DEPARTMENT OF HEALTH AND HUMAN SERVICES

SECRETARY'S TRIBAL ADVISORY COMMITTEE

October 15, 2015

Secretary Sylvia Mathews Burwell
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Re: Secretary's Tribal Advisory Committee Follow up items from September meeting

Dear Secretary Burwell,

On behalf of the Secretary's Tribal Advisory Committee (STAC), we thank you and your staff for the productive meeting that was held from September 15-16, 2015. The agency's willingness to hear our concerns and address key issues in a responsive, and frank manner is always appreciated and we look forward to working with you to advance many of these priorities in the months to come.

The following letter presents the STAC's key issues from the September meeting. While there are many other topics that are important, these we feel are the top priorities.

Inter-Agency and Inter-Departmental Cooperation

In June 2013, President Obama announced the establishment of the historic White House Council on Native American Affairs. According to Executive Order 13647 which created this body, "The Council shall improve coordination of Federal programs and the use of resources available to tribal communities." Yet, two years later, Tribes still experience federal departments that do not appear to be coordinating in several key areas including alcohol and substance abuse; marijuana policy; implementation of the Employer Mandate under the Affordable Care Act; implementation of P.L. 102-477 programs; and Indian Child Welfare Act enforcement.

- Please provide STAC with information on how HHS works with other agencies to address issues that are cross-departmental such as the Affordable Care Act (ACA) employer mandate and excise tax, alcohol and substance abuse, suicide prevention, and implementation of the ACA.
- How can Tribes be more heavily involved in the actions of the agencies to work jointly to administer federal programs to Indian Country?
- How can STAC and other Indian Country tribal leaders interact directly with the White House Council on Native American Affairs and its subcommittees?

Mental Health and Suicide Epidemic

In the STAC's follow-up letter to our June meeting, dated June 30, 2015, the Committee expressed several priorities and concerns relating to effective treatment and prevention of mental health in Indian Country. We listed priority areas such as implementation of traditional healing methods, deployment of Commissioned Corps officers to Indian Country for mental health and additional research on the impacts of historical trauma in Tribal communities. We also noted inter-departmental and inter-agency coordination as key concerns for addressing this epidemic in Indian Country.

We appreciate the detailed and thoughtful response given by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the response letter provided to the STAC on September 16, 2015, however, STAC was hoping to also hear responses from other Department of Health and Human Services (HHS) agencies who have jurisdiction over these key issues (such as the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), National Institutes of Health (NIH), and the Indian Health Service (IHS)). This only serves to emphasize our request that the Secretary exercise her authority to break down silos within HHS, to increase flexibility in use of program funds and lessen the tribal administrative burden to permit tribal control, and to decrease the conveyance of funds by competitive grant to the fullest extent possible. As the Tribal advisory committee for all of HHS, STAC requests that responses are conducted in a coordinated, and thoughtful way by all relevant agencies of jurisdiction.

- We request that STAC receive responses from all relevant agencies of jurisdiction on suggestions made in the June 30, 2015 letter to HHS.
- Can HHS detail how it plans to address mental health/ suicide crisis in Indian Country through inter-agency cooperation?
- How can tribal leaders work with HHS break down barriers between agencies and departments to ensure that the mental health crisis in Indian Country is being tackled from all areas of the federal government?

Arizona Medicaid Expansion Waiver – Centers for Medicare and Medicaid Services

In March, Arizona passed SB 1092, which will require the Director of Arizona's Medicaid program, Arizona Health Care Cost Containment System (AHCCCS), to apply for an 1115 waiver to the Centers for Medicare and Medicaid Services (CMS) by March 30 of each year for permission to institute cost-sharing requirements, work requirements and lifetime limits for adults receiving AHCCCS benefits.

Some of the requirements of SB 1092 include the following:

1. Institute a work requirement for all able-bodied adults receiving AHCCCS services, excluding long term care, to become employed, actively seek employment, attend school or a job training program, or both at least 20 hours a week, and to verify compliance with this requirement and any change in family income.
2. AHCCCS will verify when a person is seeking employment and to confirm changes of family income and re-determine eligibility for services
3. AHCCCS can ban an eligible person for one year if the individual knowingly fails to report family income changes or makes a false statement regarding work related requirements
4. Place a five-year lifetime limit of benefits on able-bodied adults that begins on the effective date of the waiver or amendment to the current waiver, excluding any previous time a person received AHCCCS benefits.

These requirements will have lasting negative and devastating impacts on the American Indian population in Arizona and adversely affect 100,000 Tribal members in Arizona who are currently enrolled in the AHCCCS, as there are few job opportunities and employment resources for Tribes in Arizona. Imposing these requirements on the most impoverished areas in the State only compounds the hopelessness and lack

of adequate health care that prevail. In the response letter provided to STAC, CMS noted that the waiver was currently undergoing review. However, we believe that this review should absolutely include thorough and meaningful Tribal consultation.

- Please comment on CMS' plan to consult with Tribes in Arizona as they review the implications of this 1115 waiver request by the state of Arizona.

Federal Medical Assistance Percentage (FMAP) Expansion

The States of South Dakota and Alaska have submitted proposals asking CMS to expand the current policy on 100% FMAP to Purchased & Referred Care (PRC). CMS has conducted two All Tribes Calls and held a consultation session the National Indian Health Board's Annual Conference in September 2015. During these consultation sessions, CMS explained that Alaska has requested 100% FMAP for emergency and non-emergency medical transport and transportation-related expenditures as well as for services provided through PRC referrals; and that South Dakota has requested 100% FMAP for telehealth services, specialty services provided through collaborative arrangements, and services provided by community health representatives. We applaud CMS for reconsidering its past policy position that 100% federal reimbursement only applied to care provided inside the four walls of IHS facilities. Section 1905(b) of the Social Security Act provides that it applies to all services "received through," the IHS or tribal health facilities, and the PRC program is a program provided through the IHS and tribal health facilities. Expanding CMS's existing interpretation to cover PRC services will benefit IHS and Tribal health programs by allowing States to expand coverage for AI/ANs, either by covering additional population groups or additional services.

- We respectfully request that CMS approve the 100% FMAP proposals for Alaska and South Dakota, as well as the rest of the Indian health system.

Employer Mandate in the Affordable Care Act

Tribal governments continue to seek relief from the employer mandate in the Affordable Care Act. The Employer Shared Responsibility Rule, otherwise known as the Employer Mandate, states that all employers must offer health insurance to their employees or pay a penalty. Tribal governments are currently counted as large employers for application of this rule. American Indians and Alaska Natives (AI/ANs) are exempt from the Individual Mandate to purchase health insurance. This is in recognition of the fact that AI/ANs should not be forced to purchase healthcare that is obligated by the federal government's trust responsibility and which is delivered through IHS. Requiring Tribal employers to provide AI/ANs with such coverage anyway, and penalizing them if they do not, functionally invalidates the AI/AN exemption from the individual mandate by shifting the penalty from the individual to the Tribe itself.

While the vast majority of Tribal employers have always provided health insurance to employees, and will continue to do so, for several Tribal employers, this is an impossible choice. Because Tribes do not have the luxury of raising prices or taxes to offset costs, many Tribes are left deciding to lay off workers, cut services, or pay unaffordable fines. STAC recognizes that the HHS and the Department of Treasury

both have jurisdiction over this issue, and therefore, encourage HHS to take the lead in initiating an inter-departmental effort to provide relief for Tribes.

While the Internal Revenue Service (IRS) does not believe it has the legal authority to issue such an exemption through the regulatory process, tribes believe HHS and IRS possess all necessary authority to interpret provisions of the ACA favorably for tribes that would fully or partially mitigate the consequential burden on tribes that was unintended by the Congress. The recent district court decision in *Northern Arapaho Tribe v. Burwell* (Case No. 14-CV-247-SWS) that noted the employer mandate does apply to Tribes is both not directly on point and represents the significantly high threshold that must be overcome for a court to overrule the administration's interpretation of statute. The HHS and IRS and tribes in consultation may collaborate to implement the ACA through readily applicable interpretations of its provisions in regulation without injuring tribal interests by issuing a clarifying regulation.

- STAC requests the HHS and IRS work together in consultation with tribes to clarify regulations that appropriately interpret Tribal employers in the Employer Mandate in the Affordable Care Act.
- We request that HHS and IRS collaborate to delay the enforcement of the employer mandate provision for one year so that there is more time for the agencies to consult with Tribes and determine a path forward.

Winnebago Service Unit CMS Certification Termination

On July 23, 2015, CMS terminated certification for the Winnebago Service Unit which serves the Winnebago and Omaha Tribes, making the facility ineligible to bill Medicare or Medicaid for services provided. This CMS termination was a direct result of the findings of a series of successive CMS investigations into the IHS's management and operation of this facility. In fact, during the course of successive CMS surveys, there were deaths at the hospital which CMS found to be directly related to the Winnebago Hospital's failure to provide adequate medical care.

All of Indian Country stands in unity with the Winnebago and Omaha Tribes as they seek to find a solution to this problem. It is nothing short of unacceptable that American Indians and Alaska Natives should have to suffer this standard of care at the hands of an IHS-run hospital. STAC calls upon the Indian Health Service working with HHS and CMS to take all necessary steps to correct deficiencies at the Winnebago Hospital, keep the Winnebago and Omaha Tribes fully informed of its plans and actions, and to include the Tribes as fully as they wish to be in all aspects of the operation and improvement of the Winnebago Hospital, including the financial status of the Hospital.

- Please provide a detailed outline of how HHS will exercise its leadership to coordinate an improvement plan at the Winnebago Service Unit so that no person's life is put at risk again.
- STAC requests regular updates to Tribes of any information or assessments it may have regarding any deficiencies, risks to certification, consideration of substantive changes in operations, or other matters that could affect quality of care at, access to, and financial viability of, any other hospital operated by the Indian Health Service.

Employee Contract Settlement – Indian Health Service

On May 22, Acting Director of the IHS Principal Deputy Director Robert McSwain notified Tribes that the Indian Health Service had reached an agreement with employee unions. On July 29, an update letter was sent by IHS to the Tribes. In the response to STAC on September 16, IHS noted that most of the settlement payment was borne largely by the service units. While STAC recognizes the need to provide settlement funds, Tribes where the facilities are in question are still concerned about the amount of funds that would be used to pay the settlement. Tribes are also concerned about what purpose the extra funds were intended to be used for at the service unit level when IHS is funded at only 59% of actual need.

- Please provide a detailed account about where the settlement funds came from, and the response each unit provided IHS of what each service unit had intended the unobligated balances to be used for.

Contract Support Costs – Indian Health Service

The STAC is highly encouraged by the actions of the Administration to move forward on full-funding of contract support costs (CSC). The budget proposal this year to enact mandatory appropriations for CSC is an important first step in ensuring that these costs are fully funded. The IHS' CSC workgroup has also been working to come to an agreement on how we work on issues around incurred cost mythology. Tribes would like to initiate a pilot project to would allow agency to determine best way to reconcile CSC on a contract by contract basis and consider imposing CSC for 3-5 years.

- Please discuss the feasibility of this suggested pilot project and how we can move forward in a collaborative way.

Marijuana Policy

As noted in our previous letter, Tribes continue explore pathways to pursuing both medical and recreational marijuana enterprises on Tribal lands. Congress has provided that states are free to regulate in the area of controlled substances, including marijuana, provided that state law does not positively conflict with the Controlled Substances Act (CSA) (21 U.S.C. § 903). States have not "legalized" medical marijuana, but instead exercised each state's reserved powers to not punish certain marijuana offenses under state law when a physician has recommended its use to treat a serious medical condition.

State laws qualify for prosecutorial discretion from the U.S. Department of Justice (DOJ) when robust regulatory regimes are implemented, and not all states regulations are suitable in the view of DOJ. DOJ issued memoranda and guidelines for tribes, postulated as eight law enforcement priorities directed to marijuana activities on tribal lands, however, these application of these priorities remains unclear, especially in the context of consequences for tribes' HHS funding, and tribes continue to seek specific answers from HHS and DOJ. We appreciate your response that the Department of Justice has primary jurisdiction on enforcement and are encouraged by your confirmation that Tribal HHS would not be adversely impacted if they operated a marijuana grow or dispensary on Tribal lands as long as federal funding was not used. The 2011 letter from IHS Chief Medical Officer issued "findings" on the medical uses of marijuana. These "findings" mischaracterized applicable law in a "finding" that under Article 6 of the Constitution, States are violating federal law by legalizing medical marijuana, and in asserting that

health care providers at IHS-funded facilities would not be covered by the Federal Tort Claims Act (FTCA) if they failed to meet the requirements of the Controlled Substances Act. This statement does not accurately reflect the case law on applicability of the FTCA. HHS has a key role in how a drug can be rescheduled in the CSA. HHS FDA would recommend rescheduling and provide a scientific and medical evaluation of the drug. The Drug Enforcement Administration (DEA) must find that the drug does not meet the requirements for inclusion in any schedule. DEA would then engage in rulemaking to remove or reclassify the drug from its schedule. In 2011, the Governors of the states of Washington and Rhode Island petitioned HHS to have marijuana rescheduled as a Schedule II drug.

- STAC urges HHS to engage in conversations with DOJ to determine how it would enforce marijuana on Tribal lands.
- STAC also encourages HHS to engage jointly with DOJ in Tribal consultation with those Tribes who intend to legalize marijuana.

Implementation and Expansion of P.L. 102-477

Since 1992, the 477 program has allowed Tribes and tribal organizations to consolidate programmatic employment related funding from the Departments of Interior, HHS, Labor, while streamlining program approval, accounting and reporting mechanisms, thus offering a model for Administrative flexibility. The law allows for increased efficiency, decreased administrative burdens, and empowers self-determination. STAC was pleased to hear the agency confirm that the Community Services Block Grant is eligible for the 477 program. However, we were disappointed to hear that HHS considers LIHEAP and Head Start funds to not be eligible for 477.

- Please provide legal justification as to why the determination was made not to add LIHEAP and Head Start to the 477 program.

Head Start – Administration for Children and Families

Head Start programs provide vital services to Tribal communities, despite the fact that only 16 percent of age-eligible Indian child population is enrolled in Head Start. Only about 188 Tribes have access to the program, and few of those programs actually have sufficient funding to implement the necessary program improvements that would result in better outcomes for our young people. The Indian Head Start programs are on the frontline in the struggle to preserve Native language and culture, which have proven to be key elements in Native student confidence and success in later years.

STAC echoes the recommendations of the National Indian Head Start Directors Association outlined in their Comments on RIN 0970-AC63, "Head Start Performance Standards." These recommendations include concern over the loss of slots that will occur due to the cost of the Proposed Rule's mandates, particularly, the full-day and full-year requirements. Several of the proposed requirements are not compatible with distinct cultures and needs of our communities. Several areas are drafted in a state-centered way, creating requirements that are not consistent with the unique government-to-government relationship between Tribes and the federal government. Finally, the Indian Head Start Directors Association and STAC are concerned that several provisions in this Proposed Rule call for research-based practices, yet research-based practices have not been developed for AI/AN communities and existing research has excluded AI/AN children and families.

- We urge the Office of Head Start to revise the Proposed Rule so that it is compatible with the distinct needs of Indian Head Start programs and adopt Indian-specific exemptions where appropriate.
- We urge the Office of Head Start to maintain flexibility and local control of Indian Head Start programs in order to honor the unique needs of Native communities, families and children.

Effective Implementation of the Indian Child Welfare Act – Administration for Children and Families

Today, AI/AN children still face serious obstacles to receiving the full protections provided under the Indian Child Welfare Act (ICWA). 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.[1] 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, assisting states as they build capacity to comply with ICWA, and reversing the inequities and disparate treatment that can occur when ICWA is not followed. In order to support the Administration's priority to improve ICWA implementation and related HHS activities we note the following priorities of STAC.

- We are pleased that ACF has committed to establishing new ICWA related data elements in Adoption and Foster Care Analysis and Reporting System (AFCARS) and the development of a report detailing how states are doing in implementing the Title IV-B requirement that requires them to consult with Tribes on measures to comply with ICWA. These efforts will contribute significantly to an increased understanding of how AI/AN children are doing in state child welfare systems, areas where improvements need to be made, and the status of state and tribal relationships with regard to implementing ICWA. However, we are very concerned at the slow pace at which these initiatives are moving ahead. The intent to publish an AFCARS Supplemental containing proposed ICWA data elements was published in the Federal Register on April 2, 2015, which included a statement that ACF has determined that it has authority under Title IV-E to collect this data. This followed a general AFCARS notice of proposed rulemaking (NPRM) where several Tribes and Indian organizations provided strong support for including ICWA data elements in AFCARS and comments on suggested ICWA data elements to be included. Furthermore, the American Public Human Services Association, which is a membership organization of state human services programs, has previously gone on record to support the addition of ICWA related data elements in AFCARS. If the AFCARS Supplemental is not published very soon it is at serious risk of not being able to become a Final Rule during this Administration. These are the top two priorities of STAC related to improving ICWA implementation and we appreciate your efforts to make these initiatives a priority in this quarter.

- The report on how states are doing in meeting their obligations under Title IV-B to consult with Tribes regarding ICWA implementation has been in process for over a year and was originally promised to be released at the June STAC meeting. This is a report that contains public information

[1] Summers, A., Woods, S., & Donovan, J. (2013). Technical assistance bulletin: Disproportionality rates for children of color in foster care. National Council of Juvenile and Family Court Judges: Reno, NV.

derived from existing aggregate data that ACF tracks and which does not contain any new policy interpretation or guidance. As with the AFCARS data initiative, this is a high priority for STAC, so we urge ACF to have the report disseminated before the next STAC meeting so tribal leadership may have time to review and participate in dialogue with ACF at the next STAC meeting.

- Consult with Tribes on efforts between the DOJ, Department of Interior (DOI), and HHS regarding the Attorney General's ICWA initiative and Administration's priority on improving ICWA compliance. 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. We appreciate the updates on what HHS is doing with regards to ICWA implementation, but would like to hear more on how the work HHS is doing with the DOI and DOJ, and other activities that are being discussed. We also encourage having DOI and DOJ appear at STAC to provide updates as well.

Timeliness in Response

As noted above, STAC appreciates the work done by HHS to response thoroughly and thoughtfully to respond to STAC's letters at the conclusion of each meeting. These letters make it possible for the Committee to track key issues and understand the latest status on a variety of topics. We use the information provided in the response letters to determine our priorities to address at each meeting. However, the last response letter was not received until almost immediately before the STAC met with the Secretary. This does not give STAC members and technical advisors adequate time to read the response letter and adjust our requests accordingly.

- STAC requests that any response to this letter be received in the preparation materials that are provided at the STAC meeting, and at a minimum, a full 24 hours in advance of the STAC meeting commencing. This will enable STAC to utilize our limited time more effectively and to make measurable progress issues that are important to the health and well-being of Indian Country.

In conclusion, we would like to reiterate our appreciation for your willingness to work with us and for your prioritization of issues in Indian Country. We look forward to continuing a strong relationship with you and to hearing your response to these requests.

Sincerely,

Cathy M. Abramson

Cathy Abramson
Chairperson
Secretary's Tribal Advisory Committee