HHS Region II Tribal Consultation

Executive Summary

The 2011 Tribal Consultation for Region II was held March 29, 2011, in Verona, New York. The primary purpose of the consultation was to allow Tribal leaders to discuss programmatic issues and overall concerns of Tribes at the local level with U.S. Department of Health and Human Services (HHS) officials. The regional session also provided an opportunity for Tribes to hear updates from HHS, discuss the updated HHS Tribal Consultation Policy, provide testimony and/or comments on topics of interest, and pose questions on issues that concern Tribal communities and members.

Charmaine Frederick, Oneida Indian Nation, opened the meeting and introduced Mary Blau, Oneida Indian Nation, who gave the opening prayer. Participants were then welcomed by: HHS Regional Director, Jaime R. Torres, Region II; Kim Jacobs, Commissioner of Nation Administration, Oneida Indian Nation; and Dee Sabattus, United South and Eastern Tribes, Inc. (USET). All attendees introduced themselves. Ms. Frederick and Dr. Torres served as co-moderators. Tribal leaders and other consultation attendees provided testimony and comments on topics of concern.

The Tribal priorities cited were:

1. Self-identifying as American Indian to ensure appropriate health care.
2. Data, data access, and data-sharing: Statewide Planning and Research Cooperative System (SPARCS), mandated by Article 28, Resource and Patient Management System (RPMS), and EpiCenters.
3. Co-pay issue under HHS regulations; care is provided free and they are not allowed to collect a co-pay, including for people who access two different Tribal clinics.
4. Communications networking with various departments, especially Medicaid.
5. Finding a pool of providers who accept Medicaid rates to whom they can refer people.

Highlights of issues brought up by Tribes and responses from regional staff participants for all four panel sessions are provided in the HHS Region II Tribal Consultation Summary Report (under separate cover). Objectives that arose from this meeting were:

- Indian Health Service (IHS) will provide Tribes with an update on health insurance for Tribal employees.
- Explore data-sharing agreement between USET and New York State on SPARCS-sharing.
- Forward issues on interface or data-sharing between RPMS and SPARCS.
- Kristina Rogers will follow-up with the Seneca Nation on remaining user population issues.
- USET, Maternal Child Health (MCH) will work with the Administration for Children and Families (ACF) to disseminate information on ACF funding opportunities.
- Work more closely with Administration on Aging (AoA) and Dr. Bruce Finke to disseminate information on available AoA grant opportunities.
- Cheryl Donald and IHS, Dr. Ricks or Dr. Brown, will follow-up to encourage Tribes to apply to be a National Health Service Corps (NHSC) site.

- Work with the Health Resources and Services Administration (HRSA) to review section 330 of the Public Health Service Act, and assist Tribes in competing for HRSA grants.
- Cheryl Donald will let Tribes, USET, and IHS know whether Tribes can apply for HRSA grants under a single authority, e.g., USET.
- IHS will find out how to work with the Medical Reserve Corps (MRC) to backfill positions or work on short-term projects.
- Philip Mossman will inform Tribes of upcoming Medicaid Redesign Team (MRT) meetings.
- Michael Melendez will set up Tribal consultation quarterly conference calls, beginning by proposing tentative dates over the next 2 weeks.
- Mr. Melendez will arrange an all-day discussion on Medicaid.

Cross-cutting Issue Area #1: Affordable Care Act (ACA)
Michael Melendez, Centers for Medicare and Medicaid Services (CMS), began by noting that CMS is reviving its quarterly Tribal calls, and expanding them to all–HHS calls. Therefore, Mr. Melendez needs everyone's updated e-mail address and phone number. Glen Harrison will be the CMS contact, and Region II people will work with Dr. Torres. Full implementation of health insurance changes is expected by 2014, but key provisions that became effective in January 2011 include exemptions to co-pays; the requirement for regular State–Tribe consultation, the all-encompassing definition of "Indian," and no cost-sharing if income falls below 300% of the Federal poverty level. In addition, the Center for Medicine and Medical Innovation was created to find new ways to provide health care.

Cheryl Donald (HRSA) reported that the NHSC has been reauthorized through 2015. The maximum loan repayment award was increased to $50,000. National Area Health Education Centers (NAHEC) are focusing on the aging population and expanding career incentives. Nurse faculty members are now eligible for loan repayment programs. The Act also authorizes a pediatric subspecialty. Delivery system provisions include nurse-managed health centers, patient navigator and chronic disease outreach programs, and teaching grants. The National Health Care Workforce Commission (NHCWC) will serve as a national resource for planning and assessment of the health care workforce. ACA instructs HRSA to redesign medically underserved areas and improve health professionals data banks; HRSA manages the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner Data Bank (NPDB). For more information, see: http://www.healthcare.gov/ and http://www.hrsa.gov/index.html.

Reached by telephone, Lisa Wilson and Pete Nakahata, Office of Consumer Information and Insurance Oversight (OCIIO), reviewed OCIIO functions, namely helping people navigate the health insurance products, and making them aware of premium tax credits available to American Indians whose income is below 300% of the Federal poverty level. American Indians also have special monthly (not annual) enrollment periods and can switch plans at any time. Finally, the relationship with Medicaid is expanded to 133% of the Federal poverty level.

Indian Health Service Budget and Priorities Update
Debra Martin, St. Regis Mohawk Tribe, showed the video, "Akwesasne Gathering Health Data for the Next Seven Generations," which she produced to educate community members and hospital employees about the importance of American Indians identifying themselves as American Indians in emergency rooms or hospitals.

The overview of IHS by CAPT Timothy L. Ricks, DMD, MPH, Nashville Area, focused on ACA, electronic health records, facilities, and Tribal health priorities. ACA extends benefits to adults under 26. The Indian Health Care Improvement Act (IHCIA) authority has been expanded to behavioral health, long-term care, dialysis, and urban programs. Tribally hired health care professionals are treated the same as Federal employees, i.e., IHS requires that they be licensed in a State, but not necessarily the State in which they work. IHS Director, Dr. Yvette Roubideaux, has made internal IHS reform a priority, including the hiring process (IHS can now hire within 80 days of posting a vacancy), how business is done (increased consultations), and how care is delivered. Implementation of Tribal priorities for IHS reform includes improving funding distribution or formulas, the consultation process, and contract health services. Facilities projects include the Tuscarora Nation's contract health services, and work with the Shinnecock Indian Nation to determine their healthcare needs and how IHS can help.

Cross-cutting Issue Area #2: Human Services Issues / Initiatives
Barry Klitsberg (AoA) reported on Title VI funds, which are intended to keep older Americans in their homes (and out of nursing homes). Services include meals (either home-delivered or congregate), assistance to caregivers, transportation, homemaker services, information and referrals, and case managers to direct caregivers to available services. Information can be found at: http://www.olderindians.org/ or by contacting Acting Director Margaret Graves (212-357-3502; Margaret.Graves@aoa.gov) or Mr. Klitsberg (212-264-2976; Barry.Klitsberg@aoa.gov).

Joyce Thomas (ACF) reviewed ACF's programs and departments intended to help families achieve economic success, promote health, and improve capacity to do a job well. These include: the Administration for Native Americans (ANA); the Native American Affairs Advisory Council (formed in June 2010 and chaired by ANA Commissioner Lillian Sparks); the Office of Community Services; Assets for Independence, which partners with banks and credit unions to teach people about finance and saving; the Children's Bureau; and a new Tribal Court Improvement program. She noted that Head Start grants must be re-competed every 5 years. ACF funding opportunities are listed at: http://grants.gov/ or http://www.acf.hhs.gov/grants/.

Dennis Romero, Substance Abuse and Mental Health Services Administration (SAMHSA), announced that the Tribal Law and Order Act (TLOA) reforms how the Federal government works and collaborates with the Tribes. SAMHSA has pulled people together to determine how best to level the playing field for grant applications and awards for Tribal applicants. The 2012 budget provides a behavioral health prevention grant, a block grant to Indian Country's Federally Recognized Tribes. The two-tiered process offers a basic level of funding with a non-competitive grant; in late spring and summer, a formula for distribution of additional funds will be identified through formal consultations. This money is to be used to address alcohol and substance abuse or suicide.

Cross-cutting Issue Area #3: HHS Initiatives
Cheryl Donald, HRSA Office of Regional Operations, gave HRSA's core functions as: to provide leadership, foster greater alignment and collaboration, conduct surveillance and analysis of health care environment trends, provide technical assistance, generate collaborative efforts, and support the recruitment and retention of primary health care providers in areas of need. The Oral Health Initiative results from an Institute of Medicine consensus study. A Behavioral Health Initiative is integrated with primary medical and oral health care. Patient Safety and Clinical Pharmacy Services Collaborative

integrates evidence-based clinical pharmacy service into care and management of high-risk and high-cost, complex patients. Finally, the HRSA Web site promotes these initiatives with the "Indian Health" section.

April Velasco, Office of the Assistant Secretary for Health (OASH), discussed five relevant programs: the Office of Minority Health, the Office of Population Affairs, the Office of Women's Health, the Medical Reserve Corps, and the Regional Resource Network. Activities and initiatives include: eliminating health disparities, preventing healthcare-associated infection, preventing and treating HIV/AIDS, ensuring mental health after trauma, preventing obesity and promoting a healthy lifestyle, ensuring preconception health for women, and supporting immunization. A supporting activity is the interactive Web site, http://healthypeople.gov/2020/default.aspx, which covers 13 topics, e.g., sleep health, social determinants of health, genomics, and global health. The Working Group on Environmental Justice is a collaborative of 11 Federal departments and several White House offices. Each identifies and addresses disproportionately high and adverse human health or environmental effects of its programs, policies, and activities on minority and low-income populations.

Cross-cutting Issue Area #4: Tribal–State Relations

Philip Mossman, New York State, outlined new requirements, namely that the State is required to consult with Tribes on anything that will impact them. The proposed process is that when a notice is published in the *New York State Register*, an advance copy will be sent to the Tribal leaders who will have 15 days to comment, followed by written notification at least 60 days prior to final publication and submission. Mr. Mossman also gave an overview of the work of the Medicaid Redesign Team (MRT), which was formed to evaluate the State Medicaid program. Of the recommendations they received, 79 will be implemented during 2011–2012 (all 4000+ are posted on the Web). The package includes: a global State Medicaid spending cap of $15.1B accompanied by measures to reduce spending if it exceeds the pre-determined line; elimination of statutory cost drivers (e.g., automatic inflation adjustments); greater focus on access to primary care to keep patients out of the hospital; and flexibility to encourage cost-saving measures and find efficiencies.

Adjournment

After the final session, Dr. Torres thanked everyone who had made this consultation possible, especially Chief Jacob and the representatives of the other Nations. Ms. Frederick thanked Dr. Torres and his staff, as well as Ms. Aguilar and her staff for making the consultation possible. The consultation ended with a closing prayer delivered by Mary Blau, Oneida Indian Nation.