DEPARTMENT OF HEALTH AND HUMAN SERVICES

SECRETARY'S TRIBAL ADVISORY COMMITTEE

June 30, 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 from December meeting

Dear Secretary Burwell,

On behalf of the Secretary's Tribal Advisory Committee (STAC), we would like to express our deep gratitude for the highly very productive meeting on June 2-3, 2015. Your commitment to top concerns of Indian Country is clear, and we look forward to working you and the whole Department of Health and Human Services (HHS) to accomplish some of the key goals of Indian Country, especially when it comes to health.

In order to advance this productive relationship, we would like to present this letter to reiterate some of the topics discussed at the meeting, and share additional topics that did not get addressed at the meeting due to time constraints. The following letter does not constitute a comprehensive list of Tribal priorities for HHS, but represent some of the critical issues for Indian Country.

Mental Health and Suicide Epidemic

The STAC would like to thank you and your staff for the serious attention you are giving the recent suicide epidemic in Indian Country. Although the root causes of this crisis are complex, we are encouraged by the efforts at HHS to try to address it. Tribal leaders reiterate their desire to work in partnership with the agency on this matter to address both the short-term crisis and long-term strategies. To summarize our conversation at the meeting, we have the following recommendations:

- Better coordination of care between primary care and behavioral health services
- Better integration of culture and traditional spiritual practices into health care services at the local level
- Additional funding for staffing resources in Indian Country for mental health professionals and additional training for staff in local areas to be able to identify problem areas (i.e. increased funding under the Tribal Behavioral Health Grants)
- Additional funding for nationwide research on historical trauma and Adverse Childhood Experiences in Indian country
- Extensive listening to Native youth on this crisis for causes and solutions. This should include those who have been directly affected by suicide in the community including survivors, parents, friends and other loved ones
- Engaging communities in efforts to destigmatize mental and behavioral health issues and treatment
- Creation of demonstration projects to address mental and behavioral health in Indian Country and increased support for existing grant programs that address youth suicide and mental health

- Deploying immediate assistance, in consultation with the affected communities and in a culturally sensitive manner, to communities currently addressing suicide epidemics.
- Addressing long-term issues such as the dire economic conditions in many communities
- Inclusion of tribal representation on inter-departmental working groups to address the issue

Implementation of the Affordable Care Act – Centers for Medicare and Medicaid Services

The STAC would like to present our top four priority issues related to the implementation of the Affordable Care Act below.

We are concerned that the cost-sharing protections that are specific to American Indians and Alaska Natives, and are detailed in CMS regulations, might be being implemented in a manner that is not consistent with the regulations. Specifically, as detailed in 45 CFR § 155.350(b) and as explained in the preamble to the final rule on this provision, American Indians and Alaska Natives (AI/ANs) who meet the definition of Indian under the Affordable Care Act and who are enrolled in Marketplace coverage are eligible for at least the "limited cost-sharing variation." (Those with incomes determined to be between 100 percent and 300 percent of the federal poverty level and who are eligible for premium tax credits are eligible for the "zero cost-sharing variation.") We would like to engage with CMS to review these provisions and confirm that the provisions are being implemented in a manner consistent with the regulations and with the underlying provisions in the Affordable Care Act.

- We request that CMS consult with Tribes on this issue and review 45 CFR § 155.350(b).

On a related note, during a webinar presented on May 19th, CMS presented information that there is a cap for limited cost-sharing for American Indian and Alaska Natives at 400% of the FPL. CMS has since acknowledged that they presented incorrect information and that there is no cap for limited cost-sharing for AI/ANs. Correct information is critical to ensure increased enrollment in Indian Country.

- We request that CMS thoroughly train all personnel on the AI/AN special provisions and protections if they are going to be presenting information on it so that they are consistent in their messaging to Indian Country.

As documented in a recent study by the Tribal Self-Governance Advisory Committee to the Indian Health Service, government established requirements in the Federally Facilitated Marketplace (FFM) have had a positive impact on the number of QHP contract offers to Indian Health Care Providers (IHCPs) in FFM states when compared to contract offers to IHCPs in non-FFM states. But, we are seeing that some Qualified Health Plan (QHP) issuers are not offering contracts to IHCPs in FFM states per the Center for Consumer Information and Insurance Oversight (CCIIO) requirements. In addition, some QHP Issuers in FFM states are not including the QHP (Indian) addendum when they do offer contracts to IHCPs. In non-FFM states, though, offers of contracts to IHCPs by QHP issuers is much less frequent, with or without the QHP Indian Addendum.

- We recommend that CCIIO investigate non-compliance by QHP Issuers in FFM states and require non-FFM states adopt policies to ensure QHP issuers in their state meet the federal network adequacy standards, and absent meeting the standards institute a back-up mechanism requiring the adoption of the requirements in the CCIIO 2015 and 2016 Issuer Letters.

Our fourth priority issue is that some QHPs are requiring IHCPs to provide a referral for cost-sharing protections for each item or service the AI/AN receives from non-IHCPs. This is not practical and is resulting in blocking access to needed health care for these AI/AN enrollees in Marketplace coverage.

- We would like a comprehensive or blanket referral for cost-sharing that would apply to all medically necessary services that the AI/AN receives from non-IHCPs.

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. The Inter-Tribal Council of Arizona estimates that more than one-third of the approximately 100,000 Tribal members now enrolled in AHCCCS would be adversely affected. These requirements are beyond the capabilities of most American Indians in Arizona. For the most part, there are few job opportunities on Indian reservations in Arizona. There is only a hand-full of employment sources.

Imposing these requirements on the most impoverished areas in the State only compounds the hopelessness and lack of adequate health care that prevail. Medical services to citizens who are in dire need of preventative health care for diseases such as diabetes will terminate. Federal reimbursement will also no longer be available.

- We urge the Secretary to deny this waiver request as it will have a significant detrimental impact to American Indian population in Arizona.

Employee Contract Settlement – Indian Health Service

On May 22, Acting Director of the IHS Robert McSwain notified Tribes that the Indian Health Service had reached an agreement with employee unions. The settlement resolves claims by IHS employees for overtime compensation for work that they performed in or for federally-operated IHS hospitals, clinics, or facilities and for which they were not adequately paid. The total amount of the settlement totals $80 million. Of that $80 million, $20 million will come FY 2015 funding that was originally designated for staffing at the Kayenta Health Center in Arizona. The remainder of the settlement ($60 million) will come from past year's appropriations and third party collections. Tribes are concerned that there was not any notification to Tribes on this matter until the settlement was finalized and that the funds used to pay this settlement will negatively impact patient care and other IHS operations. Indian Country believes that a supplemental appropriations request from Congress would have been more appropriate to address this concern.

- Please provide additional details on how the settlement funds will be allocated at the service unit level with an explanation of what the funds would have been previously used for.

Special Diabetes Program for Indians – Indian Health Service

The Special Diabetes Program for Indians (SDPI) is a program with significantly demonstrated successes. Data clearly shows that these interventions are working to decrease diabetes and obesity amount our population. However, this program has not received an increase from Congress since 2002. Many new Tribes would like to receive this money, but cannot without cutting others. The HHS has requested funding for this program at only $150 million/ 3 years. The Tribal request has consistently been $200 million / 5 years. One way to achieving this increase would be to request it in the President's Budget.

- Why has HHS not asked for an increase to this highly successful and underfunded program?
- Can HHS commit to asking for increased funding for SDPI in FY 2017 ($200 million for 5 years)?

Contract Support Costs – Indian Health Service

Tribes are in support of achieving mandatory appropriations for Contract Support Costs (CSC) at the IHS. We would like to reiterate our gratitude that you heard this request and submitted it in the President's FY 2016 Budget Request. Tribes have concerns about the proposed 2 percent set-aside for Administrative costs outlined in the proposal and the fact that it was only a proposed as a three-year option. Therefore, we encourage you to:

- Work with Congress to support permanent mandatory funding of CSC without the 2 percent Administrative set-aside.

Tribal Oral Health Profiles – Indian Health Service

American Indians and Alaska Natives suffer disproportionately from oral health afflictions more than other ethnic groups. AI/AN children ages 2-5 have six decayed teeth, while the same age group in the U.S. population has only one. Tribes continually list dental health as one of their top budget priorities,

but the statistics for oral health disease in our communities remain the same. More must be done. A good starting point, would be for Tribes to have more information about the status of dental health in their communities through the creation of an "oral health profile" at the Tribal level. This profile should include tribal specific data of dental service needs in Tribal Communities; dental provider rates and shortages (number of dentists, dental hygienists, dental assistants and their ethnicity); available dental facilities (dental operatories and their utilization) and turnover rates for providers over a 10 year period. It would also be useful to know the Purchased/Referred Care backlog for dental care services over the past ten years, (ie., deferred services for any dental care services.) For example, according to the FY 2016 President's Budget Request: "Approximately 90 percent of the dental services provided fall into the basic dental services by category." It would be very helpful for Tribal government officials to know exactly what their specific community service needs are as they work to staff dental facilities in their communities. Some Tribes have completed this assessment out of their own funds, but many do not have that capacity. We request that IHS provide this for Tribes.

- Can IHS Dept. of Oral Health create these "oral health profile" reports with input from area offices and services units?
- Can the IHS present a report on the use of Electronic Health Records in Federal Direct Service Units? Is there collective information on each of the billable dental codes for each Area and nationally? Can the Dental Support Centers provide similar information for the Self-Determination and Self-Governance Tribes?
- Could the IHS or HRSA develop an oral health workforce plan that identifies what it would take to fully staff each Tribal Community with a complete team of dentists, dental therapists, hygienists and dental assistants? This plan might propose a 5 to 10 year strategy for doubling the workforce and describing what is happening in each Area to encourage American Indians and Alaska Natives to consider becoming a part of the oral health workforce.

Hepatitis C in Indian Country – Indian Health Service:

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. We appreciate the statement of HHS in the response to STAC's December 2014 letter. The response implies that all of the HCV treatments are accessible and affordable at all IHS facilities. However, experience has demonstrated that simply inclusion on a formulary does guarantee access.

- Given the epidemic proportion of the increasing diagnosis rates, and the high curability of the disease, STAC is asking IHS to create a program with a specific funding allocation to deal with this and potentially end this disease in Indian Country.
- We request the Indian Health Service to provide STAC with data on many people within IHS service population have been diagnosed with HCV and how any are currently receiving treatment through IHS?
- The Committee recognizes IHS' contributions and participation in the formulation of the HHS action plan, and would like to see a report on IHS' progress achieving the goals and action items for which they are named as a participating agency. The Committee would also like to know

IHS' plan to develop more specific policies that relate to operationalizing the action items named in the HHS action plan (including guidance, policies or procedures for clinics and hospitals to follow).

- The agency's response to the December 2014 letter indicated that "All HCV treatment products are available for purchase through the IHS National Core Formulary (NCF)." The STAC would like to know if these options meeting patients' needs. The Committee would like some assurance that patients know of their HCV status, know their care management plan, and know when they can expect treatment.

Medical Marijuana Policy

Tribal governments are grappling with the question of how to best regulate marijuana in our communities. The answer will be different at every Tribe. For example, many Tribal elders take prescription medications with terrible side effects, and medical marijuana could offer a good alternative for some of these patients. The widespread increase in medical marijuana use calls into question the position taken in the Controlled Substances Act (CSA) that marijuana has "no currently accepted medical use." Yet, despite the fact that medical marijuana is legal in more than 35 states, IHS "recommended" in a 2011 letter that all IHS, Tribal and Urban programs fully adhere and comply with Federal law by not prescribing, recommending, possessing, cultivating, processing, manufacturing, or distributing marijuana for medical or other purposes."

Many tribes are seriously considering participating in a grow or dispensary enterprise as an actor or regulator. The Department of Justice has been unhelpful in understanding the boundaries of federal prosecutorial discretion. This is not a hypothetical concern. On May 8, 2015 Washington State Governor Jay Inslee signed into law HB 2000 , Marijuana — State Agreements with Indian Tribes, which authorizes the Governor to enter into agreements with federally recognized Indian tribes regarding any marijuana-related issue that involves both state and tribal interests or otherwise has an impact on tribal-state relations. The law exempts tribes from state sales, excise, and use taxes with respect to tribal commercial activities involving marijuana, but only where such exemption is covered by a tribal-state agreement. The law authorizes licensed marijuana retailers to purchase and receive marijuana and processed marijuana products from a federally recognized Indian tribe as permitted by a tribal-state agreement. And the law authorizes state licensed marijuana producers and processors to sell and distribute marijuana and processed marijuana products to a federally recognized Indian tribe as permitted by a tribal-state agreement.

Tribes must understand the consequences to federal funding that may be tied to CSA limitation and to federal agency policy. A viable and profitable economic venture must be balanced with an understanding of affects to federal Indian program funding. Further, a number of medicinal uses of cannabis are proven efficacious for a select number of afflictions. The use of medicinal prescriptions for tribal members at tribal IHS funded clinics needs to be analyzed in the context of the CSA and IHS policy.

As Tribes exercise their sovereignty on this issue, we seek HHS' open communication and transparency.

- Please share any policies of HHS that may affect a tribe that legalizes marijuana.

- Please share whether HHS has consulted with the Department of Justice regarding its enforcement priorities regarding marijuana in Indian Country.
- Please share where HHS or any of its agencies have withheld any funding to State governments based on their legalization of recreational or medical marijuana.
- Please share whether HHS is prepared at this time to engage in government-to-government consultations with individual tribes that intend to legalize marijuana.
- Would a tribe's HHS program funds be jeopardized should the tribe, or a subdivision or subsidiary of the tribe, operate a marijuana grow or dispensary enterprise on its tribal lands?
- Would a tribe's HHS program funds be forfeited or at risk in any way should the tribe regulate a third-party operated marijuana grow or dispensary enterprise on its tribal lands?
- Would a tribal organization / consortium HHS program funds be forfeited or at risk in any way should a member tribe of the organization / consortium operate or regulate a marijuana grow or dispensary enterprise on the tribal lands whereupon the tribal organization / consortium programs are operated?
- Has HHS or any directorate within HHS issued a policy statement or guidance about implications of a tribe's operation or regulation of a marijuana grow or dispensary enterprise on tribal lands? If not, is there a plan to release such guidance?
- Is any HHS regulation involved in the human consumption of marijuana products, including medicinal, smoking, inhalant or edible products? And if so, under what statute and regulations?
- Does "Federal property" in the CSA refer to any HHS funded facility or real property?

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, 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. HHS 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:

- 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.
- Assure in writing that funds will continue to be transferred through ISDEAA contracts and compacts.
- Return to reporting mechanisms that worked so well prior to 2009, and permanently rescind the 2009 Compliance Circular.
- Include other eligible programs into 477, such as LIHEAP, Community Services Block Grant, Tribal Vocational Rehabilitation, and Head Start.
- Support enactment of H.R. 329, and S.1443 bills 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.

Self-Governance Title VI proposal

We appreciate the Department's engagement on the expansion of Self-Governance within HHS. Multiple studies on this topic have found that this is feasible. 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. 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.

- We reiterate our for a request that a renewed Tribal Federal workgroup 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.

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 required to comply with approximately 1,900 program standards, which often places a significant burden on already tight program resources.

Culture and language play a critical role in Indian Head Start programs, yet Native elders are not certified teachers. Programs currently must hire additional, certified staff merely to accompany the very elders who are in fact most highly qualified to educate Native children on cultural and linguistic matters. Indian Head Start is deeply committed to providing excellent programs. However, there needs to be further dialogue about developing reliable measurements of program quality in culturally diverse environments. The Classroom Assessment Scoring System (CLASS) lacks valid research on American Indian and Alaska Native children and was designed as a professional development tool rather than a monitoring tool. Triennial reviewers using CLASS have not proved to be culturally sensitive, placing programs in jeopardy based on the Designation Renewal System's (DRS) criteria. The use of CLASS to automatically trigger placing the lowest-scoring 10% in DRS regardless of their CLASS score is problematic.

- Lightening this regulatory burden, in accordance with recommendations in development from the National Health Start Directors Association, would free up vital staff and resources, particularly as many of these regulations impose unfunded mandates that require Indian Head Start programs to divert already scarce program resources.
- Head Start programs need additional Quality Improvement funds. Indian Head Start programs are deeply committed to providing high-quality services to Native children and their families. These programs, therefore, desperately need adequate Quality Improvement funds for staff training and

development, staff retention, improved classroom facilities, increased services, and other program needs.

- Tribes should, therefore, be able to develop their own locally designed certification programs in order to certify teachers for their Indian Head Start programs. Head Start programs should be able to revise performance standards themselves. Tribes should be able to develop their own performance standards under Head Start similar to how Tribes can develop their own performance standard under the No Child Left Behind Act at Department of Education. Additionally, Indian Head Start programs should be able to locally develop their own, culturally appropriate curriculum based on the language and knowledge of the communities they serve.

- Tribal programs should not be placed in DRS until after a year of consultation and re-evaluation, allowing Indian Head Start programs to improve and strengthen their services. NIHSDA would welcome the opportunity to work with Federal partners to develop better, more accurate assessment tools.

Temporary Assistance for Needy Families (TANF) – Administration for Children and Families

The goal of the TANF program should be to reduce poverty, not welfare rolls. We have many families that are approaching 60 months or have reached 60 months who are still dependent on welfare assistance to overcome various barriers not due to their lack of effort but due to a lack of opportunity and insufficient program resources. In fact, a 2014 Government Accountability Office (GAO) noted that "Action is Needed to Better Promote Employment-Focused Approaches."

- The work participation rate metric is flawed and inappropriately used, and should be replaced with metrics developed by tribes.
- TANF performance evaluation should be revised to scrap the current emphasis on using error rates for eligibility determinations.
    - New benchmarks and performance incentives should be developed that acknowledge the full range of services needed to make welfare reform effective
- Increase the number of years allowable for TANF services, especially in Tribal communities.
- What is the status of the HHS response to the GAO recommendation that HHS issue guidance to clarify how the career pathways approach can be used by TANF agencies and identify potential changes to address the lack of incentives in the TANF program?

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

The Indian Child Welfare Act (ICWA) was enacted by Congress in 1978 in response to alarming numbers of American Indian and Alaska Native (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.[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,

[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.

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 of AI/AN children and families we note the following priorities of STAC and thank HHS for their pursuit of these. The Department of Health & Human Services (DHHS) has authority to administer Title IV-B and Title IV-E, and through those, state compliance.

- 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. We are pleased that ACF will be releasing their study in August 2015 on state activities to meet Title IV-B planning requirements to consult with tribes on ICWA implementation. We are also encouraged by ACF's work to consult with tribes on the development of ICWA related data measures for inclusion in the Adoption and Foster Care Automated Reporting System (AFCARS). ACF clarified that the Notice of Public Rulemaking Supplemental that will contain these proposed ICWA data elements will be published this summer.
- 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. This item has been highlighted in discussions between STAC leaders and HHS staff, but no plan for how this will be addressed has come forward. STAC leaders know that there are states that would be interested in receiving this type of assistance and examples where state non-compliance has been well-documented where assistance could be beneficial. We encourage HHS to reach out to tribes and STAC members to discuss how this priority might be addressed.
- 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. ACF has been reaching out through the Tribal Capacity Center to address technical assistance and training needs, but there are additional opportunities to improve assistance to tribes that have not been explored. We would note the recent Region X listening session with tribes from the northwest states as another example. We encourage ACF to continue their efforts in other regions and look for opportunities to further involve national Indian organizations and tribes in these efforts.
- 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. We appreciate the updates on what HHS is doing with regards to ICWA compliance, but would like to hear more on how the work HHS is doing intertwines with the DOI and DOJ work, and other activities that are being discussed. We also appreciate having DOI and DOJ appear at STAC to provide updates as well.

Foster Care –Administration for Children and Families

Tribes are becoming more and more concerned as states begin to consider privatization of foster care. Our concerns relate to accountability of private foster care agencies whose only concern when a tribal child requires placement may be placement. Privatization of foster care ensures that this generation of tribal children in state foster care – and perhaps more – will be lost to private foster care agencies not knowledgeable or caring of how to apply the minimum Federal standards established by ICWA in 1979. Not being knowledgeable about ICWA is not an excuse, especially when current and future generations are at such substantial risk. HHS should collaborate with the Department of the Interior, Social Services, ICWA Programs, and states that are in the process of relinquishing their foster care responsibilities to private agencies.

- How will States ensure and DHHS monitor compliance with ICWA, especially as it relates to ICWA's placement preferences, active efforts to reunify families, and meeting the minimum Federal standards established by ICWA in order to terminate Native parents' rights?

Community Services Block Grant – Administration for Children and Families

The Community Services Block Grant (CSBG) program has a 5% indirect capped rate for the FY 2014 grant. Implementing the capped rate severely constrains this program and Tribes' general funds that must pay for under-recoveries due to the capped rate. For example, Central Council's CSBG program assists tribal citizens by promoting the creation of Alaska Native small businesses, by supporting existing Alaska Native small businesses as well as promoting the creation of culturally-relevant training in high-growth industries, by promoting employment in high-growth industries, by increasing tribal member accessibility to training and employment services, and by collaborating with regional organizations to understand regional economic development and create strategies for addressing obstacles and achieving goals for our tribal citizens and their communities.

- The indirect rate capped at such a low percentage makes our achieving tribal program goals a very difficult task that is a burden on Tribes' general funds.

Data Collection – Administration for Children and Families

As Tribes develop their children and family program systems and access federal funds, there is an increased demand for accountability that can prove more burdensome and costly than effective. Historically, Tribes have not enjoyed access to sophisticated and comprehensive data management systems, and routinely operate several different data bases to collect tribal data based for each of many programs.

- Tribes need access to federal resources to develop and maintain data management systems that meet our needs to collect our own data, report our outcomes, and most importantly, in order to tell our own stories through data.

Other Key Issues For follow-up

In addition to the priorities listed above, the STAC continues to track priorities that were discussed with the HHS in previous meetings. We await a response on the following topics:

- Employer Mandate Under the ACA – Many Tribal governments are concerned that the requirement to provide health insurance for their IHS-eligible employees will be a significant cost burden, will make those employees ineligible for premium tax credits and Indian cost-sharing

exemptions, and will be a disincentive for individuals to sign up for the Insurance. HHS has noted that it is working with IRS on this issue. STAC respectfully requests an update on this effort.

- 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. Advance Appropriations will allow IHS, Tribal and Urban Indian Health facilities the ability to coordinate care, plan, and provide overall better service to Tribes.
- Report on Tribal HHS Funding – STAC continues to request a report for grants received by Tribes and Tribal Organizations by HHS. While we understand that data collection can be challenging across agencies, it is critical for us to know how many Tribal entities are being funded for HHS so that we may understand where challenges lie in getting funding from HHS. We want the report to address how many applications there have been, and how many were funded.
- HIV Funding in Indian Country – Tribal communities continue to be concerned that CDC chose not to fund any Native-specific organizations when it comes to HIV Prevention efforts, despite the fact that HIV rates continue to rise in our communities. We understand that CDC has specific grant review criteria, but urge the agency to consider the government-to-government relationship that the federal government has with Tribes, not simply status as a minority group.
- ACF consultation: Tribes request that this be an annual event. Annual consultation events will assist in obtaining meaningful dialogue. By this, our overall program goals will be met and adequately funded.

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