BEHAVIORAL HEALTH AGENDA FOR INDIAN COUNTRY

All federal agencies serving Indian Country should have a part in preventing these devastating and violent incidents. While the Indian Health Service (IHS) is often the primary health provider for Indian Country, the federal trust responsibility is for health and not limited only to one agency or federal department. We request:

1. *A plan of action, led by the U.S. Department of Health and Human Services (HHS), that will demonstrate how programs for behavioral health serving American Indians and Alaska Natives are coordinated across agencies*
2. *The Administration will work with tribes to develop a behavioral health agenda for Indian Country so that we can work across agencies to achieve measured long-term, sustainable progress on these issues.*

Current Status of Issue

SAMHSA is advancing the behavioral health of the nation through its policies, programs, and activities. The agency's strategic plan, Leading Change 2.0, outlines six strategic initiatives to guide budget, policy, and resources. These initiatives focus on prevention of substance abuse and mental illness, health care and health systems integration, trauma and justice, recovery support, health information technology, and workforce development, and are pertinent for supporting development of a TBHA that takes advantage of national behavioral health investments.

SAMHSA is using the initial input received from tribal leaders to develop a framework for obtaining broad input from tribes, engage federal agencies that have a bearing on behavioral health services for tribal communities or that have an impact on behavioral health, and develop a TBHA that has broad support and guides collaborative action. Immediate next steps include: (1) a discussion regarding trauma (with a focus on historical trauma) at the March 17 STAC meeting; (2) input on the framework from the SAMHSA Tribal Technical Advisory Committee (comprised of tribal leaders) on April 15; (3) a meeting with federal partners in late April; and (4) an all-tribes call in May. Initial discussions are taking place in partnership with IHS.

Response:

The Department acknowledges the impact that historical trauma has had on the lives of American Indian and Alaska Native people. Tribal leaders have requested the development of a TBHA that accounts for historical trauma and other root causes of the behavioral health problems affecting their communities. HHS will build on investments in trauma and work collaboratively with tribes and federal partners to get this done. Administrator Hyde and Kana Enomoto, Principal Deputy Administrator, will present an overview of current trauma work and have a discussion with the STAC on what works to address historical trauma and what still needs to be done. They will also have this discussion at the SAMHSA Tribal Technical Advisory Committee meeting on April 15, 2015.

Point of Contact: Sheila Cooper, Senior Advisor for Tribal Affairs, SAMHSA
Sheila.cooper@samhsa.hhs.gov

CONTRACT SUPPORT COSTS

The full funding of Contract Support Costs (CSC) for the last two years has been a major victory for Tribes and for self-governance. However, the current way that CSC is funded —via the discretionary appropriations process— means that there is always a risk that CSC could take funds away from other IHS services if the precise amount needed is not appropriated at the start of the fiscal year. In fact, services saw a $25.1 million cut in FY 2014 in order to address CSC need that was not known early in FY 2014. Health programs in Indian Country should not be made to compete for resources against each other. In order to stabilize this funding, Tribes believe that the costs for CSC should be mandatory. Therefore, we request that you work with the Office of Management and Budget and the Department of the Interior to:

1. *Support legislation to enact mandatory funding of Contract Support Costs*

Current Status of Issue

IHS has committed to ongoing regular communication on CSC and will continue to work with the IHS CSC Workgroup to refine uniform business practices. In recent meetings with the IHS Tribal Self Governance Advisory

Committee and the IHS CSC Workgroup, Tribal representatives indicated their initial support for the CSC mandatory proposal in the FY 2016 President's Budget and requested an expedited consultation, especially since Tribal consultation was already held on this issue for the last year, and the proposal implements the top Tribal recommendation from that consultation. IHS expedited the consultation on the CSC mandatory proposal; a letter was sent to Tribal leaders announcing a 30 day consultation period on February 9.

Response:
Last year, Tribes made it clear that while they want full funding of CSC, they did not want it at the expense of the rest of the Services budget. The leading Tribal recommendation was to make CSC a mandatory appropriation and to separate it from the rest of the Services appropriation. The FY 2016 President's Budget for IHS and BIA proposes a two-part, long term approach to fully fund CSC for both IHS and BIA. The first part is that CSC is fully funded in FY 2016, and second part is that the budget proposes to shift CSC to a mandatory appropriation in FY 2017. On February 9, IHS sent a letter to Tribal leaders announcing a 30 day consultation period on the CSC mandatory proposal in the FY 2016 President's Budget; IHS has expedited Tribal consultation in response to Tribal feedback.

Point of Contact: Roselyn Tso, CSC Team Lead, IHS
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ADVANCE APPROPRIATIONS FOR THE INDIAN HEALTH SERVICE

Tribes continue to work toward achieving Advance Appropriations for the Indian Health Service, and are seeking the support of the Administration. As we saw in FY 2014, Congress is not afraid to play politics with our budget and the health of our people should not be put at risk because of this. Habitual short-term continuing resolutions and government shutdowns are having negative consequences on the delivery of health to our people in a system that is funded far below actual needs. The Administration vocally supported Advance Appropriations for the Veterans' Administration in 2009. Like Veterans, Tribal communities have made sacrifices for this country, both historically and contemporarily. We request that:

1. *The Department of Health and Human Services support IHS Advance Appropriations in its FY 2016 Budget*

Current Status of Issue
In April 2014, the Senate Committee on Indian Affairs recently had a Hearing on the proposed amendment to the Indian Health Care Improvement Act (IHCIA) to authorize advance appropriations for the IHS by providing 2-fiscal-year budget authority. This proposal requires Congressional Action, and an amendment to the Affordable Care Act since the IHCIA is a part of that appropriation. The Administration has not taken a position on the issue and has not been asked to provide technical assistance by any Congressional committee. In order to understand whether advance appropriations will address the need, OMB requested data in the form of hard numbers that support Tribes' descriptions of the impacts of CRs and the shutdown that occurred in FY 2013. Only a few Tribes submitted data in response to a data call for this information. Both Senator Murkowski (AK) and Congressman Young (AK) have expressed frustration in hearings during the past year that the administration has not taken a public position on this issue and has not included it in their budget proposals.

Response:
The Administration is aware that Tribes and Congress have asked if the Administration will publicly declare their support for this proposal. The proposal is currently under review by the Administration. We understand the challenges Tribes face with a lack of consistent funding at the beginning of the fiscal year. We would like to work with Tribe son this issue and identify any additional options that might result in a better outcome.

Point of Contact: Kenneth Cannon, Acting Director, Office of Finance & Accounting, IHS
Kenneth.cannon@ihs.gov

HEPATITIS C IN INDIAN COUNTRY

Hepatitis C Virus (HCV) affects an estimated 150 million persons worldwide, and about 5 million in the United States. National data suggest that there are many tens of thousands of HCV patients in Indian Country, with a high proportion of them undiagnosed. Hepatitis C leads to highly elevated risk of death from liver disease, including cirrhosis, liver cancer, end-stage liver disease, chronic liver disease (CLD) and other complications. American Indian

and Alaska Native people have much higher rates of deaths from CLD. We request the following to help treat this disease in Indian Country:

1. *Specific Funding Allocations for the treatment of HCV with recently approved regimens among AI/AN persons receiving services at Indian Health Service/ Tribal/ Urban (I/T/U) facilities.*
2. *IHS should make public their coordinated plan and response to the rising levels of Hepatitis C among AI/AN people. Creating and sharing a coordinated plan would allow for a cross-clinical national response to the epidemic, and allow for the pooling of resources.*
3. *Systematic exploration of opportunities to reduce the costs of new HCV treatments. New HCV treatment regimens are both extremely effective and expensive. IHS has relied upon accessing pharmaceutical patient assistance programs, but this is not a sustainable response to the HCV epidemic in Indian Country.*

Current Status of Issue

IHS does not allocate specific funding for the treatment of HCV infection among AI/AN persons receiving services at I/T/U facilities. Funding for medications is included in the Hospital and Health Clinics budget which is funded at 56% level of need. IHS sites provide treatment and use the full scope of options available to them to pay for their patients' treatment regimens by leveraging federal resources throughout other federal agencies, such as Veterans Affairs, third-party billing through the Affordable Care Act and private insurance, the Purchased and Referred Care program, and pharmaceutical Patient Assistance Programs. All HCV treatment products are available for purchase through the IHS National Core Formulary (NCF).

Response:

1. *Specific Funding Allocations for the treatment of HCV with recently approved regimens among AI/AN persons receiving services at Indian Health Service/ Tribal/ Urban (I/T/U) facilities.*
   The IHS does not allocate specific funding for the treatment of HCV infection among AI/AN persons receiving services at I/T/U facilities, but all HCV treatment products are available through the IHS National Core Formulary (NCF).

2. *IHS should make public their coordinated plan and response to the rising levels of Hepatitis C among AI/AN people. Creating and sharing a coordinated plan would allow for a cross-clinical national response to the epidemic, and allow for the pooling of resources.*
   The HHS action plan for Viral Hepatitis was released in 2011, *Combating the Silent Epidemic of Viral Hepatitis: Action Plan for the Prevention, Care, & Treatment of Viral Hepatitis* (VHAP). The HHS action plan includes the IHS HCV action plan that specifically addresses the HCV needs of AI/AN people.
3. *Systematic exploration of opportunities to reduce the costs of new HCV treatments. New HCV treatment regimens are both extremely effective and expensive. IHS has relied upon accessing pharmaceutical patient assistance programs, but this is not a sustainable response to the HCV epidemic in Indian Country.*
   Funding for medications is included in the IHS Hospital and Health Clinics line item, which is funded at 56% level of need. IHS sites are providing treatment and using the full scope of options available to them to pay for their patients' treatment regimens by leveraging federal resources throughout other agencies, such as Veterans Affairs, third-party billing through the Affordable Care Act and private insurance, the Purchased and Referred Care program, and pharmaceutical Patient Assistance Programs. All HCV treatment products are available for purchase through the IHS National Core Formulary (NCF).

Point of Contact: Sandra Pattea, Deputy Director for Intergovernmental Affairs, IHS
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ELECTRONIC HEALTH RECORDS AND MEANINGFUL USE

One of the stated goals of the American Recovery and Reinvestment Act (ARRA), enacted in February 2009, is to increase the "Meaningful Use" (MU) of Electronic Health Record (EHR) technology among medical providers. The Indian Health System has severe challenges embedded in the system, which make achieving MU extremely difficult, and in some cases impossible: High Health Care Provider Turnover Rates; Lack of Technology, Equipment and Infrastructure; Dependence Upon the IHS EHR System (RPMS) – a system that has experienced substantial delays in certain required updates; Chronic, Persistent and Dramatic Underfunding; Policy Barriers; Security requirements written by office of the National Coordinator (ONC) for the private sector that did not accommodate working with

the federal health systems. These challenges effectively prevented the Tribal health system from deploying EHR by December 2014. Therefore, Tribes request that:

1. *Providers in the Indian Health System must be made exempt from the Centers for Medicare and Medicaid (CMS) penalties for non-compliance with MU*
2. *The federal government must make a substantial and sustained investment in Tribal health and the achievement of MU.*

Current Status:
The IHS and CMS are currently working together to meet Meaningful Use requirements, such as security and system requirements.

Response:
The IHS is currently working with CMS to meet Meaningful Use requirements and is exploring options that might be available regarding penalties for non-compliance.

Point of Contact: Kitty Marx, Director, Tribal Affairs Group, CMS
Kitty.marx@cms.hhs.gov

EFFECTIVE IMPLEMENTATION OF THE INDIAN CHILD WELFARE ACT

The Indian Child Welfare Act (ICWA) was enacted by Congress in 1978 in response to alarming numbers of AI/AN children being removed from their families by public and private child welfare agencies, most often being placed in non-Indian homes far from their tribal communities. Today, AI/AN children still face serious obstacles to receiving the full protections provided under the law. AI/AN children are disproportionately represented nationally at 2.0 times their population rate and among individual state foster care systems as much as 10 times their population rate. While no single federal agency is provided full responsibility to monitor and ensure compliance with ICWA, the Administration for Children and Families (ACF) has oversight over much of state child welfare practice, including data collection, ensuring appropriate outcomes, and assisting states to improve their practice and policies to be in compliance with federal law. ACF has a critical role in helping collect important data, promoting effective tribal/state collaborations, increasing state capacity to comply with ICWA, and reversing the inequities and disparate treatment that can occur when ICWA is not followed. In order to assist the Administration and HHS in the implementation of ICWA and protection AI/AN children and families we respectfully request the following issues to be addressed:

1. *Enhance data collection by ACF on issues pertaining to effective implementation of ICWA, including collection of data elements related to key ICWA requirements in individual ICWA cases and greater oversight of the Title IV-B requirement for states to consult with tribes on measures to comply with ICWA.*
2. *Administrative procedures and policy changes should be made that require action and follow-up by ACF in states where there is knowledge of ICWA non-compliance. When ACF becomes aware of ICWA non-compliance, they should work with the selected states and tribes within those states to develop clear action steps to address non-compliance and follow-up should be continuous until compliance has been met.*
3. *Work with tribal governments and national Indian organizations with expertise in this area to develop improved technical assistance and training to help states effectively implement ICWA on an ongoing basis.*
4. *Consult with tribes on efforts between the Department of Justice (DOJ), Department of Interior (DOI), and DHHS regarding the Attorney General's ICWA initiative. The Attorney General's ICWA initiative acknowledges the need for greater federal collaboration on efforts to ensure compliance with ICWA and the disastrous effects that ICWA non-compliance has had on AI/AN children, families, and communities.*

Current Status of Issue:
State compliance with the Indian Child Welfare Act (ICWA) is an ongoing issue of concern for many tribes. While HHS does not have jurisdiction to enforce compliance with ICWA, it does administer and provide oversight for other federal child welfare programs authorized by titles IV-B and IV-E of the Social Security Act. Federal law requires that state title IV-plans (also called "Child and Family Services Plans") contain a description, developed after consultation with tribes, of the specific measures taken by the state to comply with the ICWA. A number of activities are underway, both in HHS and in other federal agencies, relating to ICWA.

Response:

1. *Enhance data collection by ACF on issues pertaining to effective implementation of ICWA, including collection of data elements related to key ICWA requirements in individual ICWA cases and greater oversight of the title IV-B requirement for states to consult*

with tribes on measures to comply with ICWA.
On February 9, 2015, ACF issued a Notice of Proposed Rulemaking (NPRM) to revise the Adoption and Foster Care Analysis and Reporting System (AFCARS), the major source of national data on children in foster care or who are adopted from the foster care system. The NPRM, as published, did not propose to collect data on ICWA. However, given the strong ongoing interest in this issue, ACF intends to seek additional input from states and tribes on whether and how to collect such information relating in AFCARS.

2. *Administrative procedures and policy changes should be made that require action and follow-up by ACF in states where there is knowledge of ICWA non-compliance. When ACF becomes aware of ICWA non-compliance, they should work with the selected states and tribes within those states to develop clear action steps to address non-compliance and follow-up should be continuous until compliance has been met.*
The Children's Bureau is in the process of compiling a report summarizing state responses to the portion of the Child and Family Plans focused on ICWA. The Children's Bureau will share this report with tribes and states as a means to identify any best practices and areas for improvement. In addition, in instances where we become aware of significant concerns with state practice in terms of consulting and collaborating with tribes and/or assessing and describing compliance with ICWA in the Child and Family Services Plan, the Children's Bureau is working with states to improve their practices and is seeking to facilitate improved communication between states and tribes, where possible.
3. *Work with tribal governments and national Indian organizations with expertise in this area to develop improved technical assistance and training to help states effectively implement ICWA on an ongoing basis.*
The Children's Bureau is in the process of launching a new technical assistance structure, involving three capacity-building centers, to work with state child welfare agencies, tribes, and courts. ICWA will be among the issues to be addressed by the new centers as part of their work.
4. *Consult with tribes on efforts between the Department of Justice (DOJ), Department of Interior (DOI), and DHHS regarding the Attorney General's ICWA initiative. The Attorney General's ICWA initiative acknowledges the need for greater federal collaboration on efforts to ensure compliance with ICWA and the disastrous effects that ICWA non-compliance has had on AI/AN children, families, and communities.*
HHS is participating in a workgroup with representation from the Departments of Justice, Interior, and HHS to explore how the agencies can work together to improve understanding of and compliance with ICWA. The group is in its early stages of work. We will share additional information as the work of the group progresses this spring.

Point of Contact: Joo Yeun Chang, Associate Commissioner, Children's Bureau, ACF
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IMPLEMENTATION OF THE FUTURE OF CHILD CARE DEVELOPMENT BLOCK GRANT TRIBAL SET ASIDE:

The Child Care Development Block grant was reauthorized by Congress in November 2014. Importantly, the new law includes language increasing the Tribal set-aside for this program. Before the set aside was a maximum of 2 percent for Tribes, now it is "not less than 2 percent" meaning that is the minimum that could be set-side. We recommend that the Secretary Burwell continue the trend of providing the maximum amount allowable to tribes under CCDBG and increase the FY 2015 reserved amounts above the required 2% for tribal governments.

Current Status of Issue:

The new law establishes a discretionary set-aside of not less than 2 percent. The prior law limited the discretionary set-aside to up to 2 percent. In light of the needs in tribal communities, the Office of Child Care (OCC) increased the Tribal Child Care and Development Fund (CCDF) Discretionary set-aside from 2 percent to 2.5 percent for FY 2015, which allows tribes access to an additional $12 million. This increase recognizes the crucial role that CCDF plays in tribal communities in offering child care options to parents who are working or pursuing education/training while at the same time promoting learning and development for children.

Response:

While many of the new provisions clearly apply to states and territories, the law does not explicitly indicate the extent to which they apply to tribes. The Office of Child Care (OCC) will conduct consultation with tribal leaders and CCDF administrators before issuing regulations and policy guidance on how the provisions in the new law will apply

to tribes. OCC is planning to begin a series of formal consultations, conducted in accordance with ACF's Tribal Consultation Policy. The new law establishes a Discretionary set-aside of not less than 2 percent. The prior law limited the Discretionary set-aside to up to 2 percent. In light of the needs in tribal communities, OCC increased the Tribal CCDF Discretionary set-aside from 2 percent to 2.5 percent for FY 2015, which allows tribes access to an additional $12 million.

This increase recognizes the crucial role that CCDF plays in tribal communities by offering child care options to parents as they move toward economic self-sufficiency, and in promoting learning and development for children. As we determine how the specifics of the new reauthorization law apply to tribes, we anticipate that tribes will use the additional funding provided in FY 2015 to begin working towards the overall goals of reauthorization by strengthening health and safety requirements, improving the quality of care, and promoting family-friendly subsidy policies. As part of the upcoming consultation sessions, we would like to seek tribal input on the funding level for future years.

Point of Contact: Rachel Schumacher, Director, Office of Child Care, ACF
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PUB. L. 102-477 IMPLEMENTATION

Since 1992, the 477 program has allowed tribes and tribal organizations to consolidate programmatic employment related funding from the Departments of Interior, Health and Human Services and Labor, while streamlining program approval, accounting and reporting mechanisms, thus offering a model for Administrative Flexibility. The law empowers tribes and tribal organizations with the ability to increase efficiency, decrease administrative burden, increase self-determination and ensure superior results than their counterparts at the state and county level, all while maintaining program guidelines. Streamlined funding for 477 Plans through transfers under the provisions of the Indian Self-Determination and Education Assistance Act ("ISDEAA") has been an essential element of the success of the 477 Program. IHHS programs, including TANF, Child Care and Native Employment Works are important components of this successful program. The STAC respectfully urges the Secretary to use your administrative powers to take steps that will fulfill the promise of this important tool for AI/AN success in moving people from welfare to work, such as:

1. *Remove new guidance requiring one or two years of managing a program and three previous clean audits (already required by the 477 Initiative) before inclusion into a tribe's 477 Plan.*
2. *Assure in writing that funds will continue to be transferred through ISDEAA contracts and compacts.*
3. *Return to reporting mechanisms that worked so well prior to 2009, and permanently rescind the 2009 Compliance Circular.*
4. *Include other eligible programs into 477, such as LIHEAP, Community Services Block Grant, Tribal Vocational Rehabilitation, and Head Start.*
5. *Support enactment of H.R. 329, a bill that will amend the Indian Employment, Training and Related Services Demonstration Act of 1992 to facilitate the ability of Indian tribes to integrate the employment, training, and related services from diverse Federal sources, and for other purposes.*

Current Status of Issue

The tribes and federal partners have worked together for the past several years and have made significant progress addressing many of the concerns tribes raised with respect to Pub. L. 102-477 demonstration projects. We have always said we must find a way to balance the need for flexibilities in order to accomplish the goals of 477 projects with the fiscal responsibilities our stewardship of taxpayer funds requires.

On January 24, 2014, the 477 Work Group agreed to conclude deliberations on the pending issues in disagreement and to move forward with new reporting forms and instructions to the Paper Work Reduction Act (PRA) review process, as well as a concurrent tribal consultation. This represents a significant win for all parties. Tribes will have consistency in the way in which 477 projects are reviewed and will be able to tell their stories through more flexible reporting. The federal partners benefit from strengthened relationships across DOI, HHS, and DOL, and will have greater assurance that 477 funds are being spent in the best interest of tribal members. The initial comment period for the report forms ended on April 15, 2014, and a Tribal Consultation was held during the week of March 13, 2014, where tribes had the opportunity to provide written and oral testimony for consideration.

Our joint, collaborative efforts have resulted in significant accomplishments, including more streamlined financial and narrative reporting intended to help tribes tell the story of how they are assisting their people.

- We have developed a checklist to help facilitate the process of reviewing proposed 477 Plans, and we are making it possible for tribes to submit a single 477 plan rather than needing to submit separate 477 and TANF plans.
- We have completed a revised statistical report and instructions.
- We have developed a narrative report with instructions that provide an opportunity for the tribes to tell the story of how their 477 funds are used.
- We have developed a financial reporting form with instructions that gets away from dollar-for-dollar reporting and moves to reporting based on functional categories like child care and education, employment, and training services, for example.
- We have identified flexibilities within the law to allow tribes to consolidate a significant amount of their 477 funds for the purpose of supporting economic development.
- We have fostered a much improved and more trust-based relationship between the tribes and the federal partners.

We have not accomplished all that the tribes have wanted. But, we did agree to move forward to consultation and review with the materials we have developed. As we move forward we will build on our new relationships by convening regularly to update materials as needed and to hear from the tribes about their suggested improvements to the program.

As instructed by Congress in the most recently passed Consolidated Appropriations Act, we have worked with our colleagues at DOI and other agencies of government on a report that DOI was charged with submitting that outlines the many accomplishments we have made, an explanation for why we could not come to full agreement of several outstanding issues, and laying out path forward to regular communications on 477 issues with the tribes. This report was submitted in April. In mid-August, the federal partners came together to discuss comments submitted by the tribes during the public comment period on the newly proposed report forms. Our partners at DOI worked to finalize all of the forms for submission to OMB. In November, the tribes requested additional time to comment on the proposed report forms and DOI granted that request. The proposed forms went through a second round of comments, and that comment period ended in late January. We are now awaiting the OMB process for final approval.

Point of Contact: Nisha Patel, Director, Office of Family Assistance, ACF
Nisha.patel@acf.hhs.gov

TRIBAL STATE RELATIONS/SECRETARY SEBELIUS' DEAR GOVERNOR'S LETTER

1. *Send a follow up letter to Governors about expectation that states consult with Tribes, specifically regarding the Indian Child Welfare Act.*

Current Status of Issue

On April 29, 2013 ACYF Commissioner Bryan Samuels sent a letter emphasizing the importance of states and tribes to work together and to engage in "meaningful consultation around the delivery of child welfare services and the measures taken by each state to comply with the Indian Child Welfare Act (ICWA)." Additionally, the Children's Bureau is conducting an analysis of state and tribal IV-B plans to assess coordination on ICWA implementation. Results of this analysis should be available in a few weeks. It would be helpful to reference report findings in a Governor letter.

Response:

HHS is currently conducting analysis of state and tribal IV-B plans to assess ICWA implementation and planning a retreat with DOJ and DOI to identify how all three agencies can work together to promote ICWA implementation in the states. HHS will suggest to DOJ and DOI that all three agencies send a join letter to the Governors, waiting until the retreat will also allow us to reference our analysis of ICWA implementation in the letter we send to Governors. ACF is recommending that to make the letter more meaningful, we send a joint letter from the three agencies involved with ICWA implementation.

Point of Contact: Stacey Ecoffey, Principal Advisor for Tribal Affairs, Office of Intergovernmental and External Affairs Stacey.Ecoffey@hhs.gov

ISSUES NOT RAISED DIRECTLY WITH THE SECRETARY BUT IN THE LETTER

TRIBAL EXEMPTION FROM THE EMPLOYER MANDATE UNDER THE ACA

Under the Internal Revenue Service's (IRS) employer mandate rules, a Tribe would be required to offer and pay for insurance for tribal members who are tribal employees, even though they are exempt from the individual mandate to buy insurance under the ACA. An offer of coverage, though, will disqualify tribal member employees from the premium subsidies on the Exchanges. If they comply with the mandate, they will be required to purchase insurance coverage for Tribal member employees who are otherwise exempt and disqualify those tribal members from the benefits for Indians in the Exchanges. If they choose not to comply with the mandate, they will be forced to pay significant IRS tax penalties. Tribes are being forced to pay for health care for their Tribal members simply because they are employed by the Tribe. CMS has been actively encouraging Tribes to enroll their members in the Exchanges, but the IRS employer mandate works at cross purposes to this policy by disqualifying Tribal members who are employees of the Tribe from enjoying the benefits of the Exchanges. To address this concern, Tribes request that:

1. *The Department of Health and Human Services (HHS) work with the IRS to exercise its legal authority to provide a categorical relief for Indian Tribes, Tribal organizations, and Urban Indian Organizations from the employer mandate.*

Current Status of Issue

The Northern Arapaho Tribe (NAT) recently filed a lawsuit against the Department of Health and Human Services (HHS) and the Internal Revenue Service (IRS) within the Department of the Treasury arguing that the employer mandate was not applicable to tribal employers. In rejecting the Tribe's motion for a preliminary injunction, the court found that the tribal employers were unambiguously employers within the meaning of ACA's statutory scheme. The court concluded that IRS's regulations that included Indian tribes as employers were consistent with Congress' intent. The court recognized the dilemma faced by NAT, but found that the dilemma the tribe was faced with was also Congress' intent, not just for tribal employers, but for all employers. The court also suggested that granting the preliminary injunction could most harm NAT's non-Indian employees, who would be required to carry health coverage, but would not be able to obtain it from their employer.

Response:

HHS and IRS collaborated extensively on the development of regulations implementing the ACA, and HHS has pursued regulatory relief when the relief is warranted, and the Department finds the authority. For example, HHS promulgated a regulatory hardship waiver from the individual shared responsibility payment for Indian Health Service beneficiaries who are not members of federally-recognized tribes. The concerns raised by Indian tribes here about the employer mandate, however, are concerns about the ACA itself. HHS recognizes that the statutory employer mandate poses a dilemma for Indian tribes, but it is a dilemma intended by Congress to apply to large employers, including Indian tribes.

Point of Contact: Stacey Ecoffey, Principal Advisor for Tribal Affairs, Office of Intergovernmental and External Affairs
Stacey.ecoffey@hhs.gov

MEDICARE-LIKE RATES FOR NON-HOSPITAL PROVIDERS:

As announced at the December meeting, the Indian Health Service issued a proposed rule on December 5, 2014 that would expand the Medicare-Like Rate cap for Purchased/Referred Care payments to non-hospital providers. The expansion of Medicare-Like Rate payment caps to care purchased from non-hospital providers would result in significant savings to IHS and tribal Purchased/Referred Care programs, who still often must pay full billed charges for those services. Request:

1. *Given the significance of this proposal, the IHS and the Department must allow for meaningful and complete Tribal consultation before finalizing any rule.*

Current Status of Issue

In 2007, IHS published a final rule adopting MLR for hospital services using payment methodologies established for the Medicare program. GAO report 13-272 recommended capping payment rates to physicians and non-hospital providers and estimated a potential savings to the IHS of $32 million annually. The MLR cap is a budget-neutral

mechanism to the IHS that will allow the PRC program to save millions of dollars and increase the care they are able to provide through the PRC program. The Director's Workgroup on Improving Purchased/Referred Care and Tribal consultation responses support capping payment rates to physicians and non-hospital based providers.
The IHS requested comments on how to establish reimbursement that is consistent across Federal health care programs, aligns payment with inpatient services, and enables IHS to expand beneficiary access to medical care and whether it should be allowed to negotiate a rate higher than the MLR. IHS received 54 comments to the proposed rule.

Response:
Now that the comment period has closed, IHS will review the 54 timely comments and take action based on the comments. Many of the comment discuss possible exceptions or alternatives to avoid loss of access to a provider. In accordance with the IHS Consultation Policy, IHS will develop the final regulations with active Tribal participation. To implement the rule, IHS will develop and offer comprehensive training and assistance for PRC programs to transition to the new payment methodologies. MLR savings will be used to pay for other services that the PRC program currently is unable to fund.

Point of Contact: Carl Harper, Director, Office of Resource Access and Partnerships, IHS
Carl.harper@ihs.gov

PROVIDING A COMPLETE REPORT ON TRIBAL APPLICATIONS FOR HHS COMPETITIVE FUNDING
The Department has made great strides in creating and monitoring the grants matrix, which served to educate both tribes and HHS programs about the array of opportunities available for Tribes and tribal organizations that are not specific to Native programs. The STAC has requested several times for a follow up report that demonstrates how many tribal applications were submitted and how many were granted in other departments, what has been the outreach, and what are the results. HRSA and SAMHSA both provided information at the last STAC meeting about the increase of funding and applicants, but the other departments did not. Request:

1. *Please provide this report, as well as reports from the tribal advisory groups for the agencies under HHS.*

Current Status of Issue
The ICNAA previously worked on increasing Grants Eligibility for Tribes across HHS which led to the development of the Grants Eligibility Matrix. The matrix is a large tool to determine which HHS funding opportunities are open to Tribes. The most current version of the Grants Eligibility Tool can be found at the following website: http://www.hhs.gov/iea/tribal/. The matrix is a highly intensive manual document. The next steps are to collect more up to date information and identify methods to obtain the data electronically to reduce the intensity of the collection process. By reducing the data collection process, HHS hopes to post the information on a timelier basis and improve the data monitoring process. Some highlights of the work intended for the upcoming year are included below:

1. The ICNAA is also working on developing a Tribal portal for information on HHS grants. The website will be developed to:
    a. Identify and simplify the grant reporting process;
    b. Provide a centralized location for grant information for Tribes.
2. The ICNAA will also work on improving the grant review process at HHS including identifying best practices for recruiting AI/AN reviewers for grant review processes across HHS. In addition, the ICNAA is currently exploring developing a single source database for all AI/AN reviewers for use across the agencies within HHS.

Response:
As a way to measure the impact of this work, the ICNAA is currently developing appropriate impact indicators. The STAC recommendation to create a report that demonstrates how many tribal applications were submitted and how many were granted in other departments is a great example of a measure we can utilize to determine the impact of our work. Currently as it stands, the data systems (Grants.gov, TAGGS, etc) HHS has in place are not aligned with one another and do not provide accurate data across agencies. Since there is an alignment issue between the two systems, the ICNAA must determine how to improve data collection of applications received in Grants.gov and ensure that

once awarded that grantees are appropriately categorized within TAGGS. The ICNAA will identify a team to lead the work on developing a more streamlined approach to collecting application data and ensuring HHS data systems align with regards to Tribal categorization.

Point of Contact: Lillian Sparks Robinson, Commissioner, Administration for Native Americans and Chair, Intradepartmental Council on Native American Affairs
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IMPROVING AND MAKING CONSISTENT THE IMPLEMENTATION OF THE DHHS TRIBAL CONSULTATION POLICY

The DHHS Tribal Consultation Policy was established in 2010 as a compliment to the President's 2009 Executive Memorandum regarding tribal consultation. The DHHS Consultation Policy outlines the principles and procedures for ensuring an effective government-to-government relationship between tribal nations and DHHS. Several operating divisions within DHHS also have their own tribal consultation policy documents as well.

While the documents provide the necessary guidance, implementation has been inconsistent between operating divisions. During interactions with agency staff, tribal nation representatives have become aware of the lack of awareness of the policies and their capacity to carry out the requirements. For example, in some operating divisions consultation is viewed very narrowly in terms of when it needs to be carried out and how it is conducted. In these places, posting proposed rule changes in the Federal Register is considered to be all that is required to meet the consultation policy requirements or consultation is considered to only be required when the issues are specific to tribal grantees as opposed to impacts upon AI/AN children and families in general. These narrow definitions of how the consultation policy applies have led to numerous policies and issuances being developed with little, if any, tribal consultation over the last few years. Subsequently, the resulting policies and issuances provide little guidance on how to address tribal issues or concerns.

1. *We recommend immediate and mandatory training for all DHHS staff on the requirements of the DHHS Tribal Consultation Policy and consultation with STAC and other DHHS advisory groups on how to interpret the policies in individual circumstances involving DHHS operating agencies.*

Current Status of Issue

IEA is the principal office responsible for carrying out HHS intergovernmental consultation responsibilities for state, local and Tribal governments. A Department Tribal Consultation Policy was developed jointly with Tribal participation in 2005. It was then evaluated and revised in 2008. In December 2010 HHS Secretary Kathleen Sebelius signed the new and improved Tribal Consultation Policy that was in direct response to President Obama's November 2009 Executive Memorandum. Additionally several Operating Divisions within HHS have Tribal Consultation Policies of their own that mirror the HHS Tribal Consultation Policy. The following agencies have Tribal Consultation Policies:

1. Administration for Children and Families
2. Centers for Disease Control and Prevention
3. Centers for Medicare and Medicaid Services
4. Health Resources and Services Administration
5. National Institutes of Health
6. Substance Abuse and Mental Health Services Administration

Response:

The concern regarding the incorrect implementation of the consultation policy across HHS is a newly raised issue. IEA and ICNAA will take the lead on utilizing existing training (GoLearn through OPM) to ensure each agency is implementing the HHS policy as well as their own agency policy correctly. In addition we will begin hosting internal quarterly calls about the HHS consultation policy to ensure appropriate education and implementation of the policy.

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SELF-GOVERNANCE TITLE VI PROPOSAL

In 2000, P.L. 106-260, included a provision for designating HHS to conduct a study to determine the feasibility of a demonstration project (Title VI) extending Tribal Self-Governance within the authority of the Indian Self-Determination and Educational Assistance Act of 1975 to HHS agencies other than the Indian Health Service (HIS). The HHS Study, submitted to Congress in 2003, determined that a demonstration project was feasible. Self-Governance represents efficiency, accountability and best practices in managing and operating Tribal programs and administering Federal funds at the local level. Expanding Self-Governance translates to greater flexibility and efficiency with federal resources for Tribes to provide critical social services within agencies such as the Administration on Aging, Administration on Children and Families, Substance Abuse and Mental Health Administration, and Health Resources and Services Administration. The Self Governance Tribal Federal Workgroup (SGTFW) provided evidence in the success of the governance concept and made great strides in identifying a way forward in this federal-tribal partnership and process. Leaving the work undone and the goal unreached is unacceptable to the Tribes. We appreciate your open and interactive approach and we believe re-establishing a workgroup on this most important subject is in accord with this concept and approach. Tribes firmly believe that a pilot initiative would constructively advance the federal-tribal partnership. Request:

1. *We request that a renewed Tribal Federal workgroup be established to continue the work left undone (Pilot Title VI of ISDEA) at the cessation of the Self Governance Tribal Federal Workgroup (SGTFW) two years ago.*

Current Status of Issue

HHS understands the request of the STAC to establish or reinstated a SGTFW that would continue work that the tribal representatives perceive to be undone. HHS has taken the position that the establishment of another workgroup would not be beneficial to moving this issue forward to implement a self-governance demonstration project. HHS has concluded that there is no existing legal authority that would permit a tribal self-governance demonstration project.

We know that the Tribal SGTFW workgroup members as well as the Tribal Self-Governance Advisory Committee of the Indian Health Service (IHS) have expressed disappointment with our current position that we cannot advance self-governance in their preferred way without new statutory authority. In addition, as members of SGTFW know, part of HHS' review with identified programs at ACF, SAMSHA and ACL, numerous legal, logistical, and design barriers to implementation of a self-governance demonstration project under an ISDEAA model were identified.

Response:

HHS representatives, on several occasions over the past two years, have offered other suggestions to the STAC on ways that we could advance the conversation with the respective affected agencies, in particular with ACF and SAMSHA. The current position of HHS is reinstating or developing a new a SGTFW would not be beneficial without the fully understanding that HHS cannot move forward with an ISDEA model of self-governance in other HHS agencies. We have continued to support any discussions between the STAC/Tribal leaders and the pertinent agencies to discuss this issue further. We strongly encourage the STAC to meet with the leadership of these agencies to develop a path forward.

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