

# **Tribal Leaders Roundtable**

## **Department of Health and Human Services**

### **November 3, 2009**

### ***Welcoming Remarks***

**William Corr, Deputy Secretary of Health**, opened the roundtable and welcomed participants to HHS for what he characterized as “the beginning of an historic week for you and for us.” He added that he was looking forward to discussing how HHS can improve and deepen its relationship and partnership with each of the Tribes represented in the room (as well as with all Federally recognized Tribes). Corr also noted that HHS had assembled a broad group of senior leaders for the listening session, and he asked each to briefly introduce him or herself.

### ***How HHS Agencies Serve Indian Country***

**Yvette Roubideaux, Director, Indian Health Service (IHS)**, said that she agreed to join the Obama Administration because it really cares about what is happening to American Indians and Alaska Natives. She stressed that the business of IHS is done in partnership with Tribes, and that IHS has heard loud and clear that the Tribes want change.

Roubideaux outlined four priorities:

- to renew and strengthen partnership with Tribes
- to bring reform to IHS
- to improve the quality of, and access to, care
- to make all IHS’ work transparent, accountable, fair, and inclusive

Wrapping up her brief remarks, Roubideaux said she was looking forward to hearing more about the issues facing Tribes.

**Charlene Frizzera, Acting Administrator, Center for Medicare & Medicaid Services (CMS)**, said that this was the first time in her 30-plus years at CMS that the agency has made significant progress in addressing tribal issues. She noted several improvements, including:

- establishing full-time positions dedicated to tribal affairs
- establishing liaisons for tribal affairs in each of CMS’ 10 regional offices
- a renewed priority on the Tribal Technical Advisory Group

Frizzera added that CMS has also found new funding to increase its outreach and enrollment efforts in Indian Country (including having Native communities partner with CMS to develop appropriate outreach programs).

**Rima Cohen, Counselor to the Secretary for Health Policy**, indicated that she was one of three counselors at HHS who act as the Secretary's eyes and ears to ensure that the various agencies work together effectively and are responsive to the needs of the American people including American Indians and Alaska Natives. Cohen added that her portfolio includes oversight of three agencies within HHS (CMS, the Agency for Healthcare Research and Quality, and the Office of the National Coordinator for Health Information Technology).

**Carmen Nazario, Assistant Secretary, Administration for Children & Families**, noted that her agency is deeply committed to strengthening the government-to-government relationship with Tribes and to strengthening the list of programs that ACF provides.

**Sharon Parrott, Counselor to the Secretary**, indicated that her portfolio at HHS includes the Human Services programs within the government (both programs for children and programs under the Agency on Aging).

**Eric Broderick, Acting Administrator, Substance Abuse and Mental Health Service Administration (SAMHSA)**, said his agency's goals were pretty straightforward with regard to Tribes. They include:

- recognizing and promoting the sovereignty of Tribes and promoting government-to-government relationships
- increasing grant writing and other technical assistance to boost the percentage of grant resources that go to Tribes

Broderick added that SAMHSA has a partnership to fund a methamphetamine initiative in a number of Native communities, and will continue to work with Tribes on suicide prevention activities. Finally, he noted that his agency has established a 14-member Committee on Tribal Affairs.

Several other senior HHS staff also attended the session, including **Chief of Staff Laura Petrou**; **Mary Wakefield, Administrator, Health Resource Service Administration**; and **Caya Lewis, Director of Outreach and Public Health Policy, Office of Health Reform**. **Paul Dioguardi, Director, Office of Intergovernmental Affairs**, served as moderator for the session.

## ***Remarks by Secretary Sebelius***

Secretary Sebelius welcomed the assembled tribal leaders to HHS, and stressed that making sure American Indians and Alaska Natives have high quality care is a top priority for the Department. She also emphasized that HHS believes strongly in government-to-government relations and consultations.

Secretary Sebelius noted that the appropriations bill for the Department of the Interior, signed by the President on Friday, contains a 13-percent increase in funding for IHS (the largest increase in 20 years). She added that the increase includes additional monies to maintain current service levels and new funding for a wide range of programs. We're not satisfied with the status quo, she said. This is a starting place for a conversation and an important threshold for Year 1, said Secretary Sebelius.

Secretary Sebelius also talked about the Department's efforts to develop and disseminate the H1N1 vaccine and asked tribal leaders for their help in getting the word out about both prevention and vaccination.

Wrapping up her remarks, Secretary Sebelius talked about the importance of health reform. In particular, she noted that HHS was working to ensure that the mandate on individual responsibility contained in the draft legislation does not apply to Indian Country.

### ***Discussion: Healthier Indian Nations***

Prairie Band Potawatomi Nation Tribal Chairman, Stephen Ortiz, opened the discussion by noting that Region 7 has done a great job of making his Tribe aware of all the services within the HHS umbrella. He then expressed concern that the software in his Tribe's PMS is incompatible with OMB software. As a result, he said, American Indians are being undercounted. The software systems need to talk to each other, he said. He also urged HHS to speed up the deployment of electronic medical records in order (1) to save on storage fees; and (2) to ensure the continuity of medical histories (since IHS physicians switch out so frequently).

A tribal leader from Arizona expressed concern about a proposal to split the Phoenix region. He indicated that this would pose a serious resource problem and urged HHS to reconsider.

Tribal Chairman Ned Norris, Jr. of the Tohono O'odham Nation said that he had listened to commitments and promises before without any follow through. While he was encouraged by what he was hearing from the administration, he asked: Where do we go from here? He noted that IHS is historically underfunded and wondered what it would take to really begin to address health care issues in Indian Country. He also talked about the Federal obligation to provide health care to tribal communities. Finally, he lamented that the system was creating 21<sup>st</sup> century medical professionals and then trying to entice them to practice medicine in an antiquated health care system.

A tribal leader from Alabama talked about the need for an emphasis on wellness programs.

A tribal leader from the Ute Indian Tribe in Utah said that seniors are coming to him and saying they are ineligible for Medicaid because of their income. Efforts to address the problem through the Utah Medicare and Medicaid Office have so far been unsuccessful. He said that one big problem is that

several families often live under one roof—and that because of the per capita payment formula they are often ruled income ineligible even though each family is a separate entity. The definition of family must be redefined, he said.

The same tribal leader also noted that one of his tribal members had described IHS as “a first aid station.” One problem, he said, is that there are now four dentists (up from two) but there are still no dental tools.

Vice Chairman Gary Hayes of the Ute Mountain Ute Tribe noted that many Tribes have elected to make up for Federal funding shortfalls for Medicaid by setting up tribal health care plans. As a result, he said, what is needed from IHS is understated by these subsidies. He said that when a Tribe pays the claim, it should be covered by the Contract Health Service (CHS). However, he said, the payments are often late, tribal budgets are reduced, and people are penalized. He added that, to make up for the shortfall, Tribes are forced to fund only critical care. Tribal self-funded plans should be entitled to the same Medicaid rates that IHS receives, he said.

The same tribal leader also identified two additional concerns: (1) the need for health care in adult and juvenile facilities; and (2) the need for states to consult and collaborate with Tribes over how to allocate the federal funds that they receive.

A tribal leader from Buckland, Alaska, talked about the role of traditional healers.

A tribal leader from the Red Cliff Band of Chippewa Indians expressed concern with the caps on assistance under programs administered by ACF. Also, there is a need for traditional healers to charge for their time, as well as the need for more funding to address both prescription drug abuse and language maintenance. A colleague added that there was a regional funding disparity (and that the Tribe was receiving only about 30 percent of its level of need) and asked: Do you have plans to address this, and what are they?

A tribal leader from Wisconsin expressed concern with the fact that there were agencies within HHS that were not aware of the Tribes’ government-to-government relationships, and suggested that perhaps a “tribal czar” needed to be appointed to serve as a liaison with all the agencies within HHS. He also spoke about the need to provide Tribes with maximum discretion in funding.

Rosalie Tepp, Chairperson of the Kenaitze Indian Tribe, pointed out that there is no running water in tribal villages. She also noted that the state has been atrocious in dealing with Alaska Native children; and that the Tribe is forced to sign a waiver of sovereign immunity to get funding from the states.

Another tribal leader from Alaska said that health care in his Tribe has improved significantly since the Tribe took control. He said that his Tribe is concerned about end of life issues. This includes the fact that, while there was funding to build several assisted living facilities, there is no money to operate them.

President of Nome Eskimo Community Tribal Council, Lestor Keller, said that his Tribe is working hard to address suicides. He added that funding for his Tribe's new hospital has given the Tribe an opportunity to develop a vision for a residential treatment facility.

Sam Penney, Executive Committee Chairman of the Nez Perce Tribe, asked for clarification on the extension of coverage under the torts act, because the need for physicians to purchase their own malpractice insurance is making it cost-prohibitive for them to practice in Indian Country. He also asked HHS to look into a tribal law and order act that was making its way through Congress in order to ensure that it also provides family, mental health, and drug counseling to people who are incarcerated.

A tribal leader from Oregon cited four specific concerns: (1) the impact of health care reform on Tribes; (2) the need for increased funding (he noted that contracted health care costs are too high and that his Tribe exhausts its funding prior to the end of the year); (3) the need for facility funding (and the fact that (a) there is no way for Tribes to access IHS funding for facilities; and (b) Tribes can't save money for this because all their existing dollars are going to fund ongoing care); and (4) the need for ongoing funding for disease prevention (including the diabetes funding program).

Tribal Chairman of the Yakama Nation, Ralph Sampson, Jr., urged his fellow tribal leaders to lend their voices to help pass health care reform.

Joanne Polston, First Chief of the Mendas Cha-AG Tribe of Healy Lake, advocated for expansion of health services in Alaska. She said that existing facilities are both understaffed and underfunded (noting, as an example, that in the interior of the state it can take up to a year to get an appointment to get your teeth cleaned), and that more emphasis needs to go to educating the community health aides who serve as the main access to primary health care. She also talked about the need for IHS to provide better care, citing as an example that IHS refused to pay for a second dose of TAMIFLU for her son because IHS said the drug eliminates symptoms but doesn't cure H1N1.

Ivan Posey, Chairman of the Eastern Shoshone Tribe, asked that HHS keep its ears and hearts open to helping tribal peoples at the local level.

A tribal leader from Alaska talked about the need for a new clinic. We don't have running water, he said, and we don't have transportation to haul people to faraway clinics. He also talked about the need for technology, including computers and a medical database.

Derek Bailey, Tribal Chairman of the Grand Traverse Band of Ottawa and Chippewa Indians, reiterated the need for more funding. He also expressed his desire to see a Bemidji Health Board.

Charles Locust, Assistant Chief of the United Keetoowah Band of Cherokee Indians in Oklahoma, said that because his Tribe was listed as a co-jurisdiction they're not counted individually as a Tribe. This also impacts the census numbers, he said. He said he was asking HHS for help so that his Tribe won't be left out in the cold. He also suggested that tribal members be identified via tribal ID cards.

A tribal leader from the Spokane Tribe of Indians reiterated funding challenges, and said they were especially dire within CHS and the Agency on Aging. He also expressed concern that the Internal Revenue Service was going after Tribes that were using gaming revenues to provide health care to their people.

Joseph Manuel, Lieutenant Governor of the Gila River Indian Community, noted that drug abuse, diabetes, suicide, and homicide are rampant in Indian Country. He said that the relationship with IHS has been good and that he hopes this continues in order to provide services to urban American Indians. Finally, he reiterated that health care services to Native Americans is a Federal Trust responsibility.

Affiliated Tribes of Northwest Indians President, Brian Cladoosby, said that government-run health care is a national disgrace. We need to reaffirm the administration's policy on Indian health, he said, including restoring lost IHS funding. We don't need a hand-up, he said, we need you to help us solve our problems with us.

A tribal leader from Portland said that a major source of contention is the fact that HHS sends funding to the states—and not directly to Tribes. He also talked about the need to provide health care services in a culturally appropriate way, and he said that IHS should not be the payer of last resort. Finally, he reiterated the fact that providing health services to American Indians and Alaska Natives is a Federal Trust responsibility.

Ronda Metcalf, Vice-Chairman of Sauk-Suiattle Indian Tribe, talked about the fact that the state's practice of privatizing services (including mental health and welfare services) is cutting Tribes off from service. When they complain, she said, the response is "You people have IHS." She also expressed concern (1) that the state's decision to allow home health workers to unionize infringes on tribal sovereignty; (2) about disproportionately high rates (specifically citing suicide rates as well as the high percentage of American Indian foster children in institutions); and (3) the fact that many Tribes are using more and more of their funds to provide care to returning veterans in rural areas (as it is hard to get to the Seattle VA hospital). Finally, she expressed concern with the trend toward telemedicine, saying that the Tribes need providers and the money to provide health care services.

The President of Quinault Indian Nation, Fawn Sharp, talked about climate change and the need for a health care component to address adaptation and mitigation strategies.

A tribal leader from central California noted that, while an expanded IHS budget will help, disparities continue to exist. He said that mental health funding is very important. He also talked about ensuring that the census accurately counts American Indians and that the Health Care Reauthorization Act be reauthorized. Finally, he asked to talk with Nazario about a problem with his Tribe's local ACF program.

A tribal leader said that while he was grateful that his Tribe has a health clinic on the reservation, they have outgrown the capabilities of what they can do there. He said that the Tribe would like a larger

facility in order to increase its service area (notably to provide coverage and care for the growing number of tribal members who have moved off the reservation in search of both housing and jobs).

Cheryle Kennedy, Chairwoman of the Confederate Tribe Grand Ronde Community of Oregon, reiterated the need for more funding. She noted that IHS is the only HHS agency that provides direct primary care to people—and yet it is cut in equal proportion to other agencies within HHS. She said she would like to see other HHS dollars reassigned so that the per capita allocation for health care for American Indians does not continue to be the lowest in the nation. She also noted the huge health disparities in Indian Country, including the disproportionate number of people with disabilities.

Winnebago Tribe of Nebraska Chairman, John Blackhawk, also reiterated the need for more funding along with the need for more staff.

A tribal leader from Oklahoma said that her Tribe's major issue was the state's failure to conform to the Indian Welfare Act.

Carey Wahwahsuck, Vice Chairperson of the Sac and Fox Nation, said that she had asked tribal members what they wanted her to tell people in Washington. She said they wanted (1) name-brand prescription drugs through IHS (even if they have to pay a co-pay); (2) education and outreach to young people (including around the issue of teen pregnancy); (3) more funding; and (4) to understand how health reform will impact the Native American population.

Pueblo of Isleta Governor, Robert Benavides, also said that he was concerned about funding. He suggested that a working group be established to improve funding for Indian Country. He also expressed concern about direct funding coming through the state for IHS (as well as funding for transportation). He said these concerns arise in part because the states don't have a Trust responsibility.

Another tribal leader from New Mexico said that President Obama, as a candidate, had pledged full funding for Indian health care. How much will it take to do this? he asked. He also asked HHS officials to provide a written response to those tribal leaders who had provided written comments to HHS.

Charlene Nelson, Chairman of the Shoalwater Bay Tribe, said that while she was glad that senior HHS leaders were present, she was sorry that Secretary Sebelius was not able to stay and hear directly from tribal leaders about their concerns. She highlighted two concerns: (1) the need for culturally appropriate drug treatment prevention programs, treatment programs, and facilities; and (2) the importance of the Medicare encounter rate to funding her clinic.

Kim Clausen, Oglala Sioux Tribal Council Member, said that if you are not a Priority 1 case then you do not get care. She also talked about problems with Medicare and Medicaid funding (including reimbursement requests that are denied) that are arising in part as a result of the troubled relationship between the Tribe and the state. As a result, she asked for a meeting with CMS officials in Washington as soon as possible. Finally, she cited the need for health care providers to be performance-based and to

speak English, and the need for a consistent provider to develop a pain plan. It's terrible out there, and it is time that changes, she concluded.

A representative of the Omaha Tribe, Virginia Hill, said that the Tribe has to look at its tribal enrollment and the number of people using ACF programs to set a base level of funding for the Tribal Temporary Assistance for Needy Families (TANF) program. She also asked whether there was additional funding for post-treatment care. In addition, she requested that HHS officials look into developing some regulations and putting some enforcement behind the Indian Child Welfare Act. Without it, she said, states, judges, and Child Protective Services workers have been allowed to ignore the Federal law.

Chris Devers, Tribal Chairman of Pauma/Yumia Band of Mission Indians, also spoke of the need for all HHS staff to understand the Federal Government's Trust responsibility. He then cited two additional issues: (1) the need to broaden consultations to hear consistently from a broader range of tribal leaders; and (2) the need for HHS to engage on Medicare and Medicaid (especially as to why funding goes to the states on behalf of the Tribes rather than directly to the clinics). Finally, he urged HHS staff to speak up and support H.R. 3962.

Santa Ysabel Band of Diegueno Indians Tribal Chairman, Johnny Hernandez, also reiterated the need for more funding, and the need for funding for American Indian health to come directly to the Tribes (and not through the states). He also spoke of the need for more American Indian doctors, the lack of any American Indian hospitals in his state, and limited access to drug prevention programs.

A tribal leader from North Dakota said that his Tribe had to sue to get indirect costs support. He added that just getting the direct costs would be a step in the right direction. Finally, he said, please just fund us at 100 percent of what is currently there. He also noted that there were 11,000 tribal members but that his Tribe had received only 250 doses of the vaccine. We don't just service our Tribe, he said; we service multiple Tribes.

Jonathan WindyBoy, Chippewa Cree Tribal Council Member and Montana State Senator, said that addressing issues of state-Indian tribal relations is paramount. He also spoke of the need to break down silos and better coordinate funding (as an example, he noted that the Bureau of Indian Affairs, IHS, and SAMHSA each have methamphetamine funding—but they aren't coordinating their efforts). In addition, he noted that mental health issues, including domestic violence, were at epidemic proportions among children and youth. Finally, he asked why the Indian Health Care Act needed to be reauthorized every 10 years. Why can't we make it permanent? he asked.

Jasmine Andreas, Tribal Council Member and Secretary of the Bishop Paiute Tribe, discussed her Tribe's challenges in dealing with ACF and getting access to Tribal TANF. She said that her Tribe gets the runaround from Region 9, which seems to have made its mind up already and is not interested in tribal input. We need respect, decency, and understanding, she said, and we haven't been given this by ACF in our region. She added that she was escalating the issue today so that Nazario understands how her staff is treating people in Indian Country. Finally, she reiterated the need for culturally appropriate programs.

Tribal Chairman of Reno Sparks Indian Colony, Arlan Melendez, who is also a member of the U.S. Commission on Civil Rights, spoke of the need to address both funding and health disparities in Indian Country. He also noted that the funding formulas need to change.

Finally, a tribal leader also in ACF Region 9 said that her Tribe too was getting the runaround and being denied Tribal TANF. She asked to speak with Nazario. We're not asking for money, she said, we're asking for communication.

### ***Closing Remarks***

Wrapping up the session, several HHS senior staff spoke about next steps. Charlene Frizzera said that CMS was working with the State of California to figure out how best to provide Medicare and Medicaid funding to the Tribes. Carmen Nazario gave tribal leaders her direct line, and told them to please call or write directly to her if they get a runaround from an ACF office. Finally, Mary Wakefield pledged to send a letter to tribal leaders detailing what HRSA is doing to support people in Indian Country.