January X, 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 write today thank you and your staff for a highly productive meeting on December 4-5, 2014. It was clear from the meeting that the government-to-government relationship, the federal trust responsibility and other issues affecting Indian Country are top priorities for this Administration. No other Administration in the history of the United States has made such great strides toward the First Peoples of this country, and we would like to express our sincere gratitude for your efforts to continue that approach.

In order to advance this productive relationship, we would like to reiterate and request agency follow-up on some of the issues presented to you during our last meeting. We believe these to be some of the top concerns and look forward to working with you on these issues in the next year. All the topics below are of paramount importance for American Indians and Alaska Natives (AI/ANs). We stand ready to provide additional background materials for any of the topics mentioned.

*Electronic Health Records and Meaningful Use – Centers for Medicare and Medicaid Services:*

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. Such as 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; such as, Security requirements written by office of the National Coordinator (ONC) for the private sector that did not accommodate working with the federal health systems. – which effectively exclude the Tribal health system from deploying EHR by December 2014. Therefore, Tribes request that:

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

*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 those tribal member 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:

* 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.

*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:

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

*Contract Support Costs – Indian Health Service*

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:

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

*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. 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:

* **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.
* **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.
* **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.

*HIV Funding to Indian Country – Centers for Disease Control and Prevention (CDC)*

The rates of HIV incidence in American Indian and Alaska Native communities has continued to rise over the past decade while the rates have fallen elsewhere. The CDC has funded organizations in the past specifically to work with American Indian and Alaska Native communities, and this funding has helped to establish and re-affirm national leaders in HIV prevention, care and treatment in Indian Country. However, the CDC did not fund an American Indian or Alaska Native organizations to provide support or capacity building activities for the next five years.

Therefore, we make the following requests:

* **Fund Tribes/Tribal organizations** directly for population-based, public health activities and infrastructure development.
* **Create granting mechanisms** that will ensure that Tribes receive funds and have the ability to determine use of programs dollars allocated/granted to states that are intended to reach or are inclusive of Tribal communities within the state.

*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. As expressed in December, the STAC has a couple of questions about this matter:

* 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.

*Mental Health Agenda for Indian Country*

In 2007, the National Center for Health Statistics noted that AI/ANs experience serious psychological distress at rates far greater than the general population. Of particular concern, the AI/AN population experiences the highest rates of suicide of any group in the U.S. for all ages. Yet, prevention and treatment for mental health in Indian Country is often not coordinated. All federal agencies serving Indian Country should have a part in preventing these devastating and violent incidents. While the 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:

* **A Plan of action**, led by HHS, that will demonstrate how programs for mental health serving AI/ANs are coordinated across agencies
* The Administration Work with Tribes to **develop a mental health agenda** for Indian Country so that we can work across agencies to achieve measured, long-term, sustainable progress on these issues.

*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.[[1]](#footnote-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, 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:

* **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.
* **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.
* **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.
* **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.

*P.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:

* **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.

*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.

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

*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.

* 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.

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 building a strong relationship with you over the next two years and to hearing your response to these requests.

Sincerely,

**Secretary’s Tribal Advisory Committee**

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. [↑](#footnote-ref-1)