increasing the number of behavioral health professionals that are participating in the loan repayment program as well as our scholarship program for behavioral health related fields. And so those are the major areas that we are addressing in the FY 2017 budget after hearing from so many tribal members in various settings on some of those particular issues.

So I am here today to listen to your concerns on how we move forward with not only those requests, we also have the FY 2016 increase for that — where IHS received \$10 million for the purpose area 4 focused on Native youth through the MSPI. So we are planning to roll out some of that information through the National Tribal Advisory Committee on Behavioral Health next Wednesday. And then do a broader consultation through a Dear Tribal Leader letter and I imagine this issue will also come up in many of the other consultation sessions through Indian Health Service.

And then look forward to hearing you guys recommendations as well on the FY 2018 budget. So thank you for allowing me to speak and I look forward to our discussion today.

MR. ANTONI: Thank you, Beverly. Mary Smith is not here, so we are going to go down to a tribal leader testimony that will start off our discussion and this will be done by Vernon Miller, Chairman, Omaha Tribe of Nebraska. Vernon?

Tribal Leader Testimony

*by Vernon Miller, Chairman,
Omaha Tribe of Nebraska*

MR. MILLER: Thank you. I want to thank our presenters so far on what they provided to give us an update as well as an overview of the 17 and specifically ask for recommendations for FY 2018. I do have one that I wanted to recommend as it relates to behavioral health grant funding and that is that it be increased to \$50 million and that funds specifically be appropriated for pre-determination such as obviously suicide intervention, expansion of mental health counseling capacity and infrastructure and surveillance of and mediation of increasing levels of domestic violence.

I also wanted to make a recommendation too that we still work on an understanding in regards to tribes for funding. You know it is — I can give an example of my tribe. You know, our alcohol program is administered, the funding level from the state. And often times, you know, I get the director coming to me and saying, hey can you give a call to the state to do this — to follow up on this or to you know, to try to initiate this process and release this funding or stop holding up this funding because of this reason? And so it is almost an arduous process now in working with our state. And I realize that every state is different and unique but you think for a state who only has four tribes that they be able to administer the funding at a more reasonable and flexible in what it currently is and so I would — continue to encourage the funding for tribal communities should be

directly administered to tribes instead of through state governments. And that is just one example that I can definitely utilize and sharing that.

I also wanted to reaffirm and also look forward to the release of the National Tribal Behavioral Health Agenda. It is going to be something that is going to be beneficial and examining and really looking forward to how we as tribal leaders can also utilize this agenda in advocating and also reminding our partners as well as the Congressional side too of how they need to be a part of the process of helping us solve a lot of these issues that we are dealing with in trying to address and trying to hold our communities together.

And so this agenda is really going to allow that form and a dialogue starter to definitely be able to utilize in moving forward with that. And I also just wanted to I guess reaffirm to that I mentioned it last week and I also mentioned it this morning, that you know, in really thinking about how the professionals that are coming to our communities or not coming to our communities, we really do a self examination of an assessment of how we were recruiting those individuals to rural areas, whatever tribes are in rural areas of the country. And I mentioned yesterday that we really need to look at making sure that the reflective of our community, those professionals and those staff members, because you know we truly — we truly can empathize with what we are going through in our communities and so what better way to provide those services than by ourselves and to our community members being able to be those professionals. Whether it is mental health or a counselor or other staff members that can help really provide those services and counseling or definitely addressing some of those addictions that our communities are dealing with.

And so I mentioned that in different realms and when you look at our IHS facilities, you know, how awesome would it be for our professionals in that level too to be

reflective of the community. And so I just wanted to reaffirm that it is definitely something that we continue to pursue and that we really look at models that we can really implement further and all facets of professionals within SAMHSA in terms of the local tribal level that we can provide.

I know IHS scholarship that is a model that is available. And I know SAMHSA has one program but also just to continue to expand that so that we can start really utilizing our community to address some of our behavioral mental health needs as well as substance abuse needs within our community. So I want to thank you once again for the time to provide a response and to also to just reaffirm the work that SAMHSA is doing and to also provide those couple of recommendations that I had on behalf of not only my tribe but also the Great Plains Area as well as my role as an At-Large member on STAC. So thank you.

MR. ANTONE: Thank you, Vernon. And our federal representative for question and answer is Martha Beadle, director, Office of Tribal Affairs and Policy at SAMHSA. But we also have Beverly and Kana. So I am going to open it up to any questions and comments.

Questions and Answers

MR. VIGIL: Thank you, Chairman, again Gil Vigil, president of National Indian Child Welfare Association and we did — provide written testimony also and so my comments are going to be brief. Our Native children and their family face some of the greatest obstacles of any population to secure mental health service that can heal the trauma they have experienced. Especially services that are culturally appropriate as Vernon was talking about.

In many tribal communities there are no mental health services of any kind. Children and their families are forced to travel long distance to find any services. Most of which are not designed with the cultural or unique circumstances in mind. Even fewer tribal communities have mental health service available to employ child and adolescent providers, again something to Chairman Miller's comments.

The need for children's mental health service is high in most tribal communities especially where generations of families have experienced trauma that has not been sufficiently treated or resolved. The result from ongoing intergenerational trauma and the lack of core mental health services to treat victim is predictably high rates of depression, alcohol and substance abuse and suicide. This should not come as a surprise to anyone of course and if we are going to get out of this dangerous trend, we have to continue to listen to what the tribal leaders are telling us about their communities need and the best approaches of meeting these needs.

There is no short cut for addressing this critical issue. On our top — our FY 2018 children's mental health budget priorities are as follows. Increase the FY 2018 funding request from SAMHSA programs of regional and national significance to \$8.5 million. With \$6.5 million reserved for Circles of Care program. This will increase the number of tribal community's grantees by approximately 30 percent and provide much needed assistance in developing Native Pacific children in mental health programs.

Continue to 2017, request of \$50 million for the Tribal Behavioral Health Grant for FY 2018. This is a much needed tribal specific funding that is needed to address communities which already have high rates of behavioral health distress where existing resources are insufficient to address crisis level issues such as suicide. And of course, the

National Tribal Behavioral Health Agenda is also an important part of this whole process. So we can specifically identify some of these issues to address our concerns. Thank you.

MR. ANTONE: Thank you. Do we have any responses? Mirtha?

MS. BEADLE: I just want to thank all of the tribal leaders for the comments that you have provided. Certainly I think part of today's session, this session is really to help us kind of figure out how we move forward. And I think the recommendations that have been made are really important ones as we think about FY 2018. So thank you for that. I do want to mention just an example and this is basically tying in the session this morning with the session now because there is a lot of I think — there is connection between what we heard this morning and what is happening now.

I think an area where SAMHSA can really help and Mr. Vigil, you talked about the Circles of Care program. An area where SAMHSA can really help especially in children's mental health is Circle of Care but also the related programs of Systems of Care. There is an example this morning of equine therapy and the importance of that. And many tribes might be working on this, we don't know all of the tribes working on this, but an example that we have funded under the Systems of Care, which again is the sister program to Circles of Care is Sinte Gleska that has this program funded specifically for children with serious emotional disturbances.

I think we do have some models that we can actually look at in terms of how to expand those. And so I think the programs that have been named are really critical ones to be able to look at for FY 2018. So I am just acknowledging the importance of what you shared and sharing an example of how we might do that. So thank you.

MR. ANTONE: Thank you. I will call on Mr. Joseph.

MR. JOSEPH: (Speaking in Native language) I really want to thank you for this opportunity. I am from the Colville Tribe and I also chair the Northwest Portland Area of Indian Health —. I have seen the — I got an e-mail from SAMHSA and it has the Native American Culture Wisdom Declaration and I really support what was written in that declaration. To me, I believe it — you know there is answers in that our culture and our tribes and in our people that know and understand how to use that as a healing practice is the best medicine that it can ever get. You know, in a northwest tribes we have the canoe journey and a canoe families and we have — my tribes is a horse tribe and we have this big race and there are several races that go on and there is that time you have to spend with horses to really understand and become you know, a part of that horse to get him to do what you want him to do.

But there is that pride that you get as well from being able to be in the spotlight, you know, doing those competitions, kind of like basketball for some people that is a really good activity that keeps our kids from getting involved in drugs and alcohol. And well, we have our — it is getting close to the time of the year where we do our root gathering and the young girls that go out and gather roots for their first time in Head Start's, some of their kids get their first root.

And they are put in the middle of a room like this and they are honored and know that kind of teaching will stick with them for the rest of their lives. They are going to want to feed this medicine to the community, to their grandparents and they might have an uncle or an aunt that is going to really thank them for honoring them with that food that they gathered. So that declaration really kind of spells — spells that out and I totally agree with it.

You know on the Healing Lodge of Seven Nations is a youth treatment center and what I would like to see there is and I would want to see it at all of the other youth treatment centers is an encounter rate for providing that service, if we can get an IHS encounter rate for those — they are 24 hour care. Some of them need 90 days of treatment. And in order to really fund them at I guess a good rate would be to come up with an encounter rate to do that type of inpatient service. I brought it up before, there is a I believe some kind of a 16 bed issue. With some of those treatment centers that actually needed to serve more than 16 people.

And I would hope that that issue could be worked out so that those children can get the cultural type of healing — the Healing Lodge of Seven Nations actually has — they do horse equine — they also do music, they make music and I can't stand that rap stuff but that is what they are doing these days. And but it is successful. Some of these kids are winning Grammys doing these rap things.

So, and then there is — they do make us proud to make those kinds of accomplishments and they bring that home to the people that are trying to — that they lived with before and so they hear that music and it is kind of healing to them as well. So I really think our best practices is those things and they should be allowed to be billed for it — if it can't be in I guess — if they can't be considered a practitioner or something if there is an encounter rate that just covers the whole 24 hour stay or you know, 90 day stay that at least the work would be getting done and they are successful. I heard Pam Hyde say that the Healing Lodge was one of the most successful youth treatment centers in the nation. So I would want that for all the areas. So, but I guess that is all I have to say for now.

MR. ANTONE: Any response from IHS?

MS. COTTON: Sure. So we have definitely made the issue of reimbursement for the youth regional treatment centers a priority. The National Tribal Advisory Committee on Behavioral Health has asked us to address that. So over the last year there has been some work on looking at an analysis or a cost report for those youth regional treatment centers.

So we are looking forward to that being finalized in the upcoming months so that we can share the results with tribal leaders and among those youth regional treatment center directors as well to come to a solution and look for next steps on how we could address that. There is a wide variation with reimbursement for youth regional treatment centers especially because you are taking many youth from not just your state but from your entire region. And often times outside of your region are coming to those youth regional treatment centers.

So it is a definitely a huge important issue that we are looking forward to providing an update to all of you on.

MR. ANTONE: Thank you. Is there anybody — Mr. Aaron?

MR. PAYMENT: So we covered this actually — we have been covering this a lot in the last couple of days and so I had a chance to talk to the Secretary and talked quite a bit about it and then this morning we talked about it. But so just to reinforce because there is additional people here, is so when I came back to office, one of our very athletic, beautiful, young, bright tribal members who was I think probably 19 years old at the time, was involved in sports. You would never imagine that she would have gone this route but she tried black heroin for the first time and she died.

And so we put together a task force of all of our cross silos — we have silos in the tribe too and facilitated a conversation to identify how do we get to the heart of this

and how do we address it. And so that was the beginning of the development of our TAP. We have a TAP under the Department of Justice that we are working on wrapping that up and finalizing it.

So some of the concerns are you know, we applied for a grant. We have been looking at this real closely, we can make the justifications real closely. But I think it was a SAMHSA grant and we didn't qualify because part of the application process based on need relies upon local medical examiner information and suicide rates. And if we still have the issues of racism in our communities where the medical examiner might check a box in a certain way without sensitivity or maybe even with a strong bias towards our Indian community.

So relying on that piece of an application to score an application is faulty. Also, I think that and this isn't probably racial but the mischaracterizations of some accidental overdose is not a suicide because I see them on a continuum and how I understand that is through studies of anomie and anomic suicide. And so when I relate historical trauma to our understanding and applications of social anomie in Indian Country and the outcomes of an anomic state are alcoholism, violence, suicide, accidents and transients.

And we can demonstrate very clearly that we have the worst of the worst statistics on all of those dimensions. So if there was ever evidence to anomic suicide and the conditions of normlessness, it is our community. We absolutely demonstrate that. I think we are making some headway through STAC and through the other committees for an understanding of that. But I think it deserves a much greater attention. I appreciate the triage approach to addressing in an emergency way the suicides that are happening in

Indian Country but that is just patchwork. That is putting a little bit of money here, a little bit of money there.

But without understanding the root origins and trying to address that.

Now, I know it is systemic. I know it is huge. You know because how do we — that is the President's challenge with My Brother's Keeper, how do we address the conditions in which young black men find themselves and they have high rates of violence and deaths related to gun violence.

However our statistics are worse than that. And that gets overlooked.

And that is why I have committed to participating in My Brother's Keeper to make sure a Native voice is included and I support what My Brother's Keeper is doing. So this is going to be a harsh statement and it might be hard to hear but our current suicide and accidental overdoses are the legacy of genocide practiced by the United States government.

And so to give you an example, prior to intervention, we had over 10 million and some estimate, up to 20 or 30 million Natives in what is now North America, in 1900 we had 100,000. We were almost extinct because of small pox. And so I want to share quickly with you from our oral tradition in my community the Little Traverse Band, which is located right here and part of my blood is Little Traverse, traveled out to Washington to negotiate and what they gave them as a gift was a little cedar boxes inside of cedar box and all the way down like about 6 boxes.

And in the center of the box was a swatch of Pendleton swatch infected with small pox. And so I know this from our oral tradition and stories that have been passed down that when the community got that in a very communal way in the way that we lived, everybody looked at that, everybody touched it and everybody smelled it. And two thirds

of their population was decimated as a result of that experience. That is not only oral tradition, it is also documented.

So, in then a simulation tactic through the boarding schools. So physically and then also emotionally and mentally the practices were to assimilate us. So then you ask yourself, well why were they assimilating us? Some people think well we had to assimilate them because then they could become farmers and productive members of society but really what was behind the simulation was the federal government was not as smart as us when we signed the treaties and we obligated the federal government for health education and social welfare for as long as the grass grows and the winds blow and the rivers flow.

Our leaders had the vision to include that and that is the basis for the trust responsibility and treaty obligations. And so when you have that obligation and it is legal and it has been upheld through the Marshall Courts, then you have to find a way to lessen the number of people that you have an obligation to. And so there was a concentrated genocidal effort with American Indians. So I share that with you not to look for pity or not to try to make blame, but to underscore the responsibility of the federal government to correct that past practice.

So I said earlier today, SAMHSA is like one of the best shining lights and beacons for our possible healing in our community but it is drastically underfunded and it is competitively pitched out that we have to compete with each other. My tribe is really good at that and so I should probably just keep my mouth shut and competitively get all the money. But we have a responsibility in our communal way to each other and there are communities that don't have the resources.

There are many tribes that don't even have revenue, they don't have gaming independent of the federal responsibility. And so those grants should be

compacted. And I think at some point and I have asked and maybe the White House Council will take on the leadership here, and look for ways across silos and agencies to address this issue because the issue was created by the federal government and compact that funding.

There is an example of that and that is under the CTASK. CTASK under the Department of Justice has coordinated that funding and so I think that is the — that is the direction that we need to go to. But — and then finally, I am from a family I have 16 siblings and without exception there is only two of us that are sober and we live healthy lifestyles because we are sober and the rest are alcoholic. I have got siblings that have been in and out of treatment for probably like 6 times. I have one sister who is institutional now. She is in and out of jail because she feels more comfort and able to stay sober in jail.

And it is absolutely the experience of historical trauma that I can identify. My sister is studying this in her dissertation. So I am working with her on that. But so that is what I wanted to share.

MR. ANTONE: Thank you.

MS. CHARLES: Again Frances Charles, tribal chair for Lower Elwha. I just want to make a couple of comments from what I have heard from these other leaders here as well with the grant aspects of it for the youth prevention. In regards to the treatment facilities and us being from me, from being from the Pacific Northwest and I am a canoe family member.

And with some of the grants and having the opportunity earlier on with our youth for the prevention in the canoe journeys, of making regalia, making paddles, making gifts as we traveled along the rivers and the oceans and the straits as our roads, highways and what not. But there has been some limitation for the languages in these

grants that prohibit us for these resources and in regards to restrictions that have been applied to as some. And in regards to the preventions for our youth and having them have that social with our elders.

So it puts restrictions on us. But I also wanted to note what Andy had indicated with references to the treatment facilities being 90 days long. We have many of our young women, young children who have children. And they are addicted babies. Methadone, cocaine, prescription drugs, whatever the course is out there, the black heroin in our territories of our neighboring tribes, we share that information and we collaborate and work with one another.

When other tribal memberships are excluded and kicked off of their reservations, they find other areas to go to. Not only that, not only with the Natives but other origins out there that integrate with our young women and having relationships with them to bring in the drugs into our territories. These young women can't do it in 60 days or 30 days. Sometimes not even 90 days. They continue to go back for the treatment.

We have sent many of them off to treatments for six months so that they can get the counseling and the parenting realms into them so that they can understand not only how to take care of themselves but to take care of their children that have been born addicted. That had been sent off reservation to different towns that don't have family support sometimes because of the cost to be in Seattle, the cost to be in Everett. Wherever these needs are for these young parents to be sent away. So we need resources in that manner to help them because we get locked in that manner to be able to carry them through for a long duration in these hospitals and these facilities.

We sent some of our families to support their young ones that are sent away — far away from the reservations because we appreciate the collaborations and the

neighbors and the connections we have with those in Spokane with those in Yakima and those in other territories to send our children and our families away to these facilities. So those are some of the issues that we deal with because we hear when I go to listen to their testimonies when they are ready to be released on how they are afraid to go back home because they are going back into that same environment.

They are afraid because of their friends and their own family and the ones that their parents had turned them onto the drugs. Their friends that had used them as experiments, the sexual activities and the human trafficking that is taking place. The domestic violence that they are adapted into. So these are some of the challenges that we are faced with as many of you sit around here in this room today. We need some guidance and assistance on transitioning homes.

There is a program in our town that is called the Oxford House and it is a transitioning home. And many of our people lose their houses because of their addiction. They are HUD homes and some of the low income tax bracket programs because of these addictions and the challenges that they have to get back into but they feel comfortable, they have the guidance and the support in these Oxford Homes to keep them there for a short period of time and then they are back out couch surfing. So those are just the statements that I want to express within our community. Thank you.

MR. ANTONI: Are there any thoughts from the panel? Kana?

MS. ENOMOTO: Thank both of you for your very profound statements and your sharing. I have tremendous respect for the points that you made, at SAMHSA we do recognize the sovereign state of tribes and the government to government relationship and the trust responsibilities that we have to serve. So I think your points are not lost on me

and I think we have acute awareness of the impact of intergenerational and historical trauma that plays out today in a very modern and tragic ways.

So, I am looking forward to us continuing to work together to think through ways to try to tackle these problems because there is nothing that would be more meaningful to me than to make progress on the pain and the burden that tribal communities are experiencing related to mental illness, substance use, overdose and suicide.

Just as a point of clarification, we received the original Tribal Behavioral Health Grant with very clear statutory requirement to make the grants only to tribes with the highest rate of suicide and so we were required to use that. In FY 2016, the new grants that will be coming out will no longer require those specific data. So I think we will have a little bit more flexibility in the — in our ability to give grants to tribes that may not have the documentation that they would have needed in the previous cohorts. So I am glad to be able to share that with you today.

Certainly we understood the challenges that arose with that requirement. And then in terms of you know 90 day treatment, 60 day treatment, 10 day medical detox, it is becoming clearer to me that unfortunately what we would hope would be a clinical decision — a clinical decision between a provider and the individual and their family, in terms of what was the best course of treatment is very frequently a financial decision.

I recently took a call from a family friend yesterday and she said I am so embarrassed to be calling you, my son overdosed at home after the family had been spending 24 hours a day trying to monitor him but they didn't know that he had a stash in his closet and he just — so we got him 10 days inpatient and now he is going to outpatient. And is that enough? You know, and what do you say? Because that is what she could

afford. That is what her insurance would cover. And for us, whether a program — we don't limit whether a program is 30 days or 60 days or 90 days. That is not what we do at SAMHSA and we don't necessarily dictate a length of treatment that we think people should be going for. It is really should be more about the science tells us and then also what we — what an individual and their doctor decide.

Often times — on the flip side what happens is once you build a residential facility, sometimes the decision gets made in the other direction. Someone who might not need that level of care, gets that level of care because we need that system operating at capacity so that we are not losing money on that particular facility. And so we have to continue to have conversations as a field on what the right solution is and how to work with our colleagues at CMS and with our colleagues at IHS on helping people get the pathway to recovery that is right for them.

Medically, clinically, personally, spiritually, culturally and not just what is an artifact of what our system pays for. Thank you.

MR. ANTONE: Thank you. Mr. Trudell?

MR. TRUDELL: There is a lot of interest, to steer the conversation back and forth and I know that a lot of places you couldn't really have a treatment center. I mean, it had to be taken a number of probably tribes. One of the things because you mentioned that, probably don't need a certain level of treatment. One of the things that we have been looking at, you know, I don't how we would ever put it together or not but is the concept of a safe house where you might have a young family that is interested in taking in somebody who is in that particular mode at the present time but that would have to be removed out of their family unit but in a place where they are protected and watched over for that 24 hour period.

There is what it takes and I do think we have probably on every reservation, that people that are interested in that. But don't have the home available to put them in a home like that. To take those type of young people in. I just wanted to share a little bit. Thank you.

MS. ENOMOTO: Sorry I was remiss to mention that in general SAMHSA grants don't restrict or prohibit traditional practices. I think we try to work very hard with our tribal grantees to find the right solution while almost all of our programs lead off with requiring evidence-based practices. We also do allow flexibility for tribes to make the case for a culturally based interventions for practiced based evidence and for traditional practice to be either blended with evidence-based practices or made as adaptations to other models. So you know, if anyone is having a challenge with that, with the SAMHSA grant, please let me know or let Mirtha know, or Sheila know. We are happy to address that with our folks and try to find a compromised way forward.

MR. ANTONE: Thank you. Are there any other? From Alaska?

MR. KEITH: Yes, my name is Robert Keith from in the — area president. The first things that in 1993 when I got elected, several of my council, one of the first thing, we didn't have a grant writer but the first grant I wrote was a suicide prevention grant which is just a little \$13,000 grant. Many years later I come to find out the state of Alaska and this is a state grant and the only state grant that you can get back then from the state was — that a tribe could get was a suicide prevention grant and I thought it was state money but apparently many years later I find out it is SAMHSA money.

You know, before that though, you know I come to learn about SAMHSA because I joined an alcohol and prevention program and I got a lot of training out of that and that really helped me in my duties as an elected official. And you know I really

appreciate the comments about self governance because I sit on the self governance committee on the BIA side of the tribal advisory committee.

But — and then I hear the comments about that some tribes don't have the capacity to operate a self governance compact. And a lot of the — you know, the federal government reacts or deals with the state in a compact like way they are trusted grantee. They operate a lot of programs that go directly to the state. And then they pass that on to various entities within the state. That is not — our relationship, the tribe's relationship with the states is off and on. Some issues worked together well and some issues we don't.

And what — I don't really have a point. It is — because you are talking about human behavior. And that is one of the most complex and sometimes most emotionally intense issue to deal with and a lot of times, we were talking about budgets and I think this is supposed to be a budget meeting but a lot of this discussion is program. And the solutions will be local. And the funding needs to be local to make it happen.

But capacity is often a roadblock. The smaller tribes have less capacity, they have less human resources. And that presents a challenge in how do you deliver services to those areas that are more challenged. And I think that is a solution. I think some of our solutions will be with getting together with other tribes and building a program and pulling in — this issue of all these different agencies, I forgot the name for it. The gentleman — silos, there are a lot of silos out there.

And getting the federal government and the state to work together collaboratively, you know the more people working on the same issue, more is going to get done and you won't be spending as much money if there is collaboration. And that is really a very important thing that I have learned in the years of services as a tribal leader.

I have seen one of our senators get very aggressive about water and sewer. The state and there is four different federal funding agencies. But he made them guys work together and collaborate and it really has eliminated a lot of the problems. Because there wasn't a lot of new money put into water and sewer in Alaska but there was some. But there was a lot more collaboration and that made the really — that really made the big difference. And a lot of that collaboration went to the All Alaska compact eventually. They kind of took that over.

But that is an example of I think this is something that needs to happen in the lower 48 quite a bit more. Tribes need to get together or they are geologically located close together and work together and start taking over those federal programs collectively. And that forces collaboration too. Thank you.

MR. ANTONE: Ramona and I think that will be our final one. Go ahead.

MS. ANTONE NEZ: Thank you, Councilman Antone. I just want to say thank you to Dr. Cotton and SAMHSA for your recent visit to the Navajo Nation. You do know and you have seen that we have many co-occurring disorders on the Navajo Nation and surrounding. What I would like to ask about is particularly to SAMHSA is workforce. In comparison with IHS and I know that we had talked about the high rate of vacancies and the lack of access to professional providers on the nation. So I am curious about what is the status for workforce and is there funding — how does SAMHSA work with building the capacity for professionals? And providing professionals, accessing professionals to come to in this case American Indian/Alaska Native communities to assist with and or stay, provide technical assistance, building capacity infrastructure?

Because we know that we have this urgency of need in public health to address these — this is a chronic issue. And it has a lot to do with historical trauma and

history and then the modernized trauma that we also have too. So my question specifically for budget purposes is what is your priorities and how much are you putting towards it in terms of finances and then what can we —?

And then I would like to make a recommendation towards building that capacity, the dollar amount for FY 2018 to start looking at that in the long haul because we certainly from my opinion need to build up our capacity. Thank you.

MS. ENOMOTO: That is an excellent opinion and I agree with you wholeheartedly that as we look around the nation in general, around behavioral health, we have workforce shortages and lack of capacity in many places. And that is felt no more acutely than in Indian Country. For a SAMHSA we have a small workforce footprint. We have a minority fellowship program which focuses on African American, Latino, American Indian, Alaska Native and Asian American and other Pacific Islander population.

So it is advanced training for professionals who are interested in focusing on minority communities. Particularly we have growth in the area of those professionals who are interested in working with young people 18 to 25. That program spans psychology, psychiatry, nursing, social work, counseling and marriage and family therapy and addictions counselors.

That is a relatively small program around \$10 million. In FY 2017, our workforce priorities is focused on peer services and that would be partnerships with community colleges to implement peer credentialing programs and training and education programs. And we thought of that as a two folded benefit. Not only would we provide a venue for training peers. Whether that is for prevention treatment, mental health substance abuse but also in adult, child, family but also we would be creating an

educational ladder because from our point of view and what I have heard many times over is that employment is recovery support. Employment is treatment.

People find meaning — people with a meaningful social role are more invested in their own health and the health of others and the health of their community. And so it is an important tool to give people. And so having peer training happening in the community college gets someone back into that educational setting and gives them some credits and maybe they can build on that and take that to the next level. And there is really no telling where people would stop.

But what I think — to your point and what you are wanting to do in terms of building the behavioral health workforce, a lot of focus in FY 2017 is in HRSA and also a piece in IHS. And so we are really excited to be working with both HRSA and IHS on the investments that are proposed for the National Health Service Corps as well as for training for staff and IHS facility. So I might defer my colleagues to speak more on those proposals.

MS. COTTON: So I mentioned earlier the 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. So I think tribes would benefit greatly not only from the National Health Service for increased funding but from the increased funding for the loan repayment program. That is a huge recruitment tool for IHS and tribal facilities. To apply for that loan repayment program and they can continue to reapply to get all of their loans paid off so there is not a limit. Doesn't cut off in two years and that is all you would be able to apply for. You could keep applying until all of the loans are paid off underneath that program.

So it is a huge recruitment tool. We are looking forward to utilizing and as that component as well as having an increased focus on the INPSYC Program, that is funded through Indian Health Service and focused on Indian psychologist.

MR. MACRAE: Hi, I am Jim Macrae from HRSA. Nice to see you. Just in terms of for 17, the President's budget does include actually targeted money for both behavioral health as well as substance abuse related to the National Service Corps. Approximately \$45 million increase to support and targeted initiative to expand our capacity to provide more loans and scholarships for behavioral health and then a second \$25 million to support providers that have medication assistance treatment accreditation in support.

And so it is a targeted effort for us and it is something new but just recognizing the need for substance abuse for mental health services, we just think is critical. The other piece is that for 18 — even though it is not our discretionary request we do have in the President's budget, in 17 an actual request in 18, 19 and 20. For \$810 million. So a significant increase in the National Service Corps. It would actually take our field strength from approximately 9,600 to over 15,000 which we anticipate would be a significant increase and I think recognizes the need for getting providers out into under served communities of which tribes and tribal organizations are eligible.

MR. ANTONE: Ramona?

MS. ANTONE NEZ: Thank you for the response. I would like to make an additional recommendation, Mr. Chairman Antone and tribal leaders that are here. I appreciate that there is feedback from the presenters IHS Behavioral Health, SAMHSA and HRSA. What I would like to recommend and actually make a request is to have these

budget dollars put to — in one packet, a summary sheet so that we as tribal representatives can see in one glance where this is coming from.

I think that the advantage that our federal partners have is that they know their budget fairly well and they are — they understand where their priorities are. As we come to the table, it would be helpful to see that in one spreadsheet if you will. So then we could start to see where the possible gaps are and there is \$10 million that are mentioned from IHS and then SAMHSA and then \$45 million. But how much of that actually comes to Indian Country? And when it gets there, perhaps as we move and look forward to making a change towards the gap that has been chronic, how do we increase and improve our workforce in order to meet the public health urgency of seriously mental ill, the social illnesses and the need for treatment?

I just see that it would be beneficial that we start to look at that and start to make that a priority is to get a workforce built up — I mean, it just seems so important that we do that. And having — especially with our tribal members to become those professionals and provide those services to our own — within our communities and other communities as well.

And they are there for the long haul. For the long — for a lifetime because the other chronic condition or chronic issue that we also understand is that many, not all but many professionals come to our nation and they stay for a number of years and then they leave. So we are dealing with that chronic turnover and workforce as well. But it would — those are my recommendations, Chairman Antone.

MR. ANTONE: I am going to have Lillian respond to that and then after her response, we will go to the Medicare, Medicaid. Thank you.

MS. ROBINSON: I can just respond to the one request about the budget and having a document that makes sense for folks. Because you are right, we do know what our budgets look like and a lot of times we are not even sure how different parts of the budget within HHS work together or how they fit together nicely.

So the woman who spoke earlier this morning, Jillian Curtis, her shop would actually be the right place to do that and so we can take that back to ask for and ask them to put together something that would be easy for folks to understand what the budget — at least with the budget proposals are for any given fiscal year. I know we used to put something similar together for the STAC but I think it has been a couple of years since we have done that.

But we can certainly put something together so you guys will have a quick reference sheet and so that we can also have a quick reference sheet as well.

MR. ANTONE: Thank you. I also want to thank Beverly Cotton and Mirtha and Kana for their presence here. And right now we are going to go to the Centers for Medicare and Medicaid Services. Thank you.

(Pause)

MR. ANTONE: — on this panel, Jessica Schubel, senior advisor, Centers for Medicaid and CHIP Services, CMS to do the discussion and we also have Kitty Marx here who will be the federal representative for Q&A if it is needed. Thank you.

Centers for Medicare and Medicaid Services

Federal Leadership Updates

*by Jessica Schubel, Senior Advisor,
Centers for Medicaid and CHIP Services, CMS*

MS. SCHUBEL: Good afternoon everyone, it is a pleasure to be here with you. I see some familiar faces from when I was presenting at the STAC meeting earlier this week. So I am really excited to speak to you guys about Medicaid. We have — we had a really big announcement last Friday. Hopefully everyone saw it but I also wanted to talk about what was about Medicaid expansion in addition to the guidance that we issued on Friday on the availability on the enhanced match for services that are received through IHS and tribal facilities.

So let me just start off with Medicaid expansion update. As of today, we have 30 states and the District of Columbia that have expanded. The benefits to Medicaid expansion are very clear. There have been several studies out, two recently were published in January that showed residents in expansion states skip fewer medications because of costs, had less trouble paying their medical bills and beneficiaries with chronic conditions got more regular medical care when you compared residents living in non-expansion states.

And there are specific benefits of expansion in Indian Country because more American Indians and Alaska Natives are covered by Medicaid in states that have taken up the expansion. This has allowed more IHS funding particularly for PRC services to be freed up. And so I have seen data from my colleagues over in IHS showing how IHS facilities in states that have expanded Medicaid have been able to purchase services at the priorities 3 and 4 level. So really exciting news there.

And another exciting point that I wanted to just mention today about expansion is that when Louisiana announced that it also intended to expand Medicaid back in January, more than 50 percent of those estimated taking coverage from Medicaid expansion or about 4.4 million people live in states that have done so. So it was really a big tipping point for us. And some of the more recent expansions in states have been states with significant Indian populations.

As you all know, Alaska expanded Medicaid back in September. And the state estimates that approximately 40,000 Alaska Natives have been enrolled. And Montana expanded Medicaid effective January 1 and 57 percent of American Indians in Montana between the ages of 19 and 64 are uninsured. And so the state estimates about 19,500 American Indians will be eligible because of expansion.

So, we are really excited about those figures and we continue to work with states — with other states as they consider Medicaid expansion and I remain hopeful that we will have a few more this year. So for the main event so to speak of my talk, I just wanted to talk about our recent guidance on the availability of the enhanced manager, the 100 percent FMAP for certain services that are provided through IHS and tribal facilities. And this policy is really going to better support the delivery of health care for American Indians and Alaska Natives.

So just to back up just a little bit, as you all probably know on October 27, we issued a request for comment/a white paper and wanted to obtain feedback from folks on our proposed policy change. And so we encouraged states, stakeholders and tribes to submit their comments by mid November and we received over 80 letters and e-mails, 60 of those from tribes, tribal organization and urban Indian organizations. And we received

overwhelming support from state Medicaid programs, tribes and tribal health programs. And as well as beneficiaries who were in support of the proposed policy change.

As we finalized the guidance, we took those comments that we received into consideration. And so while I won't walk through every nook and cranny of the guidance, I did want to provide some high level points on the guidance itself. The first main point is that we expanded this scope of services that the enhanced match applies to. So the 100 percent FMAP applies to any service that — in IHS or tribal facilities is authorized to provide.

And provided that that service is also covered under a state's Medicaid state's plan. And the two services that I just want to highlight because they are biggies are long-term services and supports as well as transportation. So the nuts and bolts of the policy work as follows. Services must be requested by the IHS or tribal facility practitioner and that practitioner is really going to maintain responsibility for the patient's care. It is really important to have an established patient provider relationship between the practitioner and the beneficiary.

And this includes coordinating their care and maintaining their medical records. The patient's medical record. Services are then provided by the non-IHS or tribal facility practitioner but that person also needs to be a Medicaid provider and has to sign a written care coordination with the IHS or tribal facility. Just to make sure everybody knows who is doing what and everyone is clear on roles and responsibilities.

I do want to just divert just a second and just mention that telehealth can help facilitate both the provisional services but also establishing and maintaining that very important patient/provider relationship between the Medicaid beneficiary and the IHS or tribal facility practitioner. So I just want to note that there.

And the final thing that I just want to mention on the guidance is the billing flexibility that we talk in greater detail in the state health official letter. And I just want to note that we have two options. The first option is that non-IHS or 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.

And in that case, the specific billing rates would vary by service. So just wanted to note that there. And finally the last plug I will put in for our guidance is that folks really have — want to learn more about it in depth or have really specific questions, we are hosting an All Tribes Call on March 8, so next Tuesday from 2:00 to 3:30 p.m. eastern time and if you guys need any more information, please feel free to reach out to myself or to Kitty and we will be happy to pass along the logistical information for the call.

Before I stop and take questions, I just want to mention one last thing, which I think Deputy Secretary Wakefield will speak about more later today. And that is the Department's commitment to improving the health care quality and access for American Indians and Alaska Natives, particularly in the Great Plains Area. I was fortunate enough to take a trip to South Dakota in January and I do say fortunate despite the sub zero weather.

It was a great trip. It was a wonderful trip that I took with both my Medicaid and IHS colleagues. And while I was there, I was able to meet with an urban Indian program in Sioux Falls. I got to visit with the staff at the Wagner Health Center in Yankton as well as with the Governor, state representatives, state officials — other state health officials as well as the representatives from the tribes that live in or reside in South Dakota. So that was really exciting and was a great trip.

So in collaboration with the state and my colleagues at IHS, we have developed an extensive work plan that helps identify ways within the IHS health care

delivery system where we can improve telehealth capability and also to establish agreements — provider agreements with non-IHS providers as well as how to enhance enrollment and intake of South Dakota tribal members in Medicaid.

So really leveraging the work that we have been doing in Medicaid to help streamline the eligibility and enrollment process for the millions of individuals that we have been able to cover in the past couple of years. And finally, despite Monday's announcement by the Governor of South Dakota, I remain hopeful that Medicaid will be expanded in South Dakota but I also know that the updated CMS tribal policy — the one that we issued on Friday, will directly contribute to improving the quality of health care, not only in the Great Plains but across the nation.

So it was great to be able to work on that project. So again it was great to see you all. If you have any questions, Kitty and I are happy to take any questions that you may have.

MR. ANTONE: Before we do that, I would like to call on Chairman Trudell.

Tribal Leader Testimony

*by Roger Trudell, Chairman,
Santee Sioux Tribe*

MR. TRUDELL: Thank you. Roger Trudell, representing the Great Plains. Thank you ladies for your great efforts. There is prepared testimony. I imagine several tribes will be presenting and also our good friends at the National Indian Health Board representing, so. I will keep mine pretty short. We thank you for issuing the directive on 100 percent FMAP for — that even hit Nebraska. Caused my good friend to say that she can retire, Nancy Rios. Fortunately talked her out of that. She is too valuable a person to lose, too young too. So.

So we thank you for all those efforts, they make a lot of difference. We are glad that you know that CMS has put forth this effort and we know it is very challenging. South Dakota and Nebraska, you know two of the toughest states in this country I think. You know, two of the biggest Republican holdouts. I don't even know — they are beyond Republican I guess. Two of the most conservative states I should say that you have to deal with.

So, we I guess just as tribes in the Great Plains, you know we have sometimes are very critical of the organizations that we work with. But you know, we can also be very what would be the proper word? Appreciative and we are appreciative. Sometimes we don't express it and you only hear our criticism. But on the other hand, we are appreciative of the hard work that goes into making change in Indian Country, especially in some of the tougher states, sitting next to a girl a South Dakota girl and adopted Lakota warrior over here. So just cannot say enough I guess. And I don't want to be too sugary or anything but where appreciation is due and thanks are due, on behalf of the Great Plains, I extend that to you. Thank you.

MS. SCHUBEL: Thank you very much, that means a lot.

MR. ANTONE: Opening it up now for questions, comments.

Questions and Answers

MR. ANTONE: Arlan?

MR. MELENDEZ: Yes. And I had received the paper where it just came out and I was trying to — as a tribal leader I don't totally understand it. But the 100 percent FMAP, is that — it sounds like it is an advantage to everybody that worked on this but I guess the question would be is there a downside to the tribes in any way? I mean, it sounds as if outside providers in our health center — and I don't totally understand it totally but if

they are going to charge the same rate, then it is like \$350 or something the rate or something like that. So one question that was asked and I had called our health director and it says CMS has just opened the door for the states to receive 100 percent FMAP reimbursement for all non-IHS tribal programs that see our patients. This could include non-tribal providers getting the same reimbursement rate as our tribal clinics.

I would advocate that we should be allowing our tribal programs to be able to build anything in the state Medicaid plans, not just a list of services. And tribal programs should not have a cap on daily billable encounters. It should be unrestricted especially for tribes like ours who are trying to expand services. Currently there is no consistency as far as different encounters within the different states, Nevada we were at 2 and now we are up to 5 encounters.

Being able to bill how many times they come into the health center and I think in Oregon it is 6, in California they billed 2 and Washington 7. So it is kind of all over the place. And we are trying to generate third party revenue. And then we get the federal encounter rate at \$350, it would be important that states allow the tribes flexibility in managing the referrals to non-Indian providers for reimbursement.

Right now, one option is they only get their normal provider rate and this doesn't help the providers. We want them to get more by seeing our referrals. And then it is a — and then she says, there are two options — CMS gave option one as the non-Indian providers would bill the state but only get their regular non-Indian provider rates. Option two is the tribes have to bill for the non-Indian providers services since they provide outside in their clinics.

But the states have to determine what services they will allow and they have to also approve the rates for those encounters so the tribes to incur the cost of billing

staff and we will have to figure out how we are to reimburse the non-Indian providers. Seems like it is going to end up being a lot of work for tribes and I assume that it is liability and I guess our liability in assuming all of the billing for these providers.

And I guess the question — another question would be to ask is if the outside providers get to bill at the federal encounter rate of \$350 and the tribes have to incur the cost of billing these encounters? Can tribes arrange a lower reimbursement to non-Indians and keep part of the \$350 to help cover their expense, will this be allowed?

For example, we bill for the non-Indian providers at a rate of \$350. But we only reimburse the provider \$200. So I guess there is a difference in you know. I don't totally, this is what my health director sent on the e-mail, so.

MS. SCHUBEL: I will take your first question to say yes I do think that this is going to be helpful for tribes. I think this policy is going to help increase access to care. I think it is also going to help strengthen the continuity of care and improve health outcomes for the tribal members. I would say that the billing piece is complicated and I would highly suggest that your health person come to our All Tribes Call — because we are going to kind of walk through in depth on how this works but I will turn it over to Kitty to address some of the specifics.

MS. MARX: Yes, thank you, Jessica. And just to remind everybody, we have a copy of the save the date notice with the All Tribes Call, conference call number and password out on the registration table.

MS. SMITH: Oh Kitty, can I interrupt because I made a commitment yesterday at STAC and maybe you guys can include this. I committed that we could share the provider agreement too. You know you guys could have that too.

MS. MARX: Yes, I think that some tribes were interested in receiving the IHS provider agreement. Arlan was asking about some of the billing arrangements that are laid out in the SHO. So and they are a little bit complicated as Jessica said. But I just want to just clarify that the options that are laid out in the SHO regarding billing arrangements are intended to be flexible for tribes. I mean, that is clearly what we heard through the tribal comment process.

They wanted the flexibility to work with their states and also to maintain you know, relationships that they might have with non-IHS providers now. So to the one concern from your health director that this might result in additional work, if you have to pay the provider and then bill up through the — your tribal facility, you will still have the option that if you want the non-IHS provider to bill the state Medicaid program directly, that is an option for tribes.

So just to clarify that. And it is not our intention that the non-IHS providers would be able to bill at the all inclusive rate, the encounter rate. We recognize that as unique to the IHS and tribal facilities. The billing arrangements vary generally as I understand them, perhaps the tribal facility — the practitioner would need to request services such as an x-ray from the radiologist down the street. They could send that patient out to the radiologist, the radiologist would send the x-rays back, so that is coordination of care.

And perhaps the tribal facility has a negotiated rate with that radiologist now. The tribal facility would bill that radiologist and then would bill through Medicaid, at the encounter rate. It could be an example of somebody who comes in with a broken arm, the physician sees the patient and the patient needs to have an x-ray of their arm and then the facility would bill Medicaid for that encounter. That diagnosis of a broken arm. And it is

not our intention through this SHO to limit the number of encounters that states have negotiated with tribes.

The whole purpose of the SHO is to expand on the 100 percent FMAP so that there is greater access to services through the Medicaid non-IHS providers that perhaps IHS and tribes cannot provide now and also to recognize that as Jessica mentioned, that long-term support services will now be covered by the 100 FMAP and non-emergency transportation. And that could include services that are provided not necessarily by non-IHS providers but by tribal employees as well.

And so we are hoping that there will be greater avenues and possibly greater reimbursements or better arrangements with the states. So.

MR. ANTONE: Okay. All right, thank you.

MS. MARX: Did that answer most of your questions, Arlan?

MR. MELENDEZ: Yes, yes. I had one more question. This one I didn't totally understand and it has to do with the ARRA and it has to do with the state recovery and maybe you are a little familiar with that. And tribes should be exempt from the state recovery in ARRA especially because now the states are reimbursed at a 100 percent FMAP. Indian people should not lose their property or assets because we are mandated by CFRs to apply for Medicaid or we will be denied CHS funding as a patient. Once we become eligible for Medicaid, the Indian can then lose property or assets which is unacceptable given the trust responsibility of the federal government to our people. Do you have any comment on that?

MS. MARX: Right, well that is the — under Medicaid, there is a Medicaid estate recovery rule that does require the states to place a lien to recover services that are provided for long-time services to individuals over the age of 55. But under the American

Reinvestment and Recovery Act, ARRA of 2009, Indian trust income and land is protected from that recovery. And that remains in effect as well. By the SHO, we are not changing that.

MR. MELENDEZ: Okay, all right, thank you.

MS. MARX: And we know that the long-term services that are being provided by tribes is very, very important. And this SHO letter will cover those home and community based services as well.

MR. MELENDEZ: Okay, thanks.

MR. ANTONE: Aaron?

MR. PAYMENT: So — all right, so you may get a laugh out of this one. Early in my tenure on the STAC committee when the Secretary was — when we were presenting to the Secretary, Secretary Sebelius and remember her duty was to go out and get people signed up and then with all of the stuff that happened along with that, so she was a little sensitive about the issue, so I have to put it in context. But we have been concerned from the very beginning about the implications for Indian Country — what it would mean for us. Because we have a Constitutional right to health care.

And so as this was formulating because I am a good solid — a person of a certain party so I believe in what the Affordable Care Act is intended to do. But we have all often kind of wondered well how does this then relate to Indian Country? Because if everybody has this opportunity then what we had before which was a lack of fulfillment for that responsibility should be much, much greater than. As a result. And one of the things that I kept bringing up and I brought it up to the Secretary and then I got this look.

But it was that — all right so my people — one third of my people — we have 43,000 members. One third live in the service area which used to be called the CHSDA

but now we don't really have a name for it now that it has changed to Purchased/Referred Care services, only one third live in that territory. We get 56 percent of the identified need in that territory which means we put in the rest. So that is a promise unfulfilled. That is where we are subsidizing the federal government in their trust responsibility.

Then one third live in lower Michigan and one third live outside of Michigan. So at that point in time, the state of Michigan hadn't seen the wisdom of jumping on board with the Affordable Care Act and the match and all of the benefits of it. And one funny aside, is Cathy Abramson who was the previous chair for STAC, raised it at a meeting with the Governor and it is the Governor of Michigan, the whole Flint issue, and so you get the context for that. And he said well we are not doing that. And Cathy said we will see. And so then, I think a year later then he said, oh I guess we are doing that.

But so the one issue though when I raised about the fact that the Affordable Care Act and the coverage under the expansion and the ability to go on the Exchange, only works if the state agrees. And when you look at that fundamentally we are subordinated then to the state. And our government to government relationship doesn't have anything to do with the state. The state didn't even exist. And our treaty that we signed allowed the state to become a state a year later. And so that is the part that she didn't like.

Because she was like, well we are doing all we can, you know. And so I don't — maybe we have 30 states that are on board but there are still 20 states that are not on board.

MS. SCHUBEL: Don't forget D.C., sorry I am a D.C. resident.

MR. PAYMENT: 30 and D.C. that are on board but then we still have — and we have members that live here too, there is actually a couple in the room. But that is

still 20 states that we are subordinated to the states that have not agreed to do it. So one of the things that we have talked about at NCAI although we never really came up with a real clear plan was to be treated as a 51st state in order to implement the Affordable Care Act.

I think that is in the interest of the administration to get the states out of the way with respect to signing up American Indians to be covered under the Affordable Care Act. That would be a way to help fulfill the trust responsibility because it does close that gap. In Michigan when we finally did get to qualify, my tribe was very aggressive with getting our people in and signing them up. There is what is called a Navigator in Detroit in which the greatest concentration of the Detroit Natives are my members and my cousin is the medical director there.

But so once given the opportunity to sign up for the Affordable Care Act, we have shown that we will. So I don't know if there is something creative that the administration can look at to be able to allow for us to be treated separately and independently from states and then we can get on the way of signing up more American Indians under the Affordable Care Act. But she gave me this look like how dare you ask that question?

MS. MARX: Yes, we have — actually we have heard of this issue before about tribes being treated as a 51st state for purposes of Medicaid and actually Jessica, I think you were out of town but we had a tribal delegation come up to Baltimore to talk to us about this very subject. But the way the law is written now, through title 19 of the Social Security Act, it is a state/federal partnership. That is how it was set up.

But under the Indian Health Care Improvement Act there was authority for the Secretary to conduct a report on the feasibility of the Navajo Nation to operate as a

state Medicaid Agency. And so CMS produced that report, we have submitted it to Congress. We have submitted it in May of 2014 and the conclusion of that report is that it would be feasible for the Navajo Nation to operate as a state Medicaid agency.

And so that report is with Congress. The report does indicate that there will be legislative action necessary. It would require an amendment to title 19 and there is appropriations or funding that might be needed because there is a cost to establishing and setting up a state Medicaid agency. So I mean, that is one possibility that Congress is aware of, Navajo Nation is aware of and I think that is really in Congress's court right now to review that report and if necessary take a legislative action.

So I don't know if that actually answers your question but —

MR. PAYMENT: I think it does and I think obviously we would support that because they have a four state sort of approach to where their members reside. That is not unlike our situation because one third of our population and our nation do not reside in Michigan at all. So the obviously, I can say this but you can't — the challenge is the climate with the existing Congress is unlikely to do that because they keep promising to repeal the Affordable Care Act entirely.

So working on it through the other avenue would be meaningless because there would be no more Affordable Care Act. So we need to look forward to the future.

MR. ANTONE: Thank you. Thank you Jessica and Kitty and well let's stand up for a while, while the IHS team is coming up here. Stretch out and get ready for IHS. And they are scheduled for 2:45, in five minutes.

(Whereupon, a brief break was taken.)

MR. ANTONE: Would everyone please take their seat. We are ready to begin with the Indian Health Service Budget Priorities Open Discussion. And we will have

the federal leadership, the IHS leadership team here and I think that consists of two people. Ann Church and Mary Smith. And we will open it up for these two.

Indian Health Service Budget Priorities Open Discussion

Federal Leadership Updates

*by Ann Church and Mary Smith,
IHS Team*

MS. SMITH: Well, good afternoon everyone. I see we have lost a few people. You got to be perseverance in these meetings, but I am going to be here. I have a call that I want to just apologize, I have a call at 3:00. So I am going to let Ann who has — who is the expert and she is a head of our budget office, do the main presentation and then if there is time when I am still here for questions, I am certainly happy to answer. And then of course, as everyone knows I am always available. So I will turn it over to Ann.

MS. CHURCH: Good afternoon, everyone. It is an honor to be here speaking with everyone and I appreciate this open dialogue. I am going to keep my comments very brief because I want to have plenty of opportunity for Mr. Joseph to provide an update. You have all heard the update on the 2017 budget and looking forward to 2017, we did have within the IHS a National Budget Formulation work session beginning of February. There was a lot of discussion which includes a number of you. I have seen some familiar faces today.

We are kind of continuing the trend on the 17 with a heavy focus on behavioral health issues. Certainly continuing the efforts on quality care, making sure that there is plenty of access to that quality care and of course going along with that, is our ability to recruit qualified health professionals and then make sure that we have the

support system so that we can retain those individuals. So with that, again I just want to keep my comments very brief and at this time, I will turn it over to Mr. Joseph. Thank you.

IHS Budget Formulation Team

*by Andy Joseph, Jr., Council Member,
Confederated Tribes of the Colville Reservation*

MR. JOSEPH: (Speaking in Native language) Good day, my name is Badger Andy Joseph, Jr. I serve on the Colville Business Council, it is in Washington State and area rep for the Portland Area at the Budget Formulation Workgroup. And on the budget work group, I serve as a co-chair for the Budget Formulation Workgroup and I want to thank you for allowing us to present the Fiscal year 2018 budget recommendations for the Indian Health Service.

The Tribal Budget Formulation Workgroup members are appointed by tribes from each of the 12 Indian Health Service areas to develop the annual and national tribal budget recommendations for the IHS budget. And in this annual process, tribes within each area meet during the fall and establish their budget priority recommendations for IHS. The area then each sends two delegates to Washington, D.C. to participate in a national budget formulation in February.

This group then negotiates specific national tribal IHS budget priorities for the next HHS budget formulation cycle which is two fiscal years in the future. This year is once again strongly recommending full funding for IHS at \$30.8 billion. During the national work session, tribal leaders share difficult stories from their communities which reinforce the importance of full funding for health services. Federal Indian trust responsibility for health is a sacred promise that our ancestors made with the United States long ago.

It is only too clear from the stories that we continue to hear from our tribal communities that our people continue to suffer needlessly from — because of the lack of resources. In the last several years, bipartisan collaboration between Congress and an administration has helped us realize robust increases in the Indian Health Service budget with an overall increase of 54 percent since FY 2008.

However, much of these increases have gone to support increases due to population, growth, inflation and the rightful funding of contract support costs. We must do more to ensure that health care services are actually increasing. To begin the 12 year phase in of full funding for IHS, the workgroup recommends a 37 percent increase for the IHS or a \$7.1 billion. The top five priorities including increases to hospitals and clinics, Purchased/Referred Care, mental health, alcohol and substance abuse and dental services.

Tribes believe this will provide an important start to give IHS funding that we need and deserve. During the Obama Administration, tribes have also strengthened relationships with federal officials who have priorities meaningful tribal consultation input and priorities. Over the last several years, we are grateful for the strides we have made on collaboration and coordination of health service. Hope to continue this in the future.

The workgroup also set forth priorities this year to ensure funding of new provisions of the Indian Health Care Improvement Act. This historic law has meant many great new opportunities for the Indian health system but not all provisions have been equally implemented. Representing another broken promise to Indian Country, we have identified top priorities as long-term care, behavior health treatment, diabetes prevention, treatment and control, health care professional, chronic shortage demonstration project and mental health technicians as top priorities.

Over the next few weeks, our tribal — 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 priority, are important to your communities. With that we can open up the session for remarks of other tribal leaders.

I would like to mention you know, over the years, there used to always be — I don't know how many of our people that we have lost from the workgroup. I had a really good friend, Darryl Readygo(sic) that was presented one year and you know, I just pray he rests in peace. You know, at our workgroup each of us — you know I always have to remind them you know, one of these days we are going to meet our creator and there might be a line of our chiefs waiting there to greet us.

And they might ask us, you know, if you — why didn't you ask for everything that we was promised? And under the other administration prior to this one, we was given a real space budget. We are lucky to get a 2 percent or 3 percent increase. And those increases if you really do the math, I always — I said this last year, the total need space budget is at \$30 billion. We always kind of pat ourselves on the back for getting you know an increase over the — what is really the 16 percent of what is really needed. And so that is why we — this year we are pushing for this big step and not knowing what the administration is going to be, I am hoping it is the same one and praying that too.

But we really need to somehow be funded more than people that are incarcerated in federal penitentiaries. If we are treated as third class citizens, to me I think — I wear this kind of proudly serve my country, we got people in prison that never — they rape and kill our people at home and they get better health care than we do. You

know, is this — this has got to change sometime and I always want OMB at the table. I wish they was here today.

MS. SMITH: They actually are. They are in the back.

MR. JOSEPH: Well, I really would like to see them come to Indian Country and see what are — what is going on. You know the children — the President got to go to see the youth and the youth came to the White House. I wish that a group of our elders could come there and do the same because a lot of them are living in pain. A lot of them don't get to even become elders and we are burying them. So I guess that is all I have to say for now. Thank you.

Question and Answers

MR. ANTONE: Aaron Payment?

MR. PAYMENT: All right, so I almost sick of hearing myself today, but I do have my tribe's testimony now. And I want to give proper treatment to it. So now would be the appropriate time for that? It is IHS testimony?

MR. ANTONE: Yes.

MR. PAYMENT: Okay, so I have written testimony and my team back home prepared testimony related to IHS, SAMHSA, Administration on Aging, ACF, Child care, Head Start and then several components within those. But so I just want to say that the proposed IHS each fiscal year is presented to tribes fall short of the needs of American Indians/Alaska Natives for health care coverage and services. This reality does not comport with the promises held in treaties for the land mass that was seated to form what is now the United States.

While I appreciate the increase, they do not cover the unmet needs of tribal people who suffer the greatest health disparities in the country. One third of my

people reside in what is now our Purchased/Referred Care services area. That means two thirds do not reside there. IHS Funding only covers 56 percent of the need within our service area and does nothing for the two thirds of our members who live outside.

Even incarcerated persons receive a larger amount per capita of dollars spent on them for health care of the American Indians. This disparity and inequity continues to exist. Shortfalls, sequester, and government shut downs have drastically impacted tribal governments and caused our programs and services to close for a period. This has had the effect of erasing gains made in previous fiscal years.

Sadly the quiet crisis for the invisible Americans continues. I would recommend that we exempt IHS and other programs for American Indians from sequestration. I urge support of the passage of S1497 which is the exemption from sequestration for Indian Service. Indian Health Service budget appropriations should not be discretionary or subject to sequestration. Funding for Indian Health Care is a trust obligation based on treaties that the United States entered into with the tribes. If we cannot have the land back, then we expect these agreements to be honored as a government is only as good as its word.

As you know, I have pushed for several years for advanced appropriations for IHS which will normalize our operations to retain health professionals and critically needed services. My tribe recommends passage of the IHS Advanced Appropriation Act 2015 which is HR395. Without advanced appropriations the impact of my tribe has been stark. Over the last few years, we have lost significant number of employment team members. A total of 15 employees were laid off including a nurse practitioner, pharmacist, registered nurses and registered dietitians, secretaries and a data analyst.

Direct patient services were effective. Some of these positions that were vacated are still vacated three years later as it is difficult to recruit qualified individuals into a rural area without some secured resources. We are a tribe with supplemental resources, imagine those tribes who don't have those resources to supplement.

I wanted to — Cathy had asked me to talk briefly about Special Diabetes. Diabetes still ranks highest in American Indians in terms of disparity with other Americans. 100 percent of my family members over the age of 50 have diabetes. With only one exception, my family life expectancy is about 60 years old with my loved ones dying from heart disease and diabetes.

My grandmother and several elders who have had either one or more limbs amputated as a result of this disease. Sometimes people like to form an opinion and think that it is only poor nutrition why people have diabetes or sedentary lifestyles. And certainly that is an area to focus on for treatment but I have a nephew who is 25 years old who has juvenile diabetes. He has had it since he was 15 years old. It is a genetic issue. He takes 2 to 3 shots a day in order to keep — to live. He is only 25 years old.

The prognosis for juvenile diabetes is really bad still. Our Special Diabetes Program has been phenomenally successful in reducing the A1C levels and achieving long- and short-term positive outcome measures. Reauthorization of the Special Diabetes Program has been problematic for Indian tribes.

I also want to talk chronic and delayed notice of award for community funding for grants has been problematic. The gap in program funding results in having to close down services and lay off team members for up to two months in my community. If you look at the timing for the awards and the award notices and the annual budget, there is a nexus of a problem where we just don't have the funding to continue employment. And

we have lost several team members as a result of that because they want secured employment.

So my written testimony includes specific requests for recommendations related to elders and nutrition/chore services, child welfare, title IV, foster care, Head Start and emergency preparedness. So I will just leave it at that. And I want to thank you once again for being part of the greatest Presidential team we have ever seen with respect to fulfilling the treaty and trust responsibilities for American Indians with compassion and care.

I stand with the Obama Administration to work to find permanency for this new standard and covenant that has been set. Jimmy Gritch(sic).

MS. CHURCH: I just want to thank you for those comments. We really appreciate all of the feedback and your points are very well taken. In a tricky financial environment, with HHS seeing some decreases but IHS seeing some increases, that is a very positive sign. But we completely agree that there is still a very great need. And that is why we really sincerely appreciate the feedback and the partnership in developing our budget priorities and moving forward in addressing all of those needs.

MR. ANTONE: Chairman Trudell?

MR. TRUDELL: Roger Trudell, representing the Great Plains and again thank you for your presentation and hard work. I just like to talk a little bit about I think there are some flaws within the national budgeting process that when you start consolidating the priorities from all of the various regions that you know some of our — although we have a lot of the same health problems, how they are viewed in particular areas are sometimes substantially different.

So a lot of times the Great Plains are priorities are beaten or — is beaten the right word? We lose out I guess on our priorities based upon the combined priorities of everybody. And I am sure everybody suffers some. But it seems like ours is almost annually when we go through this process. Our budget priorities are not amongst the top four or five or whatever and Santee Sioux Nation, you know we don't even go through that process with the Bureau of Indian Affairs, you know like, what is your top ten priorities because everything is a priority and we kind of view the Indian Health Service the same way. It is all priority or we wouldn't be going through this whole process and all that type of stuff.

But to try and determine — say when everything is lax financially and it is critical, then how do you put a priority on any of that. I mean, it is all a priority. It is like having an ugly step child, you just throw that ugly stepchild out or whatever, you know because they are uglier than the rest of your children or anything. So, you know, we just can't take things that are all critical and try to prioritize them in this is more critical and this is more critical. They are all critical. And they have all gone without adequate funding for so long that you know they are even becoming more critical and more critical and more critical.

For instance, you know, what is the problem in the Great Plains with you know, with all the potential shut downs of clinics and hospitals et cetera. Lack of funding. Don't have the ability to replace equipment. Don't have the ability to offer medical professionals the type of salaries that they can get elsewhere. And a lot of them go to — want to become doctors so that they can work in large hospitals and specialize. As Dr. Sloan used to say years ago — you pretty don't even know who he is, but he was a regional — he was our area director at one time. He would say geez, we can't — nobody wants to come here because we don't have croissants.

So you know that is the kind of things out in our area that is going to lead more and more difficulty. And I know that Indian Health Service and everybody is trying to put this effort into you know preserving where we are at, at least. But without adequate funding and for equipment, to take into consideration we are asking doctors and top medical people to leave the secure areas with these excellent schools and the opportunity to send your children to excellent schools to come up and live amongst us in our shacks and you know, send your kid to the broken down, 150 year old school over here with the wind blowing through the cracks and all that type of stuff.

So you know unless the infrastructure not only Indian Health Service but all through the reservation system is somehow assisted in being corrected then. You then we will always be in this position I think so. I know I have done a lot of rambling and will probably do a lot more again one of these days but it is just — I think each area needs to be looked at differently.

Each of the health areas need to be looked at differently and that you can't combine all of our — all of our what we consider priorities in our areas and combine them all together and whoever gets the most votes from the area or whatever, you know because we have 17 — we have 17 tribes I think in the northwest area over there, there is 50 some of more. You know. So we are not even competitive vote wise with them. So I don't know how many is in your area.

MR. : We have the lowest for the Midwest. We just got a — and that is probably why.

MR. TRUDELL: But you see the disparities in trying to treat each region the same and have the same priorities. It used to be that part of the budget making process

needs to be either done away with or needs to be recognized that it is not a fair way to deal with each of the individual areas. Thank you.

MS. CHURCH: Thank you for those comments. I am really glad that you raised that point. In the fiscal year 2018 process we have heard this feedback before and so we experimented with adding in local priorities. And so we asked each of the areas and through consultation to bring to the group what all the individual priorities are for the very reason that you mentioned.

Each area has very different needs. Certainly there are commonalities but we wanted to hear what the specific needs were for each area so that we could look at those and see if there is another way that we could develop the budget that adequately represents those specific needs. So we started that process for 18 and we asked for the workgroups assistance in helping us make sure that we can make that a meaningful process and really incorporate that.

MR. ANTONE: Mr. Joseph?

MR. JOSEPH: And I am glad that that was part of our process. I always kind of wish — I think we mentioned this last year at the consultation that it would be good to once the budget is brought forward that each area could take their share and divide it up according to how they assigned it to headquarters. That way you know, we would be able to spend them in areas that we need. I believe there is other areas that have more higher diabetes rates than some of the other areas and you know, they should be able to spend more money in that area. So that more of their people are being cured of that illness.

One thing that I did want to bring up is for IHS is I would hope that the Secretary could look at what IHS is allowed to pay their providers and compare that to the VA, I believe the VA are able to pay their health care providers a higher rate of pay so they

don't have as much I guess vacant positions. In Indian Country, a lot of us are really struggling trying to get health care providers and if we would be able to compare to the VA, hiring rates, it would probably draw more health care providers into Indian Country.

So I just wanted to just to for Colville, we declared states of emergency for health care providers and that is part of the problem is that we are compared to the frontier, like the Alaskan frontier and how many people will come and live in that rural of an area. So I think they are, we need to really look at the pay rate so that you know, we can draw more providers. Thank you.

MR. ANTONE: Ramona and then the gentleman.

MS. ANTONE NEZ: Thank you, Councilman Antone and dear tribal leaders, it is a privilege to be here with you today. I would like to address IHS and thank you for your presentation. My name is Ramona Antone Nez and representing the Navajo Area, Navajo Nation today. In regards to the budget, I want to say on behalf of the Navajo Nation thank you for the formulation process, although there are some issues that are in the process but it allowed us to platform the facility constructions and water and sanitation which is important to Navajo.

With that, we recognize that we have a facility listing that we will — that we have been advocating for decades. And we are getting to a place where we will likely look forward to appropriations for our new facility. So I just want to say thank you for that. And it is due to the process. Although as I mentioned, we do have some concerns about the processing itself.

What I do want to advocate that the Navajo Nation would like to have — hold harmless the sequestration effect that we have here in particular to the Navajo Nation as well as bring to your attention the effect that we have when there is a continued

resolution. The CR and then it goes to one of our tribal leaders who spoke earlier about the delay of notice of award. At some point that we convey to you and have you understand that we understand that you have your OMB process at the federal level, but please understand that we have a process to at our tribal nations.

In particular to the Navajo Nation, when we get a delay of notice of award or an award that comes the day before the end of the fiscal or calendar year and then even after the fact. We really have a hard time with where to put our people, how it affects their employment processes and it just with the requests that I have is to please take that into consideration as you have your time line on when you are going to actually execute or release these notices of awards because it does impact the Navajo Nation, to get in our processes in place so that we can recognize these federal dollars.

The other that I want to continue to advocate for is to allow for IHS dollars to become mandatory. There is distinctions between discretionary as well as mandatory and so we continue to ask for the mandatory funding and line items that are of interest to the Navajo Nation. With that, I want to also encourage that the collaboration between the different agencies continue to take effect because it really can benefit the Navajo Nation when your agencies at the federal level collaborate and allow us to navigate and get to a point of discussion and open communications such as what was brought forward with your colleagues in terms of SAMHSA, IHS and CDC working on a particular issue.

So it really helps us with that and we look forward to building up our tribal law plan that we have been starting to advocate more so. With that, on behalf of the Navajo Nation, we just want to thank you for your federal partnership.

MR. ANTONE: Gentleman from Alaska?

MR. KEITH: You know, in regards to docs and PAs and nurses, we struggled at — corporation board with trying to fill vacant positions and so we squeezed our budget a bit and tried to make working there for the docs more attractive. And a few minutes later, a tribal consortium south of us, one upped us. And my — how I characterize that was like a pricing war or what do you call it an arms race for docs.

And I don't think that is something we didn't want to get into with another Native organization — health organization. But I think the — we need the long-term solution and it isn't going to be bringing people in from the outside. And it is going to be raising up our own to fill these positions. That needs to be a long-term strategy and then if we partially fund them or fund them to go to school, some of these are really expensive but then re-obligate them for those many years that we fund them to work in our health facilities.

And we have been fortunate we have had like two or three docs that have been there like forever. And some of them are in semi-retirement. They are outsiders but they are vested into the community. And we need our own people in these positions. That is the only — I think that is going to be the only long-term solution to our staff shortages out there. Thank you.

MS. CHURCH: Thank you for those comments. I think we have done a lot to — in partnership work on focusing on recruitment and retention. Specifically on scholarships and loan repayment as one of those methods that we can take individuals from the community and help them get that training that is so expensive. And then use that service payback to keep them back in the community.

Another thing that we are doing in that arena for retention is title 38. We have some of those authorities now but one of our proposed legislative actions in the 17

budget is to actually expand that authority. So hopefully that will help us also once we get the qualified individuals identified, that will help us with providing a more attractive pay scale that we can keep those providers. So thank you for your comments.

MR. ANTONE: You know that is what I was going to ask you about the pay scale? Whether there was going to be any consideration on that being that they were talking about the budget. And along with that — yesterday we were talking about or someone had mentioned, I don't know who, I think it was Mary, that there was an x number of vacancies in the Great Plains Area. Yes, a big number. So my question is, where did that money go that is dedicated towards those vacancies, those staffing? That amount of money where did that go?

MS. CHURCH: Thank you for that question. In that case, the funds are still at the area level in order to fill those positions. Of course, there are still challenges. While we work on filling those positions of course, there is the heavy price for the contract services that are filling those positions. So that we can make sure that we can cover that care.

MR. PAYMENT: So we wrestle with that back and forth and we budget for locums when we can't find physicians. The cost of a locum is at least a third to almost half or twice as much as a physician. So when the Ebola scare hit, we pulled together resources, we found a way to get in there to find doctors to address that issue.

This issue that we are talking about is no less important and is as significant as the health need. Because people and we have had testimony yesterday that people are dying. And in one case, we heard testimony that people — and this was Vernon, dying like five or six days in a row, people were dying because of their lack of having boots on the ground. And so your phraseology is perfect with it, this is the situation that some

pockets of Indian Country are facing. And so, the money might still be there but the time to fill a direct service position — physician position for one of those tribes we have already asked for a time study to find out if we can streamline and do a parallel path in the screening to get people hired.

But obviously we are not doing enough if we have that many vacancies and we have the money budgeted but we have that many vacancies. So we have to find a different solution. We have to move this up the priority list and to be as important as the Ebola scare.

MS. CHURCH: You are absolutely right. We are very committed to working on improving the hiring and making sure we can address those needs in a more timely fashion. We have a number of goals both short term and long-term, because we don't want to just fix the situation right now. We want to make sure that we can implement these recruitment and retention strategies so that long-term, we don't see a recurrence. We want to make sure that we can recruit those individuals to the areas, especially where they are needed the most. But then also sustain that moving forward.

MR. ANTONE: Yes, the session — other sessions this issue has come up over and over. So I think that is probably something that really needs to consider when we are talking about the budget. And find some solutions to that — I guess the long-term would be what you are talking about, the loan payment program? And the scholarships but I think the immediate solution needs to be done pretty quick for the Great Plains Area because you are losing revenue when you are losing certification. So just like to say that today.

MS. CHURCH: Thank you for those comments. And for the immediate term, especially the Great Plains Area, we do have health professionals who are being sent

directly to those locations to provide that immediate need. So we are working to try to address that.

MR. ANTONE: I have time for one more. Gil?

MR. VIGIL: Yes. And thank you, Gil Vigil from New Mexico. This time I am going to put my southwest regional hat on and that has to do with the consultation that we have in our regionals area for the budget. And one of the things that I still — IHS is still doing is prioritizing. I hope you would take the lead with BIA. BIA took away prioritizing. So you want to check with them what they have done.

Because everything is important to us. I mean, they are all priority. And when you ask us to put it in, I think 304 priority, it is kind of hard to do that. So I would recommend that maybe you look at what the Bureau of Indian Affairs did as far as not prioritizing some of these costs anymore.

MR. ANTONE: We have time for another. Vernon?

MR. MILLER: I can answer that too, so it will help. I also serve on TPAC for BIA and what we have done is we now ask the tribes and then the regions to submit based on what their unmet need is. That will allow us to further really assess problematically what is there and how much has been unmet over different annual times or periods and so that has been helpful. I also just wanted to — I mentioned this morning about long-term care services and how I just wanted to reaffirm that from an IHS perspective how important those services are to not only my tribe but other tribes that have the facilities or want to have the facilities to provide nursing home services, hospice care services. As well as in my community, the dialysis center.

You know, we solely utilized the Medicaid dollars to run those facilities and so if there was an IHS allocation, that would really support the tribes in trying to

provide even more quality care even though we are providing the quality care but an increased level and also just ensuring that we are able to operate at a level which can respond to the needs of our communities.

So I wanted to reaffirm that. And also just I know it is something that is going to be mentioned later too. But just reassuring that tribes are exempt from those sequestration, if that was to happen. Right now, it is a very volatile time politically and a new president and some push back at the Supreme Court level. And so that — I would really hate for that to be filtered down again and when the budget discussions come to the table and it is on the Hill and so I just wanted to reaffirm that IHS advocate to — for tribes to be exempt from that process, because it is the responsibility of the U.S. government to provide health care services to Indian Country. So thank you.

MR. ANTONE: — we will wait for her and then continue our discussion while we wait. Is there anyone else that wants to make comment? Ask a question? Mr. Joseph?

MR. JOSEPH: I agree with you know what has been said about the IHS and staffing needs and Mary asked earlier about the VA and I was — what I would recommend is that they look at how many veterans we have that reside in or on our reservations and do similar with what the IHS does on user population. It could probably calculate a user population of all of our veterans. And if you know the VA could potentially fill in some of those vacant positions or even appoint some docs and nurses to those tribes based under veteran population.

To me, I think if we had a VA provider in our clinics, we probably would open the doors to any vets that live in our areas and it might even help the VA get some of

the services so that their veterans wouldn't have to travel so far. But to me, I think that would be another way of getting providers. Thank you.

MR. ANTONE: Okay so I think that the — IHS really ought to consider what we just discussed. Like the pay scale, whether anything can be done about that or even contracting with the physicians or staff. That will be another part to this situation. So I kind — also was kind of thinking about, I know that the IHS is a part of the government.

The government has these I guess institutions, one of them being employees, long-term, short-term. And benefits tied to them. So I guess if you contract it out for employees then you won't provide the benefits. Would that be the case?

MS. CHURCH: I think within the contracts, there is a certain amount that is built into that for their benefits but it is not the same level that we would pay for an actual federal employee.

MR. ANTONE: So presumably that would save some money?

MS. CHURCH: I would speculate that if it was a short term hire, there might be some savings but as was discussed, you know we do know that contracted health providers are more costly than hiring somebody on a more permanent basis.

MR. ANTONE: So that would be an argument to not do that?

MS. CHURCH: I think ultimately the desire would be to hire full time qualified health professionals and using those mechanisms that we talked about with the scholarships and loan repayments and really recruiting within the community, there is a strong tie there with individuals who have come from that community and are really there to help serve their people.

MR. ANTONE: Thank you. We are now at the Tribal Leaders and Health and Human Services Secretary's Budget Council Roundtable Discussion and representing

Secretary Burwell is Deputy Secretary Mary Wakefield. And so we will — in this part, we are going to have to adhere to the order from chairmans, vice chairmans and et cetera for the tribal leader discussion. Just letting you know beforehand. So I will turn it over to Mary.

Tribal Leaders and HHS Secretary's Budget Council Roundtable Discussion

Deputy Secretary's Remarks

by Mary Wakefield, HHS Deputy Secretary

MS. WAKEFIELD: Great. Thank you so much,

Mr. Chairman and let me say on behalf of the Department of Health and Human Services how much we appreciate your willingness to chair the meetings and to help facilitate the dialogue. It is extremely important and very helpful for us. I also want to acknowledge Lillian Sparks and thank her for being here and then of course, Mary Smith as well and all of the rest of you, welcome.

This administration is deeply committed to improving the lives of American Indians and Alaska Natives. And we recognize that probably every one without a doubt seated at this table and others in the audience have many competing demands on your time. And so we are so appreciative that you are here today. Some of you have been here for the Secretary's Tribal Advisory Committee as well. And I just want to say thank you to each of you for taking time to be with us. It is so important for us to hear from you and of course we welcome the opportunity to share with you some of the work that we have underway.

I also wanted to say that I was — had the pleasure of participating in the Secretary's Tribal Advisory Committee meeting yesterday which a number of you at the table are a part of. I am not intending to repeat the information that I shared yesterday,

just in case you are worried about that. I do — there are some new faces though in the room and I wanted to say too, that while I am the acting deputy secretary for HHS, I only work on Washington, D.C., I actually live in North Dakota.

It is a bit of a commute home and I don't do it very often because it is rather expensive. But I say that by way of saying that I grew up in the northern plains and right outside of Spirit Lake Nation. And in that capacity when I was growing up, I had the opportunity through my parents actually to have a fair amount of interaction with some of the tribal families and individuals. My parents both at different times of their careers worked for that particular tribe. My mother was a teacher. And my father was an aviator and would fly the tribal leadership in the region to different meetings. And so my parents worked for the local tribe and I — and so I had that opportunity to grow up and really learn to appreciate the resilience and the strength of that part of Indian Country.

And it has always been a pleasure for me to be part of the Secretary's Tribal Advisory Committee. When I was chairing the Health Resources and Services Administration or leading that agency, we made it an extremely high priority over the six years that I was part of that agency to do everything that we could to leverage into making sure that we were doing our part to deliver resources on behalf of American Indian and Alaska Native communities.

I did want to just really quickly say what perhaps every one already in the room knows. So this part I will repeat and that is to acknowledge that this week we had a very important change in leadership at the Indian Health Service. And so with Bob McSwain stepping down from the leadership position, effective on Tuesday, our IHS Deputy Director Mary Smith, an enrolled member of the Cherokee Nation, assumed the position of principal deputy for the agency and has been delegated the responsibilities as director.

And I have had the opportunity to work with her now for five months. And I can barely keep up with her. So we are so pleased to be able to have her and then to continue to have Bob's contributions as well. And in addition, I wanted to also mention that we have another person brought in to help augment the leadership of IHS, Dorothy Dupree, who helps to lead our quality efforts. And she is known to many of you — a wonderful contributor because of the tremendous background that she has as well.

So those are important additional strengths to the leadership team and the terrific folks that are working within IHS. Well with that, let me make just a couple of comments about the President's budget and then I will stop and I will listen and will be happy to engage in conversation. So as you know of course, the President just recently released his 2017 budget and across the board, it requests some key broad budget requests in some important areas.

Requesting for example increases in key mandatory spending in areas that are important to all of us. Areas like supporting early childhood education, fighting the opioid epidemic, expanding behavioral health care for example. So they are really overarching priorities in the budget that are important to all of us. In addition though, to those broad priorities, the budget of course, also reflects the administration's commitment to tribal self determination.

Whether that is carried out by tribes that are operating their own health care programs for example or tribes that elected to have IHS operate programs on their behalf. And for our vantage point, the budget is very much about upholding the trust. A relationship that is vital in terms of our government to government interactions. And the budget is also from where we sit, important in that it — through a number of its provisions, strengthens tribal communities.

I would say just a few words about the budget, generally. First of all, it proposes as you probably are aware \$6.6 billion for the Indian Health Service. And that is an increase from last year of \$402 million from last year. And am I telling people things that they already know?

MS. : Yes.

MS. WAKEFIELD: Okay, all right. Okay because the chairman would start to tap on his watch. So that is why I asked Lillian, Mr. Chairman. Because he did that to me yesterday. But anyways, so it is \$6.6 billion for the Indian Health Service. As I said, an increase of \$402 million more in funding from last year. So what that is during the course of this administration that is an increase of 53 percent since 2008 in that budget.

So it has been a steady uptake since the beginning of the first four years of the administration. The budget fully funds contract support costs at \$800 million. And that is an estimate of about \$82 million more than last year. So that is an uptick. It also includes \$71 million in new behavior health investments. We have heard that theme through the Secretary's Tribal Advisory Committee and also through regional consultations. The importance on focusing on behavioral health and you see that reflected because of our consultations.

In this investment that we think is critically important to drive down suicides, to drive down substance abuse, to support individuals with behavioral and mental health illnesses. Beyond IHS though, we also have some additional budget components that are important. And so for example, we have in the President's budget, requested an additional \$192 million over last year's request to help American Indians and Alaska Natives through some of the programs that are operated through some of our operating divisions.

So an increase of \$192 million to support programs at the Administration on Children and Families through CDC and through SAMHSA. And along with the President's budget, our department is working also to make sure that people that are served by IHS get as much support as possible. And so that is why last Friday, CMS issued guidance that would expand the scope of Medicaid services such that — expanding the scope of those services received through IHS and through tribal facilities that are eligible for a full 100 percent FMAP.

So that is another very recent announcement and as a matter of fact, I was talking with the Governor of the state of Alaska about that change just earlier this week actually, I was on the phone. So this is very recent that this announcement was made. And that we think will be an extremely important support in terms of financial streams as I mentioned.

In terms of the Indian Health Service specifically, 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. And new expectations even for how we do our work. That is how we operationalize Indian Health Service. So we are very focused not just on what we are funding behavioral health et cetera, but also how we are doing our work through the Indian Health Service.

There is a lot of emphasis and I have already talked with Mary Smith about the how of our work. We are working together and with the IHS leadership team and more broadly across HHS to bring in — really introduce some cutting edge management practices. And to look systematically at how we are doing our work in order to leverage every dollar as effectively as we can through the Indian Health Service.

And so we are hard at work for example to — through Mary's work, to work on policies around contract support. How we can promote telehealth services that are so crucial for our rural communities. So it is very much with an eye towards what we are focused on but also how we are engaging these and other priorities.

The — in conclusion, as you already know, this is our final budget for this administration. I say that actually with a heavy heart in this room because I had the pleasure of being at the very first Secretary's Tribal Advisory Committee and the first budget consultation with Secretary Sebelius and when we started all of this work many years ago and I am here now at this last meeting and I would just want to say thank you to all. It has been a privilege to be able to work along side of you and in support of you. We will continue to do that and leveraging every bit of energy we have.

I have no doubt about that, the Secretary has made it very clear that no part of this agency is in a status quo mode. We are not waiting and watching the calendar unwind. We are moving every hour, every minute, every day that this administration is in office to drive this agenda forward. So we very much look forward to working with you right through the very end of the administration.

We firmly believe that it is our responsibility, that the United States has a responsibility to make investments and to make sure that our investments are working for Alaska — for American Indians and Alaska Natives and I very much look forward to hearing from all of you about how we can continue to do that or better for the remaining amount of time that I have, Mr. Chairman. So I will turn that back to you. Thank you.

MR. ANTONI: For this session, as indicated earlier, we will go with the tribal chairmen, governors, presidents for comment or anything that you want to discuss with Ms. Wakefield.

Tribal Leaders Discussion

MR. ANTONE: Aaron?

MR. PAYMENT: Okay, so I am really kind of sick of hearing myself for the last couple of days and so I should just say read the report. But this is an opportunity to highlight some of the stuff that we have been saying. So what I just did was pull forward some of the things. One of them is, and again you have heard this already, contract support costs. I can't express how appreciative I am for the President's requesting full funding and for us for the request to include a request for mandatory funding.

That is what we have been asking for. We have got that and we know that it is a team effort and we appreciate Secretary Burwell's unique skill set from OMB to understand that. Mary is a new energy that she breathed into this process and so we are grateful for that. We are also looking for and we are supporting legislation that would exempt tribes from sequestration and we are looking for advanced appropriations.

We have shared a lot of detail about what happens in Indian Country when we have to wait for a notice of awards and the cycle is really detrimental. I testified earlier that we have lost 15 health professionals in the last 3 years and we have not been able to recruit them back because they are scared to come to work in such an insecure environment with not knowing whether or not the funding is going to be there.

So the impact on us is very real and we know other tribes that don't have the kind of resources to backfill temporarily are impacted even more. So across agencies, we have talked about historical trauma and suicides. So I am going to again underscore my request. It is a couple year request that I have been making it now. For an epidemiological exploration of the independent variables that impact the outcomes and social indicators that are anomic.

Like suicide, alcoholism, accidents and transients. We have the worst statistics on all of those dimensions which means we have evidence that there is something going on and it is anomic and as a result of the historical trauma. So SAMHSA and Special Diabetes and this is a term that I heard the other day, I am going to lift up, I hear that many, many times the other day during someone's testimony but I am going to lift up area HSA and Special Diabetes. They are wonderful programs that have great promise in Indian Country.

And unfortunately they are not funded at the levels that they need to be funded. So I really want to underscore our appreciation for those programs and the need to increase the funding for those. Those — SAMHSA especially in historical trauma to address that, is to address the genocidal efforts of U.S. Indian Policy as a legacy.

We recognize that is the reason and so we need to get to the core of that and try to address that. So that is not just —, you know it is historical and social restorative justice issue but it is also a treaty and trust responsibility because we have agreements that commit the federal government to provide health education and social welfare. Those are specifically cited for as long as the grass grows, the winds blow and the rivers flow. And that is forever.

So we had some very wise negotiators when we entered those treaties. And so it is — Cathy Abramson uses the term, "We prepaid for that" with the blood, sweat, tears and the millions upon millions of acres of our ancestors and we hope that this government will follow through with that. So having said that — so that was kind of the critical side, the Obama Administration has been the best administration that we have seen to date. We stand with the Obama Administration to find permanency for this new commitment and covenant.

And one suggestion that I made earlier was to have the White House Counsel look at across agencies, this issue of how do we address the outcomes and the social indicators of which we have the worst of the worst statistics on. And also update the quiet crisis report. So that is a long time coming and I think that we probably have seen some gains but if — you know in our applications, we are held to a certain standard to prove our use of the funding.

And so we would like the federal government to demonstrate the efficacy of the funding that they have put forward to try to address our issues and the quiet crisis is one way to look at that because it pulls all of that information together. Finally the birth of the modern day and I would like to hope that it stays the modern day, tribal advisory and consultation came about — well originally under the Clinton Administration so I want to say that — and Mary probably recognizes that. But carried forward in the Obama Administration and then he gave it new life.

And he brought forward the expectation that true consultation happened. And then Secretary Sebelius gave that its legs and those legs were this tribal — HHS tribal Advisory Committee. There is a couple of other committees that have been established but I think of the time that we have left in this administration and we need to look across all of those agencies, those advisory committees and then look to writing an MOU forward to the next administration to say this is what worked, this is how we gauge the input from Indian Country and this is the importance of it in partnering with them. I have a lot of hope and faith about what our next administration will be.

However, we don't want to lose any ground. We want to pick up right from where we are in being able to continue to go forward. So with, I am grateful for this administration and the new covenant that it represents. Thank you.

MR. ANTONE: Chairman Trudell?

MR. TRUDELL: I never get tired of hearing myself talk. Roger Trudell, representing the Great Plains. I just wanted to thank everybody for all of their wisdom these past few days and the sharing of a lot of information. And glad I was able to be here. Even found out that aneurism is not prevalent among Indians but happens to be at a higher rate in northern and southern plains. So we did find that out.

So that is how fast people act around here because I think that might have been just yesterday or so that I asked that. So appreciate that. I appreciate that you know, we are provided with all of the information that can be given to us. That you can actually get on an airplane on the way home and all that type of stuff. So I really admire Lillian's necklace.

I was testing her Indianness, because back home you say you like something and they give it to you but — and she knows all the tricks already because she is from out in Indian Country. So. Anyway I just wanted to say that I appreciate all of the information and I appreciate all of the — everything that was said. The extra meetings that people sometimes they feel where you put an imposition on because I know they had a long day. Got to get up and start early and all that type stuff. So I really appreciate that. And thank you very much on behalf of the Great Plains.

MR. ANTONE: So as you know, Mary, I chaired the CDC Tribal Advisory Committee, and you were talking about investments. So I would like to read some testimony to you. 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 are regularly left out of state wide public health plans and federal funding decisions for public health programs.

We thought a local tax base and — if any outside funding, tribal communities are often the most in need of public health dollars. Tribes were ignored during the formulation of the U.S. public health system and it is now time to reverse this wrong. Tribal communities must cobble together public health funding from a variety of federal, state, local and private funding sources. Often times tribes are either not eligible to compete for the funding or are woefully under represented in the grantee pool.

This leads to rampant unpredictability and inconsistency among tribal public health initiatives. And these are some recommendations for CDC. A CDC should require states to receive CDC funding to declare and provide evidence of how they will include tribes and 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. Such as capacity building, wire(sic) hepatitis, HIV, suicide prevention, substance abuse, and chronic disease prevention.

Public health accreditation has been a driving force in recent years to improve public health department functionality. No tribe to date has been accredited. 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 tribal behavior health agenda and I believe you have heard that before. And the 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.

And the CDC needs to continue the current efforts and continue to explore how the program can be expanded to include direct funding to more tribes. This comes from a lot of efforts from the tribes to recognize that tribal practices are probably most effective in healing or preventing suicide, alcohol, substance abuse. You know, we have a lot of youth who probably have a natural inclination to tribal practices. So a lot of them question at times their cultural identity. And so that gives us an idea that there is something there that we need to address. That is tribal governments.

Unfortunately a lot of the deaths from suicide tell us that. It is not — it is not something good to hear but I think to me that is what has happened. Letting us know their loss and then who are we. And so we need to bring that back. Bring that spirit of the warrior back into our youth. So that is the foundation that can help them fight this epidemic. So.

And I am going to stop here and I will give you this and I don't want to take too much time because I wanted to ask any other tribal — Mr. Joseph?

MR. JOSEPH: (Speaking in Native language)Badger is my name. I really want to thank you. I want to ask you to thank the Secretary for Mary's appointment. And also the group here that sits here before us, I have heard about this group that has been naturally working on our tribal issues and to me that is really something that we need and I

would hope that — I believe a few years back, we were asking that IHS director be bumped up that scale to be right under the Secretary position if that would give more spending authority or somehow I guess, so that you know, our tribes are important.

And to me that is really — I asked if OMB was here because I work with Mary on the contract support costs work group and you know, we had some bumpy meetings when it first got started. And I was really grateful when Mary started working with that — with our group that you know we feel that there is a lot more ground being gained and you know, working towards the overall goal of getting that completed.

As a group, that group is made up of federal staff, it is made up of tribal leaders. It is made up of your attorneys. It is made up of our attorneys and our policy analyst people that really — we are trying to look at this as a win-win for the tribes and the government. As co-chair of the group, we have all agreed that in the language on that policy, the medical inflation rate be added to the language and I am glad OMB is in the room and I hope that they hear that our work group is recommending that be put in the language.

You know, part of my chairing that workgroup is I want to make sure that in this administration that we do something that is totally right. And to me that would help all of our tribes that are running our programs, you know, be able to look forward to I guess gains versus losses. So to me that is really important that we have that language. It is — I hear it is in the rider in the policy, that — and that is good if it gets approved it will be there.

But I would like to hear good news like what we have heard about the 100 percent FMAP on this policy as well. The time and hourglass is getting short and we want to have this completed by this summer. And to me, that would save me from having to come back to several more meetings and free me up to do some other things that need to be

accomplished. I co-chair the National IHS budget as well. And you know, this administration has been really good to us. But we are still funded less than what a federal penitentiary inmate would receive for health care and to me that is inhumane way to treat the first people of this country.

We serve our countries more than any other race in the nation and we do that so we don't have to deal with some other foreign country coming in here trying to bully us around. Our chiefs signed agreements and our president, he agreed to them as well. I would hope that that — our country should be the one that honors every agreement ever signed. Thank you.

MR. ANTONE: Any other — Vernon?

MR. MILLER: Good afternoon, I just wanted to start off by saying how thankful I am. This is my first meeting as a member of STAC and so I was kind of green coming into this. And so I definitely embrace the opportunity to as a National Member At Large represent all of the Indian Country's concerns. And I think it is important that STAC is here and I just wanted to acknowledge and reaffirm that I do appreciate the diversity of narratives that were brought to the table throughout this experience not only today but the past two days.

And allowing those of us to ensure that Indian Country's needs in terms of the health and human services that are provided are not only maintained but also continually assessed and how it can be improved and how it can be reactionary to what some of the current needs are. And how Indian Country is evolving and how some of our needs, you know, are sometimes more of outer focused or youth focused and in between. And so I just wanted to acknowledge that.

And I also just wanted to talk briefly about, from a budgetary standpoint. I know we have been asked and since I have become chairman of the past couple of years, we are always asked to prioritize. What is your priority? We understand you have all these issues but you know, tell us what your top 10 are? And then from our level, from the Great Plains Area we then as a tribal entity decide what our priorities are and then we come together in an area region format and then there is 17 or 18 other tribes in areas that we have to you know, share and explain why our priorities are this way and why other tribes are different. And somehow come up to a consensus amongst those tribes. And then bring it to a national level.

And because of some of our tribes are smaller, some of our needs aren't as prevalent as other areas because of the diversity. Sometimes it feels like the needs and the priorities you know, that we have been forced to identify are truly reflected in the budget process. And so I just wanted to bring that kind of notion to the forefront and maybe we need to think about changing to a needs-based format. Because that would really allow tribes and of the lower regions and areas to really have an understanding of what the needs are and the — that really assess budgetary ways how we can go in that direction.

I know from the — at the other site, the — we have changed this year to a need space format, that has really been helpful to establish what has been unfunded. What levels and percentages has it been unfunded and unmet? And so that really helps provide a little more of a higher level perspective on the budgetary process. And so I wanted to bring up that — that concept and maybe that notion of maybe how we can improve the budget process and how we are going to move forward.

And so once again I just want to thank every one also that is here today and thank those that provided this opportunity and I look forward to future opportunities

where we can discuss how we can all work together collaboratively in partnership with HHS to establish a better relationship. So thank you.

MR. ANTONE: Thank you.

MR. VIGIL: Thank you again, Gil Vigil. I have been coming to these consultations for probably the last four or five years. Since even when Secretary Sebelius started the STAC and I commend her for that. And I commend Secretary Burwell for continuing this because I think it is an important process and this is probably the only agency that is doing something like that. And I also want to thank the STAC members that are part of this because I think they are looking out for the best interest of all Indian Native people — Indian Nations.

Currently I don't know who our representative is from the Albuquerque Area. I think she is also new and he is also new and I just need to engage with that person because they are supposed to be here on our behalf and I don't see Albuquerque Area being represented here. But I think our issues, our concerns are similar to some of the presentations that have been made here already and of course, funding is always going to be the issue where we are not funded adequately to do some of our programs on all levels.

All the issues that I talked about today and I am sure they probably discussed that at STAC meeting yesterday or the day before. But one area that was not talked about today and I didn't see a representative is from Head Start. I have always been a proponent for Head Start. And I always start my presentation like Head Start works, the problem is so many rules and regulations within Head Start that prohibit some of these things to do a better program.

Like for example, the requirement to have our staff to get degrees. And then once we get them degreed, the problem is we don't have enough money in Head Start

to pay them a salary that is equitable through other school districts down the road. So once they get their degree, they go to another school district and we lose them and we are starting at ground zero again.

The other one is even though we have done the over income eligibility requirements, that is still an issue. Because we still have a lot of kids that are over income and when I say Head Start works, it is those same parents that went through Head Start are now — have professional jobs but their kids aren't eligible for Head Start. And so that needs to be looked at and revisited again also.

And of course, funding is always going to be an issue. And then the competition that we are faced with with other Head Start programs in our area. And some of our areas in our Pueblos, there is a Head Start program within the state, a few maybe three or four miles down the road and then we can't — we are competing for kids basically. We are competing for those same kids.

And then the requirement that you can't go over a certain area. And our kids are in that area. Meaning some of our — our Native kids are in that area. And so those are some of the things that I wanted to express on the Head Start's behalf. And I know the Southwest Head Start is going to have their conference I think next week and they are going to have a consultation session in Albuquerque so I am sure we will probably bring these issues up again at that point. But I just wanted to express that at this time. Thank you.

MR. ANTONE: Are there any others — Ramona?

MS. ANTONE NEZ: Thank you, Chairman Antone. And thank you, Dr. Wakefield for your presentation and your leadership to the — the Department of Health and Human Services. I am from the Navajo Nation and I just want to emphasize six points

that we have testified throughout the day. Number 1 is about the sequester. We continue to advocate to hold harmless the American Indian Alaska Native on this endeavor.

Number 2, is the effect of continued resolutions that impact Indian Country. Specifically for Navajo when we receive a — because of the CR, we have a tendency to have a delay in notice of award and it just impacts. It has a rippling effect about how we operate and that would be number 3. The delay of notice of award. Number 4 is we provided short testimony on the Navajo Nation Medicaid agency feasibility study that was reported to Congress in 2014.

And the start up cost estimate is \$134 million to \$243 million over a five year period. We will continue to advocate for that and also work towards a title 19 amendment for legislative action. Number 5 is the request or we talked a little bit more about the workforce. Many of your directors had talked about workforce dollars and increasing dollars for the capacity building and I have been requested that there would be a synopsis or a brief glance at — of all the dollars that are being provided to Indian Country in terms of workforce and capacity building. How much of it is actually coming to the Indian Country.

And number 5 is the last one that I had — excuse me, yes, number 6 — is our continued request for technical assistance in many areas. To be able to connect with our federal partners to assist us with any time we have contract compliances, cooperative agreement requests or places of the — the contract part of it is one part but the other part is also the implementation.

As we look to provide an increase of services and the effectiveness and the quality through programs that we are funded for, we continue to ask for effective process of technical assistance. And those would be my point at this time. Thank you.

MR. KEITH: Yes, my name is Robert Keith from Native Village of Elim but I sit on Norton Sound Health Corporation Board. I am also — I also sit on the court boards that which we do Head Start and I really heard what you are saying about Head Start because it is a very burdensome program to run but it is a very important program to have.

You know when I was about 14 years old, change of subject a little bit, it was about 45 years ago, Richard Nixon instigated I believe it was the Indian Self-Determination and Education Act. I think that was a real important seat change. It marked the end of a very dark history and some new beginnings. But I think the intent of that legislation has best been represented by IHS. I had experience with BIA on the court side of our organization. We had BIA programs. Norton Sound handles the health.

And I sat on our housing authority when the houses came about and I have had experience — this is my first meeting here at this level. And I have had little bit of experience under IHS, but my observation is IHS has done the best in implementing self governance and self determination.

And I do think President Clinton really gave us a lot of sails but I think President Obama has really put a lot of wind in those sails. And I will end my conversation there. I thank you for the opportunity. We do have — Norton Sound does have one last annual report — we will save it for you. Thank you.

MR. ANTONE: Do we have anybody else?

(No Response)

MR. ANTONE: Well, it looks like — anybody in the audience? We have about 15 minutes. Okay. Well thank you very much. Oh.

MR. STEIGER: Just a brief point on Head Start and Mark can elaborate on this. We are finalizing rules this year that should reduce the number of regulations by potentially as much as a third.

MR. VIGIL: Mr. Chairman, just to add to his comment, I have been providing testimony, we have a Head Start regulations used to be this big. But I guess you are listening to me because it is kind of like this now. So maybe with that third, it will be a lot less.

MR. ANTONE: Mr. Joseph?

MR. JOSEPH: I got to speak for our elders too. Long-term care was included in our budget request. I was attending an IHS facilities meeting that I am a part of as well. And we brought up long-term care there as well. During that meeting we heard that our — one of the Crow Tribe went in with the state of Montana and worked out an encounter rate for their rest home facilities. They got 15 beds. My tribe runs has had a long-term care facility for — this is 33 years now.

And it costs our tribe anywhere from \$400,000 to \$900,000 tribal dollars to keep its doors open. Our rest home, we call it our convalescence center has some of the — we lost like — we have the — and pow wow there and we have at home, it is getting close to root gathering season. And they have the root feasts and berry feasts and salmon feasts. Things like that our elders grew up with as youth and we even have spiritual ceremonies that happen.

You can't get that in the outside — off the reservation. So I would hope that somehow the Department of HHS could look at helping IHS and tribes work out an encounter rate like the Crow Tribe did for all of the tribes. That would probably help open

the doors to tribes wanting more, more tribes wanting to provide that kind of services under — near the reservations. To me I think it is something that we need to look at.

We also need to look at an encounter rate for providing hospice care and you know, in-home care to elders that wish to live in their own homes and if we were to do assisted living program, if there could be an encounter rate for that even. Just to help our elders, I just — I always think when my dad first came to me when I got on council and he said a lot of you say you are going to do stuff for your youth and elders and I don't see you doing anything. But you know I do sit on my elder committee and I became an elder last year of my tribe.

And you know, I am hoping that I can stay away from having to go into a rest home myself but my little wife wouldn't be able to move me around. So, you know I always worry about our elders and so to me, they deserve the best care possible. So thank you.

MR. ANTONE: Chairman Payment?

MR. PAYMENT: All right, so you prompted me. So title VI. I want to talk about title VI for a minute. So we have a title VI program. We have had one and it is one of our very first programs. We have 5,200 elders in our service area. And we have 9 elder subcommittees, so we have created a governance structure where our elders are advisory to our governing board. We have 9 subcommittees and then we coordinate our meal problems along with the subcommittees. We have five subcommittees that have meals once or twice a month.

And then we have four meal sites where they do three or four times a week, where we do congregate meals. Congregate meals are amazing because we can do in-service programs on what we have available. We coordinate chore services to them. We

do nutrition, wellness, sociability and even bring in people who talk about how to file for taxes, what scams to look out to protect them.

But for all of the good that does, we have funding for only one site. And so we have to use travel dollars to pick up the difference for all of the other sites. And also we haven't seen real significant increases for many years. I did talk with Cynthia and we do have hope because in the new budget there is some increases that are going to be available for the title VI program.

In our community, our elders — somebody said it earlier, youth are critically important to us — Andy did, and where the President was impacted by that. But we believe that the wisdom of our community is from our elders. Because there is a direct connection with them, with our ancestors and maybe in the time that we have left, we should do something to take a look at and have a conversation with our elders from across the nation to see what they think our needs are. And certainly more funding for those programs that work. Title VI is an amazing program.

If not for that program, there is some of elders where their families have become westernized or civilized or assimilated or whatever the right word is and they don't care for them the way that we do in a traditional. I grew up where my great-uncle lived with us and all of my family — we all lived in one household. And so the meal program is an ability for them to come and socialize with other Indian people so they don't get chronically depressed and give up. So it is a great program, we just need more money for it.

MR. ANTONE: Gil and then I will acknowledge Cynthia and that will end this session.

MR. VIGIL: As I mentioned, I am also the activity director for the Eight Northern Indian Pueblos Council. And I took over the shop probably about two and a half

years ago and the first thing I was hit with was when they changed the way — the number of the population count. When they went from the federal count to the local count, which was a drastic change. It hit us — sequestration had just got kicked in. And then that hit us and we were cut by \$100,000 for our four centers that we had. The issue is that there should have been some kind of consultation session before they did that because it would have talked about the impacts they would have. It greatly impacted my programs.

It impacted staffing. We had to reduce staffing. Hours had to be reduced. And so it really impacted our services to our community. We just did our annual — report on the last three years to our Governors and I showed what the impacts were. We are finally trying to recover from those impacts but it has taken this long and we are still not there.

I do have to commend Cynthia and her office for assisting us because the impacts were going to more than we got. But they limited but even that amount still hurt our organization with our program. And like Mr. Payment — Chairman Payment is saying, that is a very important part of our programs.

So when our programs are hit like that, of course, who is going to complain? Our elders. And they always complain to me about when are you going to make things better? And we are working on it but it is hard to make it better when we don't get the funding. Thank you.

MR. ANTONE: Cynthia?

MS. LaCOUNTE: Thank you. I guess this is on — thank you everyone and thank you Chairman Payment and also Chairman Vigil for your comments. I wanted to say thank you from the bottom of my heart for including elders because we don't always have

this discussion around title VI and I have heard lots of discussion also around long-term services and supports. So I am thrilled.

We as many of you know, we have an MOU with Indian Health Service and with CMS around the delivery of long-term services and supports in Indian Country. And we are doing that because there is no money funded under the long-term services and supports under the ACA. So what we are doing collectively as three agencies is providing training. CMS has our website on their page.

We are providing a lot of training, a lot of assistance from tribal leaders. We have a road map developed on developing long-term services and supports in your country — or in Indian Country and we are trying, trying to stay ahead of that game. One thing that I wanted to mention is that some of you weren't here yesterday to hear that we got a \$6.5 million increase in title VI.

(Applause)

MS. LaCOUNTE: And that is due to your local efforts and that I believe was due to Representative Cole who heads the finance committee. He is from Oklahoma and he is the member of the Chickasaw Tribe and he called us from ACL over to ask about tribes and urban elders. So we were thrilled with that increase. And that will give you about a 15 to 20 percent in your grants next year.

Another thing we are doing is developing a guide to help you bill Medicaid for services provided under title VI and title III of the Older Americans Act. And Colville, since you are AAA, that also includes title III. And what that means is that as CMS was talking today about their new provision around long-term services and supports, we can bill for transportation that we provide in senior programs.

We can bill if transportation provided to Medicaid eligible clients of course. We can bill for home delivered meals. We can bill for congregate meals. We can bill for case management. We can bill for in-home care, as you were just asking for. And so what that means is either you can bill as a title VI program or you can bill through your tribe and through your clinic as you normally have been.

The Menominee Tribe of Wisconsin is our stars in this effort and they have been billing under their title VI program for three or four years now. They began — they are now a Medicaid billing agency — my program, they are not going through the tribe. But in the first year of billing when they billed only for home delivered meals through eligible clients, they brought in \$84,000.

That almost doubled the money that I give them. Now, three or four years later they have got their whole billing system in place for elderly services. They are retrieving about a million and half into that senior program each year. I want to jump up and down and scream and holler and run the block I am so excited about that potential. Because I don't think we are ever going to make — meet the need with our existing federal funds. It is — we just don't see that happening down the pike. But you can definitely increase your revenue into title VI. We are leaving money on that table.

We are providing those services. Either they are coming out of Older Americans Act funds or they are coming out of your tribal dollars and we are leaving that money on the table. So this next year one of our priorities in title VI and Old Americans Programs is to train the tribes, finish that billing guide and begin to train the tribes in billing under title III and title VI services.

And that should also expand into your CHR Programs. Because your CHRs provide many of those same services to those same clients. So watch for all of that coming

down the pike. Your leadership will be getting our billing guide first. But then we will be training your providers. So let them come to our national conference in Denver in August.

And I also want to let you know quickly, one last thing. Is that I am developing ACL's Consultation policy. We haven't had a policy on our own before. We have gone under HHS's and I am developing a policy that I want to get into place before we leave Assistant Secretary Greenlee. Thank you.

MR. ANTONE: Thank you. And that concludes the session. We are right on time. And so I am going to thank Mary Smith, Mary Wakefield and all the folks that came to the table. And we are going to turn it over to Emily Barson for the wrap up.

HHS Wrap-Up

*by Emily Barson, Director,
Office of Intergovernmental and External Affairs*

MS. BARSON: Great. Thank you so much. And I really just want to echo Dr. Wakefield's thanks to all of you for your time in being here and traveling here from across the country to a very gray Washington day. But we really appreciate all of you coming here to represent your tribes and your communities and really bringing forward a lot of these issues that are priorities and we — this is certainly not the end of the conversation. We will continue working with you on these throughout the year. So thank you and have a great travel back. Thank you.

MR. ANTONE: As is customary, I have asked Mr. Joseph if he could provide us with a closing prayer.

Tribal Closing

By Andy Joseph, Jr., Council *Member*,

Confederated Tribes of the Colville Reservation

MR. JOSEPH: I was taught from my elders to acknowledge elders in a room if I am ever asked to pray, so I don't mean to offend you in any way in the way that I pray. I believe in our belief every one of us were given gifts when we were conceived, a gift of a spirit. And my elders told me it is up to you to find out what that is.

So sometimes some of our people we might sit on a mountain or we might sit by the water. We might be a curious little kid or a boy out there playing in the wilderness. And he might be fortunate to hear some kind of a song and there might be an animal that — doing that.

And you know, just the other day we got our first thunder and lightening storm that came through and it is really early for that to happen in my territory. You know one time I was sitting on the mountain and the winds start blowing and the sky got really, really dark and I seen the lightening come and from mountain top to mountain top to where I was at. And you know there is cleansing when that first storm comes in.

Sometimes you know, our people don't realize that it is blessing. But you know the next day — yesterday when I was home, the sky was all clear and it was — the air was clean and the grass was turning green and our roots are going to be coming and that is going to feed our spirit. That water that comes on the mountain has got a lot of medicine in it right now. And so our people might bathe in that water and ask for a blessing as well. So I will say a prayer that I say every day and —

(Closing Prayer)

MR. JOSEPH: Thank you. That is all.

(Whereupon, the meeting adjourned at 4:37 p.m.)