



A PROMISE
KEPT:
HONORING OUR
TRUST AND
INVESTING IN
OUR FUTURE
TODAY

THE NATIONAL TRIBAL BUDGET FORMULATION
WORKGROUP'S RECOMMENDATIONS ON THE
INDIAN HEALTH SERVICE
FISCAL YEAR 2016 BUDGET

May 2014

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EXECUTIVE SUMMARY

The federal government's trust responsibility, honored by decades of treaties and doctrines, is based on need. Funds to the Indian Health Service are prepaid obligations between the United States and indigenous Tribes and cannot be means-tested. American Indians and Alaska Natives have long experienced health disparities when compared with other Americans. Shorter life expectancy and the disproportionate disease burden exist because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity, poor social conditions, and decades of historical trauma.

Although the Obama Administration and Congress have proven over the last few years that they are willing to take steps to address this crisis, the federal government *must do more* to meet its obligations *to fully fund* the urgent health care needs of American Indians and Alaskan Natives. Indian health care is not measured in dollars, but in lives. In FY 2013, sequestration cuts devastated Tribal communities throughout the United States. In a health care delivery system that has been chronically underfunded for decades, this was pure disaster for clinics across Indian Country. Losing these dollars, combined with a calamitous federal government shutdown at the start of FY 2014, has nullified many of the funding gains of the last six years. When compounded with rising medical inflation and population growth, Indian health budgets are quickly trending backwards. FY 2016 will be the final year of the Obama Administration, and represents a historic opportunity for the United States government to make a true commitment to fulfil its trust responsibility and create a lasting historic legacy. Proposing a FY 2016 budget that begins to aggressively tackle the devastating health challenges of our people, will ensconce this Administration's place in history for bringing equality and justice to Indian Country. More importantly, will set a strong precedent for future Administrations with respect to honoring the Trust responsibility. Until the Indian Health Service is fully funded, the promised health care that American Indians and Alaska Natives deserve *will not* become a reality.

The National Tribal Budget Formulation Workgroup recommends the following budget for FY 2016:

Tribal Total Needs Based Request: \$28.7 Billion over 12 Years

FY 2016 Tribal Budget Recommendation: \$5.4 Billion

Highlights of the FY 2016 Budget Recommendations:

- ❖ Increase FY 2016 IHS Budget by 17.58% in FY 2016:
 - \$166.1 million for full funding of current services
 - \$199.7 million for binding fiscal obligations
 - \$449.0 million for program expansion increases
- ❖ Restore Cuts/Shortfalls in FY2013-15 resulting from sequestration, inadequate increases to cover Congressionally mandated budget categories, and no provision for inflation for Continuing Services & Binding Obligations
- ❖ Advocate that Tribes and Tribal programs be permanently exempted from sequestration
- ❖ Provide an additional \$300 million to implement the provisions authorized in the Indian Health Care Improvement Act (IHCA)

TABLES: FY 2016 TRIBAL RECOMMENDATIONS

FY 2016 National Tribal Recommendation	
<i>Planning Base - FY 2015 Pres. Budget</i>	\$4,634,177
Current Services & Binding Agreements	\$368,935
Current Services	\$166,069
Federal Pay Costs	7,806
Tribal Pay Costs	9,936
Inflation (non-medical)	17,877
Inflation (medical)	63,000
Population Growth	67,450
Binding Agreements	\$202,866
New Staffing for New & Replacement Facilities	70,818
Contract Support Costs	43,153
New Tribes (California and Nashville)	13,895
Health Care Facilities Construction (Planned)	75,000
Program Expansion Increases – Services	\$393,754
Hospitals & Health Clinics	119,307
<i>Hospitals & Health Clinics - Increase Services</i>	0
<i>Indian Health Care Improvement Fund</i>	0
<i>Information Technology</i>	0
<i>Long Term Care</i>	0
Dental Services	11,141
Mental Health	51,456
Alcohol and Substance Abuse	41,980
Purchased/Referred Care (formerly Contract Health Services)	145,402
Public Health Nursing	0
Health Education	5,415
Community Health Representatives	3,040
Alaska Immunization	0
Urban Indian Health	15,000
Indian Health Professions	1,013
Tribal Management Grants	0
Direct Operations	0
Self-Governance	0
Contract Support Costs	0
Program Expansion Increases - Facilities	\$52,082
Maintenance & Improvement	14,477
Sanitation Facilities Construction	13,173
Health Care Facilities Construction, Other Authorities	19,432
Facilities & Environmental Health Support	0
Equipment	5,000
GRAND TOTAL	\$5,448,948

% and \$ Change over Planning Base

17.58%

\$814,771

**Detail of Changes
FY 2016 National Tribal Recommendation**
(Dollars in Thousands)

Program	CURRENT SERVICES										INCREASES					FY 2016 +/- FY 2015 PB				
	FY 2015		Pay		Pay Subtotal		Inflation		Inflation Subtotal		Pop Growth		Current Services Subtotal		Staffing for New Facilities ¹		Binding Agreements		2016 National Recommen	
	Presidents Budget ¹		Federal Pay	Tribal Pay	Non-Medical	Medical	Medical	Medical	Subtotal	Growth	Subtotal	Current Services Subtotal	Staffing for New Facilities ¹	CSC Shortfall	New Tribes ^{1,4}		HCFC (Planned)	Binding Agreements Subtotal		Program Increases
SERVICES																				
Hospitals & Health Clinics	1,862,501		4,994	6,458	11,452	2,557	19,955	22,512	33,328	33,328	67,291	70,818	0	10,395	0	81,213	119,307	2,130,312	2,67,811	
Dental Services	175,654		648	515	1,163	91	1,381	1,672	2,997	2,997	5,832	0	0	0	0	11,141	16,973	192,627	16,973	
Mental Health	82,035		231	299	530	51	798	849	1,408	1,408	2,787	0	0	0	0	51,456	136,268	54,243	49,501	
Alcohol & Substance Abuse	193,824		143	1,143	1,286	37	2,676	2,714	3,521	3,521	7,521	0	0	0	0	41,980	243,325	49,501	49,501	
Purchased/Referred Care	929,041		1	0	1	0	33,169	33,169	16,176	16,176	49,346	0	0	3,500	0	3,500	145,402	1,137,289	198,248	
Total Clinical Services	3,243,045		6,016	8,415	14,431	2,736	58,179	60,916	57,429	57,429	132,776	70,818	0	13,895	0	84,713	366,286	3,839,820	586,775	
Public Health Nursing	16,333		377	324	501	27	388	615	1,256	1,256	2,375	0	0	0	0	0	0	18,728	2,375	
Health Education	18,263		31	87	117	3	225	228	315	315	660	0	0	0	0	0	5,415	24,338	6,075	
Community Health Representatives	59,386		6	416	423	10	865	875	1,109	1,109	2,406	0	0	0	0	0	3,040	64,832	5,446	
Immunization AK	1,855		0	13	13	0	27	27	35	35	76	0	0	0	0	0	0	1,931	76	
Total Preventive Health	155,857		315	740	1,055	41	1,705	1,745	2,717	2,717	5,517	0	0	0	0	0	8,455	169,829	13,973	
Urban Health	41,375		13	189	201	62	359	622	775	775	1,398	0	0	0	0	0	15,000	57,973	16,598	
Indian Health Professions	38,466		15	0	15	723	0	723	0	723	738	0	0	0	0	0	1,013	40,217	1,751	
Tribal Management Grants	2,442		0	0	0	100	0	100	0	100	100	0	0	0	0	0	2,542	2,542	100	
Direct Operations	68,065		408	128	536	530	0	530	0	530	1,066	0	0	0	0	0	0	69,131	1,066	
Self-Governance	5,727		14	0	14	24	0	24	0	24	38	0	0	0	0	0	0	5,765	38	
Contract Support Costs	617,205		0	0	0	8,786	0	8,786	0	8,786	8,786	0	40,000	0	40,000	3,153	669,144	51,939		
Total Other Services	773,280		450	316	766	10,225	559	10,784	775	12,326	12,326	0	40,000	0	40,000	19,166	844,772	71,492		
TOTAL SERVICES	4,172,182		6,781	9,471	16,252	13,002	60,443	73,445	60,921	60,921	150,619	70,818	40,000	13,895	0	124,713	396,907	4,844,421	672,239	
FACILITIES																				
Maintenance & Improvement	53,614		0	0	0	991	0	991	1,000	1,000	1,991	0	0	0	0	0	14,477	70,082	16,468	
Sanitation Facilities Construction	79,423		0	0	0	1,071	927	1,998	1,439	1,439	3,437	0	0	0	0	0	13,173	96,033	16,610	
Health Care Facilities Construction	85,048		0	0	0	1,427	0	1,427	0	1,427	1,427	0	0	0	0	75,000	19,432	180,907	95,859	
Facilities & Environmental Health Support Equipment	220,585		1,025	465	1,490	1,380	873	2,253	3,683	3,683	7,426	0	0	0	0	0	0	228,011	7,426	
	23,325		0	0	0	4	757	762	407	407	1,168	0	0	0	0	0	5,000	29,493	6,168	
TOTAL FACILITIES	461,995		1,025	465	1,490	4,875	2,557	7,432	6,529	6,529	15,450	0	0	0	0	75,000	52,082	604,527	142,532	
TOTAL BUDGET AUTHORITY	4,634,177		7,806	9,936	17,742	17,877	63,000	80,877	67,450	67,450	166,069	70,818	40,000	13,895	0	199,713	448,989	5,448,948	814,771	

¹ In order to fully fund estimated Contract Support Costs in FY 2014, IHS reduced funding for the Director's Emergency Fund, Tribal Management Grants, Self-Governance, and the Indian Health Professions program. The FY 2015 Budget restores these cuts so that these programs reflect FY 2013 funding levels.

² The amount for New Staffing for Newly-Constructed Facilities was placed in Hospitals & Health Clinics as a placeholder.

³ California Area proposed to put the recurring funds for the New and Restored Tribes of \$3,524,037, under CHS or Purchased/Referred Care. The amount proposed at the National Meeting was \$3,500,000.

⁴ Nashville Area proposed to spread the amount of \$7,495,339 for Shamrock and proposed \$3,267,560 for Tonawanda. The amount proposed at the National Meeting was \$10,395,000.00. It was put into H&C as a placeholder for further review.

INTRODUCTION

Throughout his Administration, President Obama has demonstrated an understanding of the unique government-to-government relationship between the United States and sovereign Tribal Nations, striving to fulfill his promise to fund the Indian Health Service (IHS) adequately. Under this Administration, the IHS has seen its first year-by-year budget increases in decades with a historical increase totaling 24% over the past six years. However, funding for Indian health care services and programs still falls significantly short of what is required for parity between Indian health and other federal healthcare programs.

“The United States has a duty to uphold its trust responsibilities to Native people in good times and in challenging times. Yet... there is a large gulf between promises made and promises kept.”

Senator Brian Schatz, November 14, 2013

In FY 2014, for example, IHS received an increase of \$304 million over FY 2013 enacted levels. Most of this increase was designated to fully fund contract support costs (CSC), as well as new staffing packages, at the direction of Congress. While Tribes are appreciative of these important account increases, the agency was forced to cut an additional \$10 million from the overall IHS budget. This means, that funds were not available to restore sequestration cuts from FY 2013 and adjust for inflationary increases and population growth. Tribes are insisting this year that the Department and Congress fully restore the draconian FY 2013 sequestration cuts and provide funding to maintain current services, as well as provide a meaningful increase in the Services line item.

Tribes request that for FY 2016, the Administration:

1. Phase In Full Funding of IHS - Total Tribal Needs Budget of \$28.7 Billion Over 12 Years
2. Present a 17.58% increase in the overall IHS budget from the FY 2014 President’s Budget request planning base*
3. Restore Cuts/Shortfalls in FY 2013-15 resulting from sequestration, inadequate increases to cover Congressionally mandated budget categories, and no provision for inflation for Continuing Services & Binding Obligations
4. Advocate that Tribes and Tribal programs be permanently exempted from sequestration
5. Provide an additional \$300 million to implement the provisions authorized in the Indian Health Care Improvement Act (IHCIA)

The National Tribal Budget Formulation Workgroup members include Tribal representatives from each of the 12 IHS Service Areas who are tasked with consolidating budget recommendations developed by Tribal leadership and program staff of the 12 IHS Areas (regions) into a national set of budget and health priorities for a given fiscal year. The Workgroup provides input and guidance to the IHS Headquarters budget formulation team throughout the remainder of the budget formulation cycle for that fiscal year.

**includes placeholder estimates for CSC, Staffing for new facilities & new Tribes*

FY 2016 represents a historic opportunity for this Administration to create a lasting legacy for Indian Country. While the damage of sequestration, rescissions and other budget cuts have created significant setbacks

\$28.7 BILLION

TOTAL TRIBAL NEEDS BUDGET

\$28.7 billion request for services & facilities:

- **\$14.89 billion** for Medical Services
- **\$1.56 billion** for Dental and Vision Services
- **\$3.49 billion** for Community and Public Health Services
- **\$8.77 billion** for facility upgrades and upfront costs (non-recurring investments)

The costs are calculated using comparisons with other federal benchmarks such as federal employee vision and dental coverage and current IHS spending ratios. Population data is estimated based on expanded user populations for IHS eligible AI/ANs. One time facility upgrades included in this calculation would not be required year after year. After the initial investment recurring infrastructure costs are built into annual per capita cost factors, which is typically between 6 to 8 percent of the average US health care spending for capitalized costs associated with space. This model establishes the parameters needed to obtain rough parity with the population at large.

for Tribal health programs, the final budget proposed by the Obama Administration can make a strong statement toward reversing some of these cuts. By preparing a budget that fully honors the federal trust responsibility, we will not only reduce, but *also eliminate* the vast chasm between the health conditions of Native peoples and other Americans. The target for the IHS budget of **\$28.7 billion** over twelve years contained in this brief offers a path forward and clear direction, countering those who argue this cannot be done. In defying this cynicism, we are reminded of the timeless wisdom of Abraham Lincoln, where we “...*determine the thing that must and shall be done, and then we find the way.*”

This administration, in partnership with Tribes, can truly be the change that moves health care in Indian Country toward a brighter future. Nothing can undo the damage done in the past, but we can use the lessons to guide our future. Together, we can ensure our children have the opportunity to have healthy and productive lives and that our elders leave this life with dignity.

A PROMISE KEPT...

To Indian people, the federal budget is not just a fiscal document, but also a moral and ethical commitment. The budget request for Indian health care services reflects the extent to which the United States honors its promises of

justice, health, and prosperity to Indian people. For Tribes to recommend a budget that falls short of providing even the most basic of health care services to all our people is no different from deciding which member of your family will be able to get life-saving treatment.

Washington must not continue to neglect or ignore its trust responsibility to Tribal Nations. Instead, Congress and this Administration must begin a new era of honoring its promise to Indian Country. These are not duties to be grudgingly accepted, but must be embraced in a way that defines the character of this great nation. It is a matter of honor.

HONORING OUR PAST...

The provision of federal health care services to American Indians and Alaska Natives is the direct result of treaties between the United States and Tribes and subsequently reaffirmed by Executive Orders, Congressional actions and two centuries of Supreme Court case law. Through the cession of lands and the execution of treaties, the federal government took on a

About the Indian healthcare delivery system: The Indian healthcare delivery system consists of services and programs provided directly by IHS; Indian Tribes and Tribal organizations who are exercising their rights of self-determination and self-governance; and services provided through urban organizations that receive IHS grants and contracts (collectively, the “Indian healthcare system” or I/T/U). The Indian healthcare system has a user population of 2.6 million individuals. Currently, the IHS FY 2014 budget is \$4.4 billion. That is only (on average, system wide) 59% of the level of need.

trust responsibility to provide for the health and welfare of Indian peoples. This federal trust responsibility is the foundation for the provision of federally funded health care to all members of the 566 federally recognized Indian Tribes, bands, and Alaska Native villages in the United States.

...INVESTING IN OUR FUTURE

Although the Indian health care system has made significant improvements in mortality and morbidity rates for AI/ANs, serious health disparities persist. More must be done to finally end long-standing inequities in health status for First Americans. The health of AI/ANs, while improving in some areas, is still grave, with the AI/AN life expectancy that is 4.2 years less than the rate for the U.S. all races population.

The Centers for Disease Control and Prevention (CDC) issued a report in April 2014 noting that AI/ANs death rates nearly 50 percent greater than non-Hispanic Whites.

“After I became President, I said that given the painful chapters and broken promises in our shared history, I’d make sure this country kept its promises to you.”

*President Barack Obama
White House Tribal Nations Summit
November 2013*

According to IHS data, AI/AN people die at higher rates than other Americans from alcoholism (552% higher), diabetes (177% higher), unintentional injuries (138% higher), homicide (82% higher) and suicide (65% higher). Additionally, AI/ANs suffer from higher mortality rates from cervical cancer (1.2 times higher); pneumonia/influenza (1.4 times higher); and maternal deaths (1.4 times higher). An alarming number of Tribes are reporting a sharp increase in both prescription and illegal drug abuse. Indian Country has asked for an urgent call to action to help combat these issues. We request that the Administration make these issues a key priority when developing the FY 2016 budget request.

Devastating health risks from historical trauma, poverty and a lack of adequate treatment resources also continue to plague Tribal communities. According to IHS data, 39 percent of AI/AN women experience intimate partner violence, which is the highest rate of any ethnic group in the United States. One in three women in AI/AN communities will be sexually assaulted in her lifetime. AI/ANs suffer at higher rates from psychological distress; feelings of sadness, hopelessness and worthlessness; feelings of nervousness or restlessness and suicide. Additionally, public health risks due to alcohol and substance abuse are sadly widespread in many Tribal communities, leading to other health disparities such as poverty, mental illness, and increased mortality from liver disease, unintentional injuries and suicide. Dental health concerns also continue to affect AI/ANs at higher rates than other Americans do. Ninety percent of AI/AN children suffer from dental caries by the age of eight, compared with 50 percent for the same age in the US all races population. Our children ages 2 to 5 have an average of six decayed teeth, when children in the U.S. all races population have only one.

The Indian health care delivery system, in addition to significant health disparities, also faces significant funding disparities, notably in per capita spending between the IHS and other federal health care programs.

In 2013, the IHS per capita expenditures for patient health services were just \$2,849, compared to \$7,717 per person for health care spending nationally. Compared to IHS calculations of expected cost for a blend of Federal Employee Health Benefits, average IHS per user spending in 2013 was only 59% of

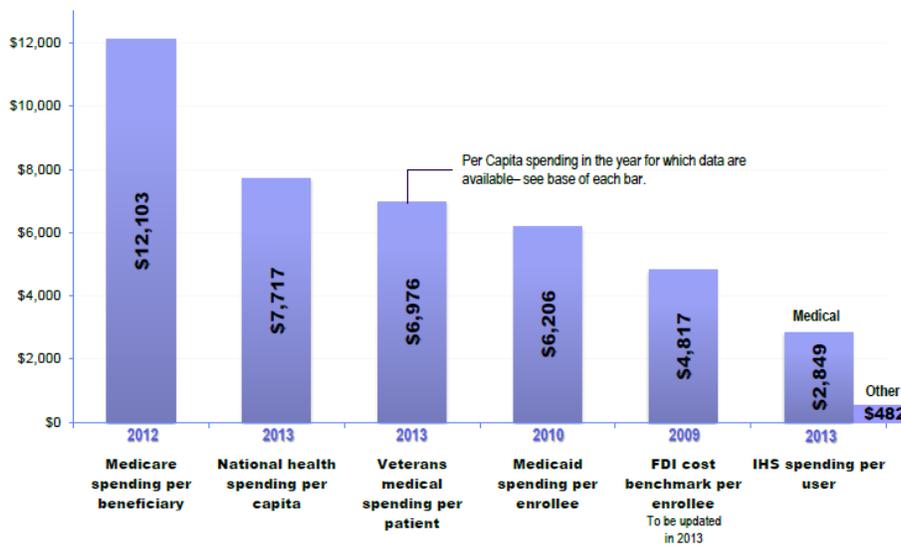
“We shall continue to fulfill the federal trust responsibility for the physical and financial resources we hold in trust for the tribes and their members. The fulfillment of this unique responsibility will be accomplished in accordance with the highest standards”

*President Ronald Reagan
1983 Statement on Indian Policy*

calculated full costs. The actual percentage varies between IHS areas, with some funded at much less than 59% of need. New health care insurance opportunities beginning in 2014 and expanded Medicaid in some states may expand health care resources available to American Indians and Alaska Natives. However, these new opportunities are still no substitute for the fulfillment of the federal trust responsibility, and the budget gap will remain. It will be some time before reliable data is available to determine the impact of these changes on American Indians and Alaska Natives.



2013 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita



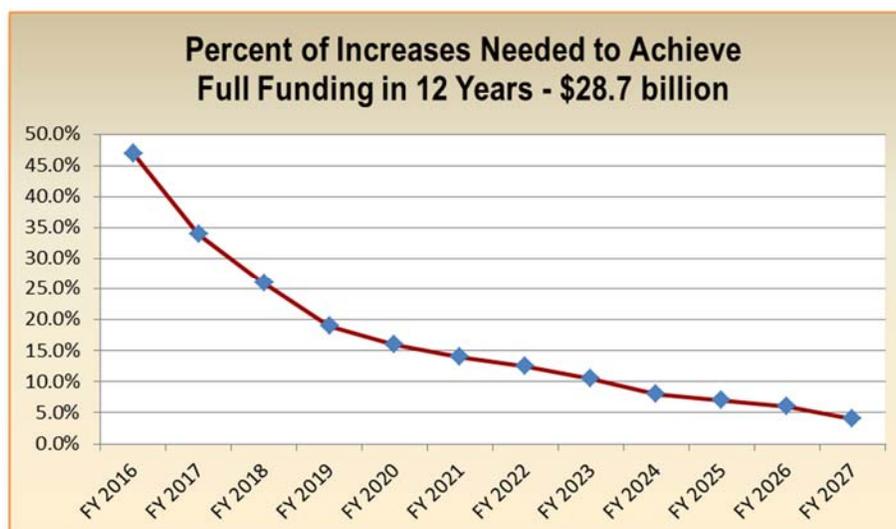
FY 2016 TRIBAL BUDGET RECOMMENDATIONS AND PRIORITIES

❖ 1ST RECOMMENDATION: PHASE-IN FULL FUNDING OF IHS - TOTAL NEEDS BASED BUDGET OF \$28.7 BILLION OVER 12 YEARS

Early in 2003, the Workgroup met to develop the national Tribal budget recommendations for FY 2005. Tribal leaders were disheartened that the planning base for the IHS budget was \$2.85 billion, less than 15% of the total funding required to meeting the health care needs for AI/ANs. This level of funding was not even sufficient to maintain current services in the face of inflation and increases in the Indian population. Tribal leaders warned that continued under-funding would thwart the Tribes and IHS's efforts to address the serious health disparities experienced by our AI/AN people. To address this shortfall, IHS, Tribal and Urban programs worked together to develop for the first time a true Needs Based Budget (NBB) and for FY 2005, proposed a IHS NBB totaling \$19.5 billion. This includes amounts for personal health services, wrap-around community health services and facility capital investments.

The FY2005 Budget Formulation Workgroup responsibly proposed a 10-year phase-in plan, with substantial increases in the first two years and more moderate increases in the following years as this Workgroup understood that meeting the NBB of \$19.5 billion in one fiscal year was unlikely, due to the importance of balancing the Federal budget and other national priorities. Furthermore, IHS and Tribal health programs lacked the health infrastructure to accommodate such a large program expansion at one time. The most significant aspect of the 10-year plan was that it would require a multi-year commitment by Congress and Administration to improve the health status of AI/ANs.

That was 10 years ago. In the intervening years and with failure to produce necessary funding to fulfill this 10-year plan, the health disparities between AI/ANs and other populations continued to widen, and the cost and amount of time required to close the funding disparity gap has grown. The NBB has been updated every year, using the most current available population and per capita health care cost information. The *IHS need-based funding aggregate cost estimate for FY 2016* is now **\$28.7 billion**, based on the FY 2013 estimate of 2.7 million eligible AI/ANs served by IHS, Tribal and Urban health programs. With the lack of adequate increases over the years, the phase-in of the NBB at \$28.7 billion would need to occur over the next 12 years.



FY 2016 AI/AN Needs Based Funding Aggregate Cost Estimate

GROSS COST ESTIMATES

Source of Funding is not estimated

FY 2013 Need for Existing Users at I/T Sites	FY 2013 Need Expanded for Eligible AIAN at I/T/U Sites*
1,576,629	2,653,324

SERVICES	\$ Per Capita	Billions	Billions
Medical Services	\$5,611	\$8.85	\$14.89
Medical services and supplies provided by health care professionals; Surgical and anesthesia services provided by health care professionals; Services provided by a hospital or other facility, and ambulance services; Emergency services/accidents; Mental health and substance abuse benefits; Prescription drug benefits.	Based on 2008 FDI benchmark (\$4,100) inflated to 2013 @4% per year	\$ Per Capita * Users	\$ Per Capita * Eligible AIAN
Dental & Vision Services	\$587	\$0.93	\$1.56
Dental and Vision services and supplies as covered in the Federal Employees Dental and Vision Insurance Program	2008 BC/BS PPO Vision (\$87) and Dental benchmarks (\$342) inflated to 2012 @4% per year		
Community & Public Health	\$1,316	\$2.07	\$3.49
Public health nursing, community health representatives, environmental health services, sanitation facilities, and supplemental services such as exercise hearing, infant car seats, and traditional healing.	19% of IHS \$ is spent on Public Health. Applying this ratio, \$1,316 per capita = (.19/.81*\$5611).		
Total Annualized Services	\$7,514	\$11.85	\$19.94

FACILITIES	\$ Per Capita	Billions	Billions
Facility Upgrades Upfront Costs		\$6.51	\$8.77
Annualized for 30 year useful Life		\$0.38	\$0.51

IHS assessed facilities condition (old, outdated, inadequate) and has estimated a one-time cost of \$6.5b to upgrade and modernize. A 30 year useful life assumption is used to estimate the annualized cost (assuming 4% interest) of the upgrades.

TOTAL

Total Annualized Services + One-time Upfront Facilities Upgrades		\$18.36	\$28.71
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Gross costs for mainstream health care to AIAN and facilities upgrades are based on typical cost factors. The actual costs that would be experienced among I/T/U sites would vary. Gross costs are estimated expenses without specifying sources of payment. Under current law, a portion of gross costs would be paid by Medicare, Medicaid, and private insurance depending on the number of AIAN eligible—which varies place-to-place and time-to-time. The extent that gross costs would be offset is not precisely known. For certain planning assumptions, IHS assumes a crude 25% nation-wide.

*Crudely—AIANs residing in service areas, including urban areas, discounted for AIAN already partially served by I/T sites.

❖ 2nd Recommendation: Present a 17.58% Increase in the Overall IHS Budget from the FY 2014 President's Budget Request Planning Base

While the Workgroup's and Tribes' primary recommendation remains full funding of the IHS NBB, Tribes in each Area were asked to prepare budget recommendations at specific funding levels. Taking the Area recommendations, the Workgroup recommends an increase of **17.58%** or **\$814 million** over the FY 2015 President's proposed IHS Budget. This includes **\$166.1 million** for *Current Services*, **\$199.7 million** for *Binding Agreements* with Tribes and **\$449 million** in *Program Increases Expansion*. Current Services and other Binding Agreements provide the base for program increases designed to expand services. These base costs, which are necessary in order to maintain the status quo, must be accurately estimated and fully funded before any real program expansion can begin. The Program Expansion Increases are the additional funding needed to address critical health services and new facility authorities aimed at slowing the growing health disparity rates in Tribal communities.

Program Expansion Increases

Additional *Program Expansion Increases* totaling **\$449 million** are needed to address the ever-widening AI/AN health disparity and funding gap. With major setbacks brought on by the FY 2013 Sequestration in mind, all 12 IHS Areas identified the Purchased/Referred Care and Hospitals & Clinics (H&C) line items as key priorities for increased funding. H&C includes funding for the Indian Health Care Improvement Fund, Health Information Technology, and Long Term Care, as well as general H&C increases. Top Tribal priorities are reflected by the critical line item increases listed below.

- Increase funding for *Purchased/Referred Care (PRC)*¹ by **\$ 145.4 million**.
- Increase funding for *H&C* by **\$119.3 million**.
- Increase funding for *Mental Health* by **\$51.5 million** to address resource deficiencies at behavioral health programs that are providing outpatient and emergency crises services and community based prevention programs.
- Increase funding for *Alcohol & Substance Abuse Services* by **\$42 million**.
- Increase funding for *Health Care Facilities Construction & Other authorities* by **\$19.4 million**.

If the requested Program Expansion increases are not funded, AI/ANs will continue to live sicker and die younger than other American citizens do and will continue to drain existing available resources for costly urgent, emergent and chronic care at higher rates than other populations. The prospect of a better future, the dream of healthy communities, and equal opportunities for improving the health status of all AI/ANs will remain out of reach for most Tribal Nations.

¹ Formerly called Contract Health Services

**INDIAN HEALTH SERVICE
FY 2016 Budget Process
Summary of Area Budget Recommendations
+17.58% Level National Recommendations**

Planning Base for FY 2016

FY 2015 President's Budget of \$4,634,177 x 17.58% = **+\$814,771,000**

Current Services: +\$166,069,000

All 12 Areas recommended funding for Federal and Tribal pay, inflation (medical and non-medical) and population growth

Binding Agreements: +\$202,866,000

- Contract Support Costs for New and Expanded Programs: +\$43,153,000
- Health Care Facilities Construction Projects: +\$75,000,000
- Staffing Costs for New Facilities: +\$70,818,000

Addition:

- New Tribes - +\$13,895,000

Program Expansion – Top 5: +\$377,577,000

1. Purchased/Referred Care (CHS): +\$145,402,000
2. Hospitals & Health Clinics: +\$119,307,000
3. Mental Health: +\$51,456,000
4. Alcohol/Substance Abuse: +\$41,980,000
5. Health Care Facilities–Other Authorities: +\$19,432,000

Other Budget Recommendation: +\$63,264,000

6. Urban: +\$15,000,000
7. Maintenance & Improvement: +\$14,477,000
8. Sanitation Facilities Construction: +\$13,173,000
9. Dental: +\$11,141,000
10. Equipment: +\$5,000
11. Health Education: +\$5,415,000
12. Community Health Representatives: +\$3,040,000
13. Indian Health Professions: +\$1,013,000

Current Services & Binding Agreements

The Tribes believe that all known expected cost obligations must be transparent in the budget request in order to demonstrate the true funding base required to sustain current services and meet obligated fiscal requirements. It is from this true funding base that recommendations for real program increases can begin. These cost obligations include actual federal & Tribal pay costs, true medical and non-medical inflation, population increases, “must have” staffing and construction project requirements, Contract Support Costs (CSC), and all expected off-the-top mandatory assessments. Understating the amount necessary to meet

these fiscal obligations creates a false expectation that increased funding is available to expand program services when, in fact, funding levels may not even be sufficient to maintain the status quo.

Current Services: +\$166.1 Million

The FY 2015 President's Budget request included an additional \$2.6 million in pay increases for IHS and Tribal employees at the service delivery level. If Tribes and IHS are to retain quality health professionals, it is critical that we honor these employees by providing a competitive wage. The FY 2016 Tribal budget request includes an increase of \$7.8 million for Federal Pay Costs and \$9.9 million for Tribal Pay Costs. Competitive pay for both Tribal and federal employees is crucial to ensuring that the Indian health system is able to recruit and retain qualified staff, which directly affects our ability to provide quality care to patients. In addition, the Workgroup feels strongly that commissioned officers, civil service, and Tribal employees should be exempt from any federal employee pay freeze that may be imposed in FY 2016.

The Current Services request also includes \$17.9 million for Non-Medical Inflation and \$63 million for Medical Inflation above the \$63 million included in the FY 2015 President's Budget. However, the actual inflation rate for different components of the IHS health care delivery system is much greater. As a component of the Consumer Price Index (CPI), inpatient hospital care is currently at 4.3% and outpatient hospital care is at 3.8%. The Workgroup asserts that the rates of inflation applied to H&C, Dental Health, Mental Health, and PRC in developing the IHS budget should correspond to the appropriate components in the CPI. Otherwise, the estimates developed by IHS underestimate the true level of funding needed to maintain current services.

Another \$67.5 million in Current Services funding is requested for Population Growth to address increased services needs arising from the increase in the AI/AN population, which in recent years has been growing at an average rate of 1.9% annually.

Binding Fiscal Obligations: \$202.8 Million

Funding must be appropriated to enable IHS to meet its existing contract support, staffing and facilities program obligations to Tribal communities. In FY 2016, the Workgroup also included recurring funding for newly recognized Tribes as a binding obligation.

Contract Support Costs (CSC) New & Expanded: \$43.2 Million

The Workgroup recommends a **\$43.2 million** increase to fully fund Contract Support Costs (CSC) in FY 2016. The Indian Self-Determination and Education Assistance Act (ISDEAA) of 1975 authorized Tribes to enter into contracts or self-governance compacts to manage federal programs previously administered by IHS. The well-documented achievements of the Indian self-determination policies have consistently improved service delivery, increased service levels, and improved third-party reimbursements. This policy has strengthened Tribal governments, institutions, and improved services for Indian people. Every

WORKFORCE RETENTION AT IHS

Federal pay freezes that have occurred since 2010 have created a crisis for recruitment and retention for Indian Health professionals. Private sector employers have not had the restrictions on pay, leading many to seek positions elsewhere. The industry-wide shortage of health care professionals only exacerbates this problem. Tribal communities already have great challenges in attracting qualified medical staff to their remote locations. It is critical that federal employees are paid a fair wage in order to ensure that Indian health programs have the staff they need to provide the care promised to our people.

Administration since 1975 has embraced this policy and Congress has repeatedly affirmed it through extensive amendments to strengthen the Self-Determination Act in 1988 and 1994.

The United States Supreme Court has twice considered the Government's responsibility to pay CSC to contracting Tribes and Tribal organizations under ISDEAA contracts. In both instances, the Supreme Court has held that due to the legally binding nature of an ISDEAA contract a tribal contractor has the right to recover its promised CSC in full, even if the contracting agency underpaid those costs due to aggregate restrictions on amounts allocated by the agencies or appropriated by Congress for payment of CSC. In FY 2014, the Administration proposed to individually cap CSC recovery at the contract level. Understanding that absent full funding, Tribes are forced to reduce direct services in order to cover the government's CSC shortfall, this proposal was rejected by Congress and specific language to "fully fund" CSC was included in the FY 2014 Consolidated Appropriations Act (P.L. 113-76).

The President's FY 2015 budget request includes full funding of estimated CSC need (a placeholder amount of \$29.8 million increase to fund the estimated CSC full funding amount totaling \$617.2 million in FY 2015). Assigning a specific funding amount to this "need" is difficult to estimate in large part because the IHS cannot predict with certainty the amount of new and expanded programs that will produce CSC need. Since the number of Tribes assuming new or expanded contracts in FY 2015 is unknown prior to this document's submission, the estimated figure is given with IHS providing updated information as it becomes available. Actual need for CSC is calculated after the appropriation year with updated information. Through the Consolidated Appropriations Act of 2014, Congress charged IHS developing a "long-term" solution through consultation with Tribes, a process that, at the time of this writing, is currently under way.

Staffing for Newly Constructed Facilities

The Workgroup recommends a placeholder amount **+\$70.8 million** for Staffing and Operating Costs for New and Replacement Facilities, reflecting the anticipated need based on estimated dates of beneficial occupancy. This funding allows the IHS and Tribes to provide the necessary services associated with operating these facilities. In the case of Joint Venture projects, Tribes have taken on great risk in financing the construction of new or replacement facilities. This risk is taken with a commitment from the IHS to fund necessary staffing and operating costs upon completion of facility construction. Failure to fund staffing and operating costs in a sufficient and timely manner leaves Tribes without the means to safely operate these facilities, compromising their ability to service loan agreements while jeopardizing the health and safety of entire communities.

Funding for Newly Recognized/ Restored Tribes

The Workgroup elected to include additional placeholder funding for six newly recognized/restored Tribes within the category of binding obligations. Federal recognition obligates the government to provide for the health and welfare of Tribal nations. Currently, four Tribes in the California Area and two Tribes in the Nashville Area operate without the appropriated funds for health care services to which they are legally entitled.

In some cases, this has gone on for several years, in spite of previous requests for funding from the IHS. While other Tribes have access to their full apportionment of IHS funds, these Tribes have only small amounts of "bridge" funding through the PRC program or no funding at all.

We are pleased that the Administration acknowledged their obligation to five of these Tribes and proposed \$8 million in the FY 2015 President's Budget. However, as the Congressional Justification reveals, this

amount is far below funding levels formulated and requested by the California and Nashville Area IHS Offices based on the costs of providing health care services to each Tribe's active user population. While the California Area requested a total of \$3.5 million for four Tribes, the Administration has requested only \$2.03 million for three Tribes. Although the Nashville Area has previously requested a total of \$8.8 million for two Tribes, the Administration only provides \$5.9 million for these Tribes in its FY 2015 Budget Request. Adjusting for inflation, the Administration's FY 2015 funding requests for newly recognized/restored Tribes are markedly insufficient.

This Administration and Congress must deliver on the promise made to these "new" Tribes and provide new appropriations that will allow for parity with other Indian health programs nationally. We urge the Administration to request new appropriations in the following amounts:

California Area

- Tejon Indian Tribe (Restored Federal Recognition, 2012): \$995,950
- Wilton Rancheria (Restored Federal Recognition, 2009): \$1,824,558
- Koi Nation (New Federally Recognized Tribe, 2000): \$191,633
- Smith River (Unserved Tribal Population residing in Curry County, Oregon): \$490,304

Funding Request: \$3.5 million

Nashville Area

- Shinnecock Indian Nation (New Federally Recognized Tribe, 2010): \$7,495,339
- Tonawanda Nation (Tribe requesting IHS funding): \$3,267,560

Funding Request: \$10.395 million

New Tribes Funding Total: \$13.895 million

Program Expansion Increases - Services

Tribes request that the Obama Administration commit to the goal of achieving full funding of the Tribal needs based budget of **\$27.8 billion** over the next 12 years. To accomplish this, the Workgroup recommends the FY 2016 Budget Program Increases outlined in this section of the budget request which will continue the significant progress made by this Administration in the past 4 years to bring AI/AN into parity with other citizens of the United States.

Hospital & Clinics: +\$267.8 million

Adequate funding for Hospitals & Clinics (H&C) is a critical Tribal budget priority for the 650 hospitals, clinics, and health programs that operate on or near Indian reservations. This core budget line item provides for the direct service delivery to AI/ANs. IHS/Tribal/Urban Indian (I/T/U)-managed facilities are predominantly located in rural settings with service at many locations limited to primary care, due to inadequate funding. IHS H&C funding supports essential personal medical services, including inpatient care, routine and emergency ambulatory care, and medical support services, such as laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy, and other services. H&C funds also support community health initiatives targeting health conditions disproportionately affecting AI/ANs, such as specialized programs for diabetes, maternal and child health, women's health, and elder health.

The demands on the IHS H&C are continuously challenged by a number of factors such as the increased demand for services related to trends in significant population growth, the increased rate of chronic diseases, rising medical inflation, difficulty in recruiting and retaining providers in rural health care

settings, and the lack of adequate facilities and equipment. For many AI/ANs, this represents the health care access in its entirety, both in terms of monetary resources but also facility access. Consequently, any underfunding of H&C equates to no health care. For many in Indian Country, there are no alternatives.

Health Information Technology

The IHS/Tribal/Urban Indian facility uses secure information technology (IT) to improve health care quality, enhance access to specialty care, reduce medical errors, and modernize administrative functions consistent with the Department of Health and Human Services (HHS) enterprise initiatives. For FY 2016, the Workgroup recommends **\$10 million** to maintain current investments and an additional **\$6 million** to implement meaningful use requirements and ICD 10 at IHS operated facilities.

Principal OIT customers include Tribal and IHS hospitals and clinics, Area IT offices, and IHS headquarters staff. Information technology is essential to effective quality health care delivery and efficient resource management in the IHS. Health care is information-intensive and increasingly dependent on technology to ensure that appropriate information is available whenever and wherever it is needed. The IHS IT infrastructure includes people, computers, communications, and security that support every aspect of the IHS mission. The IT infrastructure is based on an architecture that incorporates government and industry standards for the collection, processing, storage, and transmission of information. The IHS IT program is managed as a strategic investment, is fully integrated with the agency's programs, and is critical to improving service delivery across the Indian health care system.

Revenue generation is supported through third party billing. Without proper IT infrastructure and support, the ability of tribes to meet Meaningful Use and ICD-10 requirements is severely compromised, resulting in lost revenue that would otherwise support quality patient services. Furthermore, IT provides monitoring methods to identify trends in population health, can support AI/AN enrollment in clinical trials (with proper design and integration) and documents need and performance measurements for grant funding.

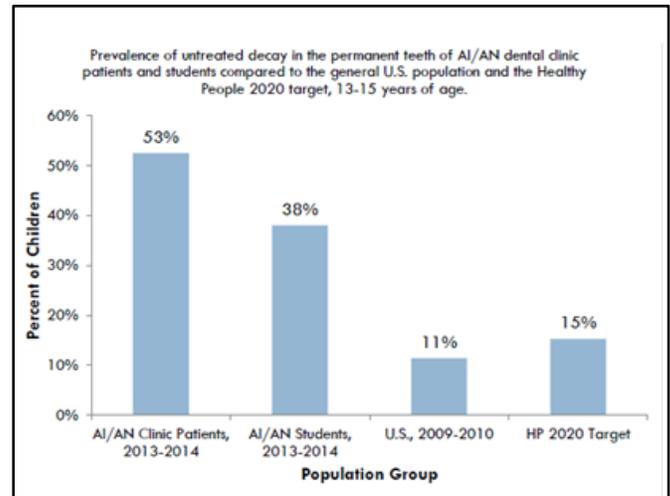
With limited resources devoted toward transition to ICD-10 and meeting ongoing CMS Meaningful Use standards, it is critical to take a strategic approach that does not ignore the day-to-day operational management and maintenance of both RPMS and non-RPMS systems. Health IT is no longer just a business solution but has evolved to become a necessary extension of patient care; it is imperative that current investments in IT be managed with dedicated resources and stable funding for on-going capital planning and investment. Capital Planning and Investment Control (CPIC) makes sure that IT investments line up with the IHS mission, goals, objectives, and supports business needs, while minimizing risks and maximizing returns throughout the investment's life cycle. CPIC relies on systematic selection, control, and continual evaluation processes to ensure meeting investment objectives.

Investments in IT enhance organizational performance. When carefully managed, IT can improve business processes, make information widely available, and reduce the cost of providing essential Government services. As IT rapidly evolves, the challenge of realizing its potential benefits also becomes much greater.

Dental Services: +\$17 million

Dental health is a top Tribal health priority. Dental disease can affect overall health and school and work attendance, nutritional intake, self-esteem, and employability. This disease is preventable when appropriate public health programs are in place.

The IHS Dental program supports the provision of dental care through clinic-based treatment and prevention services, oral health promotion, and disease prevention activities, including topical fluoride application and dental sealants. The demand for dental treatment remains high due to the significant dental caries rate among AI/AN children. Funds are used for staff salaries and benefits, contracts to support dental services, dental lab services, training, supplies, and equipment. These funds are needed primarily to improve preventive and basic dental care services, as over 90% of the dental services provided by I/T/Us are used to provide basic and emergency care services. More complex rehabilitative care (such as root canals, crown and bridge, dentures, and surgical extractions) is extremely limited, but may be provided where resources allow.



THE IMPORTANCE OF THE DENTAL HEALTH AIDE THERAPIST MODEL

Where authorized under state law, the Dental Health Aide Therapist (DHAT) model provides services in areas where regular dental care is not available. DHATs live and work in the communities they serve providing continuity of care, increasing dental health literacy, and providing a valuable service that prevents far costlier expenditures down the road. Pioneering this cost-efficient and effective method of providing much needed dental services; Alaska has 27 certified DHATs providing direct access to care to over 35,000 AI/AN people. This program provides a rewarding career for people wishing to remain in their villages while serving their people. The program also provides two-year post high school dental provider education targeted at rural Alaska students from areas where access to dental care is limited. Students complete two years of education to provide basic dental restorative services (fillings and extractions) and prevention program implementation. A supervisor provider works as part of a team led by a licensed dentist. The DHAT Educational Program has annually generated an average of 76 jobs (dental assistants, training program faculty, management, and ancillary staff) and generated \$9 million in economic activity in rural Alaska (Scott and Co., 2010 Survey of Tribal Health System Dental Directors). The DHAT model has proven effective, but the training program is primarily grant funded and currently at risk of closing down unless stable funding is secured.

The Workgroup strongly recommends that the IHS work to expand the use of DHATs throughout the I/T/U service delivery area by working within current law.

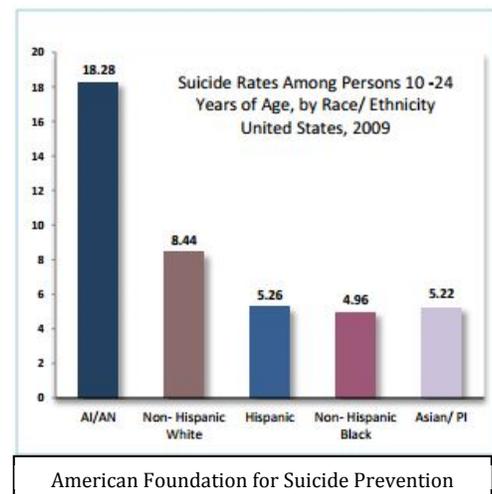
Mental Health: +\$54.2 million

Tribal leaders identified that Mental Health is a top concern and recommended a **\$54.243 million** increase above the Fiscal Year 2015 Budget Request. The increase that was afforded (\$4.04 million) was limited to the provision of medical inflation, additional staffing at three new healthcare facilities and a small portion for New Tribes. Without a major infusion of resources in FY 2016, IHS and tribal programs will continue to have limited staffing for their outpatient community based clinical and preventive mental health services. Further, any inpatient and intermediate services, such as adult and youth residential mental health services and group homes, which are sometimes arranged through states and counties, will have to be accessed off the reservation.

Access to adequate care, from local para professional providers to contracted specialty care providers is critical to address the vast mental health needs for American Indians and Alaskan Natives who seek care from their Tribal health and direct service facilities. Many tribes recognize historical trauma as the root of disproportionate rates of depression, suicide, reoccurring trauma from domestic violence and sexual assault. Historical trauma, which Duran refers to as “Soul wounding” can be described as unresolved generational trauma, generated by historical policies of genocide, boarding schools, relocation and more currently child welfare practices. These experiences, and the subsequent loss of traditional kinship systems, traditional language, spiritual practices and cultural values impact the core of self-worth and identity, and has left a legacy of familial and community grief, and a cycle of economic conditions that continue to contribute to the extraordinary mental health needs.

In 2007, the National Center for Health Statistics noted that AI/ANs experience serious psychological distress 1 ½ times more than the general population. Of particular concern, AI/AN represent the highest rates of suicide of any group in the U.S. for all ages. An eleven-year study (1999-2010) by the Dr. Jacqueline Gray, University of North Dakota, reveals the suicide rate for AI adolescents and young adults from 15-34 is 2.5 times the national average for that age group. Unlike other groups where the suicide rate increases with age, AI/AN rates are highest among the youth and decrease with age.

According to the American Foundation for Suicide Prevention, “90% of individuals who die by suicide had a diagnosable psychiatric disorder at the time of their death...” However, without adequate resources to address mental health needs, rates of suicide of AI/ANs will continue its current trend.



The IHS National Tribal Advisory Committee on Behavioral Health was established in 2008. The Committee has provided technical support to the IHS Behavioral Health Work Group, composed of Tribal and urban Indian health representatives who are providers and experts in the field of behavioral health. Since that time, the Committee and the Work Group advised IHS on the development of the National

American Indian/Alaska Native Behavioral Health Strategic Plan (2011-2015). This was a critical process, as the plan relays that the future of AI/AN health depends on how effectively behavioral health is addressed by our families and communities and integrated in our local health care delivery systems. The plan provides an honest assessment of a wide spectrum of mental health disorders and illnesses and community wide challenges that effect many AI/AN communities. It also lays out positive community and cultural approaches and traditional practices balanced with western approaches that would be implemented to address urgent, short term and longer term needs. These include some of the prevailing and serious issues such as depression, suicide, domestic violence and co-occurring mental health

and substance abuse disorders. The plan takes into serious consideration how the passage of the Affordable Care Act, which included a major revamping of the Indian Health Care Improvement Act section on

A CRY FOR HELP

An April 2014 shooting of two State Troopers in a small community of Alaska led local Tribal leaders to call for more behavioral health resources for rural communities. “We need village-based counselors in our communities” stated one community member. Community-based counselors and services in other communities have proven to be an effective means of local intervention and prevention of mental health and substance abuse issues.

Behavioral Health, that is the cornerstone to aid the development of inpatient, outpatient and prevention services essential to the overall health of Tribal communities and each community member.

Alcohol and Substance Abuse Treatment: +\$49.5 Million

Of the challenges facing AI/AN communities and people, no challenge is more far reaching than the epidemic of alcohol and other substance abuse. Tribal leaders understand this and identified it as a top concern for FY 2016. The Workgroup recommends a program increase of **\$49.50 million** over FY 2015. In the FY 2015 Budget an increase of \$7.4 million is limited to the provision of medical inflation,

additional staffing at three new healthcare facilities and a small portion for New Tribes. Without a major infusion of funding, AI/AN people will continue to be consistently over represented in statistics relating to alcohol and substance abuse disorders in which higher rates of methamphetamine, cocaine and marijuana use are reported. Now that Tribes manage a majority of alcohol and substance abuse programs, IHS is in a supportive role to assist the Tribes plan, develop and implement a variety of treatment modalities. The collaboration has resulted in more consistent evidenced-based and best practice approaches to address substance abuse disorders and addictions. At the community level, this is accomplished through individual and group counseling, peer support, and inpatient and residential placement. Treatment approaches also include traditional healing techniques that link the services provided to traditional cultural practices and spiritual support for the individual AI/AN that Tribal

ADVERSE CHILDHOOD EXPERIENCES

The association between ACE (Adverse Childhood Experiences) and unhealthy adult lifestyles has been well documented. Adolescents with a history of multiple risk factors are more likely to initiate drinking alcohol at a younger age and are more likely to use alcohol as a means of coping with stress than for social reasons. The adoption of unhealthy lifestyles as a coping mechanism might also explain why higher ACE exposures are associated with tobacco use, illicit drug abuse, obesity, and promiscuity as well as why the risk of pathologic gambling is increased in adults who were maltreated as children.

Adolescents and adults who manifest higher rates of risk-taking behaviors are also more likely to have trouble maintaining supportive social networks and are at higher risk of school failure, gang membership, unemployment, poverty, homelessness, violent crime, incarceration, and becoming single parents. Furthermore, adults in this high-risk group who become parents themselves are less likely to be able to provide the kind of stable and supportive relationships that are needed to protect their children from the damages of toxic stress. This intergenerational cycle of significant adversity, with its predictable repetition of limited educational achievement and poor health is mediated at least in part by the social inequalities and disrupted social networks that contribute to fragile families and parenting difficulties.”

Shonkoff, Jack P., et al. "The Lifelong Effects of Early Childhood Adversity and Toxic Stress." *Pediatrics* 129.1 (2012): e232-e246.

programs have found successful.

IHS funding supports the operation of youth residential treatment facilities and services for women with children up to age 24, but as in all health care, third party reimbursement has become increasingly relied upon by these facilities. Medicaid reimbursement is an important resource, however not fully accessible and always contingent on state policies with regard to the level of reimbursement for covered and optional services if adopted in a State Medicaid Plan. The Youth Regional Treatment Centers, for example, serve tribal youth from multiple states and youth do not obtain residential status for at least 30 days. Limited funding often results in placement decisions based on the availability of alternate resources and the providers’ clinical recommendations.

The National American Indian/Alaska Native Behavioral Health Strategic Plan (2011-2015) provides a comprehensive approach to address alcohol and substance abuse and its tragic consequences, including death, disabilities, families in crisis and multi-generational impacts. IHS, Tribal and urban Indian health alcohol and substance abuse programs continue to focus on integrating primary care and behavioral health services, being more responsive to emerging trends and the instituting best and promising practices that align with culture based prevention and treatment.

It should be noted that Congress and this Administration recently highlighted the need to address the major issues of violence and sexual and domestic abuse against AI/AN women in the re-authorization of the Violence Against Women Act (VAWA) (Public Law 113-4) and the Tribal Law and Order Act (TLOA) (Public Law 111-211). Alcohol and other substance abuse is often a precursor to these serious issues in Tribal communities. These authorities will enhance efforts and provide potential funding and coordination of effort among agencies in the area of alcohol and substance abuse prevention, treatment, data analysis and community based research.

Purchased/ Referred Care Program (PRC): +\$198.2 million

Congress requested that the title of the Contract Health Services program be changed to Purchased/Referred Care (PRC) program in order to avoid confusion with the contract support cost line item and to more accurately describe the purpose of the program. The PRC program pays for urgent and emergent and other critical services that are not directly available through IHS and Tribally-operated health programs when:

1. No IHS direct care facility exists,
2. The direct care facility cannot provide the required emergency or specialty care, and
3. The facility has more demand for services than it can currently meet.

Funding for PRC remains a critical priority for all Tribes. The PRC budget supports essential health care services from non-IHS or non-Tribal providers and includes inpatient and outpatient care, emergency care, transportation, and medical support services such as diagnostic imaging, physical therapy, laboratory, nutrition, and pharmacy services. These funds are critical to securing the care needed to treat injuries, cardiovascular and heart disease, diabetes, digestive diseases, and cancer, which are among the leading causes of death for AI/ANs. The recent trend to construct smaller joint venture outpatient ambulatory care centers will likely increase the reliance on PRC resources for hospital-based care. In FY 2012, IHS denied 186,353 eligible PRC cases eligible, and; again in FY 2013 denied services for 213,360 PRC eligible PRC cases AI/ANs. This upward trend demonstrates that the PRC need continues to grow in the IHS system and that additional resources are needed to address this chronic and underfunded need.

MEDICARE LIKE RATES FOR PRC

In addition to providing additional funding for PRC, one common-sense solution to enable these funds to go further is for Congress to enact legislation that would require that PRC reimbursements to non-hospital providers are made at “Medicare Like Rates.” In 2003, Congress amended the Medicare law to authorize the Secretary of Health and Human Services to establish a rate cap on the amount hospitals may charge IHS and Tribal health programs for care purchased from hospitals under the PRC program. However, hospital services represent only a fraction of the services provided through the PRC system. The IHS PRC program may be the only federal government entity that does so; neither the Veterans’ Administration nor the Department of Defense pay full-billed charges for health care from outside providers.

On April 11, 2013, the Government Accountability Office (GAO) issued a report that concluded, “Congress should consider imposing a cap on payments for physician and other nonhospital services made through IHS’s CHS program that is consistent with the rate paid by other federal agencies.” We agree: these savings would result in IHS being able to provide approximately 253,000 additional physician services annually. This number will even be greater when you consider Tribally run programs.

The Workgroup urges the Administration to continue to support his legislative change in its FY 2016 Budget.

At current funding levels, many IHS and Tribally operated programs are only able to cover Priority I services to preserve life and limb and are often unable to fully meet patients' needs of even this one PRC service category. Because PRC is only treating the most desperate of cases at current funding levels, any shortfall in the program correlates to increased death rates for some communities in Indian Country.

The across the board sequestration cuts in FY 2013, which cut over \$41 million from this critical program, made the situation even more dire. Many Tribes were forced to ration care by delaying or denying Priority II referrals. These delays and denials often cause the patients' health to get worse, leading to higher treatment costs down the road and sometimes death. Failure to pay PRC claims also means that patients are often given only symptomatic treatment, leading to worse health outcomes and increased long-term costs to the Indian health delivery system.

Public Health Nursing: +\$2.4 Million

Public Health Nursing (PHN) is a community health-nursing program that focuses on promoting health and quality of life and preventing disease and disability. The PHN program provides quality, culturally sensitive primary, secondary, and tertiary health promotion and disease prevention nursing services to individuals, families and community groups. Home-based services are most often related to chronic disease management, safety and health maintenance care for elders, investigation and treatment of communicable disease, breastfeeding promotion, pre/postnatal education, parenting education, and screening for early diagnosis of developmental problems. However, PHN also offers traditional food programs that focus on food choices that are not only culturally appropriate but consider health challenges for AI/ANs, health system patient navigator assistance programs, tobacco cessation programs, cancer screening programs, onsite emergency care assistance, and community mental health support, education, and programs.

Health Education: +\$6.1 Million

The Health Education program supports the provision of community, school, and worksite health promotion, patient and professional education, and the development of educational materials for staff, patients, families, and communities. Current focus areas include health literacy, patient-provider communications, and the use of electronic health information by and for patients. The need for health education activities is important in order to empower AI/AN patients to become better informed about their own personal health and the wellness of their Tribal communities.

Community Health Representatives (CHR): +\$5.4 Million

The CHR program helps to bridge the gap between AI/AN individuals and health care resources through outreach by specially trained members of the Tribal community. CHRs integrate basic medical knowledge about health promotion and disease prevention with local community knowledge. They often play a key role in follow-up care and patient education in Native languages and assist health educators implement prevention initiatives. Their role is crucial in Indian country. They are considered an integral member of the health care team.

With the opportunity provided under the IHCIA, which expands the permissible uses of appropriated funds to include community-based care, additional resources are needed to increase CHR trainings and increase the CHR workforce.

Alaska Immunization: +\$76 thousand

Hepatitis B Program: Hepatitis and other liver diseases continue to be a health disparity for AI/ANs. The Hepatitis B Program was initiated in 1983 because of the need to prevent and monitor hepatitis B infection

among a large population of Alaska Natives with or susceptible to the disease. The Hepatitis B program is the only program that contains all of the elements recommended by the Institute of Medicine’s 2010 report on liver cancer and chronic viral hepatitis. The Hepatitis B Program also conducts the largest and longest follow-up vaccination studies on Hepatitis A and B that has demonstrated prolonged protection up to 30 years for these vaccines.

Immunization (Hib) Program: Immunization is a fundamental health prevention activity for Alaska Native people and dedicated immunization funding has ensured access to vaccines and high vaccine coverage for Alaska Native children and adults. The Alaska Native Tribal Health Consortium (ANTHC) Immunization and Hepatitis Programs led Hepatitis B immunization efforts from the 1980s forward and Alaska Native people have progressed from having the highest rate of symptomatic Hepatitis B infection in the 1970s to currently having the lowest rate of any US racial group.

Urban Indian Health: +\$16.6 million

Thirty-eight Urban Indian Health Programs provide health care and substance abuse services in fulfillment of the federal trust responsibility to more than 100,000 AI/ANs each year. Operating in 21 states, these programs are funded from an IHS line item of only \$40.7 million, which is less than 1% of total IHS budget. Urban Indian Health Programs are unable to access PRC funding and other resources from the general IHS budget, and consequently have become adept at leveraging their modest base funding with additional health care dollars from other federal agencies, states, and foundations. Urban Indian Health Programs offer services to all AI/ANs.

Indian Health Professions: +\$1.8 million

Because IHS focuses on primary and community based care, the need for professional well-staffed facilities is key for prevention and treatment for AI/ANs. Indeed, this lack of access to quality healthcare contributes to a life expectancy of 4.2 years less for AI/AN individuals.

The Indian Health Professions program manages the IHS Scholarship and Loan Repayment programs, health professions training related grants, and recruitment and retention activities for IHS and intern/ externship programs. The program enables AI/ANs to enter into health care professions through a system of preparatory, professional, and continuing educational assistance programs that serve as a catalyst for community development by enabling AI/AN health care professionals to further Indian self-determination through the delivery of health care. The program also assists in the recruitment and retention of qualified health and mental health professionals to work in the Indian health system. The program utilizes technology to provide educational and training opportunities virtually as well as clinical experience and continuing education credits. Statewide support through Locum pools help with personnel for “hard to fill” and high demand professions. The program helps fund statewide-centralized databases for professionals to allow efficient tracking and reporting of continuing education and training. Generally, individuals who come

**TAX EXEMPT STATUS FOR
IHS LOAN REPAYMENT**

Indian Health Service (IHS), Tribal and Urban facilities serve smaller, often rural populations with primary medical care and community based health care services.

IHS relies upon student loan repayment programs to recruit and retain medical professionals. However, these funds are taxable, drastically reducing the number of medical professionals that can be acquired with limited funds. If there were a tax-exempt status, the program would be able to fund an additional 105 loans. A productive strategy to increase the number of medical professionals in Indian Country without increasing the budget, therefore, would be to allow these limited funds to be tax exempt.

The Workgroup urges the Administration to continue to support this legislative change in its FY 2016 Budget.

to IHS on the student loan repayment program stay with IHS for eight years, thereby providing a more stable continuum of care for our people.

In FY 2014, the Indian Health Professions account was cut by \$5 million in order to fully fund Contract Support Costs and stay within the amount of funding allocated by Congress. While Tribes support the full funding of CSC, we also note that critical programs like this one should not suffer at the expense of others.

Tribal Management Grants: +\$100 thousand

The purpose of the Tribal Management Grant (TMG) Program is to assist federally recognized Tribes and Tribal organizations in assuming all or part of existing IHS programs, services, functions, and activities (PSFAs) under self-determination and operate these programs at the Tribal level. TMG also assists established self-determination contractors and self-governance compactors to further develop and improve their management capability and conduct health program planning.

This grant opportunity is an important resource for Tribal capacity-building and technical assistance needed to empower Tribes and Tribal organizations to exercise rights under the Self-Determination and Education Assistance Act. All Federally Recognized Tribes and Tribal organizations are eligible to apply for Tribal Management Grants. Priority is given to newly recognized Tribes and Tribes and Tribal organizations addressing audit material weaknesses.

The Tribal Management Grant Program provides discretionary, competitive grants to Tribes and Tribal organizations to conduct planning and evaluation, including the development of any management systems necessary for contract/compact management and the development of cost allocation plans for indirect cost rates; and to plan, design, and evaluate Federal health programs serving the Tribe, including Federal administrative functions. The program provides resources to allow Tribes to analyze PSFAs to determine if management by a Tribe or Tribal organization is practicable and develop the accompanying organizational and governmental infrastructure, as well as internal management systems needed to effectively carry out these PSFAs.

Direct Operations: +\$1.1 million

The Direct Operations budget supports the leadership and overall management of IHS. This includes oversight of employees, facilities, finances, information, and administrative support resources and systems. Funding is allocated to IHS Headquarters, Area Offices, and Tribal shares. These funds ensure that the IHS is able to perform its essential residual functions in support of the I/T/U. In addition, it provides management support for direct service Tribes and system-wide administrative functions, contributing to better health outcomes for AI/ANs.

Another essential function of IHS' Direct Operations is Tribal Consultation. The agency is continually, and rightfully, consulting with Tribes and their representatives in Workgroups, advisory committees, and other negotiations. These meetings require not only support for basic meeting functions such as travel and facility space, but also technical support for Tribal leaders to engage in meaningful consultation. All of these functions are essential to maintaining the government-to-government relationship and the trust responsibility.

Self-Governance: +\$38 thousand

The Self-Governance budget supports negotiations of Self-Governance compacts and funding agreements, oversight and coordination of the Agency Lead Negotiators (ALN), technical assistance on Tribal

consultation activities, analysis of new authorities in the IHCA, Self-Governance Planning and Negotiation Cooperative Agreements, and funding to support the activities of the Tribal Self-Governance Advisory Committee, which advises the IHS Director on self-governance policy issues.

Title V of the ISDEAA provides the IHS statutory authority to enter Planning and Negotiation Cooperative Agreements to assist Tribes in planning and negotiation activities associated with self-governance. Cooperative Agreement awards involve much more substantive Federal program specific involvement than a grant, which is key to a successful self-governance planning and negotiation process.

These Cooperative Agreements provide resources to Tribes first entering self-governance as well as existing Self-Governance Tribes interested in expanding their current PSFAs. Title V of the ISDEAA requires that a Tribe or Tribal Organization complete a planning phase to the satisfaction of the Tribe. The planning phase must include legal and budgetary research and internal Tribal government planning and organization preparation relating to the administration of health care programs. The planning phase helps Tribes to make informed decisions about which PSFAs to assume and what organizational changes will be necessary to support those PSFAs.

These Cooperative Agreements also provide resources to Tribes to help defray the costs related to preparing for and conducting self-governance negotiations. This enables a Tribe to set its own priorities when assuming responsibility for IHS PSFAs and assist the Tribe during the negotiation of a self-governance compact and funding agreement. Self-Governance formalizes and recognizes the government-to-government relationship between the United States and each Tribe, and empowers Tribes to plan, design and carry out programs and activities that are most responsive to the health care needs of their communities.

Program Expansion Increases-Facilities

The Workgroup recommends a program expansion increase of \$52.1 million for Indian Health Facilities over the FY 2015 President's Budget and Binding Fiscal Obligations for a total increase of **\$142.5 million**.

Maintenance & Improvement (M&I): +\$16.4 million

The recommended amount represents a program increase of **\$16.4 million** above the FY 2015 President's Budget request for the M&I line item of \$70.1 million. All Tribal Area budget formulation sessions reported the critical need for a program increase in this category. The recommended increase is to address a portion of the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) of existing health care facilities, although much more funds are needed. M&I funds support and enhance the delivery of health care services by protecting real property investments from costly deterioration. This amount would allow IHS to meet basic facilities' maintenance requirements and begin to make long overdue facility improvements.

Sanitation Facilities Construction (SFC): +\$16.6 million

The recommended amount represents a \$16.6 million program increase above the FY 2015 President's Budget for the SFC line item. Unfortunately, due to the remoteness of many Tribal communities and lack of infrastructure, the need for improvements to water supply, sewer systems and solid waste facilities in Indian Country remains substantial. The SFC program is an important disease prevention program that yields positive results by improving environmental conditions, thereby making an impact on the health of individuals and reducing medical care costs.

IHS reported in the FY 2015 Congressional Justification that as of November 2013, the estimated cost to address documented sanitation project deficiencies totaled approximately \$3.1 billion. Of those projects listed, \$1.72 billion is the amount needed for projects considered economically and technically feasible. For years, the level of appropriations has not made a significant dent on the backlog. In FY 2011, the enacted level of funding was \$95.6 million, but was drastically cut the following year and never restored. A \$16.6 million increase, however, could help thousands of families improve their living conditions by providing new and existing homes water wells and onsite waste water systems or by connecting their homes to community water and waste water systems. These homes would be prioritized from the Sanitation Deficiency System inventory in FY 2016.

Health Care Facilities Construction (HCFC): Binding Obligations: +\$75 Million & New Authorities: +\$19.4 million

The recommended increase above the FY 2015 President's Budget request is **\$95.9 million** for the HCFC line item. Tribal recommendations from several IHS Areas expounded on the lack of access to adequate health care that would be remedied by constructing projects on the IHS health care facility priority list adopted in the IHCIA and by implementing the new health care facility planning and construction system also required under the law. Dedicated resources for construction should be one of the highest priorities of the Administration and is necessary to improve quality of health care for hundreds of thousands of American Indians and Alaska Natives. While the total amount identified currently for HCFC projects exceeds \$2.1 billion, an additional \$75 million would help at least one or two more projects through the design and construction phase.

A concern of the Tribes who do not have projects on the priority list is the amount of time and resources that it will take to complete these projects. The IHCIA authorizes New Authorities in which Tribes may initiate innovative approaches or demonstration projects to deliver health care, which are identified in the law. For these purposes, an additional amount of \$19.4 million is requested in FY 2016.

Equipment: +\$6.2 Million

A recommended program increase of **\$6.2 million** is requested above the FY 2015 President's Request. Equipment funds are needed to obtain modern medical equipment for tribally constructed healthcare facilities scheduled to open in FY 2016, to replace some of the outdated equipment in other IHS and Tribal health facilities and for the purchase of new and like-new medical equipment from the Department of Defense and other sources. Tribal leaders believe that by making this increase available, more preventative screening and diagnostic services provided in IHS and tribal healthcare facilities, relieves the need to refer many of these cases to PRC providers. Some tribal clinics benefitted from the 2009 American Reinvestment and Recovery Act (ARRA) in which a portion of the funding was used to purchase needed equipment, but since that time, subsequent allocations have not kept pace with the need.

❖ 3rd Recommendation: Restore Cuts/Shortfalls in FY2013-15

This recommendation addresses restoration of the FY 2013 sequestration cuts, and the cuts/shortfalls, which resulted from inadequate funding to cover Congressional mandates in FY2014 & FY2015 above and beyond those needed to keep up with inflation and population growth. Current Services are fixed costs that are necessary to maintain services at the same level as the previous year. This means that the draconian cuts made to Tribal health programs through automatic sequestration cuts in FY 2013 must be restored. Many Tribes were forced to subsidize the federal trust responsibility in FY 2013, and those that could not cut programs and services. If increased funding is not appropriated to cover these fixed costs, programs will have to absorb these mandatory cost increases within their existing programs by reducing services or by investing other Tribal resources reserved for education, elder services or other important Tribal programs. We recommend full funding for Current Services at an estimated increase of **\$166.1 million**.

The Indian Health Services provides critical health care for all AI/ANs, just like the Veterans' Administration and Centers for Medicare and Medicaid Services. IHS programs are already severely underfunded which means any sequester or rescission has direct impact on the ability to provide individual patient care services. Vacancies for medical professionals were not filled in many facilities and others were forced to close their doors several times a month. The failure to fully restore sequestration in FY 2014 means that these vacancies still go unfilled and AI/ANs continue to receive a lower level of care. The South East Alaska Regional Health Consortium closed the Bill Brady Healing Center that provides alcohol and drug treatment to Alaska Natives. On the Pine Ridge Reservation, the health education department cut a full time physical fitness aid to part time – dramatically affecting efforts to prevent heart disease and diabetes. Also on Pine Ridge, testing and screening services for elders and babies were reduced. The Mississippi Band of Choctaw Indians said that Priority II referrals² for medical services have been delayed or denied. These delays and denials often cause the patients' health to get worse, leading to higher treatment costs down the road and in some cases death.

❖ 4th Recommendation Permanent Exemption from Sequestration

In FY 2013, Indian Health programs were subject to a 5.1 percent automatic, across the board cut. This means \$220 million left the IHS. Several Members of Congress publicly stated that this was clearly an oversight, and that IHS should not have been held to the full sequester. Nevertheless, Tribes and federally run IHS programs were left with an impossible choice – either deny services or subsidize the federal trust responsibility. In fact, many did close their doors for several days per month and others were forced to only deliver PRC for Priority I.

² For a breakdown of IHS Medical Priority Levels see:

http://www.ihs.gov/chs/index.cfm?module=chs_requirements_priorities_of_care

For FYs 2014 and 2015, Congress has found a way out of sequestration for discretionary programs. However, the Budget Control Act (BCA) (P.L. 112-25), has mandated sequestration each year through FY 2021. Indian health simply cannot take any more sequestration cuts. Section 256 of the BCA explicitly holds IHS to 2 percent for any year other than FY 2013. However, with an already underfunded rate of 59 percent for the IHS, even a 2 percent cut is too much. Tribes should not be held responsible for the inability of the federal government to balance its books.

“Our country’s financial troubles are not really stemming from our obligations to Indian Country, and frankly, we’re not doing a good job in fulfilling those obligations.”

*Senator Maria Cantwell (D-WA)
November 14, 2013*

Should sequestration occur in FY 2016, the Workgroup encourages the Administration to work with Congress to ensure that Tribes do not find themselves in this situation again, and the FY 2016 budget should reflect that commitment by permanently exempting the IHS from sequestration.

Program	Population Served	Sequestration
Social Security	Retirees, Survivors and Individuals with Disabilities	Exempt
Medicare	Citizens/Residents 65 Years or Older, Individuals with Disabilities or End-Stage Renal Disease	Exempt ¹
Medicaid and Children’s Health Insurance Program	Low-Income Families with Dependent Children, Pregnant Women, Individuals with Disabilities	Exempt
Veterans Affairs Programs	Veterans	Exempt
Indian Health Service – Special Diabetes Program for Indians	American Indians and Alaska Natives with Diabetes	2.0
Indian Health Service – Services and Facilities	American Indians & Alaska Natives	5.1

Note: ¹ Medicare is subject to a 2% reduction cut. The reductions in Medicare spending would come from payments to various health care providers, but beneficiaries would not be directly impacted. Beneficiaries may feel the effects if the payment cuts lead physicians and hospitals to stop treating Medicare beneficiaries.

❖ 5th Recommendation: Fund Indian Health Care Improvement Act New Authorities at \$300 Million

The implementation of the Indian Health Care Improvement Act (IHCA) remains a top priority for Indian Country. IHCA provides new authorities for Indian health care, however additional funding is needed to fully implement the Act. The recommendations described elsewhere in this document are to provide for

the services that IHS already provides; however, at least an additional \$300 million is critically needed in order to begin to implement and fund the new priorities in IHCA. Tribes fought for over 10 years to renew IHCA and the Administration and Congress should act to fulfill the promise enacted by the 2010 law.

Tribes recommend that IHS reprogram existing resources for Direct Service Tribes to take advantage of these new authorities that would be more beneficial for their communities, when requested and consulted. The battle for IHCA renewal was over ten years in the making. When this historic law was signed, Indian Country was elated by the promise of a new and more efficient health care delivery system for AI/AN people. However, four years later many of the provisions of the Act remain unfunded, and in many ways, represents yet another broken promise for Indian people.

The American health care delivery system has been revolutionized while the Indian health care system waited for the reauthorization of the IHCA. For example, mainstream American health care increased focus on prevention as a priority and a treatment, and coordinated mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs is now standard practice. Reflecting these improvements in the IHCA was a critical aspect of the reauthorization effort. The time and resources paid off with the permanent reauthorization of IHCA. Highlights of what is contained in the IHCA Reauthorization include:

- Updates and modernizes health delivery services, such as cancer screenings, home and community based services and long-term care for the elderly and disabled.
- Establishes a continuum of care through integrated behavioral health programs (both prevention and treatment) to address alcohol/substance abuse problems and the social service and mental health needs of Indian people.

All provisions of the IHCA are critical to advancing the health care of American Indian and Alaska Native people and should be implemented immediately. An additional \$300 million will only begin to scratch the surface of implementing these new budget authorities. Adequate funding for the implementation of these long awaited provisions is needed now.

❖ Other Policy Recommendations

Advance Appropriations for the Indian Health Service

Tribes across Indian Country support the effort to obtain Advance Appropriations³ for the Indian Health Service. An advance appropriation is funding that becomes available one year or more after the year of the appropriations act in which it is contained. For example, if the FY 2015 advance appropriations for the IHS were included in the FY 2015 appropriations bills, those advance appropriations would not be counted against the FY 2015 funding allocation but rather, against the FY 2016 allocation.

Advance appropriations would allow Indian health programs to effectively and efficiently manage budgets, coordinate care, and improve health quality outcomes for AI/ANs. This change in the appropriations schedule will help the federal government meet its trust obligation to Tribal governments and bring parity to federal health care system. Adopting advance appropriations for IHS would result in the ability for health administrators to continue treating patients without wondering if –or when– they would have the necessary funding. Additionally, IHS administrators would not waste valuable resources, time and energy re-allocating their budget each time Congress passed a continuing resolution. Indian health providers would know in advance how many physicians and nurses they could hire without wondering if funding would be available when Congressional decisions funnel down to the local level. Health care services in particular require consistent funding to be effective.

The Veterans' Administration (VA) achieved advance appropriations for its health programs in 2009. IHS, like the VA, also provides direct health care to individuals. We encourage the Administration to support parity between VA and IHS and to request advance appropriations for IHS in its FY 2016 Budget.

Medicare Like Rates for non-hospital providers

In 2003, Congress amended the Medicare law to authorize the Secretary of Health and Human Services to establish a rate cap on the amount hospitals may charge IHS and tribal health programs for care purchased from hospitals under the PRC program, formerly known as the Contract Health Services (CHS) program.

Hospital services represent only a fraction of the services provided through the PRC system. PRC programs continue to routinely pay full-billed charges for non-hospital services, including physician services. The IHS PRC program may be the federal government entity that does so; neither the VA nor the DOD pay full-billed charges for health care from outside providers. Nor do insurance companies, including those with whom the federal government has negotiated favorable rates through the Federal Employee Health Benefits program.

On April 11, 2013, the Government Accountability Office (GAO) issued a report that concluded, "Congress should consider imposing a cap on payments for physician and other nonhospital services made through IHS's CHS program that is consistent with the rate paid by other federal agencies." The GAO found that PRC program alone would have saved an estimated \$31.7 million annually if Medicare-Like

³ Advance appropriations *differs from* "forward funding," which allows funds to become available beginning late in the budget year and is carried into at least one following fiscal year. Forward funding is counted against the same budget year. Advance appropriations is counted only in the budget year for which the appropriated dollars will be spent.

Rates applied to non-hospital services. These savings would result in IHS being able to provide approximately 253,000 additional physician services annually. This number will even be greater when you consider Tribally run programs, which means that total savings are more likely to be around \$100 million.

The Workgroup requests that the Administration support legislative changes to enact Medicare-like rates for all IHS PRC programs. It would mean that these scarce dollars would be used more efficiently with no additional cost to the government.

Renewal of the Special Diabetes Program for Indians

As part of the Balanced Budget Act of 1997, Congress established the Special Diabetes Program for Indians (SDPI) to address the growing epidemic of Type II diabetes in American Indian and Alaska Native (AI/AN) communities. The Special Diabetes Program for Type 1 Diabetes (SDP) was established at the same time to address the serious limitations in Type 1 diabetes research resources. Together, these programs have become the nation's most strategic, successful and comprehensive effort to combat diabetes. SDPI is transforming lives and changing the diabetes landscape in America.

According to the Centers for Disease Control and Prevention (CDC), AI/AN adults have the highest age-adjusted prevalence rate of diagnosed diabetes compared to other major racial and ethnic groups at 16.1 percent. By comparison, this is almost twice the rate for the total U.S. adult population. Some regions of Indian Country have diabetes rates as high as 33.5 percent, with specific communities having Type II diabetes reach a level as high as 60 percent.

Today, SDPI is funded at a level of \$150 million per year and supports 404 diabetes treatment and prevention programs in 35 states. With funding for this critical program set to expire on September 30, 2015, Tribes are requesting a renewal of this program of **\$200 million/ year for 5 years**. While we understand an increase in funds during this budgetary environment is difficult, SDPI has been level-funded since 2002. This represents an effective decrease. Calculating for inflation, \$150 million in 2002 would be about \$115 million in 2014 – or *23 percent less*. In order to keep the momentum of this important program alive, it is critical that Congress continue to invest in SDPI, which will save millions in preventative care over the long term. When taking into account additional Tribes that have gained federal recognition since 2002, the dollars are even scarcer.

Without long-term reauthorization, the critical infrastructure that the Tribes have built to address the Type II diabetes epidemic in Indian Country and has greatly contributed to the success of SDPI will be lost. A delay in renewal will mean loss of SDPI staff – loss of jobs – that will severely impact tribal health: both in terms of patient health and community economic health.

CONCLUSION

It is not only reasonable and achievable to fully fund health services for AI/AN at \$28.7 billion, but it is the *right* thing to do. Health programs, services, functions and activities provided to AI/ANs through compacts, contracts, and direct operations of the IHS are Tribal trust and treaty obligations grounded in the Constitution and numerous federal laws. This President has a unique opportunity to remarkably change the course of history for Federal-Tribal government-to-government relations. The Trust responsibility accepted by the U. S. Government in treaties and agreements with our forefathers *must* be taken seriously. This President *must* leave his legacy by *acting now* to provide a meaningful increase of *at least 17.58%* for the IHS in FY 2016 and to create the necessary pathway for future Administrations to continue until 100% of our Tribal Needs budget is achieved.

To allow the existing funding gap to continue for both IHS Services and Facilities budget lines is to disregard the health and lives of all Native Americans. This country has a track record of looking out for the rights of other citizens. Our elders ask: “Why Not Us?” It is time to end the unnecessary death and suffering occurring every day in Indian communities – centuries of neglect is now an urgent humanitarian cry for justice for our People.

We urge you, as our President, to find the courage to take action now to leave a legacy of justice and dignity for all Native Americans. You have the power to make measurable improvements in the health status and quality of life of America’s First Peoples. In this constrained environment, Congress relies on the Administration to exercise its duty to responsibly carve out the necessary funds for Tribal health care within the overall President’s budget. Tribes can no longer rely solely on Congress to right size to our budget needs. We must work as partners on this.

LEGACY— CHAMPION FOR INDIAN HEALTH

President Obama has secured a legacy in reforming America’s health care system. President Obama should not only be known as a champion of health, but as a champion of change in Indian health. However, the task of reforming the Indian health care system so our people can benefit on the same basis as other Americans will only be achieved if this Administration proposes a budget that fulfills its obligation to Tribes and sets the path to fully fund the Indian health care system. We understand that this presents a challenge, but we believe that the commitment this Administration has shown in working towards the American Dream for all can and should be applied to health care for its First Peoples. Throughout this Administration, President Obama has continually spoken of the need to keep the promises made to AI/ANs – *now is the time for action, we must end this painful chapter in our shared history.*

“We haven’t solved all our problems. We’ve got a long road ahead. But I believe that one day, we’re going to be able to look back on these years and say that this was a turning point.”

President Barack Obama
White House Tribal Nations
Conference
December 2, 2011

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Appendix

❖ APPENDIX A: HOT ISSUES BY IHS SERVICE AREAS

During the fiscal year, IHS receives data call requests from DHHS and OMB regarding issues of concern that impact a particular Service Area (i.e., national emergencies, etc.). Each Area was requested to identify “hot issues” facing its regional Tribes. Any significant issues (non-budgetary, current and/or lingering) were described in brief by the IHS Area with the intention of elevating Area concerns during the National Work Session. The IHS Areas submitted the following “hot issues” topics.

Alaska

- ❖ VBC Leases
- ❖ IHS Advanced Appropriations
- ❖ Staffing Packages
- ❖ Contract Support Costs
- ❖ Indian Health Care Improvement Act – access & special unmet needs
- ❖ Long-term Care/Eldercare
- ❖ Behavioral Health (BH): Tele-BH & village access to BH
- ❖ BH: Alcohol & Substance Abuse –Heroin, Pain Management Rehab Center/similar to Fond u lac and Mayo Clinic center
- ❖ Dental Health Aide Therapy Training Center
- ❖ Health Promotion & Disease Prevention including Injury Prevention
- ❖ Lost Revenues

Albuquerque

- ❖ Hospitals and Clinics – Increase Access to care
- ❖ Multi-year renewal of the Special Diabetes Program for Indians
- ❖ Purchased/ Referred care
- ❖ MSPI

Bemidji

- ❖ Funding Parity
- ❖ Health Disparities
- ❖ Purchased/Referred Care
- ❖ Facility Construction
- ❖ Prescription Drug Abuse And Diversion
- ❖ Notification Of Consultation Meetings And/Or Comment Periods
- ❖ Healthcare Reform Implementation And Impact

Billings

- ❖ Purchased/Referred Care
- ❖ Mental/Behavioral Health Services
- ❖ Alcohol and Substance Abuse
- ❖ Hospitals and Clinics
- ❖ Health Education

California

- ❖ Recurring Funds for New Tribes

Great Plains

- ❖ Contract Support Costs
- ❖ Medicare Rate Reimbursement for Contract Health Providers
- ❖ Advanced Appropriations for IHS

Nashville

- ❖ Personnel Hiring
- ❖ IHS / VA Master Agreement
- ❖ Training for Urban Community Health Representatives
- ❖ Prescription Drug Abuse/Alcohol & Substance Abuse / Cardiovascular Disease/Smoking Cessation
- ❖ Obesity Prevention
- ❖ IHS's ability to accept GPRA data from non-RPMS sites

Navajo

- ❖ Epidemiology -Data Access for Health Surveillance
- ❖ A Comprehensive Trauma System to Provide Optimal Care for Injured Patients
- ❖ Accessibility to Veteran Healthcare and Benefits on the Navajo Nation

Oklahoma

- ❖ Medicaid Expansion
- ❖ Staffing Packages for Joint Venture projects
- ❖ Converting IHS into a mandatory Spending Program

Phoenix

- ❖ Fort Yuma Ambulatory Health care Center
- ❖ Shortage of Health Care Providers at I/T/U Facilities
- ❖ Expansion of Existing Facilities and Building Maintenance
- ❖ Dental Health
- ❖ Detox Services
- ❖ Prevention and Education for Youth
- ❖ Replacement of Outdated Medical, Dental and Optical Equipment

Portland

- ❖ Drug abuse awareness/Diabetes
- ❖ Medicare Like Rates for Purchased/Referred Care
- ❖ Full payment of Contract Support Costs
- ❖ Historical difficulty of hiring Medical Providers
- ❖ Special Diabetes Program for Indians Demonstration Projects reallocation
- ❖ Suicide Prevention
- ❖ Water Contamination
- ❖ Lack of infrastructure for IT Services
- ❖ Timely Approval of CHEF claims

- ❖ IHS & VA MOU

- ❖ Medicaid Payment Policy and Alternate Delivery Systems
 - Encounter Rate
 - Accountable Care Organization (ACO) and Community Care Organization (CCO) Delivery Models
 - Fee for Service (FFS) Moving to Global Budgets
 - Money Follows the Person (MFP)
- ❖ Public Health / Emergency Preparedness
- ❖ Budget Cuts

Tucson

- ❖ Purchased/Referred Care
- ❖ Indian Addendum
- ❖ Reimbursement
- ❖ Rocky Mountain Spotted Fever
- ❖ Contract Support Costs

HOT ISSUES NARRATIVES SUBMITTED BY IHS SERVICE AREAS

Alaska

- ❖ VBC Leases
- ❖ IHS Advanced Appropriations
- ❖ Staffing Packages
- ❖ Contract Support Costs
- ❖ Indian Health Care Improvement Act – access & special unmet needs
- ❖ Long-term Care/Eldercare
- ❖ Behavioral Health (BH): Tele-BH & village access to BH
- ❖ BH: Alcohol & Substance Abuse –Heroin, Pain Management Rehab Center/similar to Fond u lac and Mayo Clinic center
- ❖ Dental Health Aide Therapy Training Center
- ❖ Health Promotion & Disease Prevention including Injury Prevention
- ❖ Lost Revenues

ISSUE: IHICIA Improve Access and Unmet Needs

The Implementation of the Indian Health Care Improvement Act (IHICIA) remains a top priority for Indian Country. IHICIA provides new authorities for Indian health care, however additional funding is needed to fully implement the Act. Tribes recommend that IHS reprogram existing resources for Direct Service Tribes to take advantage of these new authorities that would be more beneficial for their communities, when requested and consulted. The battle for IHICIA renewal was over ten years in the making. When this historic law was signed, Indian Country was elated by the promise of a new and more efficient health care delivery system for AI/AN people. However, four years later many of the provisions of the Act remain unfunded, and in many ways, represents yet another broken promise for Indian people.

The American health care delivery system has been revolutionized while the Indian health care system waited for the reauthorization of the IHCA. For example, mainstream American health care increased focus on prevention as a priority and a treatment, and coordinated mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs is now standard practice. Reflecting these improvements in the IHCA was a critical aspect of the reauthorization effort. The time and resources paid off with the permanent reauthorization of IHCA. Highlights of what is contained in the IHCA Reauthorization include:

- Updates and modernizes health delivery services, such as cancer screenings, home and community based services and long-term care for the elderly and disabled.
- Establishes a continuum of care through integrated behavioral health programs (both prevention and treatment) to address alcohol/substance abuse problems and the social service and mental health needs of Indian people.

All provisions of the IHCA are critical to advancing the health care of American Indian and Alaska Native people and should be implemented immediately. Adequate funding for the implementation of these long awaited provisions is needed now. Recognizing the importance of new IHCA authorizations in improving healthcare outcomes across Indian Country, the Tribal Budget Formulation Workgroup recommended an additional \$300 million outside of the 17% increase in funding. Specifically, the Alaska Area Tribal recommendations focus on the four priorities below:

Behavioral Health—Workforce Development (Staff Recruitment & Retention)

BACKGROUND: Alaska experiences the highest rate of suicide per capita in the United States with Alaska Natives experiencing a higher risk of suicide than any other ethnic group. In addition, Alaska continually ranks as one of the most dangerous states for women with victimization of intimate partner or sexual violence. Furthermore, Alaska ranks one of the highest of alcohol consumption rates per capita. Moreover, evidence suggests that individuals that are addicted or abuse substances—use this as a coping mechanism to deal with a history of trauma. In addition, traumatized individuals experience difficulty with trusting others including behavioral health providers to begin their healing processes especially when staff turnover is significant. Furthermore, Alaska is fortunate to expand services through its Behavioral Health Aide Model focusing on prevention, intervention, treatment, case management and aftercare for those who are affected by substance use and mental illness.

However, Alaska’s behavioral health programs statewide struggle with hiring Masters level qualified and licensed providers necessary to improve the quality, quantity and consistency of the behavioral health workforce in Alaska.

RECOMMENDATION: Increase funding for support of recruiting, retaining and training culturally responsive Alaska Native behavioral health providers; including supporting Alaska Native students studying within the field of psychology through initiatives such as Alaska Native Community Advancement in Psychology with the mission is to increase the number of Alaska Native college students majoring in psychology, graduating with a psychology degree and to promote working in the behavioral health field throughout Alaska Native communities.

Pain Management Rehab Center - similar to Fond du Lac and Mayo Clinic center

BACKGROUND: Despite consensus on the need to develop the capacity for delivering Pain Management services, there is a current lack of resources to coordinate and carry out these services. Development and implementation of common standards of care, uniform protocols, and best practices are necessary to effectively deliver these services, but a lack of workforce expertise and coordination among Tribal providers makes this delivery impossible.

Within the Alaska Tribal Health System, a steering committee is being developed to address the issues surrounding Pain Management services; however, without funding to dedicate staff to manage this initiative, as well as funding to train providers, both the committee and initiative's potential is limited.

RECOMMENDATION: Because a systematic approach to Pain Management does not currently exist within the Alaska Tribal Health System, patient safety is jeopardized as he or she moves through the referral system and differing treatment methods are carried out.

Models of success, both in tribal and non-tribal facilities alike, do exist, with Fond du Luc and the Mayo Clinic being notable examples. However, funding is needed to coordinate the inherently multi-disciplinary nature (e.g. Physical Therapy, Behavioral Health, Nutrition, Pharmacy, Acupuncture, Massage, Chiropractic, Traditional Healers) of pain management services.

It is critical to build on the research of Mayo and other programs to investigate what works and what doesn't. The IHS should partner with I/T/Us to investigate policy and funding opportunities to enable a coordinated effort among providers to delivery effective pain management services.

Behavioral Health Access to Tele-BH

BACKGROUND: Tele-behavioral health capabilities (Video Tele-conferencing—VTC) are essential to Alaska to expand services to rural communities. Many of our Alaskan villages reside in remote areas off the road system, which contribute to the lack of access to care. Furthermore, we have difficulty recruiting and retaining clinicians, psychiatrists and other behavioral health providers statewide. Due to the remoteness of villages across the state and difficulty with transportation to these villages, maintaining licensed providers in every rural community is impossible.

Tele-behavioral health is a significant and crucial component to the spectrum of resources within Alaska's Behavioral Health programs. Moreover, it offers access to many forms of care including the following examples:

- Communities without local psychiatric services often utilize VTC as their primary source of psychiatry;
- VTC is vital for providing emergency services for urgent situations that otherwise would have a longer waiting periods to receive an in-person assessment and intervention;
- VTC is innovatively being utilized to offer group therapy across several villages at once—allowing villages to start groups without having to identify all client participants within one community;
- VTC has been instrumental in connecting clients with their families while away for residential treatment; in addition, it has been a vital resource for treatment planning and family therapy;
- Currently there are several forms of technology (i.e., web-cam, Skype, etc.) which do not offer the level of security and protocols for maintaining client confidentiality that VTC provides;

- VTC offers clients who want to maintain their anonymity by having access to a provider outside their rural community;
- VTC offers the ability to provide long-distance supervision by a licensed provider to a village based counselor in a remote community;
- Rural communities have been experiencing an increase of prescription drug abuse and other types of drug use which have required an increase in services that can be addressed through VTC; and
- Many of our regional sites use VTC for staff debriefings after critical incidents, staff meetings including team development, discussing challenges and celebrating successes.

RECOMMENDATION: Increase funding for tribal behavioral health programs to appropriately supply clinics throughout the state with Video Tele-Conferencing equipment in efforts to expand service delivery access to village based services.

Long-term Care Support Services

BACKGROUND: Organizations are opting for nursing rather than assisted living because the rates are cost based in Alaska. More organizations might be interested in assisted living if IHS provided some operating funding for individuals needing care, but not nursing-level care. These services include residential care, such as nursing homes and assisted living facilities, home and community-based services, caregiver services, case management and respite care. The authority for IHS to offer and fund long-term care services offer great promise for meeting the needs of our Elders and those with disabilities.

RECOMMENDATION: Alaska Native elders and those with disabilities should have access to the long-term services and support necessary to remain healthy and safe while retaining as much independence as possible in their communities. ANHB urges the IHS to target funds to implement LTC services as authorized under the IHCIA.

Beyond funding, there is a need to support and coordinate the efforts of IHS and the Centers for Medicare & Medicaid Services. To address reimbursement and certification/regulatory issues, there is a need for tribes and tribal organizations to collaborate with federal agencies, as well as collaboration among federal agencies themselves. Most LTC programs are reimbursed under Medicaid, and the regulations and specific programs differ from state to state, creating difficulties in applying federal guidelines and working through federal programs.

ISSUE: Contract Support Cost

BACKGROUND: The Indian Self-Determination and Education Assistance Act (ISDEAA) of 1975 authorized Tribes to enter into contracts or self-governance compacts to manage federal programs previously administered by IHS. The well-documented achievements of the Indian self-determination policies have consistently improved service delivery, increased service levels, and improved third-party reimbursements. This policy has strengthened Tribal governments, institutions, and improved services for Indian people. Every Administration since 1975 has embraced this policy and Congress has repeatedly affirmed it through extensive amendments to strengthen the Self-Determination Act in 1988 and 1994.

The United States Supreme Court has twice considered the Government's responsibility to pay CSC to

contracting tribes and tribal organizations under ISDEAA contracts. In both instances, the Supreme Court has held that due to the legally binding nature of an ISDEAA contract a tribal contractor has the right to recover its promised CSC in full, even if the contracting agency underpaid those costs due to aggregate restrictions on amounts allocated by the agencies or appropriated by Congress for payment of CSC. In FY 2014, the Administration proposed to individually cap CSC recovery at the contract level. Understanding that absent full funding, Tribes are forced to reduce direct services in order to cover the government's CSC shortfall, this proposal was rejected by Congress and specific language to "fully fund" CSC was included in FY 2014.

RECOMMENDATION: The President's FY 2015 budget request includes full funding of estimated CSC need (\$29.8 million increase to fund the estimated CSC full funding amount totaling \$616.2 million in FY 2015). Assigning a specific funding amount to this "need" is difficult to estimate in large part because the IHS cannot predict with certainty the amount of new and expanded programs that will produce CSC need. Since the number of Tribes assuming new or expanded contracts in FY 2015 is unknown prior to this document's submission, the estimated figure is given with IHS providing updated information as it becomes available. Actual need for CSC is calculated after the appropriation year with updated information. Through the Consolidated Appropriations Act of 2014, Congress charged IHS developing a "long-term" solution through consultation with Tribes, a process that, at the time of this writing, is currently under way.

It is critical to highlight that while Congress has made fully funding CSC a priority, this funding cannot come at the expense of direct program funds, which are funded at a significantly lower per capita rate versus other federal healthcare programs. In the FY2014 appropriation, IHS had to decrease other line-item amounts in the budget by an amount of approximately \$10 million to fully fund CSC. The continuation of this practice is unsustainable and we implore Congress to continue partnering with IHS and Tribes to develop a permanent funding solution that ensures stable funding for programs while meeting its contractual agreements.

ISSUE: Dental Health Aide Therapist Training Center

BACKGROUND: Alaska Native people experience the highest rates of dental disease of any race in the US. The impact of dental disease spans all ages and communities, with at least 75% of rural Alaskans experiencing dental cavities or gum disease in their lifetime. Dental disease can affect school and work attendance, nutritional intake, self-esteem, and employability. This disease is preventable when appropriate public health programs are in place. DHATs are the ideal type of provider to address this enormous disparity. They live and work in their communities providing continuity of care, increased dental health literacy and a healthy role model for the younger generations.

Currently the DHAT Educational Program is primarily grant funded and at risk of closing down, unless a continuous source of funding is secured.

Two-year post high school dental provider education targeted at rural Alaska students from areas where access to dental care is limited. Students complete two years of education, then return to Tribal Health System (THS) Dental Programs to provide basic dental restorative services (fillings and extractions) and prevention program implementation. They are a supervised provider who works as part of a team lead by a licensed THS dentist. Currently, there are 27 certified Dental Health Aide Therapists working in Alaska providing direct access to dental care to over 35,000 American Indian and Alaska Native people. This

program provides a viable career for people who wish to live in remote villages. The DHAT Educational Program and its graduates annually generate 76 jobs (dental assistants, training program faculty, management, staff) with half of these jobs and the related \$9m economic activity in rural Alaska (Scott and Co., 2010 Survey of THS Dental Directors).

RECOMMENDATION: There is an estimated need of a \$2 million operating budget per year to support 10-12 students per class capacity, enabling two staggered classes running at all times.

ISSUE: Health Promotion & Disease Prevention including Injury Prevention

BACKGROUND: By far, unintentional injury is the leading cause of premature deaths, as measured by potential life years lost, followed by our most prevalent intentional injury, suicide. Next are cancer and heart disease, both conditions that are influenced by health behaviors for which prevention through physical activity, healthy diet, tobacco avoidance, and regular screenings play a significant role. In measuring potential years of life lost, these four leading causes among Alaska Native people all fall within the scope of Health Promotion and Disease Prevention programs.

RECOMMENDATION: Funding Health Promotion & Disease Prevention is perhaps the most effective measure of ensuring that Alaska Native people remain able to lead a high quality of life and contribute within their communities. While the majority of health indicators can be measured in terms of the resulting procedure or necessary health care-related service needed, adequately funding Health Promotion & Disease Prevention activities benefits all areas of healthcare spending by keeping individuals out of the hospitals and clinics entirely. In terms of funding individual areas of the Indian Health Service, few areas offer such budgetary value as adequately funding Health Promotion & Disease Prevention programs.

ISSUE: IHS Advance Appropriations

BACKGROUND: Since FY 1998, appropriated funds for medical services and facilities through IHS have not been provided before the commencement of the new fiscal year and only one year (FY 2006) when the Interior, Environment, and Related Agencies budget, which contains the funding for IHS, has been enacted by the beginning of the fiscal year.

In FY 2010, the Veterans Administration (VA) medical care programs achieved advance appropriations. The fact that Congress has implemented advance appropriations for the VA medical programs provides a compelling argument for tribes and tribal organizations to be given equivalent status with regard to IHS funding. Both systems provide direct medical care and both are the result of federal policies. Just as the veterans groups were alarmed at the impact of delayed funding upon the provision of health care to veterans and the ability of the VA to properly plan and manage its resources, tribes and tribal organizations have similar concerns about the IHS health system.

RECOMMENDATION: Work with Congress to take the necessary steps for IHS funding to begin an advanced appropriations cycle so that tribal health care providers, as well as the IHS, would know the funding a year earlier and would not be subject to continuing resolutions.

Late funding has significantly hampered budgeting, recruitment, retention, provision of services, facility maintenance and construction efforts of tribal and IHS health care providers. Providing sufficient, timely

and predictable funding is needed to ensure the federal government meets its obligation to provide health care for American Indian and Alaska Native people.

ISSUE: Joint Venture Projects Staffing Packages

BACKGROUND: All new and joint venture facilities should receive staffing package funds in advance of the facility's completion. It takes considerable time to recruit appropriate personnel and from an operational standpoint, tribal providers should not have to wait for the facility's staffing package funding until after it opens.

Because of inadequate funding related to staffing, multiple tribal organizations in the Alaska area are at a point where their ability to carry out health care services is significantly compromised. Beyond reducing access to health care services, it puts these tribal organizations in danger of being unable to service the debt incurred in constructing joint venture facilities.

RECOMMENDATION: We urge the IHS Director to enable tribes and tribal organizations to adequately plan for respective facility operations and for the IHS to outline its challenges to do so and work with Congress, tribes and tribal organizations to ensure that funds are available in a timely manner.

Additionally, the IHS should discontinue the practice of requesting less than the full amount (derived from IHS's own calculated staffing costs) of necessary staffing funds from Congress. When the IHS requests, and subsequently receives, less than the amount it needs to meet its contractual commitments to individual tribal providers, funds must be diverted from other areas to make up for the difference. Before IHS requests, and before Congress funds, discretionary increases in other IHS accounts, contractually committed staffing packages should be paid in full.

In entering joint venture construction agreements with tribal organizations, IHS agreed to request funding from Congress on the same basis as IHS requests funding for other facilities. Tribal organizations have held up their end of the agreements and ask that IHS and Congress do the same.

ISSUE: Village Built Clinic Leases Shortfalls

BACKGROUND: The Village Built Clinics (VBCs) are essential to the IHS carrying out the Community Health Aide Program (CHAP) in villages in rural Alaska. The Indian Health Care Improvement Act mandates that IHS develop and operate the CHAP. The community health aides and practitioners use the VBCs to provide CHAP services in the villages. However, the inadequate condition of the VBCs has become an increasingly difficult obstacle to carrying out the mandated CHAP.

In many situations, the CHAP is operated in unsafe facilities and in some villages, the VBCs have to be closed and CHAP services suspended because of safety hazards to the employees and patients.

The IHS has a legal responsibility to fully fund the VBCs and has available appropriations to meet that responsibility.

IHS's failure to maintain the VBCs and upgrade them directly hampers the ability of the co-signers to the Alaska Tribal Health Compact to meet the "meaningful use" standards set by the Centers for Medicare and Medicaid Services in order to be eligible for incentive payments for electronic health records

technology. IHS should ensure that VBCs are brought up to the appropriate technological capability for tribal providers qualify for needed incentive payments to implement the electronic health record, which will improve patient health and fulfill an important congressional initiative.

RECOMMENDATION: The majority of VBC lease rentals have not increased since 1989 and current funding is not sufficient to cover inflationary increases and in particular, the cost of repair and renovation needed to keep them in a safe condition. As the CHAP has evolved to provide additional staffing and updated equipment the inadequacy of the VBCs has become an increasingly difficult obstacle to providing health care to Alaska Native people. By FY 2006, the lease rentals paid by the IHS to the villages covered only 55 percent of operating costs. To alleviate this chronic underfunding and meet its contractual requirements, the IHS must allocate an additional \$8.2 million annually to cover maintenance and operation costs.

Albuquerque

ISSUE: H & C – Increase Access to Care

BACKGROUND: H&C is an occurring amount that is funded each year at the same level. Only new facilities receive increases in H&C. ASU is on the waiting list for a new facility. H&C has not increased to keep up with inflation or increased patient load demands of the facilities or infrastructures. ASU has a large urban Indian population that continues to grow and impacts services and access to care. In addition, tribes have taken their shares and this has led to a decrease in our H&C budget. Presently, ASU has a list of over 500 people waiting for an appointment for a primary care provider.

RECOMMENDATION: Increasing H&C would aid in improving access to care and decrease the waiting list significantly through new funded positions, improvements in technology, processes, infrastructures, and systems i.e. providers, support staff such as HIM, CHS staff, business office operations, IPC initiatives, IT, EHR, etc. Hiring qualified staff, reorganizing systems and infrastructures, and improving operations will benefit in increasing access to care for our patients. Expanding clinic hours of operations and implementing urgent care services will assist in increasing access to care.

ASU recommends to fund the increase of H&C at \$78,980.

ISSUE:

Over the last several years the Canoncito Band of Navajos have been evaluating the feasibility of expanding its existing health care programs and have been confronted with federal policy barriers and lack of financial resources for adequate health care. The first issue concerns the Special Diabetes Program for Indians (SDPI), the second issue concerns is Contract Health Services, and the third issue is the pilot MSPI program.

BACKGROUND: The Canoncito Band of Navajos through its non-profit corporation, the Canoncito Band of Navajos Health Center, Inc., is evaluating the feasibility to expand its existing health care programs and the related health care infrastructure. The corporation has contracted through 638 the Substance Abuse program and the Community Health Representation program and it also receives the

SDPI grant for Diabetes. The objective is to provide better health care services than the current I.H.S. health care system and to leverage the funds with other Federal, Tribal, State and private sector funds to establish the most efficient operation. The corporation also works very closely with the local Indian Health Services to improve health care services. There are three hot issue areas that can be improved with the help of the Federal Government, which include the SDPI grant program, the Contract Health Services system and the MSPI grant program.

SITUATIONS: The first hot issue is the SDPI grant program and the reauthorization of funding every 3 or 4 years. The funding of SDPI should continue and become a permanent part of the Indian Health Service health care program. The grant program should be converted to a contract program and it should be non-competitive. This would allow Native Tribes to contract the health program through the 638 process and provide the health care services at the local level. The diabetes disease is the leading causes of death for American Indians in the State of New Mexico and cannot be solved in a 4 year funding cycle. The annual appropriation of \$200 million should be made for the Native people and the majority of funds (80%) should come down to the grass roots level through either the Tribes or I.H.S. medical facilities.

The second hot issue is the **underfunding of Contract Health Services** and the high cost of specialized health care, which results in less health care services for Native people. A priority system has been established by I.H.S. and specialized health care is provided to those people who have a disease or illness that is on that priority list. Many of the specialized medical services are not provided at the I.H.S. facilities on the reservation but are located in the larger cities off the reservation. Therefore, to keep up with the high cost of specialized medical services, more funding is needed for Contract Health Services and to create these specialized services at the I.H.S. facilities on the reservations. The local service unit needs to receive more funding for contract health services and the local service unit should be allocated more funds to hire more medical specialists. By creating these specialized services at the I.H.S. facilities on the reservations, more specialized health care can be provided to Native people.

The third hot issue is **the funding of the Methamphetamine and Suicide Prevention Initiative (MSPI)** pilot program. The MSPI project is a very good project for the community of To'Hajiilee. Our main objective is suicide prevention and the community receives a \$30,000 grant per year. This community is like many other Indian reservations in that we have a much-undeveloped reservation, no education or job opportunities, we have a lot drugs and alcohol problems on the reservation, and suicide, crime and violence are major problems. Historical trauma is also a major concern when Indian people remember what the US government did not to our people in the past. The MSPI program should continue to be funded, but at a much larger scale and it should become a permanent health care program under the I.H.S. All Indian Nations should be allowed to participate in this health care program and not just the few Tribes who apply for the pilot project grant.

Bemidji

ISSUE: Funding Parity (H&C, CHS, CSC, Urban)

BACKGROUND: The Bemidji Area is, and has been, the lowest funded Area in the entire Agency; Current Level of Need Funded (LNF) is 50.0%, while the Agency average is 56.6%. Twenty Tribes residing in the Bemidji Area are either at 45% or at lower of LNF.

RECOMMENDATION: The Area needs increased funding to meet the demand of a growing population.

ISSUE: Health Disparities (Dental, MH, ASA, LTC):

BACKGROUND: The Bemidji Area leads the Agency with some of the highest death rates related to cancer and heart disease. In addition, a child born in the Bemidji Area can expect an average life of up to 10 years less than other IHS Areas.

RECOMMENDATION: The Area needs increased funding to address the severe health disparities and chronic disease burden. In addition, the Area needs increased funding to address the behavioral health needs to include suicide prevention, mental health emergencies, substance abuse prevention and treatment, and accidental deaths.

ISSUE: CHS

BACKGROUND: Demand continues to outpace Bemidji Area CHS capacity with necessary services not available at the IHS or Tribal facilities, such as emergency or specialty care. The burden on CHS funding is further stressed due to the remoteness of Tribal locations to needed health care services.

RECOMMENDATION: The Area continues to utilize CHS in the federal and Tribal programs. Approximately 2/3 of the Area Tribes are considered very small Tribes and therefore do not typically have the capacity to provide comprehensive health services through conventional methods of a clinic and must rely upon CHS to provide services that are equivalent to and beyond the scope of a clinic. Coupling this reality with rural locations and difficult recruitment efforts to fill vacant positions only increases the demand on CHS appropriations.

ISSUE: Facilities Construction (M&I):

BACKGROUND: The Bemidji Area has significant need for new health care facilities construction at federal and Tribal sites (approximately \$300M). However, the Bemidji Area also has significant need for services appropriations to raise the federal health care disparity index for all Bemidji Area Tribes. Faced with a need to prioritize potential IHS budget increases across both appropriations (Service and Facilities), the Bemidji Area is unable to prioritize additional construction funding to alleviate the national need until such time that the average level of need funding rises to a point greater than the Federal Disparity Index of 55%.

RECOMMENDATION: While some Area Tribes have received Small Ambulatory grants, none has qualified for Joint Venture agreements. The triad of underfunding (reference LNF), remoteness, and Tribal size, creates a cost prohibitive environment for many Tribal programs to pursue capital investments. Federal funding and a facilities construction methodology that empirically addresses this triad need to be considered in order to promote equity and advancement for Bemidji Tribes. *IHS and the Tribes have developed an empirical methodology to address construction needs (total need is \$8.5B). The revised Health Care Facilities Construction Priority.*

Billings

1. **Contract Health Services** – The 1st ranked priority from the tribes of Montana and Wyoming was Contract health Services (CHS). With additional increases for CHS dollars, more health care can be provided to our patients. Current CHS funding cases must be prioritized in a category that first meets extreme criteria. Many of our Indian patients do not meet the level of criteria required to have health care covered under current CHS guidelines. With increased CHS funding a lot more health needs not being met currently would be minimized. Additional funding is necessary for patient escort when patients increase in Specialty clinics, providers on-site rather than sending patients out. The tribal leaders decided to allocate \$124,300,000 of the \$414,334,000 available to be spread out as an increase for this priority.
2. **Mental / Behavioral Health Services** – The 2nd most important budget line priority for the tribes of Montana and Wyoming was mental/behavioral health service dollars. The rationale is that many of the problems that are occurring now such as preventable injuries, car wrecks, Diabetes, suicide in adults and adolescents is a result of mental health issues that drive alcoholism, drug abuse and physical/ mental abuse both individually and to others. If Native American people are healthy both physically and mentally, many of the health programs being faced today should decline. The tribal leaders decided to allocate \$103,584,000 of the \$414,334,000 available to be spread out as an increase for priority.
3. **Alcohol and Substance Abuse** – The 3rd budget priority for the FY 2016 Budget from the tribes in Montana Wyoming is Alcohol and Substance Abuse. The Alcohol and Substance Abuse funding within the Billings Area are managed by Tribes through contracted or Compacted programs. In Fiscal Years 2009-2014 the increased funding available has been a small amount to fund pay increased for Federal and Tribal employees. This does not address the need for expanding current services specific to Alcohol and Substance Abuse. The majority of additional funding increases during these years have been earmarked for additional staff for new health care facilities. Although IHS wide outputs and outcomes have for the most part exceeded the yearly targets, compared to national averages AI/AN alcohol and drug use remains twice as high as the national average. The percentage of AI/ANs needing treatment is double the national average. Methamphetamine and Suicide Prevention Initiative funding demonstration pilot programs need to become permanently funded programs. The tribal leaders have decided to allocate \$82,867,000 of the \$414,334,000 to be spread out as the increase for this priority.
4. **Hospitals and Clinics** – the Tribes of Montana and Wyoming decided that Hospitals and Clinics (H&C) funding should be its #4 priority. At the local service unit level there is a great need for additional staffing, supplies, medical contracts, equipment, etc. With additional H&C dollars, the IHS can provide more doctors, etc., alleviating some of the cost that burdens contract health service dollars. The tribal leaders decided to allocate \$62,150,000 of the \$414,334,000 available to be spread out as an increase for this priority.
5. **Health Education** – The 5th ranked budget priority the tribes of Montana and Wyoming selected was Health Education. There is a major need to educate our patients/members on preventative care of their own health such as safety around the home; vaccinations of children and elders; exercise; diet; car seats and seat belt safety, etc. With an effective and well-funded health

education program, the costs of serious illnesses and injuries could be prevented or reduced. The tribal leaders decided to allocate \$41,433,000 of the \$414,334,000 available to be spread out as an increase for this priority.

The Tribes of Montana and Wyoming did not want to rank a top 5 at a 5% increase or decrease of any funds to prioritize any budget lines in this area. The Tribes felt that there should not be any decreases to any of the budget line items at all and that a 5% increase is inadequate for addressing the current and future needs.

California

Issue:

Restored Tribes seek temporary non-recurring CHS funds and recurring funds for IHS direct care and CHS resources.

Background:

Three restored federally recognized tribes are seeking recurring IHS appropriated funds for direct healthcare and contract Health Services (CHS). Federal budget requests are made two years in advance of the appropriations period. For example, the fiscal year (FY) 2014 budget request will be for funds appropriated for FY 2016. Therefore, if Congress decides to appropriate new tribe funding, the new tribe request made during the FY 2014 budget formulation cycle would receive funding beginning in FY 2016. In the meantime, Tribal members of the newly federally recognized tribes need health care. In California, there are no federally ran healthcare programs that new tribe members can seek care.

Current Situation:

No recurring funds have been provided to three federally restored tribes in California. Non-recurring, interim funds were provided to three restored tribes in FY 2013; however, those same funds are not guaranteed to be available subsequent fiscal years. The federal restored tribes are seeking bridge funding until they receive recurring IHS appropriated direct healthcare and Contract Health Service.

Action Plan:

IHS/CAO submits an Appropriation Request on behalf of the three tribes: the FY 2016 budget request for the Tejon Indian Tribe \$1,017,542 (377 unduplicated users); the Wilton Rancheria \$1,824,558 (676 unduplicated users) and Koi Nation of Northern California \$191,633 (71 unduplicated users).

Great Plains:

- 1) **Contract Support Costs** The ability of tribes that operated their own healthcare programs to be successful depend upon the availability of CSC funding to cover fixed costs. Absent full funding, tribes are forced to reduce direct services in order to cover the CSC shortfall. Adequate CSC

funding assures that tribes, under the authority contracts with IHS, have the resources necessary to administer and deliver the highest quality healthcare services to their members without sacrificing program services and funding.

- 2) **Medicare Rate Reimbursement for Contract Health Providers:** Extend the Medicare-Like Rate (MLR) cap on Contract Health Services (CHS) to all non-hospital Medicare participating providers and suppliers. Expanding the Medicare-Like Rate cap is a budget-neutral cost-savings mechanism that will allow IHS and Tribal facilities to stretch limited CHS dollars further and create parity with other federally funded health systems.

CHS programs are the only federal health care programs that continue to pay full-billed charges for non-hospital services. On average, full-billed charges are nearly 70 percent more than negotiated rates. The GAO report estimates that by expanding the MLR to non-hospital services, IHS and tribal CHS programs would be able to save hundreds of millions of dollars and dramatically increase the care they are able to provide. As discretionary spending grows scarce, this is a common-sense solution that would use federal dollars more efficiently. The Veteran's Administration and the Department of Defense have already capped their rates for non-hospital providers and CHS programs should be authorized to do so as well.

- 3) **Advanced Appropriations:** Since Fiscal Year 1998, there has only been one year (FY2006), in which the Interior, Environment and Related Agencies Appropriations bill has been enacted before the beginning of the new fiscal year. Because Federal appropriation bills have not been enacted in a timely manner, Tribal and IHS health care providers' budgeting, recruitment, retention, provision of services, facility maintenance, and construction efforts have been hampered.

Congress enactment of the Veterans Health Care Budget Reform and Transparency Act of 2009 (PL 111-81), which authorized advance appropriations for Veterans Administration (VA) medical care programs recognizing the difficulties inherent in the provision of direct health care that relies on the appropriations process and traditional funding cycle. Therefore the tribes in the Great Plains requests that the IHS be afforded the same budgetary certainty and protections extended to the VA which is also a federally-funded provider of direct health care and requests that Congress amend the Indian Health Care Improvement Act to authorize advance appropriations; and include our recommendation for IHS advance appropriations in the Budget Resolution.

Nashville

- 1) **Definition of "Indian" under the Affordable Care Act (ACA):** Definitions of "Indian" under the Patient Protection and Affordable Care Act (ACA) are inconsistent with those used by the Indian Health Service and the Centers for Medicare and Medicaid Services (CMS) to determine eligibility for services and protections. The definitions used to identify AI/AN for exchange eligibility are restricted to enrolled members of federally recognized Tribes. As a result, a large population of AI/AN, including those in the Nashville Area, are denied access to benefits that were intended for them by the drafters of the ACA.

After the Administration determined a regulatory fix was not possible, a legislative fix, S. 1575, was introduced in the U.S. Senate. Although the Secretary of Health and Human Services has granted a hardship exemption to Indian Health Care users, this population still does not have access to the limited and no cost-sharing plans or monthly enrollment periods afforded to members of federally recognized Tribes under the ACA. The Nashville Area, along with Tribes and Tribal organizations from across the country, urge this Administration to be vocal in its support for this critical legislation.

- 2) **Medicare Like Rates for Nonhospital Services:** A recent Government Accountability Office (GAO) report revealed that the Indian Health System is paying up to 70% more than other purchasers of care, including Medicare, Medicaid, and private insurers, for nonhospital services. Under current law, the reimbursement rate for hospital services purchased by I/T/Us is capped at Medicare-Like Rates. If this rate were extended to nonhospital services, the GAO report found that Indian Health Service federal sites alone would save at least \$32 million annually. This savings would allow precious CHS dollars to stretch further in an era of reduced appropriations.

USET, along with National Indian Health Board and other Tribal organizations, is currently working towards the introduction of legislation in both chambers of Congress that would extend the Medicare-Like Rate cap to nonhospital services. An official indication of support from the Indian Health Service would aid the advancement of this proposal.

- 3) **Advance Appropriations for the Indian Health Service (IHS):** Since Fiscal Year 1998, appropriated funds for the Indian Health Service have been released after the beginning of the new fiscal year. Most often caused by a Congressional failure to enact prompt appropriations legislation, late funding has severely hindered Tribal and IHS health care providers' budgeting, recruitment, retention, provision of services, facility maintenance, and construction efforts. Congress has recognized the difficulties inherent in the provision of direct health care that relies on the appropriations process and traditional funding cycle and has appropriated beginning with FY 2010, advance appropriations for the VA medical care accounts. Advance appropriations is funding that becomes available one year or more *after* the year of the appropriations act in which it is contained, allowing for increased certainty and continuity in the provision of services.

As the only other federally funded provider of direct health care, IHS should be afforded the same budgetary certainty and protections extended to the VA. H.R. 3229 and S.1570, The Indian Health Service Advance Appropriations Act of 2013, have been introduced in the House and Senate, respectively.

- 4) **The Special Diabetes Program for Indians (SDPI):** In response to the disproportionately high rate of type 2 diabetes in American Indians and Alaska Native (AI/AN) communities, Congress passed the Balanced Budget Act in 1997 establishing the SDPI as a grant program for the prevention and treatment of diabetes at a funding level of \$30 million per year for five years. With funding increased through subsequent reauthorizations, SDPI is currently funded at \$150 million per year and is set to expire September 30, 2014. The SDPI funds have enhanced diabetes care and education in AI/AN communities, establishing innovative and culturally appropriate strategies to combat the diabetes epidemic. As a result, the program has been immensely successful in reducing costly complications and the incidence of the disease itself.

With a diabetes incidence rate of 22.6% in the Nashville Area, prompt reauthorization of the SDPI is crucial for the maintenance of critical program and staffing infrastructure. Additionally, Tribes that were federally recognized after 1998, including two Nashville Area Tribes, are not currently eligible to apply for SDPI grants. A multi-year reauthorization could provide an opportunity for these and other Tribes not currently managing an SDPI grant to begin to combat diabetes in their communities.

- 5) **New Tribes Funding Request: Tonawanda Nation:** On November 3, 2010, an appropriation request in the amount of \$2,650,480 was submitted on the Tonawanda Nation's behalf.

As part of the FY 2016 budget formulation process and in the absence of an appropriation, the request is being resubmitted, including increases for medical inflation factors, in the amount of **\$3,163,175**.

- 6) **New Tribes Funding Request: Shinnecock Indian Nation:** On January 17, 2012, an appropriation request in the amount of \$6,285,307 was submitted on the Shinnecock Indian Nation's behalf.

As part of the FY 2016 budget formulation process and in the absence of an appropriation, the request is being resubmitted, including increases for medical inflation factors, in the amount of **\$7,231,705**.

- 7) **Need for additional AI/AN treatment centers for Eastern Tribes:** There are only two substance abuse treatment centers within the Nashville Area, both of which are geographically distant from the majority of the Area Tribes; consequently, Tribes are unable to significantly treat substance abuse patients throughout the Area, and for those patients who are able to receive treatment, it often involves lengthy in-patient treatment over long distances without family and friend support nearby. This lack of face-to-face participation with family often impacts the success of treatment in these centers.

To increase funding for alcohol and substance abuse treatment in order to establish additional treatment facilities to provide adult treatment in the Northeast; or expand existing health care facilities to include substance abuse treatment programs, along with the further integration of behavioral health services with primary care.

Navajo

Epidemiology -Data Access for Health Surveillance

The Navajo Division of Health's Navajo Epidemiology Center, as a Public Health Authority, requires direct access to Tribal health data from (not limited to) federal (Indian Health Service), state, and local sources specific to: quality population based data, vital statistics, morbidity, mortality, chronic disease, infectious disease, and disability data.

Epidemiological Research

The Navajo Nation needs to establish research priorities to address our highest health issues on epidemiological data.

Information Technology Health Data Management System

The Navajo Division of Health intends to develop a Health Data Management System to store information of ongoing collection, integration, analysis, interpretation and dissemination of data on health care, behavioral risk factors surveillance system, morbidity and mortality indicator, and health and human research to improve health outcomes. The existing technology is outdated and does not meet the standards of public health data management and epidemiological health indicator identification and priority settings.

BACKGROUND

Epidemiology -Data Access for Health Surveillance

Navajo Nation Council authorizes the Navajo Epidemiology Center through Resolution BFJA-06-12 to assist in developing the Navajo Nation's disease surveillance systems and identifying its highest priority health status objectives based on epidemiological data.

The Patient Protection and Affordable Care Act of 2010, Indian Health Care Improvement Act, Title II: Health Services, Section 230: states Epidemiology Centers -the Secretary must grant tribal epidemiology centers access to data, data sets, monitoring systems, delivery systems, and other protected health information in possession of the Secretary. The provision provides immediate authority and status to Tribal Epidemiology Centers to operate as a Public Health Authority for purposes of the Health Insurance Portability & Accountability Act (HIPAA) of 1996.

Epidemiological Research

Epidemiological data from ethical basic or applied research may positively contribute to the knowledge of health impacts to the environment and humans. It is important to develop a study design to ask a question, systematically collect information, generate a hypothesis, analyze the data and draw conclusion.

Information Technology Health Data Management System

The Health Data Management System will systematically increase the performance management capacity of the Navajo Nation to measure and ensure that public health goals are effectively and efficiently met.

The technological improvements will increase performance management by establishing linkages to public health services, coordinated care, and program communication with public health education and integration. Long-term goals are to 1) build infrastructure that would support the plan to expand into a Navajo Nation.

Medicaid Agency and third party billing; 2) build health indicator surveillance and reporting; 3) develop and improve electronic vital statistics registry; 4) infectious and chronic disease registries; 5) conduct a series of health information workshops and training to increase staff competency; and, 6) measure public health indicators.

The Infrastructure will benefit Navajo clients with improved access to public health and health care thereby; address health care disparities to improve quality, safety, and decision -making for care among the Navajo and residents of the Navajo Nation.

SITUATION

Epidemiology -Data Access for Health Surveillance

The Navajo Nation recommends the Secretary of Health to release specific identified Tribal health data to the Navajo Epidemiology Center upon request.

The Navajo Nation recommends the Centers for Disease Control and Prevention (CDC) to detail a Public Health Advisor or Epidemiologist at the Navajo Division of Health/Navajo Epidemiology Center to assist in addressing the health disparities on Navajo communities and to assist with the comprehensive development of health surveillance systems.

Establish a Data Sharing Agreement with the State of Utah Department of Health.

Epidemiological Research

The Navajo Epidemiology Center shall assist the Navajo Nation develop its research agenda, develop research with scientific methods and implement research functions, and coordinate with the Navajo Nation Human Research Review Board to address our highest health issues.

Information Technology Health Data Management System

The Navajo Nation recommends Federal and State funding support and technical assistance for the proposed Health Data Management System as a method of improving health care and services on the Navajo Nation.

Proposed Amount:

Epidemiology - Data Access for Health Surveillance Epidemiological Research

Information Technology Health Data Management System

\$990,000.

\$990,000.

\$1M.

Respectfully Submitted 12/17/20 13 by: Ramona Antone Nez, MPH, BSN Director, Navajo Epidemiology Center Navajo Division of Health Navajo Nation.

NAVAJO NATION TRAUMA SYSTEM DEVELOPMENT

ISSUE: A Comprehensive Trauma System to Provide Optimal Care for Injured Patients

BACKGROUND: The proposed trauma system will be a comprehensive coordination of quality care and rapid response efforts for injured victims. This initiative will require the integration and collaboration with many including, but not limited to, the Navajo Division of Public Safety, Indian Health Service, Contract and Compact "638" facilities, and Arizona, New Mexico, and Utah Trauma Systems. The system will address the continual increase in injury morbidity and mortality due to unintentional injuries in populated and isolated regions of the Navajo Nation, which is considered frontier in nature and where there are challenges in accessing health care facilities due to long distances and lack of proper infrastructure. In October 2010, the American College of Surgeons (ACS) -Committee on Trauma conducted a trauma system consultation and produced a report titled, "Trauma System Consultation, Navajo Nation".

Based upon the expert review, analysis and recommendations of the ACS, there is now guidance and direction to pursue the development of the trauma system to address intentional and unintentional injuries among the Navajo people. The system will serve the entire Navajo Nation with an estimated population of 300,000 with a land base of nearly 26,649 square miles where motor vehicle crashes is the leading cause of death for ages 1-44 and where heart disease is the second leading cause of death. Given the disproportionate burden of injury related mortality and years of potential life lost (YPLL) suffered by Navajo people, it is crucial to plan and implement a well-organized trauma system.

SITUATION: In following the recommendations of the ACS, the trauma system can have lasting benefits to increase and improve access to definitive trauma care, which would reduce mortality and morbidity related to traumatic injury. It will increase the potential of having timely, quality trauma care provided within the Navajo Nation. In addition, it will also allow patients referred to off reservation trauma centers to arrive with improved surgical and medical interventions, less elapsed time from injury event to tertiary care, lower complication rates, lower lengths of stay and improved repatriation. Moreover, it will improve outcomes, as care would be provided within the "golden hour".

Preliminary planning funds are needed to develop, advance and secure support for the design and implementation of the proposed Navajo Nation Trauma System, which may include any assessments that are necessary to expand the existing trauma care capability on the Navajo Nation. There will also be a need to review and develop agreements with external partners to collect Navajo specific injury morbidity and mortality data to ensure appropriate design and development of the trauma system. Other essential leadership decisions are also needed to develop an efficient and effective system that would best meet the needs of the Navajo Nation.

Veteran Healthcare and Benefits on the Navajo Nation

BACKGROUND:

The Navajo Nation a sovereign nation has over 10,123 identified veterans, those accessing services at the Navajo Department of Veterans Affairs. These veterans have been in service to the United States military system beginning with the World Wars to the present day. For their service, veterans are entitled to receive services and benefits from the United States Department of Veteran Affairs (USDVA).

Challenges facing the Navajo Veteran are accessing healthcare services and benefits. Barriers include distance to healthcare facilities; personal expenses related to accessing healthcare and benefits; culture, values and traditions; lack of information or misinformation; and language barriers.

SITUATION:

Illustrated below are Veteran integrated Service Networks (VISN), Veteran Administration Health Care System (VAHCS), Out Patient Clinic (OPC), Community-Based Out Patient Clinic (CBOPC), Vet Center (VC) (NOTE: The Vet is not an abbreviation, but its official name is Vet Center) and Regional Health Care Coordination Center (RHCCC) service centers surrounding the Navajo Nation. Two service centers situated on the Navajo Nation. In FY2013, USDVA reimbursed Navajo Area Indian Health Services \$53,587 through an MOU between USDVA and IHS. This is equivalent to \$5.30 per capita for each registered veteran of the Navajo Nation. The per capita expenditure is lower considering those not registered with the Navajo DVA. Accessibility to Veteran Healthcare and Benefits on the Navajo Nation is nonexistent. Many non-Navajo veterans living on the Navajo Nation face the same barriers.

State	VISN	VAH CS	OPC	CBOPC	vc	RHCC C
Arizona (•on Navajo Nation)	1	3	3 ^{1/2}	18	1/9	2
New Mexico	0	1	0	16	4	0
Utah	0	1	1	6	3	0

From a central community on the Navajo Nation, driving distance to Prescott is 306 miles (4 hrs.,45 mi); to Albuquerque is 231 miles (3 hrs.,40 mi); and, to Salt Lake City is 431 miles (7 hrs.,2 mi).

Appointments with area Veteran medical center become 2-3 day ventures incurring cost of meals, lodging and gasoline. Due to geographic remoteness and social and physical isolation of communities, dissemination of information is limited. Language is a barrier for the older Navajo veterans.

The elements of U.S. Department of Veteran Affairs are Veterans Health Administration, Veterans Benefits Administration, and the National Cemetery System. In FY2013, the U.S. Department of Veteran Affairs had the second largest federal agency budget. As an example, in Fiscal Year 2014 President's Budget priorities are to expand access, eliminate backlogs of claims, and end veteran homelessness. Budget requested for FY2013 is \$86.1B for mandatory spending and \$66.5B in discretionary funds, totaling \$152.6B.² Veteran Health Administration services on the Navajo Nation is limited to IHS clinic³ via a USDVA and Indian Health Services Memorandum of Understanding.

RECOMMENDATION(S):

- 1) Honor the USDA Tribal Consultation Policy through collaboration, coordination and cooperation with the Navajo Nation in the spirit of a government-to-government relationship
- 2) Expand the Memorandum of Understanding between the Indian Health Services and US. Department of Veteran Affairs to provide direct funding to IHS from USDVA for Native American healthcare services and benefits
- 3) Channel funds and resources of USDVA to the Navajo Nation assuring equitable and accessible services for the Navajo and resident veterans
- 4) Amend the U.S. Department of Veteran Affairs Act to establish and recognize the Navajo Nation as a "state-like" government for the administration and management of USDVA resources and funds
- 5) Amend the U.S. Department of Veteran Affairs Act to provide direct funding to the Navajo Nation comparable to the States of Arizona, New Mexico and Utah

References:

1. U.S. Department of Veterans Affairs. (2013). http://www.va.gov/budget/docs/summary/Fy2014_Volume_4Summary_Volume.pdf. "Executive Summary". Page 1A6.
2. U.S. Department of Veterans Affairs. (July 23, 2013). http://www.va.gov/directory/guide/region_flash.asp?map=O&ID=18. "VISN 18, 19: VA Southwest Health Care Network".

Oklahoma

1. Medicaid Expansion

Lack of expansion in Oklahoma will directly affect the opportunity to collect additional third party revenue. Patients that may have been covered under this expansion will continue to be covered by CHS.

2. Staffing Package

For those Tribes that have entered into a Joint Venture Agreement due to lack of appropriations in staffing dollars, the full funding for these programs has not been received. Until these programs are funded, it appears that the release of future joint ventures is on hold.

3. Entitlement

Funding for the IHS program should be considered mandatory (versus discretionary) funding within the Federal budget.

4. Extend FTCA to Oklahoma City and Tulsa programs

With the passage of IHCIA, both the Indian Health Care Resource Center (Tulsa) and the Oklahoma City Indian Clinic were deemed to be permanent programs within IHS' direct care program. All other direct care programs within IHS are covered by Federal Torts Claim Act (FTCA) therefore by extension these two programs should also have equal status and receive FTCA coverage.

In addition to federal and tribal employees, employees of eligible Federally Qualified Health Centers (FQHCs) funded by the Public Health Service as community and rural health centers are deemed to be covered entities and qualify for FTCA protection. Commissioned Officers currently assigned to OKCIC and IHCRC are deemed to be covered under FTCA. It is assumed by extension that civil servants who may be assigned to OKCIC and IHCRC programs in the future should also be covered under FTCA.

5. Ensure IHCIA (or ACA) remains

Ensure IHCIA survives any congressional action to repeal components of the ACA.

6. ICD-10 Implementation

Implementation of ICD-10 is currently an unfunded mandated requiring significant resources. The OCA tribes request that funding be made available in support of this effort.

7. Health Information Exchange (HIE), IHS in state HIE

In the State of Oklahoma, there are at least two Health Information Exchanges. The Area Tribes are joining but IHS had made no effort to join an information exchange. HIE increases coordination of care and a gap will exist as long as the federal component of IHS continues to not be a part of the exchanges.

Phoenix

Fort Yuma Ambulatory Health Center: The aged facility has been declared unsafe due to structural damage caused by recent earthquake activity in the region. The Phoenix Area IHS continues to monitor the facility, but seismic activity intensified concerns and it is apparent that patients and staff are at greater risk. The idea to lease space and relocate services temporarily in Yuma, Arizona was worked on last year. Still the search for a suitable space that did not require extensive renovation was not successful. Both the Quechan Tribe and the Cocopah

Tribe served by the Fort Yuma IHS Service Unit have conducted numerous sessions with IHS to address their concerns. The project has been on the IHS construction priority list for many years waiting for Congress to approve the needed resources.

Shortage of Health Care Providers at I/T/U Facilities: Tribes and urban Indian health programs both noted the difficulty they face with regard to recruitment and retention of professional health care providers. While the factors vary some of the programs noted that the issues are as basic as resources are not available to hire needed staff or to sustain the infrastructure to expedite billing and reimbursement. Rural and frontier locations have these issues to contend with along with the struggles to attract professionals to these areas.

Expansion of Existing Facilities & Building Maintenance: Tribes and urban Indian programs that do not have facility projects on the Priority list, are not able to improve the level of services they provide due to the lack of space and the high cost of maintenance required at the facilities. These factors have an impact on the quality of care that is provided.

Dental Health: Tribes and urban Indian programs identified dental services as a significant need across the Phoenix Area. It was determined that dental decay among children requires significant attention and adults also are largely restricted from obtaining alternative resources for dental services, even if eligible for Medicaid as most states only cover emergency dental services. It is hoped that this may be remedied as medical insurance plans have begun to offer affordable dental plans through the Health Insurance Marketplace and state based Marketplaces.

Detox Services: To address alcohol and substance abuse, several of the Tribes noted that current funding barely meets their needs and that one of the critical services that is lacking is detox services. These services aide individuals in crucial situations, but also prevent possible injury to themselves and others if they can be provided a safe detoxification environment.

Prevention and Education for Youth: Tribes and urban programs identified this issue as a major focus area. As a national strategy, preventing and educating youth on serious public health and chronic diseases and behavioral health issues would provide an opportunity to turn the tide on health disparities affecting Indian people.

Staff Training on the Electronic Health Record, Coding & Third Party Billing: Staff training for EHR and third party billing including coding and compliance must be consistent.

Replacement of Outdated Medical, Dental and Optical Equipment: This need was identified by several Tribes and Urban Indian health programs and is essential in order to provide better medical care.

Information Technology (IT) Services: Tribes and urban Indian programs identified the need for IT services. They noted the lack of funds to keep up with current technologies and comply with new requirements such as fully implementing the Electronic Health Record at all facilities.

Portland

Tribe: Sauk-Suiattle

Issue: Drug abuse awareness/Diabetes

With a current Tribal enrollment of less than 400, nearly a third of those are youth. Our Tribal members are considered elders at age 45 due to our death rate associated with these two diseases.

Background:

Our Community is small. We are struggling to keep our youth off drugs and alcohol and focused on cultural continuity, community pride, etc. To that end, we are endeavoring to offer a wide array of activities intended to keep our youth engaged and interested in life and appreciation of it. Our youth struggle and need tools and skills to help them avoid drugs and alcohol. We have lost three Tribal youth in the past year, with two of those being under the age of 21.

Situation:

Our community has formed a grass roots organization called, “This has to Stop” in direct response to our losses. The situation is serious and we are treating it as such.

Tribe: Yakama Nation

Issue: MLR impacting direct care to patients needing care for urgent services diagnostic, surgical, etc. this creates more challenges and strain on existing funding and staff. Very ill, elderly, or patients in severe pain are having to be transported 3hours to diagnostic evaluation appointments. The Sequestration has resulted in one CHR (transporter) being let go due to lack of funding.

Background: As other Tribe's, we are heavily reliant upon CHS to provide medical service to our patients. Hospitals and Providers do not like MLR and have even developed billing practices to separate Doctors and Pharmacy to be stand alone from hospitals.

Situation: Patients in our area including myself have received letters from hospitals stating if they are not paid within a given narrow time frame, they will send our bills to collections. I have had no current bill with this hospital at the any time. As a Tribal Leader, I was told a "young man died because a local hospital refused service. His Mother is a Tribal Member who is a nurse and retired from our clinic.

"The Yakama Nation" also agrees with the other Tribes that suicide is a hot topic with those attempting or completing are getting younger and multiple members of same families are clearly demonstrating need for intervention as well as prevention.

Tribe Yakama Nation

Issue: Shortfall of indirect cost for the past 10 years. Contract Health patient care shortfall due to meds being referred out. CHR and Home Health shortfall, due to cuts has resulted in lesser hours. If we had the full amount of CSC, we should have been able to cover these as well as behavior health.

Background: Yakama Nation IHS Master Contract has always had a shortfall in indirect cost and contract support costs for the past 10 years.

Situation: The Yakama Nation needs to be paid full amount of indirect cost and contract support costs.

Tribe: Cow Creek Band of Umpqua Indians

Issue: Contract Support Cost Shortfall Report. The Tribes do not know the true shortfall amount, as we no longer get this report from IHS.

Background: We trade 188 million in Portland Area but DHS indicates otherwise.

Situation: We request that each Tribe get a "True" CSC Shortfall report each year.

Tribe: Cow Creek Band of Umpqua Indians

Issue: SDPI Demo projects (competitive) funds need to be re-allocated to all Tribe's so they too can access DPP/HH Programs.

Background: Demo projects were developed back in 2006 to prove DM could be prevented/delayed in AI/AN populations by Congress. These programs were to be for a 5-year period. Due to funds being allocated late at the end of each cycle TLDC & Dr. Roubideaux have continued to "refine" the amount greater (via RFP) but there is no movement for other Tribes to get this funding and the valuable program.

Situation: We would like to recommend funding to the SDPI overall budget be reallocated to everyone with new a grant with the requirement to include a provision for Tribes to attend DPP or HH training in their area and implement these programs as designed and report data (tool kit)

Tribe: Sauk-Suiattle

Issue: Diseases on Reservations

Background: Historic difficulty of hiring Medical Providers

Situation: The Tribe has historically had difficulty in hiring proper Medical Providers for Diabetes, heart disease and child abuse.

Tribe: Yakama Nation, Confederated Tribes of the Colville Reservation and Spokane Tribe

Issue: Suicide

Background: We need to look at the mortality rates of suicide in Indians is higher than anyone else. Also, the age groups continue to get younger and younger.

Situation: The Tribes has been hit with multiple suicides on their reservations and sometimes more than one in one family. The age groups keep getting younger and younger.

Tribe: Spokane Tribe

Issue: Contaminants in Water Wells of Tribal Members, Epidemiology surveys

Background: The Water Wells of 17 Tribal Members have tested positive due to environmental health issues.

Situation: The Tribe needs assistance to get this fixed.

Tribe: Shoalwater Bay Tribe

Issue: Lack of infrastructure for IT Services

Background: Due to the continuous demands and changes in programs, the Tribe has had difficulty keeping up with IT Services.

Situation: The lack of infrastructure for IT services has greatly hampered the Tribe.

Tribe: Suquamish Tribe

Issue: CHEF claims not getting approved.

Background: The lack of Tribal Consultation for new program requirements.

Situation: The need for Tribal Consultation for program requirements is needed.

Tribe: Cowlitz Tribe

Issue: Medicare like Rates

Background: Hospitals are finding ways around not utilizing Medicare like rates and this need be addressed as they are receiving federal funds.

Situation: The Office of the Inspector General needs to look at how hospitals are skirting around the issue of Medicare like Rates.

Tribe: Sauk-Suiattle

Issue: Diseases on Reservations

Background: Historic difficulty of hiring Medical Providers

Situation: The Tribe has historically had difficulty in hiring proper Medical Providers for Diabetes, heart disease and child abuse.

Tribe: Cowlitz Tribe

Issue: Budget Cuts

Background: Due to the massive budget cuts, the Tribe has had to endear this year we have had to utilize Tribal resources to backfill these cuts which has put a burden on the Tribal resources.

Situation: The Tribe has had to utilize its own resources to backfill the budget cuts and as a result has strained Tribal resources.

Tribe: Sauk-Suiattle

Issue: Diseases on Reservations

Background: Historic difficulty of hiring Medical Providers

Situation: The Tribe has historically had difficulty in hiring proper Medical Providers for Diabetes, heart disease and child abuse.

Tucson

Purchased and Referred Care

Education and Awareness on the details of enrolling into Medicaid (AHCCCS) and or other benefits is important for Indian Health Service who pays for health care as a last resort using Purchased and Referred Care. An Increase in Purchased and Referred Care will help care for those without health insurance and those with special circumstances. What does insurance pay and does IHS pay deductibles is one of the questions that is related to the enrollment process and should be asked by the benefits coordinators.

Indian Addendum

Insurance carriers should have these in order to know that American Indians are exempt from certain things like enrollment deadlines, no co-pays etc. This is a part of the education and awareness aforementioned.

Reimbursement

Reimbursement for Indian Health Service for provision of health services to undocumented migrants. This issue has not been resolved and will continue to be an issue for the Tucson Area.

Rocky Mountain Spotted Fever

This continues to be a “hot topic” due to the costs associated with the eradication of this disease. Surveillance and treatment of this disease is ongoing.

Contract Support Costs

Fully fund contract support costs and ask for additional appropriations to do so and not take from the regular Indian Health Service budget.

Uncompensated Care Costs Reimbursements for Indian Health Service and Tribal 638 Programs.

These reimbursements from AHCCCS (Arizona Health Care Cost Containment System) gives the Indian Health Services some options to upgrade facilities and also to provide new services. The Reimbursements from State Medicaid brings many improvements to IHS. The continuance of the reimbursements will continue to bring much needed services to the Tucson Area.

The five priorities that the Tucson Area submitted for the FY 2016 Budget are very important also.

The Arizona American Indian Oral Health is presently getting underway with the formulation of a Statewide Executive Board and an approved charter. There are different projects the Tribes in Arizona have started. Tohono O’odham Nation has started to assess its oral health needs. This is a topic that is growing in Arizona. Oral health should be prioritized.

Tribes and Tribal organizations receive a disproportionately low number of DHHS grant awards. AI/ANs are approximately 1.5% of the U.S. population, but AI/AN entities serving them receive only 0.51% of total grant funds awarded by DHHS agencies.⁴

Based on a 2004 study the IHS awarded 72% of its total grant funding to Tribes and Tribal organizations and the Administration on Aging awarded 2% of its total funding to AN/AI groups that year. The National Institutes of Health awarded only 0.01% of total available grant funds to AI/AN groups, and made only eight awards to these groups out of a total of 55,822 grants awarded. HRSA, CDC, and SAMHSA fund disproportionately fewer grants to AI/ANs.⁵ Sadly, there has been very little improvement over the last decade.

The barriers identified and the strategies presented to address these barriers are generally related to statutory, regulatory, administrative, or policy issues and to resources of Tribes and Tribal organizations.

Statutory barriers to access DHHS grant funds include

- 1) Distribution of DHHS funds through state block grants that may not be distributed by recipient states to organizations serving under-represented population groups;
- 2) Requirements for matching funds that may be prohibitive for under-served groups that lack resources for the match; and
- 3) Programs with allocation formulas based on numbers of clients or anticipated costs that may be biased against small or rural communities with small numbers of participants and the inability to spread costs across a larger client base. (However, statutory requirements are often necessary to design programs that meet the need identified by Congress.)

A regulatory barrier is the lack of available data required to establish eligibility and meet reporting requirements at the rural and small community level. Several administrative, policy, and resource barriers include:

- 1) Lack of resources to track and identify grant opportunities;
- 2) Each DHHS program requires unique grant application formats and have different grants management requirements;
- 3) Program funding is inadequate for small community-based organizations to administer and provide services to special populations and to those in remote areas;
- 4) The inherent advantage previous DHHS grantees have in the award process;
- 5) Lack of explicit statements about eligibility in grant announcements; and

⁴ <http://taggs.hhs.gov/Reports/GrantsByRecipClass.cfm>

⁵Barriers to American Indian, Alaska Native, and Native American Access to HHS Programs: Final Report prepared for US DHHS Office of the Assistant Secretary for Planning and Evaluation April 2006
<http://aspe.hhs.gov/hsp/06/barriers2access/report.pdf>

- 6) Implementation requirements designed for projects targeted at state governments vs. Tribal governments.

A number of barriers related to the limited resources and capacity include:

- 1) potential applicants may not have resources or the experience to track and identify grant opportunities, prepare grants, or gain access to experienced grants writers; and
- 2) Tribes and Tribal organizations may not have administrative or service capacity to meet program requirements or to successfully apply and compete for grants, due to limited workforce numbers, lack of computer and internet technology and experience, and transportation barriers.

Many Tribes and organizations have very limited resources and as a result, are unable to administer a program that is not fully funded by DHHS with respect to indirect costs. Few Tribes and Tribal organizations have access to funds that could be used to provide even a relatively low level of matching funds. Some grant programs require grant applicants to provide a plan to demonstrate the sustainability of the program after grant funding ended. Sustainability of some components of the program may be possible, but some grant announcements require a plan for sustainability of the full program. If Tribes had the necessary resources to sustain a program, they would already have the program in place.

The requirements in some grant announcements for specific detailed data on prevalence of disease conditions or “need” for services are a barrier for some Tribes and Tribal organizations, particularly those in rural areas. For example, some grant announcements require that only evidence-based practices be used in a grant program; however, traditional Tribal practices may not be evidence-based or not yet researched as such. Language in the announcement needs to recognize these traditional practices and/or set up alternative standard of proof for evidence-based practice. Language such as “Tribal/ethnic/culturally-specific approaches are acceptable” could be incorporated into the grant announcement to encourage culturally appropriate responses.

Other grant announcements require the proposed program director and/or staff to have specific academic credentials. In most rural areas and reservations, there may not be a supply of people with these credentials. As a result, some Tribal staff members learn “on the job” and build extensive experience in other ways, but do not meet the specific academic or credential requirements for the grant program.

RECOMMENDATIONS:

- **Provide Grant opportunities directly to Tribes instead of funneling through state governments.**
- Increase use of annual or multi-year program announcements, with multiple due dates.
- Increase use of planning grants by DHHS agencies that may provide opportunities to build capacity and infrastructure.
- Include explicit statements about minimum population base requirements in grant announcements, if applicable.

- Include explicit statements in grant announcements that experience may substitute for academic credentials of key staff
- Increase training and technical assistance on grants processes and grants preparation skills, provided by DHHS and/or national and regional AI/AN organizations, including possible knowledge transfer between successful AI/AN grantees and less experienced Tribes and organizations.

Regarding the grant review process, some grant reviewers have very limited or no understanding of AI/AN history, culture, geography, and resource limitations. In addition, even when no minimum population base was specified in the eligibility criteria, some reviewers ranked AI/AN applications lower because of the small number of people that would be reached by the grant program. Those that have applied for grants that were primarily research-oriented or had a significant evaluation component also stated that DHHS agencies relied heavily on academic reviewers who placed disproportionate emphasis on academic credentials and degrees and discounted extensive experience of proposed staff because they did not have academic experience. Finally, some DHHS agencies sometimes do not provide adequate information on the reasons their application was rejected, and this is a barrier to learning how to improve future applications.

Recommendations: Grant Review Processes

- Consider reducing reliance on academic reviewers who place disproportionate emphasis on academic credentials of grant applicant staff, where such credentials are not necessary for successful performance and where alternative forms of expertise are demonstrated.
- Increase use of AI/AN grant reviewers and those familiar with AI/AN subjects, when AI/AN grant applications are to be considered.
- Provide orientation for grant reviewers to help them understand unique AI/AN issues and circumstances.
- Provide clear information on reasons for rejection of application.
- Follow-up contact with DHHS program staff by AI/AN organizations to clarify reasons for rejection or to obtain summary statements, if not provided by agency.

Collaboration among DHHS agencies and organizations involved in grant implementation is a way to build the infrastructure necessary to successfully administer programs and manage grant funds. For example, the Native American Research Center for Health (NARCH) is a cooperative program using funds from IHS and various research agencies such as the National Institute of Health (NIH) and the Agency for Health Care Research and Quality (AHRQ) to fund research activities and training at Tribal organizations. There can be partnerships between operating divisions; for example, if a Tribe has received a SAMHSA grant, they would then be eligible to apply for a NIH research grant/clinical trial that focuses on the purpose of the SAMHSA grant. SAMHSA and NIDA currently have this type of an arrangement.

Recommendations: Additional Issues

- Consider AI/AN "set-asides" or special grant initiatives within grant programs, including ways to address the needs of smaller/poorer Tribes and organizations.
- Improve capacity for DHHS to track grant submissions and awards by AI/AN Tribes and communities.
- Increase the number of grants targeted specifically to AI/AN Tribes/organizations.

- Require evidence that states and academic institutions have support and participation of AI/AN Tribes and organizations, if they are included in grant application.

Title VI Self-Governance Legislation (as a means to aide non-IHS funding streams):

When Congress enacted The Tribal Self-Governance Amendments of 2000, P.L. 106-260, it included a provision requiring the DHHS to conduct a study to determine the feasibility of extending Tribal Self-Governance to non-IHS programs within DHHS. In the final study submitted to Congress in 2003, DHHS concluded that it was feasible to extend Tribal Self-Governance to eleven select programs within the Department, and recommended that Congress do so. Making the assumption that Self-Governance as a practice provides a greater benefit than federally administered programs and supporting the expansion of this practice, via Title VI, is a priority for Tribes.

Benefits of Title VI Self-Governance Amendments include:

1. Expands Tribal Self-Governance; the most successful policy in the history of Tribal-Federal relations.
2. Builds on the well-documented successes of Tribes and Tribal organizations in delivering IHS health care programs and services under Title V.
3. Determined to be feasible and desirable by DHHS in its 2003 study.
4. Allows Self-Governance in DHHS analogous to that in the Department of the Interior, where Title IV allows Tribes to compact non- BIA programs and services.
5. Provides an integrative, holistic approach to ensuring healthy communities by providing services that enhance individual and community well-being.
6. Described by the Senate Committee on Indian Affairs as "the next evolution in Tribal self-governance."⁶
7. Streamline the process that allows Tribes to efficiently administer federal programs and optimize resources

⁶ National Tribal Self-Governance Strategic Plan & National Priorities 2011-2013 Self-Governance Communication and Education Tribal Consortium

<http://www.Tribalselfgov.org/NEWSGCE/documentsdownload/Tribal%20Strategic%20Plan%20-%202011-13.pdf><http://www.Tribalselfgov.org/NEWSGCE/documentsdownload/Tribal%20Strategic%20Plan%20-%202011-13.pdf>