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Testimony of
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House Appropriations Committee
Subcommittee on Labor, Health and Human Services, Education and Related Agencies

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Chairman Cole, Ranking member DeLauro and members of the Subcommittee, thank you for inviting me to this important hearing. In addition to serving as the Tribal Chairman/CEO of the Jamestown S'Klallam Tribe, I am Vice-Chairman for the Indian Health Service Tribal Self-Governance Advisory Committee (TSGAC), serve on Secretary Sylvia Mathew Burwell's Tribal Advisory Committee (STAC), which advises the Department of Health and Human Services (HHS) on issues of importance to Tribal governments and their citizens, and I also serve as Chair of the Tribal Technical Advisory Group (TTAG) for the Centers for Medicare and Medicaid Services (CMS). You asked that I address challenges of Tribes in working with the Federal government, and opportunities to improve this partnership. I appreciate this opportunity to briefly address several issues with HHS and provide the Committee with suggested recommendations and steps to resolve them.

Affordable Care Act Implementation: The formation of STAC and TTAG has provided important avenues of communication that enable Tribes to communicate more consistently and effectively with HHS and CMS. Nonetheless, there remain a number of ways that HHS and CMS could improve collaboration with Tribes by addressing the Indian-specific issues that Tribes have raised regarding the Patient Protection and Affordable Care Act (ACA) implementation. We request the support of the Subcommittee on the following four matters under CMS's existing authority which would make common sense adjustments to improve health care coverage for American Indians and Alaska Natives (AI/AN):

1. *Waive the Employer Mandate for Tribes.* The application of the employer mandate requires that Tribes qualifying as large employers buy insurance for their Tribal-member employees or pay significant fines, even though Tribal members are exempt from the ACA's individual mandate. This runs counter to the Federal trust responsibility. It also means that AI/ANs are less likely to benefit from the new resources for health care offered through ACA, which are so important to help fully fund the Indian health system. If Tribes do offer insurance

to their Tribal-member employees, those employees will no longer be eligible to receive premium assistance through the health insurance exchanges. Tribes have repeatedly requested administrative relief from the employer mandate. The employer mandate should be waived for Tribal employers with regard to employees who qualify for the Indian exemption to the ACA's individual mandate;

2. *Provide Indian-Specific Enrollment Data.* Indian-specific data is necessary to gauge AI/AN marketplace enrollment and Medicaid enrollment and to assess outreach and education efforts. Tribes, however, have not been able to obtain Indian-specific enrollment data from CMS despite numerous requests over the past 6 months. CMS should make this information available to Tribes and use the data for more effective management of marketplaces to assure that AI/ANs are participating to the maximum extent possible;

3. *Establish Indian Desk for the Federally Facilitated Marketplace (FFM) Call Center at CMS.* Tribes have also repeatedly requested that CMS establish an Indian Desk for the FFM Call Center. Currently, AI/AN callers are frequently being misinformed by call center staff who do not understand the Indian-specific provisions of the ACA. This has created much confusion and frustration as AI/AN consumers seek Indian-specific answers regarding enrollment, plan changes, tax exemptions, and other ACA-related matters; and,

4. *Fund Indian-Specific Enrollment Assistance.* Funding for enrollment assistance is essential to increasing the low proportion of AI/ANs currently enrolled in health coverage. Navigator grants, however, have not proven to be an effective mechanism for funding Indian-specific enrollment assistance, because very little of this funding has been awarded to Tribes and Tribal Organizations, and the constraints and reporting requirements make it difficult to use these funds effectively in Tribal settings. Funding is needed for enrollment assistance that is tailored to the needs of Tribal communities.

Expansion and Improvement of the 477 Program: Public Law 102-477 advanced Tribal self-determination by permitting Tribes and Tribal organizations to consolidate into a single plan consisting of employment- and training-related grant funds from four agencies, including the three major ones under this Subcommittee's jurisdiction. The 477 Program reduces administrative expenses and allows Tribes to tailor services to the needs of their communities. The 477 program has proven very successful, and was scored highly by OMB's Performance Assessment Rating Tool (PART). The full potential of the Act has not been realized, however,

due to resistance by the agencies on several fronts. Representative Don Young (R-AK) has introduced H.R. 329, the Indian Employment, Training and Related Services Consolidation Act of 2015, which would make the 477 program permanent, extend it to eight additional agencies, and clarify the authorities and responsibilities of the agencies and the Tribes. Unfortunately, HHS recently testified in opposition to the bill, based on a bureaucratic turf-protection rationale at odds with the Federal policy of Tribal Self-Governance. We ask for this Committee's support and assistance as H.R. 329 moves through the House.

Tribal Consultation: The health of the government-to-government relationship depends on timely and effective communication. In some respects, HHS is to be applauded on this score; the Department has established an effective budget consultation process that we hope will continue beyond this Administration. In other respects—for example, with some of the ACA implementation issues discussed above—HHS has fallen short of the principles and practices set forth in its Tribal Consultation Policy by failing to involve Tribes at the earliest stages in the development of regulations and policies with important Tribal implications. We would appreciate this Committee's assistance in ensuring that the agencies under its jurisdiction adhere to Executive Order 13175, Consultation and Coordination with Indian Tribal Governments to fulfill the Federal trust responsibility to hold timely and meaningful Tribal consultations before taking actions with significant impacts on Tribes and their citizens.

Federal Advisory Committee Act: One impediment to Tribal-Federal communication in recent years has been the Administration's interpretation of the Federal Advisory Committee Act (FACA). Tribal-Federal workgroups and advisory committees operate under the intergovernmental exemption from the requirements of FACA such as making documents available to the public. The Administration's narrow interpretation of the exemption, however, has led to the agencies imposing prescriptive rules of conduct that are at times ridiculous and offensive to Tribal leaders and their designated representatives. For example, Tribal leaders who attend a meeting but are not official members of the committee are not allowed to speak. The unnecessarily restrictive protocols deter free exchange of information and viewpoints. Tribal leaders would appreciate this Committee's assistance in directing HHS (which has a large number of advisory groups subject to FACA) to work with Tribes on a pragmatic approach to preserving the FACA exemption while facilitating full and open dialogue.

Appropriations Issues: We would appreciate any assistance this Committee can provide in advancing the following initiatives with HHS Secretary Burwell and with your colleagues in the House:

- *Advance Appropriations for IHS*: Tribes and Tribal health organizations currently administer over half of the Indian Health Service (IHS) budget through contracts and compacts under the Indian Self-Determination and Education Assistance Act (ISDEAA). While not directly under this Committee's jurisdiction, appropriations for the IHS profoundly affect Tribal relations with HHS as a whole. The ubiquity over the past 15 years of partial and delayed appropriations through the continuing resolution process has made it very difficult for Tribal health providers to plan budgets, retain medical professionals, and simply maintain operation of facilities. IHS should receive advance appropriations authority, similar to the Veterans Health Administration, which serves a similarly vulnerable constituency under unique Federal obligations.
- *Sequestration*: With Tribal health care already chronically underfunded, cuts due to sequestration further undermine the ability of IHS and its Tribal partners to meet the needs of AI/ANs. Congress should enact legislation exempting IHS, and all Tribal program funding, from sequestration.
- *Mandatory Contract Support Cost Appropriations*: Following two Supreme Court decisions affirming that payment of full contract support costs (CSC) is required under the ISDEAA, the Administration has proposed that CSC appropriations be shifted from discretionary to mandatory appropriations. This would bring the funding mechanism in line with the legal obligation to pay full CSC, eliminate contract claims against the U.S., and ensure that Indian health care funding is not eroded by administrative costs.
- *Behavioral health programs*: The Administration has requested Tribal behavioral health funding for a number of years but with little success. This year they requested an additional $25 million under SAMHSA as part of its multi-agency Native youth behavioral health initiative. We join with the National Indian Health Board (NIHB) and National Indian Child Welfare Association (NICWA) who are also testifying before this Subcommittee in asking for *$50 million* for behavioral health programs. We need enough funding to make a difference. Ideally, at some point funding will be available to all Tribes on a recurring basis.
- *Funding so Tribes can utilize their authority to administer the Federal entitlement program for foster care and adoption assistance*: For the first time, the Administration requested start-up funds ($27 million) and proposed program adjustments for Tribes with approved Title IV-E plans. Currently, only a few Tribes directly administer this program. Additional funding could facilitate additional Tribal participation.
- *Funds to build the capacity of child welfare programs*: The Administration has for the first time requested funding ($20 million) under the Promoting Safe and Stable Families Act to help Tribes build the capacity of their child welfare programs which will put them in a better position to keep families together, to protect children, and when needed have available alternatives.

Expansion of Tribal Self-Governance within HHS: In Title VI of the ISDEAA, Congress envisioned expanding Tribal Self-Governance beyond IHS to other programs within HHS. In 2003, HHS issued a study concluding that such an expansion was feasible, identifying 11 HHS programs as likely candidates for a Self-Governance demonstration, and providing recommendations on legislation to establish a demonstration project. Despite this favorable report, however, HHS leadership has never supported such legislation. In 2013, a Tribal-Federal workgroup established by then-Secretary Kathleen Sebelius to re-examine the issue concluded that "the overarching barrier to expansion of Self-Governance is the lack of legislative authority to conduct a Self-Governance demonstration project in HHS programs outside of IHS." Yet, HHS took the position that it could not collaborate with Tribes on developing such legislation. Expansion of Tribal Self-Governance to non-IHS programs in HHS such as Native Employment Works (NEW) and Tribal Temporary Assistance for Needy Families (TANF) represents the next logical step in the evolution of the Federal policy of Tribal self-determination. We ask that this Committee direct HHS Secretary Burwell to re-convene the Title VI workgroup and authorize HHS representatives to engage in dialogue with Tribal representatives over draft legislation to establish a Self-Governance Demonstration Project that both HHS and Tribal leadership can support.

Such legislation would address a broader issue regarding the grant-making process itself. Within HHS alone, there are 558 grants available to AI/AN Tribes and organizations, all with different application processes and reporting requirements. Tribes have difficulty accessing these grants—in particular small Tribes with minimal capacity. As a result, the grants are underutilized and do not get to the neediest Tribes. If Tribes could access the funding using a Self-Governance vehicle, the funds would be utilized more efficiently and effectively and Tribes could tailor programs to meet their community needs.

Thank you again for the opportunity to provide this testimony. If you have any questions or would like further information on these issues, please do not hesitate to contact me.