



Chapter III–National Tribal Consultation Forum

In July of 2000, the Department convened tribal leaders from all across the nation for a National Tribal Consultation Forum with top representatives from each of the Operating Divisions. This gathering was convened by Deputy Secretary Kevin Thurm and moderated by tribal leaders representing national Indian organizations. The format for the two-day meeting included presentations by panels of agencies within DHHS responding to the concerns voiced by tribes during the five listening councils. Following each panel presentation, tribal leaders and Indian organization representatives were provided time to ask specific questions or to make statements. A summary of new issues raised at this national meeting is reflected in later sections of this report. The agenda also provided time for tribal leaders to breakout into smaller workgroups to develop specific action-oriented recommendations around 7 major issue categories identified during the five listening councils.

A. Tribal Recommendations on Major Themes

The seven (7) work groups met for an hour and a half to address the specific responses provided by OPDIVS in a draft document. From these seven work groups the following recommendations were made:

1. Funding and Budget Issues

Lack of Funding. Establish a line item budget, support appropriation for health services at the “level of need.” Create a Work Group comprised mostly of tribal and some HHS personnel to assess HHS funding and unmet needs in Indian Country which will be one year or more in duration. Analyze federal funding, awarded by direct and block grants, by population through tribes, tribal organizations and state/county governments, under GPRA and/or other means.

Lack of Funding for water/sewer maintenance. Appropriately fund maintenance and improvement.
(1) Ensure adequate funding and emphasis by IHS to monitor and assess water borne diseases.
(2) Continue efforts in both IHS, CDC (with support by the DHHS) to increase funding for capital construction.

Lack of Funding to build, expand, replace and maintain health care facilities. Fund innovative financing for tribes to build health care facilities. Create a tribal workgroup as a sub-work group or committee on Facility Construction to assist the DHHS funding workgroup in exploring new non-IHS construction funding options.

Lack of funding for Traditional Native Healers/Native Practices. (1) Have HCFA institute a waiver to allow native healers to be reimbursed by states through Medicaid and other programs. (2) Continue to support amendments to Title IV of the Indian Health Care Improvement Act reauthorization bill, which expands reimbursement for traditional healers.

Lack of funding for prevention activities. The funding is only enough to address primary care. Create a sub-work group on prevention to meet in conjunction with the DHHS funding workgroup to assess Block Grants and/or other funding for prevention initiatives.

Underfunding of CHR and Clinical Health Nurse Programs and earmark of funds for CHS and increases for CHS. Continue to address through the IHS Budget Formulation Process.

Appropriate additional funds for EMS, elder care, alcohol prevention and treatment. Commit to a long-term diabetes initiative in Indian country. To compliment the HHS funding work group, create a “services” subcommittee or sub-workgroup to address funding needs in these areas in chronic and infectious diseases.

2. Services and Service Provision

Specialty Care. (1) Provide non categorical funding for pilot programs in the design of comprehensive systems, including specialty care (joint venture) (HRSA). (2) Institutionalize the pilot programs that are successful.

Dialysis. (1) We must find the means to access additional funding for kidney dialysis in Indian communities. (HRSA, NIH). (2) Develop consumer friendly educational materials on diabetes and kidney disease; expand successful preventive programs including staged diabetes management.

Cancer Screening for Men. (1) Access additional fiscal resources from DHHS agencies beyond the IHS to expand cancer screening services to both genders. (2) Ensure reimbursement for prevention services to get men screened and treated earlier, which will outweigh the more costly late-stage treatment efforts.

Lack of access to charity care. (1) HCFA encourage states to provide DSH funding to IHS and tribal hospitals (a letter is going out, but a problem in the definition of a hospital is greater than 16 beds.) (2) Work with HCFA to expand DSH payments to I/T/U programs through legislative and regulatory means.

Traditional Healers. (1) HCFA should work with state Medicaid programs to encourage and support a means to include reimbursement for traditional medicine. (2) HCFA support for legislative changes in IHCA regarding traditional healers.

Medicaid services to unmarried couples. States cannot deny Medicaid because of the parent’s marital situation, yet this is an obstacle for many Indian families. HCFA must work with the states and tribes to overcome this barrier for tribal families.

3. Care Providers

The present health professional resource situation is that there are just too few providers in critical areas and there is a high patient care load. There is a specific need for more psychiatrists, mental health professionals, and counselors trained in inhalant abuse. Tribal communities also need more Community Health Representatives (CHR's) and more Clinical health nurses. To address the many health professional shortages in Indian communities, tribal leaders made the following recommendations.

Incentives: IHS must use existing options to encourage careers in IHS, and other Indian health care facilities, such as the Federal loan repayment programs and scholarships and enhancement training of Native Americans in the health professions. *School Linkages:* Look at how to enhance relationships with schools producing physicians, nurses, and other health professionals. Encourage cooperative learning experiences between local health facilities and local school districts and college work study programs for youth to encourage interest in health professional careers.

Multi-agency Work Group: Establish multi-agency working group on health professions and Indian health with tribal participation. Establish a work group as a standing committee to look at issues (i.e., retention incentives, building educational capacity at the local level and help tribes bring it together).

Department of Justice Coordination: To assure appropriate levels of qualified mental health, chemical abuse and law enforcement staff and services, need to engage the Department of Justice.

Cross-cultural training: Ensure that cultural sensitivity education is provided for providers and communities throughout the I/T/U system.

Catalogue "best practices": Capture "best practices" and catalog programs with a cultural orientation used successfully in communities.

CHR Development: Enhance training and career development pathways for CHRs

Continuing education: Identify and develop distance learning options for continuing education credits.

4. Facilities, Equipment and Supplies

Tribes are operating under in a "crisis mode." Tribes are caught in the difficult position of trying to provide health services with less than adequate resources in facilities which are outdated and ill-equipped or the challenge. In addition, tribes need to continually devote time and energy to educating the federal agencies regarding the specific, varied and unique challenges to providing health care to American Indians and Alaska Natives.

IHCIA Reauthorization: Strong support and lobbying is needed to push through the tribal consensus amendments to Indian Health Care Improvement Act (IHCIA), Title III Facilities section.

Appropriations: Support and advocacy is needed for annual Interior appropriation bills in FY2001 and FY 2002 for facilities construction, equipment and sanitation.

Tribal committee: National tribal committee to review health care facilities methodology and develop a needs inventory

Steering committee: Dr. Trujillo, IHS Director, approved concept for a steering committee to develop the priority list and review the health care facilities methodology to endorse and support this steering committee.

Support for tribes already on the priority list: Endorse IHCIA recommendation to grandfather those tribes that are on the priority list.

Recurring construction funding: Begin to support legislation for recurring base funding through the IHS budget process, the current estimate is \$170 million. Need to have a long-term commitment for facilities for IHS tribes and the Office of Management and Budget.

Disaster preparedness plans: The IHS needs to identify what each tribe has/needs for disaster planning and preparedness.

Emergency Medical Services: Need to identify the ambulance needs for each tribe.

HHS field visits: Tribes need to make an effort to invite all the Department heads to tribal communities to that they gain a real understanding of the challenges faced by tribal leaders and health care

providers. There should be an ongoing commitment by tribes to continue inviting HHS department heads to Indian Country.

Indirect cost assistance: The IHS and HCFA will provide assistance to tribes in determining a formula to determine indirect vs. direct funding.

Accreditation costs: HCFA needs to assist in researching alternatives to the high-cost of JCACHO accreditation for Medicare and Medicaid funding.

5. Intergovernmental Relations and Related Issues

Partnerships: There is a need to explore new and creative approaches and partnerships for efficient delivery of services to tribal communities and encourage collaboration between state and tribal governments. Agencies of HHS should assist in helping private businesses become health care partners with tribes.

- (1) Agencies encouraging states to work with tribes
- (2) Convene a meeting with the National Governors Association (NGA), state health directors, tribal leaders, and program staff to discuss collaborative opportunities.
- (3) Talk to states and tribes about “best practices” and impose conditions that accompany federal funds to states, to work with tribes or else lose a portion of state Block Grants; tribes should have direct access to these resources.
- (4) Help maximize tribal access to state health resources.

- (5) Educate U.S. Congressional members, states representatives, etc., about tribes as governments, tribal capacity, etc.
- (6) Use maximum flexibility in working with tribes unless prohibited by law, develop policy guide.
- (7) Identify the parameters within various discretionary programs, such as “eligibility” and work to improve access for tribal patients.
- (8) Seek federal legislation which would authorize direct funding to tribes or require state agencies to work directly with tribes in implementing federal health programs.
- (9) HHS mandate as a directive that states provide appropriate funding to tribes.
- (10) Seek language in Appropriations bill which will set-aside specific allocations for tribes in each HHS program as opposed to seeking changes to authorizing statutes.
- (11) Work through the budget formulation process to increase HHS funding for tribal and other Indian communities.
- (12) Bring the issue of disproportionate underfunding of Indian health to the international level for discussion.
- (13) Nurture the tribal/federal agency relationships at regional levels.
- (14) Work with state agencies through cooperative agreements to improve the situation of Indian health in each state.
- (15) Look to the several “Intertribal Councils” as means to work together on state and tribal issues.
- (16) Closely examine existing HHS Block Grants to states to determine all possible ways to encourage and increase tribal participation. Establish a requirement to report federal funding going to states to the tribes. HHS Office of Intergovernmental Affairs should put pressure on the states to better work with tribes.
- (17) Participate with the National Governors Association to begin discussions about HHS Block Grants to states and tribal participation.
- (18) DHHS agencies should help facilitate tribal/state relationships, as stated in the HHS consultation policy, through the IGA.
- (19) State Plans for specific Block Grants programs should be shared with tribes so that tribes will know what services are provided, which populations are targeted and counted and the amount of federal resources provided.
- (20) GPRA requirements should be enforced which would support state consultation with tribes as a part of the New Federalism.

Advisory Boards: In regards to the establishment of a Departmental advisory body which includes tribal leaders the following specific recommendations were made.

- (1) Institutionalize a tribal voice in policy-making.
- (2) Extension of the consultation steering committee.
- (3) Tribes create this Advisory Board with a list of contacts for consultation purposes depending on the issue.
- (4) The Office of General Council will check the rules on Advisory Boards.
- (5) Intergovernmental Affairs will staff the Advisory Board.

Follow Up: Regarding planning and follow-up to this and future “consultation” meetings or Listening Councils, the following recommendations were made.

- (1) Elevate the priority of tribal consultation with additional staff.
- (2) Publish in the Federal Register as soon as possible, the consultation schedules for the next year to help with the transition, including budget, legislation, and programs.
- (3) Information to tribes about IHS design of the Final Report
- (4) Some state funding identified/earmarked for Indian programs

- (5) HHS can help with technical assistance
- (6) Identify Block Grants with restricting language and those that are open
- (7) HHS IGA should sit-in on Alaska government-to-government meetings.
- (8) There should be ongoing funding or a “tap” to support tribal consultation activities.
- (9) IGA should issue a Draft Plan and schedule of follow up meetings
- (10) Look to regional “Intertribal Councils” and other Indian organizations for strategies, coordination and direction.
- (11) The National Congress of American Indians (NCAI) should provide its resource guide to the HHS Intergovernmental Affairs office immediately and routinely.
- (12) This Final Report for the National Listening Forum must include the responses received back from individual Operating Divisions of HHS. Seek comments on format of the report.
- (13) HHS will list the “point of contact” for each of the HHS agencies as a part of the Final Report for central office and regional offices.
- (14) Provide time at future national meetings for updates about this and future consultation progress.
- (15) All DHHS agencies send budget information to tribes for opportunity to react.

6. Infrastructure

- (a) Continue increases to SDS budget (IHS/DHHS)
- (b) Continue to lobby in support of tribes;
- (c) Collaborate with other departments and agencies, such as the Environmental Protection Agency (EPA), USDA, etc., on funding projects. This would be similar to what DOJ, CPO and BIA did in the construction of detention facilities. DOJ-CPO constructs and BIA staff facility, maintenance and operation. Tribes can contribute to projects which increases the changes of funding
- (d) Facilities Backlog Advisory Board of IHS should continue looking at alternatives to the construction priority list.

7. Data and Research

- (a) HCFA and IHS will incorporate an “Advisory Committee” to meet with a group of experts to review the current data collection. Proposed meeting in September of 2000. Incorporate this into the consultation protocol.
- (b) Data council shall share the joint report with 558 tribes and shall attend the HCFA/IHS committee meeting proposed for September 2000.
- (c) In 2001: Explore valid and reliable data to ensure accurate reporting on vital statistics and to also influence the National Policy Commission.
- (d) In 2005: Morbidity and Mortality data needs to be accurate on IHS data that shall include shared data, such as for diabetes, with American Indian and Alaska Native health.
- (e) In 2005: Develop a common data set for all of Indian health nationally.

B. New Issues Voiced at the National Tribal Consultation Forum

The participants at the National Listening Forum raised new issues.

Set Aside. The HHS should establish a set-aside of at least 1.5% of HHS budget which is dedicated for programs and services for Indians. This percentage roughly represents the Indian population in proportion to the U.S. population served by HHS.

Diverse Strategies. Tribes are unique. One-size does not fit all tribal communities. HHS must keep this in mind when developing strategies and initiatives for Indian country.

Unique Relationship. Tribal/federal government-to-government relationship is based on unique political, historical relationship and NOT on status as racial minority or public involvement. This needs to be clearly understood by every OPDIV.

Current Levels. What is the exact percentage of the HHS budget now going to Indians? This data must be provided for discussion and consultation between tribes and HHS to be meaningful.

Legislative Changes. Identify specific legislative changes needed to eliminate barriers preventing Indian populations from accessing HHS categorical and formula funded programs. Can tribes and HHS develop together a technical amendments bill which could correct many of the problems with existing HHS authority?

Consultation Plans. Tribes want to know the status of draft consultation plans prepared by each OPDIV, and the steps to ensure accountability to follow these plans. Each OPDIV Plan should be consistent with the Executive Order and Secretary Shalala's policy statement. It was pointed out that consultation is a "two way street" and that only 3 of the 550 tribes responded so far to the draft consultation plans.

Community-Based Research. Note of caution about using universities as the focal point for research within Indian communities. All research should go through the local tribal Institutional Review Board. Tribes should have precedence over universities for research on Indian health. There is considerable interest in the amount of funding from NIH available for Indian research. For example if the 1.5% set aside was applied to NIH's \$18 billion budget, tribes could have access to \$250 million in research and planning funds.

Emerging Health Issues. More attention is needed on emerging health problems such as HIV/AIDS, cancer, heart disease, diabetes, domestic violence, alcoholism/alcohol abuse, methamphetamine use, youth suicides, elder care, and child sexual abuse;

Pre-meeting Notice and Document Review. There needs to be adequate notice of these type of meetings with time to review documents in advance.

HCFA Definition of "Encounter." Repeated concerns about the lack of a consistent definition for an "encounter" by HCFA. This needs to be resolved in consultation with tribes. The current "rural rate" is too low. There needs to be an all-inclusive rate for dual-eligible patients.

States Reluctant. States continue to be reluctant or even refuse to engage in meaningful discussion and consultation with tribes on many of these issues. There could be civil rights violations in the way some states have systematically excluded tribal participation in resources. One example, was the refusal by the State of South Dakota to certify nursing homes on Indian reservations with certificates of need and thus prevent access to Medicaid reimbursements. The State of Idaho refuses to pay the encounter rate to tribes. There was a request for review by the Office of Civil Rights with regard to South Dakota.

HCFA/IHS Demonstration Must Include Tribal 638 Contractors. The proposed demonstration project being planned between HCFA and the IHS to eliminate IHS facilities from cost reporting requirements should also include tribal 638 contractors. Not all tribal contractors are FQHC and could benefit from this coverage.

Direct Funding of Tribes. Tribes should receive funding directly from the federal government and not be forced to go through the states to access federal health and human service resources, such as services for Severely Mentally Ill (SMI) populations and other HCFA resources.

Devolution. Tribes are concerned about the trend toward devolution and the federal government should provide for direct funding of tribes without going through the states.

Slowness of Response. There was disappointment voiced about the slowness of responses to issues raised by tribes at the five (5) listening councils. A more expedited system is needed to provide more timely feedback and dialogue with tribes.

CDC Funding. What percentage of the total CDC budget does the current tribal funding of \$21 million represent? Tribal infrastructure for public health oversight is needed and should be supported through CDC funding. There was a specific inquiry regarding the recent decision by CDC to cut by 50% its support for Native American HIV/AIDS for capacity building in Indian communities. These funds should be restored, particularly in light of the limited disease surveillance in Indian country now.

Communication. The HHS was encouraged to utilize the national Indian organizations, such as NIHB, NCAI, NCUIH to get the message out to Indian country. But, the agency should also communicate directly with the 550 tribes, as not all tribes belong to these organizations. There was also a suggestion that the IHS Area Directors be delegated the responsibility to ensure communication is delivered directly to each tribe and opportunities for feedback provided.

International Borders. Tribes along the Mexico/US border are subsidizing the cost of emergency medical care for illegal aliens injured or sick and brought to their facility by the INS. There was a request for assistance.

Indian Health Care Improvement Act. The Department has not yet taken a position on the tribal consensus bill for the reauthorization of the Indian Health Care Improvement Act. Tribes want to know what position this Administration takes on this important legislation.

Inpatient Treatment is Too Short. There was concern raised that inpatient treatment for 28 days is not sufficient to address the multiple drug, alcohol and mental health problems experienced by Indian youth. Longer treatment is needed. Also what is available for those people returning to their communities from treatment? Support for longer treatment is needed.

HHS Agency Responses to New Concerns and Issues

Issue #1: Definition of an “encounter”

The IHS and HCFA responded to the concern raised by tribal representatives about the inconsistency among federal programs in the definition of an “encounter” and the inadequate reimbursement rate or patient encounters in remote, rural communities.

Both IHS and HCFA cited Section 1911 of the Social Security Act, which provides authority for IHS facilities to collect Medicaid reimbursements for eligible patients seen in an IHS-owned or leased facility, whether operated by the IHS or a tribe or tribal organization. The IHS and HCFA have established a “Working Group” consisting of tribal representatives who are providing input into the development of a policy memorandum, which will

include the definition of an “encounter”, and specify what services are covered by the all-inclusive rate. It is anticipated that this policy memorandum will be applied nationally to all State Medicaid programs in which IHS or tribal programs operate. HCFA proposes to send a letter to State Medicaid directors and tribal leaders clarifying the definition of an encounter to address this concern.

Both agencies have already begun steps to address this tribal concern. Meetings were held with tribal leaders to discuss a draft policy memorandum. HCFA staff met with State Medicaid directors as well. While this is not an appropriations issue since Medicaid is funded as an entitlement, the outcome of defining what services are covered under the all-inclusive rate and the definition of an encounter, will have an impact on overall funding for tribal and IHS facilities serving Medicaid eligible patients.

Medicaid is a state-administered program. Reaching consensus among the various states and many tribes operating health services in each state could be difficult to achieve. Some of the potential strategies identified to overcome this obstacle include pending legislation in the U.S. Congress. The reauthorization of the Indian Health Care Improvement Act, if enacted as proposed by tribes, would include a new “Qualified Indian Health Program” (QIHP) which specifically establishing a national reimbursement methodology for IHS, tribes and urban Indian health providers. HHS has not taken a position on QUIP. In the mean time, IHS and HCFA continue to work with the tribes and the National Association of State Medicaid Directors’ Tribal Workgroup to discuss and resolve these issues.

Key contacts on this issue are: Kitty Marx, Senior Policy Analyst, Office of Management Support, Indian Health Service (301) 443-6306; Elmer Brewster, Senior Health Specialist, Office of Public Health, Indian Health Service (301) 443-2419; Christine Hinds, Health Insurance Specialist, Health Care Financing Administration, (410) 786-4578 and Larry Reed (410) 786-3325.

Issue #2: HCFA/IHS Demonstration Project:

The IHS and HCFA each responded to the concern by tribes at the National Forum that the “Demonstration Project” contemplated by IHS and HCFA did not include tribes administering health services under the Indian Self-Determination Act (PL93-638).

The IHS and HCFA cited Section 1880 of the Social Security Act, which provides authority for the IHS and tribes to collect Medicare reimbursement for services to eligible patients, and Section 402 of the same Act which allows the Secretary to conduct the “Demonstration”. These agencies reported that currently a draft proposal is being finalized through a joint working committee of the IHS, HCFA and tribes. Medicare cost reports will continue to be a requirement of all IHS and tribal hospital facilities for rate setting for purposes of Medicaid and to make sure that IHS is receiving reasonable reimbursements from Medicare. Tribal freestanding outpatient clinics are not part of the Demonstration as planned because these clinics can bill Medicare as a “Federally Qualified Health Center” (FQHC) or under the physician provider number. The Demonstration Project will change

how the IHS is reimbursed Medicare payments from “fee-for-service” to a per capita amount. Appropriations will not be affected by this project, however it must be presented to the Office of Management and Budget (OMB).

Potential strategies to overcome these obstacles include the IHS looking more closely at the difficulties that facilities operated by tribes under PL 93-638, which are owned or leased by tribes face in accessing Medicare. Continued consultation with tribes on each of these issues is viewed as the key to moving forward and defining an effective Demonstration Project which can be approved.

Key contacts on this Project are: Dr. John Yao, Office of Managed Care, Indian Health Service, (301) 443-2522; Duane Jeanotte, Deputy Directory of Health Policy, Office of Public Health, Indian Health Service, (301) 443-1083; Elmer Brewster, Third Party Administrator, Office of Public Health, Indian Health Service (301) 443-2419; and Ann Pash, Health Care Financing Administration, (410) 786-4516.

Issue #3: Center for Disease Control and Prevention Funding

CDC responded to the concern expressed by tribes at the National Tribal Consultation Forum seeking clarification regarding the percentage of CDC funds supporting tribes and recent reductions in CDC support for AIDS/HIV capacity building in Indian country. Additional comments were made about the limited public health infrastructure, which exists in some of the tribes.

During the forum, CDC provided information that an estimated \$21 million is currently provided from the agency for Indian initiatives and programs. CDC reports that this amount represents approximately eight tenths of one percent of FY 1999 funds for CDC.

With regard to cutbacks in funding for AIDS/HIV, CDC cites limitations in data to adequately capture the full scope of the AIDS epidemic in Indian country. CDC agrees that more representative data are required to build a more accurate picture of the epidemic among American Indians, and as a result, secure increased programmatic resources. An initiative by CDC's National Center for HIV, STD, and TB Prevention to address surveillance issues related to American Indian populations is an example of the agency's efforts to address this issue to date.

The total dollar amount for HIV capacity building awards from CDC's recent "Program Announcement 00003" was lower than the amount provided by its predecessor program "Program Announcement 305". These programs provide funds for capacity building activities to national and regional minority organizations. CDC reports it was not the intent to reduce funding to American Indian organizations, but that funding decisions were made according to AIDS disease prevalence of racial/ethnic groups across the country. Using disease prevalence rates as one of several criterion represented a change from previous funding criteria decisions. This change in funding criteria was due to several factors including a series of consultations with HIV prevention partners, discussions with the Congressional Black Caucus, analyses of the experiences and success of the HIV prevention community planning process, and CDC's other experiences

in funding HIV prevention programs. This redesign focuses funding on communities "hardest hit" by the epidemic.

While the overall direct funding to American Indian organizations was reduced, CDC believes there was no actual reduction in services to the American Indian communities. Since the time of the 00003 funding decrease, CDC through its National Center for Chronic Disease Prevention and Health Promotion, awarded additional funds, approximately \$50,000 to the National Native American AIDS Prevention Center for HIV prevention technical capacity building assistance.

A primary obstacle facing CDC and American Indian communities to address this issue is the underreporting of HIV/AIDS cases in American Indian communities, both by health care providers and individuals. In addition, a cultural stigma related to HIV/AIDS remains an obstacle in many Indian communities as well as the lack of a reliable public health infrastructure for disease reporting by tribes.

Key contacts on this issue: Ralph T. Bryan, M.D., Senior CDC/ATSDR Tribal Liaison, Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention, c/o IHS Epi Program, 5300 Homestead Rd. NE, Albuquerque, NM 87110, Tel: 505-248-4226, FAX: 505/248-4393, e-mail: rrb2@cdc.gov; and Staff Liaison: Dean Seneca, Minority Health Specialist, Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention MS-D39, 1600 Clifton Rd. NE, Atlanta, GA 30333, Tel: 404-639-7220, FAX: 404-639-7039, email: zkg8@cdc.gov

Issue #4: Increased Access to HHS Funding:

All operating divisions within the Department were asked to respond to the concern by tribes that the whole HHS budget should set-aside at least 1.5% of the total budget for Indian programs and Indian communities, and federal law should be amended to allow for tribes to receive direct funding from programs now limited to state block grants. A variety of responses came back. Detailed responses for each OPIDIV can be found in the matrix of responses compiled for this report.

The IHS, for example, reports 100% of its budget is provided to serve American Indian and Alaska Native communities. Among the other agencies, the proportion of funding allocated to Indian communities varied. SAMHSA allocated 2.3% of its FY 2000 annual funding to Indian oriented programs, well beyond the 1.5% recommended by tribes. Likewise, the Administration on Aging identified 1.9% of its annual budget for Indian programming. AHQR reports that 0.95%, or \$1.938 million, of its FY 2000 funding supported Indian related matters. HCFA reports that while it does not have a complete and accurate data on exact percentages, in Fiscal Year 1998 data indicates that approximately 1% of Medicaid beneficiaries and 1% of Medicare vendor payments go to American Indians and Alaska Natives. Overall, HHS estimates that 6% of its discretionary budget went to program which directly target American Indians and Alaska Natives in FY 2000.

Some agencies respond to specific directives in appropriations bills setting aside funds for programs serving Indian communities, such as the Center for Disease Control and Prevention, which spent approximately 0.8% of its budget on Indian programs. Other agencies, such as ACF and AoA and ANAs grants to Native Americans. ACF also operates large grant programs, e.g., operate Indian specific categorical programs, such as the Administration for Native Americans (ANA), the Head Start and Child Care Block Grant program and programs who authorizing statues reseve some funding for Native Americans. Larger authorizations serve targeted populations, which also include Indian and Alaska Natives. Agencies such as the Health Care Financing Administration and the National Institutes of Health incorporate much of their efforts in Indian communities under larger legislative authority. Finally, the Food and Drug Administration does not formulate nor track its budget by population or ethnic group, but by specific functions related to its federal authorization and purpose.

A number of HHS agencies reported potential strategies to ensure that Indian communities have proper access to the funding they administer. These strategies include continuing the tribal consultation process and making specific requests for appropriations increases in upcoming fiscal years.

Key contacts on this issue: Robert G. McSwain, Director, Office of Management Support, Indian Health Service, (301) 443-6290; Yvonne Jackson, AOA Director, Office of American Indian, Alaskan Native and Native Hawaiian Programs (OAIANNHP), 202-619-2713; Alexis Clark, ACF, Budget Analyst, Office of Legislative Affairs and Budget 202-401-4530.; Wendy Perry, AHRQ, Senior Program Analyst, 301-594-7248; Nicholas Burbank, ASMB, Senior Program Analyst, (202) 690-7846; Ralph T. Bryan, M.D., Senior CDC/ATSDR Tribal Liaison, Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention, c/o IHS Epi Program, 5300 Homestead Rd. NE, Albuquerque, NM 87110, Tel: 505-248-4226, FAX: 505-248-4393, e-mail: rrb2@cdc.gov; and Dean Seneca, Minority Health Specialist, Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention MS-D39, e-mail: zkg8@cdc.gov; Sue Clain, (HCFA/OL), 202-690-8226; John Ruffin, Ph.D., Director, NIH, Associate Director for Research on Minority Health and Director, Office of Research on Minority Health. Phone: (301) 402-1366; Steve Sawmelle, SAMHSA, Intergovernmental Coordinator, Office of Policy and Program Coordination, (301) 443-0419

Issue #5: Inpatient Alcohol and Substance Abuse Treatment is Too Short

Both the IHS and SAMHSA responded to the concern that federally supported inpatient treatment for alcoholism and substance abuse is too short in duration, and seems to be disconnected to an overall continuum of care, including aftercare.

The IHS cites several statutes which specifically authorize treatment for substance abuse, including the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (PL 99-570); The Anti-Drug Abuse Act of 1988 (PL 100-690; PL 102-573); the Indian Self-Determination Act (PL 93-638) and The Indian Health Care Improvement Act (PL 94-437). The Substance Abuse and Mental Health Services Administration (SAMHSA) cites its authority in this area under 42 USC 290 (aa) and 42 USC 290 (ff).

The IHS references several evaluations of the effectiveness of inpatient adolescent treatment, women's treatment and aftercare/continuing care, which have either been completed or are ongoing. The IHS has undertaken a software and data development for measuring the substance abuse and underage alcohol problems among American Indians and Alaska Natives. The Chemical Dependency Management Information System and the Mental Health/Social Services packages of the IHS RPMS system are now available to all IHS Areas, including tribes and urban programs.

SAMHSA awards competitive grants for substance abuse treatment to communities, including federally recognized tribes. These programs, funded through SAMHSA's Center for Substance Abuse Treatment (CSAT) determine the most effective length of treatment in the design of their own programs and based on the individual needs of clients. SAMHSA's Center for Substance Abuse Treatment (CSAT) will continue to provide grants in the Targeted Capacity Expansion, Exemplary Practices for Adolescents, and Practice/Research Collaborative programs. Such funding, as it relates to AI/AN tribes, will help toward reducing the need for extended residential treatment, including that for tribal youth. Mental health funding is provided to tribes through the Children's Mental Health Initiative and Circles of Care projects funded by the Center for Mental Health Services.

IHS funding for Alcohol and Substance Abuse treatment activities in FY 2000 was \$96.824 million and \$100.54 million in FY 2001. Support for Mental Health/Social Services during the same years was \$43.245 million in FY 2000 and \$45.117 million in FY 2001. SAMHSA funding includes the following:

Targeted Capacity Expansion programs

FY00 – \$114 million (\$29.4 million for AI/AN)
 FY01 – \$163 million (\$29.4 million for AI/AN)
 (preliminary figure from Conference Action)

Practice/Research Collaborative

FY00 – \$3.1 million (\$650,000 for AI/AN)
 FY01 – \$2.7 million (\$400,000 for AI/AN)

Exemplary Practices for Adolescents

FY00 – \$4.3 million (\$430,000 for AI/AN)
 FY01 – \$2.2 million (\$430,000 for AI/AN)

Child Mental Health Initiative:

FY00 – \$82.7 million (\$7.2 million for AI/AN)
 FY01 – \$86.8 million (\$7.2 million for AI/AN)

Circles of Care (AI/AN):

FY00 – \$2.4 million
 FY01 – \$2.4 million

Strategies to address concerns about treatment length and coordination, center on improved coordination among the various federal agencies involved in substance abuse treatment and prevention in Indian country, including the IHS, SAMHSA, BIA and DOJ. Effective programs need a means to share best practices with other communities and funding agencies.

Key contacts on this issue: Craig Vanderwagen, M.D., Director, Division of Clinical and Preventive Services, Office of Public Health, Indian Health Service, (301) 443-4644 Steve Sawmelle, Intergovernmental Coordinator, Office of Policy and Program Coordination, (301) 443-0419.

Issue #6: Communication:

In the area of Intergovernmental Relations, the IHS and HHS Office of Intergovernmental Affairs responded to tribal concerns about communication mechanisms. There were recommendations from tribes to look to many of the existing national and regional intertribal organizations, while keeping lines of communication open with each individual, federally recognized tribe.

The IHS and IGA have utilized organizations like the National Indian Health Board, the National Congress of American Indians, the Self-Governance Tribal Advisory Council and the National Council of Urban Indian Health to communicate with Indian country. In addition, individual letters and correspondence is provided to tribal leadership through "Dear Tribal Leader" letters.

The IHS has incorporated into the IHS Area Director's Senior Executive Service Work Plan, the requirement to provide leadership in support to tribal governments, tribal organizations and urban Indian programs. The Area Director is responsible to ensure that tribal consultation is an integral part of HHS/IHS policy development and budget formulation.

Some of the obstacles to improved communication between agencies of HHS and Indian country, is making sure the information is provided on a timely basis through the most appropriate channels. The IGA will continue to work with tribal leaders to ensure that they receive information and invitations for consultation on all major health and human services issues.

Key contacts on this issue: IHS Response: Don Davis, Director of Field Operations, Office of the Director, Indian Health Service, (301) 443-1083, and Phyllis Wolfe, Senior Advisor to the Director of Field Operations, Office of the Director, Indian Health Service, (301) 443-1083; and Eugenia Tyner-Dawson, Senior Advisor for Tribal Affairs, Office of Intergovernmental Affairs, HHS.

Issue #7: International Borders:

The issue of tribal health programs bearing the burden of treating persons injured or sick while in the custody of the Immigration and Naturalization Service (INS) along the US/Mexico border was raised at both regional and the national meetings.

The IHS cites federal statutes which require treatment of individuals in this situation. The citations include, Emergency Medical Treatment and Labor Act, 42 CFR, Sec. 1395dd., which requires medical screening examination, stabilization, and transfer for all patients requesting emergency care; and Restricting Welfare and Public Benefits for Aliens, 8 USC, Sec. 1611, which states that an unqualified alien is not eligible for any Federal public benefit. Privacy Act, 5 USC, Sec. 552 (a), which for medical records purposes, does not cover Undocumented Aliens.

The IHS proposes to continue submitting billing and cost documentation to the INS for health services related to treating Undocumented Aliens, and continue working with tribes and the INS to formulate policies at the local level, and if necessary elevate these discussions to the national level for resolution. The IHS has already begun discussion

of this sort in the Tucson Area of the IHS, meeting with both the Tohono O’odham Nation, the US Border Patrol and the INS to resolve reimbursement issues.

There are no appropriations provided to serve this population. Because the Border Patrol considers transportation of Undocumented Aliens to IHS facilities “humanitarian rescue”, the services provided are non-reimbursable under INS policy. Additional discussion at the national and possibly international level are needed to resolve this problem.

Key contacts on this issue: Taylor Satala, Area Director, Tucson Area Indian Health Service, (520) 295-2405, and George Bearpaw, Executive Officer, Tucson Area Indian Health Service, (520) 295-2402.

Issue #9: Consultation:

Every HHS OPDIV was asked to respond to tribal concerns about the consultation process and how individual consultation plans were to be implemented and monitored.

While the IHS implemented its consultation policy in 1997, the rest of the HHS agencies based their consultation plans upon the Presidential Executive Order #13084, of May 14, 1998, which directed Federal agencies to establish regular and meaningful consultation and collaboration with Indian tribal governments and on the Secretary’s consultation policy in August 1997, directing each agency to develop an individualized consultation plan. These plans were printed and disseminated to every tribe

in the United States asking for review and comments. Several agencies such as ACF, also posted their consultation plan on the web. Only a small number of tribal comments came back to the agencies regarding these plans.

Several agencies have initiated consultation meetings or councils, such as the Administration on Aging, Centers for Disease Control and Prevention, ACF, HCFA, NIH, and IHS. All HHS agencies have participated with tribes and national Indian organizations in the budget formulation process. Each agency has described efforts to improve and expand tribal consultation.

Key contacts on this issue: Sharon McCully, ANA/ACF, Executive Director Intra-departmental Council on Native American Affairs (202) 690-5780; Douglas Black, Director, Office of Tribal Programs, Office of the Director, Indian Health Service, (301) 443-1104; Wendy Perry, AHRQ, Senior Program Analyst, 301-594-7248; Yvonne Jackson, AOA, Director, OAIANNHP, 202-619-2713; Ralph T. Bryan, M.D., Senior CDC/ATSDR Tribal Liaison, Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention, c/o IHS Epi Program, 5300 Homestead Rd. NE, Albuquerque, NM 87110, Tel: 505-248-4226, FAX: 505 248-4393, e-mail: rrb2@cdc.gov; and Staff Liaison: Dean Seneca, Minority Health Specialist, Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention, MS-D39, 1600 Clifton Rd. NE, Atlanta, GA 30333, Tel: 404-639-7220, FAX: 404-639-7039, email: zkg8@cdc.gov; Linda Brown, (HCFA) Technical Director, (202)-690-6257; John Ruffin, Ph.D, Director, Associate Director for

Research on Minority Health and Director, NIH, Office of Research on Minority Health. Phone: (301) 402-1366; Steve Sawmelle, SAMHSA, Intergovernmental Coordinator, Office of Policy and, Program Coordination, (301) 443-0419

Issue #10: State Resistance

There was concern voiced by tribes and national Indian organizations regarding some states which resist or even refuse to cooperate with tribes in areas of mutual concern. A specific example was referenced dealing with the state of South Dakota's moratorium on the use of Medicaid dollars to support new nursing homes in the state. This issue involves not just the state and the tribes wanting to build nursing homes, but also HCFA, IGA and potentially the Office for Civil Rights (OCR).

The OCR reports that the issue in South Dakota is being addressed on several levels. The Governor for South Dakota formed a Workgroup to address the problem, which includes the participation of HCFA, BIA, IHS, State Medicaid staff and Indian tribes. The issue addressed by the Governor's Workgroup is "access" to nursing home services. Without the cooperation of the State, new tribal nursing homes cannot rely on Medicaid revenues for eligible patients. Currently there is no legal authority for HCFA to pass along 100% of the federal Medicaid dollars to tribally operated nursing homes, without going through the state. In 1999, the State of South Dakota legislature extended the moratorium on nursing homes for another five (5) years. Provisions in the draft bill to reauthorize the Indian Health Care Improvement Act would allow for direct Medicaid funding for tribal nursing homes, but that legislation has not been enacted.

Addressing tribal concerns on a more national basis, HCFA has prepared a draft letter to the State Medicaid Directors and to Tribal leaders informing them that once the letters are issued, the states will have to consult with all Federally recognized tribes in their state on Section 1115 Medicaid managed care demonstration waivers, Section 1915(b) freedom of choice waivers, and Section 1915(c) home and community based services waivers prior to submission of the proposal to HCFA.

Key contacts on this issue: Nancy Goetschius, (HCFA) Health Insurance Specialist, (410) 786-0707; Cindy Myers, OCR, State Program Coordinator, 303-844-7116; Kathleen O'Brien, OCR, 202-219-2829.

Issue #11: Community-based Research

Tribes expressed concern about research and the need to funnel all research targeting Indian populations through the appropriate tribal or Indian community Institutional Review Board (IRB). Tribes were also concerned about the government's reliance upon universities to conduct research, instead of placing a premium on community based approaches. There are four agencies which responded to this concern for community-based research. They are AHRQ, CDC, NIH and SAMHSA.

SAMHSA is implementing community-based research through competitive grant-making for "Knowledge Development and Application" projects, including the Circles of Care projects funded in Indian communities. In these situations, it is the responsibility of the grantee to go through tribal Institutional Review Boards.

The AHRQ and CDC propose to continue working with tribes to forge partnerships between tribes and academic institutions and to build research infrastructure at the local level. AHRQ has many training programs which can assist in the development tribal research infrastructure, available through its website. AHRQ awarded a major grant to an Indian-based consortium to perform research on health care disparities among the Indian elderly and has funded a planning grant to an Indian-focused primary care practice-based research network. In FY 2000 a large program project grant was awarded to the University of Colorado to research health care disparities among Indian elderly. Another large grant was made to the University of New Mexico to look at diabetes care among the Navajo. A planning grant, funded by the IHS was awarded to a primary-care based research network to develop a plan for a network of office-based primary care practices dedicated to research.

CDC works closely with the Indian IRB's, and the IHS-based human subjects review boards and has assisted a tribe in the development of its own IRB, and seeks tribal partnerships in its research activities involving American Indian and Alaska Native participants.

NIH traditionally requires a university environment or setting because of the types of technology and other types of resources that are required. NIH is committed to designing programs that will provide opportunities for Tribal Colleges and Universities (TCU) and tribal community partnerships. One such effort in the NIH Center for Research on Minority Health and Health Disparities is the proposed Office for Community Based Research and Outreach. A total of \$197 million is anticipated in

Fiscal Year 2001 to support this new effort, if the Center is authorized. This center will develop state and local research programs related to health disparities and minority health. This new office will be key in increasing tribal involvement in Indian health research.

Some of the obstacles to community-based research in Indian country, are the limited number of conduits for building research infrastructure within Indian communities. There are a limited number of tribal IRBs. However, there are opportunities to expand research through the use of tribal colleges and universities and by developing tribal research infrastructure. Training of more American Indian and Alaska Native researchers is essential.

Key contacts on this issue: Wendy Perry, AHRQ, Senior Program Analyst, 301-594-7248
 Ralph T. Bryan, M.D., Senior CDC/ATSDR Tribal Liaison, Office of The Associate Director for Minority Health, Centers for Disease Control and Prevention, c/o IHS Epi Program, 5300 Homestead Rd. NE, Albuquerque, NM 87110, Tel: 505-248-4226, FAX: 505 248-4393, e-mail: rrb2@cdc.gov; and Staff Liaison: Dean Seneca, Minority Health Specialist Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention MS-D39, 1600 Clifton Rd. NE, Atlanta, GA 30333, Tel: 404-639-7220, FAX: 404-639-7039 e-mail: zkg8@cdc.gov; John Ruffin, Ph.D., Director, Associate Director for Research on Minority Health and Director, NIH, Office of Research on Minority Health. Phone: (301) 402-1366; Steve Sawmelle, SAMHSA, Intergovernmental Coordinator, Office of Policy and Program Coordination, (301) 443-0419.

