

2011 HHS Regional Tribal Consultations

Executive Summary

On November 5, 2009, at the *White House Tribal Nations Conference*, President Obama demonstrated his commitment to American Indians and Alaska Natives (AI/ANs) and to fulfilling the consultation requirements of Executive Order 13175—originally issued by President Clinton on November 5, 2000—by signing a Presidential Memorandum. Executive Order 13175 - Consultation and Coordination with Indian Tribal Governments calls for all Federal agencies to come into compliance with regards to regular, meaningful consultation and collaboration with Tribal officials in the development of Federal policy that have Tribal implications; to strengthen the U.S. government-to-government relationships with Indian Tribes; and to reduce the imposition of unfunded mandates upon Indian Tribes. In accordance with the President’s directive, the U.S. Department of Health and Human Services (HHS) convened 11 regional Tribal Consultations in 2011. Held from January 6, 2011, through June 9, 2011, the consultations’ primary purpose was to allow Tribal leaders to discuss programmatic issues and overall concerns of Tribes at the local level with HHS officials. The regional sessions also provided an opportunity for Tribes to hear updates from HHS, discuss the revised HHS Tribal Consultation Policy (signed by HHS Secretary Kathleen Sebelius on December 14, 2010), provide testimony and/or comments on topics of interest, and pose questions on issues that concern Tribal communities and members. This document serves as the executive summary for all of the 2011 HHS Regional Tribal Consultations, summarizing the common themes and overarching priorities. It is national in perspective. This is important to note because, as various Tribes have poignantly articulated, each Tribe is different and unique. Tribes face different challenges and present different needs based on their size, geographic location, structure, etc. To that end, the concerns, issues, and recommendations cited in this document reflect common items shared among them. Information on specific regional sessions is available via individual meeting and executive summaries, under separate cover.

The 2011 HHS Regional Tribal Consultations were held as follows:

- January 6, 2011, Green Bay, WI, Region V
- February 24, 2011, Oklahoma City, OK, Regions VI and VII
- March 10, 2011, Las Vegas, NV, Region IX and VIII
- March 24, 2011, Rapid City, SD, Regions VII and VIII
- March 29, 2011, Verona, NY, Region II
- March 30, 2011, Cherokee, NC, Region IV
- March 31, 2011, Boston, MA, Region I
- April 26, 2011, Window Rock, AZ, (Navajo Nation), Regions VI, VIII, IX
- April 28, 2011, Albuquerque, NM, Regions VI and VIII
- June 7, 2011*, Grand Ronde, OR, Region X
- June 9, 2011*, Anchorage, AK, Region X

* Due to a pending government shutdown, the Grand Ronde and Anchorage consultations were rescheduled from April 13th and April 15th to June 7th and June 9th, respectively.

Agendas for each regional consultation were tailored for that specific area. Generally, each consultation was conducted as follows: registration; welcome activities; introductions and opening remarks; HHS updates; testimony/comments; panel presentations and response; and wrap-up/next steps. Deliverables resulting from each consultation included an executive summary, as well as a detailed meeting summary comprising the following sections:

1. Overview and Purpose of Session
2. Tribal Priorities
3. Open Tribal Leader Comment/Testimony/Discussion
4. Highlight of Issues Brought up by Tribes
5. Responses from Regional Staff Participants
6. Agenda
7. Wrap-Up and Next Steps

Tribal leaders and representatives voiced their concerns about challenges facing their Tribal communities. Notwithstanding, a few positive remarks were consistently heard across the regions. Namely, the Obama Administration was praised for its commitment to Indian Country—as evidenced by an increase in fiscal year (FY) 2011 and the proposed FY 2012 budgets for the Indian Health Service (IHS) over FY 2010; regional directors were credited for their role in helping to improve the accountability of the Federal government; and IHS Director Yvette Roubideaux was applauded for using her Director’s Blog to keep Tribes updated on relevant issues. Similarly, Tribes and Tribal officials expressed their approval when learning of the following information:

- All Tribal employees will be eligible for Federal Employee Health Benefits.
- Intradepartmental Council on Native American Affairs (ICNAA) is addressing the issue of Tribal access to grants, including eligibility/ineligibility for HHS grants.
- ICNAA is focused on expanding self-governance outside of HHS.
- Methamphetamine/Suicide Prevention Initiative (MSPI) funding is in the proposed 2012 budget.
- Proposed 2012 Behavioral Health-Tribal Prevention grants slated for \$50 million—with a base award to every Tribe that applies of \$50,000. [Remaining \$25 million will be awarded through a distribution formula.]

Across the regions, common themes and priorities centered on the following six categories: Tribal-State relations; funding; service needs; policy; process; and data issues. Highlights pertaining to each of the categories are provided below.

Tribal-State Relations

- Role HHS plays in Tribal-State relations.
- Impact of State budgets on Tribes, especially optional Medicaid Services.
- Tribes’ options/opportunities in regards to States’ lack of consultation with them and/or lack of willingness to move forward on Affordable Care Act (ACA) activities.
- Need for Federal officials to have proof of States’ consultation with Tribes.

Funding

- Need for health care facilities construction/renovation and concern over reduction in IHS' facilities funding.
- More resources needed for mental health/behavioral health and maternal child health.
- Increased funding needed for contract health services (CHS).
- Request for direct HHS funding to Tribes.
- Community Health Representatives (CHR) program needs increased funding.
- Money needed for prevention programs.
- Concern about the high cost of implementing electronic health records (EHRs).

Services

- Strengthening Indian health providers/programs to improve capacity and access.
- Remote areas' lack of technology, roads, and conditions impact everything from ability to review plan options under ACA, recruit and retain qualified staff and medical professionals, and transport children and individuals for services.
- Need for elder care/long-term care resources.
- Need better way to provide health care in rural settings.
- Concern about suicide, alcoholism, and substance abuse and a need for treatment centers.
- Need for dental partnerships/services.
- Providing services to veterans.
- National Health Service Corps (NHSC) deployment in Indian County.

Policy

- Timely communication of ACA implementation and Tribes' engagement in the process.
- Adopt a broad definition of "Indian" and use it for all ACA benefits/protections.
- Confusion around terms: Indian, essential community providers, Federally-Qualified Health Center (FQHC), community health centers.
- Department of Veteran Affairs (VA) and Tribes cooperation/agreement on payer of last resort and how Tribes submit claims.
- Tribes to be considered 51st State for reimbursement purposes.
- Federal officials and Congress members' understanding of Tribal sovereignty, treaties, and issues in Indian County.
- Issues regarding Indian health provider licensing.
- Moving forward the issue of Tribal self-governance.

Process

- Timeliness of CHS referrals is an issue.
- Requests for timely feedback on Tribal comments, questions, and concerns.
- Requests for cross-agency collaboration.
- Need for more non-competitive grants to Tribes.

Data

- Difficult for Indian clinics to collect data and set up electronic systems.
- Tribes not informed of results when they respond to requests for data.
- Tribes' difficulty in understanding health information technology (HIT) and meaningful use.

In response to the concerns raised, at times Federal officials indicated that statutory requirements limited their ability to influence change. Other times, they were immediately able to respond. When that was not possible, they indicated that they needed to follow-up with answers at a later date. Among the Federal responses to some of the Tribal concerns included the following:

- New VA Tribal Consultation Policy was released and a new Memorandum of Understanding (MOU) between the VA and IHS instituted. From the MOU, 12 national workgroups were established to address increasing access to care; and a 13th workgroup will focus solely on Alaska.
- Training is underway to train individuals on how to become a Tribal Veteran Representative.
- The issue of payer of last resort is being discussed.
- Tribes can participate on monthly calls for ACA updates.
- SAMHSA will place regional administrators in all the regions over the next two years.
- Enrollment dates for Medicare are now October 1st – December 15th.
- ACA has provisions for long-term care services.
- CMS release of best practices regarding ways States could consult with Tribes was expected in August/September 2011.
- IHS proposing funding in the 2012 budget for youth tele-mental health projects and innovative facilities construction.
- ACA will yield Health Professions Opportunities grants; funds for Tribal Court Improvement programs; Native Asset Building Initiative, and expansion of the NHSC.

The 2011 HHS Regional Tribal Consultations focused on issues of concern to Tribes. Specifically, issues surrounding implementation of the ACA; adoption of meaningful use of EHRs; Tribal-State relations; and direct funding to Tribes, among other important topics, were voiced by Tribal leaders. Those issues, as well as the resounding requests for benchmarks, timeliness, and tracking of Tribal concerns, were heard by Federal officials. In the end, both Tribal and Federal leadership showed commitment to doing their part to improve outreach and services to AI/ANs.