

# HHS Region I Tribal Consultation

## Executive Summary

The 2011 Tribal Consultation for Region I was held March 31, 2011, in Boston, Massachusetts. 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.

Lynn Malerba, Chief, The Mohegan Tribe, opened the meeting with a Tribal blessing. Chief Malerba and Christie Hager, Regional Director for HHS Region I, served as co-moderators. Tribal leaders and other consultation attendees provided testimony and comments on topics of concern.

The Tribal priorities cited were:

1. Administration on Aging (AoA) funding opportunities and limitations because of the size of Eastern Tribes.
2. Centers for Medicare and Medicaid Services (CMS) payments.
3. Indian health provider licensing.
4. Medicare secondary payer.
5. End-stage renal disease (ESRD) program.
6. Medicare life rates.
7. Consistency with grant funding.
8. Health Information Technology for Economic and Clinical Health (HITECH) Act and how different attorneys general respond.
9. Contract health services.
10. Title VI of the Tribal Self-Governance Amendments of 2000, self-implementing and non-self-implementing portions of the Act. To move forward this should be permanently authorized.
11. Aging.
12. Federal employee health benefits.
13. Substance abuse and mental health.
14. Executive summary of the Indian Health Care Improvement Act.

Highlights of issues brought up by Tribes and responses from regional staff participants for all five panel sessions are provided in the HHS Region I Tribal Consultation Summary Report (under separate cover).

Pam Hyde, Substance Abuse and Mental Health Services Administration (SAMHSA) Administrator, let attendees know that Secretary Sebelius has established a new Secretary's Tribal Advisory Committee (STAC) and updated HHS's Tribal Consultation Policy.

Dr. Harry Brown, Chief Medical Officer, IHS–Nashville Area, reported that the 2010 Affordable Care Act (ACA) contains permanent reauthorization of the Indian Health Care Improvement Act (IHCIA).

Important provisions for American Indians are that they have the same access to State-based exchanges, with no co-pay or deductible if their income is less than 300% of the Federal poverty level; coverage was extended to those under 26 years; and Tribally hired health care professionals have the same status as Federal health care professionals (they can be licensed in any State). Multiple programs interact around electronic health records (EHR) and meaningful use, e.g., drug–drug and drug–allergy checks, smoking status, or clinical quality measures such as hypertension, tobacco use, influenza immunization.

*Cross-cutting Issue Area #1: Affordable Care Act (ACA)*

Jaye Weisman, CMS, reported that the prescription drug benefit is included to close the coverage gap under Part D, and will increase gradually until 2020. Eligibility is determined by prescription drugs obtained through Tribal pharmacies. Prevention services, e.g., cancer screenings and wellness visits, are given at no cost. Medicaid eligibility will expand and state health insurance exchanges will be introduced. The Tribal Affairs Group in CMS provides technical information; their meetings are listed on the Web site <http://www.cms.gov/default.asp>.

Jeff Reck, Health Resources and Services Administration (HRSA), said ACA does not impact HRSA in any new ways except for one program; but it magnifies resources to carry on its programs. There are now 80 programs for 3000 grantees. HRSA focuses on the uninsured, HIV/AIDS-positive pregnant women and children, primary health care, and maternal and child health. The National Health Service Corps incentivizes providers to work in medically underserved areas. HRSA has a department that focuses on rural health (62% of the country is rural; and 40% of Tribal lands are rural). A HRSA e-mail address list has been compiled, and they established a Web site specifically for Native American public health issues. With it, you can find a community health center or IHS center by typing in a zip code.

Lisa Wilson and Pete Nakahata, Center for Consumer Information and Insurance Oversight (CCIIO) [via telephone], explained that the CCIIO oversees provisions related to private health insurance. The goal is to restore power to consumers and hold insurance companies accountable. Beginning in 2014, the biggest change is helping consumers shop for and enroll in an insurance plan that fits their needs. State-based exchanges will bring individuals and small businesses into a larger purchasing group, which will allow flexibility and one-stop shopping. These exchanges are intended to distribute insurance benefits, and to regulate insurance.

*Working Lunch and Keynote Presentation: “Tribal Law and Order Act” SAMHSA’s Work to Improve Behavioral Health in Indian Country*

SAMHSA Administrator Pam Hyde sees the SAMHSA mission as to reduce the impact of substance abuse and mental illness on America’s communities. Challenges include higher adolescent death rates, youth suicide rates, binge alcohol use, illicit drug use, sexual assault and homicide against women, intimate partner violence, incarceration and arrest, and historical trauma. SAMHSA proposed for FY2012 the \$50M Behavioral Health–Tribal Prevention Grant, which is not competitive, but recipients must apply every 3 years and report annually (criteria are not set yet). The Tribal Law and Order Act (TLOA) has 24 possible partners, but none get money to fulfill it. SAMHSA is required to create an Office of Indian Alcohol and Substance Abuse with the Department of the Interior, Department of Justice, and the Education Department as partners. The law allows a Tribe to come up with a Tribal Action Plan (TAP) for substance abuse, but gives no money. The law also directs SAMHSA to inventory resources and assess needs for the 500+ Tribes throughout the country.

*Panel #2—Aging, Family & Human Services Issues*

Mary Ann Higgins, Administration for Children and Families (ACF), said ACF administers more than 60 programs, not particularly designed for Tribes. In addition to Head Start, they administer three grants that have a 5% tribal set-aside—Home Visiting Program, Health Professional Opportunities, and Personal Responsibility Education Program—and the Assets for Independence Project. Most ACF grants are not competitive and have no match at all. A 2010 resource directory has been compiled and is available on-line. ACF has begun its own consultation process.

Kathleen Otte, Administration on Aging (AoA), reported that through the Older Americans Act, AoA funded 256 grants this year, and will announce 218 care-giver grants on April 1. AoA funds are seen as a safety net, so reduced monies make collaboration more important. Gene Brown encouraged all Tribes to apply. To have access to AoA programs, the minimum age limit is currently 60 years. Title VI programs should be doing more in prevention and wellness, physical activity, health screening, nutrition counseling, and weight watching. For more information on resources, see <http://www.olderindians.org/>. Forward comments on Older Americans Act programming to <http://aoa.gov/>.

*Panel #3—Health, Wellness and Behavioral Health*

Michael Milner, Office of the Assistant Secretary of Health (OASH), Region I, reviewed OASH's functions. It works on prevention and preparedness in collaboration with other organizations, thereby fostering stronger State–Tribe interactions. ADM Milner proposes to discuss ways to bring community health directors and State health directors together—to find intersections where they can partner—and in the process integrate behavioral health and primary care.

Chris Bersani, HRSA, said that many HRSA programs are not specific to Tribes, but they are applicable, and multiple collaborative projects are underway. Emotional distress is beneath the threshold of diagnosable mental illness, but primary care providers are on the front line and prescribe more psychotropic drugs than psychiatrists. Members of this population are most often affected by high-risk behavior, e.g., smoking and lack of preventive care. Although many patients are screened, it is very difficult to measure prevention. An immediate goal is to integrate prevention with obesity.

Peter Delaney, SAMHSA Center for Behavioral Health Statistics and Quality, reported that prevention is SAMHSA's #1 goal, followed by promotion of wellness and resilience (i.e., finding good ways of coping and not moving toward drug abuse—Emergency departments' use of prescription drugs has increased 78%). Problems related to substance abuse are suicide and trauma. The criminal justice system has created trauma-informed systems. We want to create resilience in communities so people are prepared for disaster. To improve access to the community for military families, SAMHSA is working with the National Guard. The goal is to create prepared service systems, improve quality of treatment as well as prevention, and create resilience for emotional health, and a seamless set of care for the military. It's not health care unless it includes behavioral health. For this we have to think about collecting good data. The Behavioral Health Quality Framework draft will be posted on SAMHSA's Web site next week.

Gary Perlman, Agency for Toxic Substances and Disease Registry (ATSDR), reviewed multipurpose software to help Tribes deal with contaminated land, which consists of two parts, a tool to inventory sites and prioritize them, and one to analyze health risks. It is Microsoft Access-based and can store documents inside the database. The Site Visit Guide prompts visual inspection and exposure pathways. The health

risk module covers edible species and toxins that enter through the skin. The tool has been widely distributed. It is free, as is technical support and training. Mr. Perlman invited input to improve it.

#### *Panel #4—Preparedness and Response*

Gary Kleinman, Office of the Assistant Secretary for Preparedness and Response (ASPR) Region I, gave an overview of the national health security strategy, a way toward ensuring community resilience. It addresses health equity and a more holistic outlook for these issues. ASPR is responsible for public health and works directly with States and Tribes, but the Federal Emergency Management Agency (FEMA) has authority to coordinate all agencies during emergencies, so responsibilities overlap. The nature of the work is mostly in planning and preparedness activities, and operations during emergencies. In between emergencies they provide support to improve capacity to ensure community resilience. Consider the Medical Reserve Corps (MRC) the civilian Medical Volunteer Reserve Corps. Between crises, they work on prevention and want to train others.

Mark Libby, ASPR Region I, stated that Tribal nations have a couple of options for emergency preparedness and response, primarily through IHS, and Tribal members should call the 24-hour number whenever they have a problem. ASPR's mission is to promote preparedness and response, which in turn promotes resilience. They assess risk and hazards in the community, and they can help communities work through assessments of all kinds of risk and hazards. They facilitate education and training especially for the health workforce. They can also coordinate activities across jurisdictions. For response activities, ASPR is the lead Federal agency for HHS, but it receives huge support from regional health administrators. Their concept of operations is that they work for you and implement your plan; but they do not provide funds. Their response assets include access to 6000 to 9000 members of the Public Health Service Corps, the National Disaster Management Authority (NDMA), HHS, and FEMA, but the core of response is the Disaster Medical Assistance Teams. Pam Hyde, SAMHSA, noted that SAMHSA has not been part of emergency planning, but behavioral health issues happen immediately in an emergency, not far into the future, and we should think about it from the beginning of disaster preparedness.

#### *Panel #5—Tribal–State Relations*

Chris Hager, Regional Director, HHS Region I, thanked all the State officials who attended and asked for specific issues to raise.

#### *Health Information Technology for Clinical and Economic Health (HITECH)*

Susan M. Pezzullo Rhodes, Deputy Regional Manager, Office for Civil Rights (OCR), Region I, presented HITECH as a tool that gives more authority to enforce Health Insurance Portability and Accountability Act (HIPAA) rules. Penalties for noncompliance are stiff—State attorneys general give authority to bring civil action for HIPAA violations—but recognize the difference between willful neglect and accidents. OCR offers training and is working collaboratively on this.

#### *Next Steps*

Ms. Hager thanked everyone for attention and attendance. A quarterly conference call will be scheduled soon, and a list of follow-up actions circulated. Ms. Hager will keep that list open for 30 days to receive additional material. A summary will be circulated within 45 calendar days.

Follow-up actions to date:

- Gary Kleinman, Office of the Assistant Secretary for Preparedness and Response, Region I, will find out whether health care personnel must be licensed in the Tribe's State in order to practice there.
- Christie Hager will find out about people not having access to IHS clinics and not being insured so they can be served elsewhere.
- ADM Milner will put Chairwoman Andrews-Maltais in contact with Suzanne Condon, Massachusetts Department of Health, on toxic pollutants.
- ADM Milner will compile a list of staff members so everyone knows roles and responsibilities and how to contact them.
- The Centers for Disease Control and Prevention (CDC) will be invited to participate at the next meeting.
- Dr. Brown will facilitate distribution of Dr. Roubideaux's letter on tribal employees' health insurance.

Ryan Malonson, Chief, Wampanoag Tribe of Gay Head (Aquinnah) gave the closing prayer.