



# **Turning the Corner in Indian Health Treaty and Trust Obligations: *Writing a New Future* for American Indians and Alaska Natives**

*Photo Credit: James Cook, 1990 The Centennial Ride to Wounded Knee*

## **The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2017 Budget May 2015**

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## EXECUTIVE SUMMARY

FY 2017 represents a landmark opportunity for this Administration *to turn the corner* in Indian health Treaty and Trust obligations, and to finally, bring to justice the promises made to Tribes. It is time to write a new future for American Indians and Alaska Natives (AI/AN). This Administration and Congress have it in their power to eliminate the gross health disparities experienced in Tribal communities, and offer our new generations hope for a better life in our own homeland.

Tribal leaders express appreciation for the Indian Health Service (IHS) budget increases put forth in good faith by President Obama during his terms in office. While these funds have prevented irreparable deterioration in existing health services, in reality however, the increases have done little to address the deep disparate health issues plaguing Tribal communities. The majority of these increases have largely only provided a stopgap measure for inflation, staffing for new facilities, payment of Contract Support Cost (CSC) obligations, population growth, and facilities. This leaves very little funding, if any, to target the alarming disparities facing Indian communities. At the national session, Tribal leaders reported that they are forced to cut basic programs such as Purchased and Referred Care (PRC), Specialty and Dental services, deny patient travel, and ignore upgrades needed to ensure safe patient care through meaningful use of Electronic Health Records (EHR). In addition, they are often forced to defer much needed facilities maintenance and repairs or medical equipment purchases, thereby reducing the quality of direct patient care.

This grim reality is corroborated by discouraging health statistics reported annually by the Indian Health Service. The American Indians and Alaska Natives life expectancy is 4.2 years less than the rate for all other race populations in the United States. AI/ANs suffer disproportionately from a variety of afflictions including alcoholism, diabetes, unintentional injuries, and suicide. When considering the level of funding appropriated to IHS, these statistics are not surprising. In 2014, the IHS per capita expenditures for patient health services were just \$3,107, compared to \$8,097 per person for health care spending nationally. The First Peoples of this nation should not be last when it comes to health. In response to this legacy challenge to provide meaningful change, the National Tribal Budget Formulation Workgroup strongly recommends the following:

### **Tribal Total Needs Based Request: \$29.96 Billion Phased in over 12 Years**

### **FY 2017 Tribal Budget Recommendations: \$6.2 Billion (Highlights below)**

- ❖ Increase FY 2016 President's IHS Budget by a minimum 22% in FY 2017:
  - \$157.4 million for full funding of current services
  - \$325 million for binding fiscal obligations\*
  - \$591.7 million for program expansion increases
- ❖ Request a higher percentage budget increase in Hospitals & Clinics budget line to provide additional flexible "Services" budget line item funding which will be used by the IHS Areas to fund local budget priorities
- ❖ Provide an additional \$300 million in the "Services" budget line to implement the provisions authorized in the Indian Health Care Improvement Act (IHCIA)
- ❖ Advocate that Tribes and Tribal programs be permanently exempted from sequestration  
*\*includes placeholder estimates for CSC, Staffing for new facilities & new Tribes*

The FY2017 22% budget request reflects the minimal amount needed to cover inflationary costs which will keep current services whole, and to pay for current fiscal obligations of the Indian Health Service, identified by placeholder estimates based on present-day information only, for Contract Support Cost, new facility staffing and funding for new Tribes. It also proposes a minimum of \$591.7 million to provide for meaningful expansion of programs and services in FY2017. This amount includes a larger program increase in the Hospital & Clinics budget line in order to provide Areas with the funding and flexibility to address local budget priorities. For example, Tribal local priorities address funding for emergency and specialty Purchased/Referred Care (PRC) for remote communities or culturally-appropriate Substance Abuse Treatment programs in multiple Areas. On top of this, in FY 2017, the Tribes are repeating their request to add \$300 million to fund the new authorities contained in the long-fought-for Amendments to

the Indian Health Care Improvement Act. This widely supported bi-partisan bill must have funding behind it or it will be yet another empty promise made to this nation's First Peoples. In addition, Tribes request that the Administration restore all prior year cuts/shortfall and support permanent exemption from sequestration.

Proposing a responsible budget which fully honors the federal trust responsibility, and that provides *real* increases for service expansion, will turn the corner in Indian and federal relations. Together, we *can* make progress to achieve our dream of health parity for all American Indians/Alaska Natives (AI/AN). This will enable every Native young person to be treated like a valuable member not only of his or her nation, but also of the American family - providing Native youth with an equal shot at the American Dream. Let us together, put behind us the traumatic history, which has delimited the past relationship between the United States and American Indian and Alaska Native Tribes. Instead, let us write a *new future* in the spirit of respect and honor, which brings health, and hope for our next generations and instills a morale right of dignity for our elders who have endured.

## **\$29.96 BILLION**

### **TOTAL TRIBAL NEEDS BUDGET**

**\$29.96 billion** request for services & facilities:

- **\$15.82 billion** for Medical Services
- **\$1.66 billion** for Dental and Vision Services
- **\$3.71 billion** for Community & 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.

***“Turning the Corner in Indian Health Treaty and Trust Obligations:  
Writing a new Future for American Indians and Alaska Natives”***

**TABLES: FY 2017 TRIBAL RECOMMENDATIONS**

<b>FY 2017 National Tribal Recommendation</b>	
<i>Planning Base - FY 2016 President's Budget</i>	<b>\$5,102,985,000</b>
<b>Current Services &amp; Binding Agreements</b>	<b>\$482,440,000</b>
<b>Current Services</b>	<b>\$157,440,000</b>
Federal Pay Costs	8,173,000
Tribal Pay Costs	9,989,000
Inflation (non-medical)	8,510,000
Inflation (medical)	63,318,000
Population Growth	67,450,000
<b>Binding Agreements</b>	<b>\$325,000,000</b>
New Staffing for New & Replacement Facilities	75,000,000
Contract Support Costs - Need	150,000,000
Health Care Facilities Construction (Planned)	100,000,000
<b>Program Expansion Increases - Services</b>	<b>\$591,702,700</b>
Hospitals & Health Clinics	200,000,000
Dental Services	31,185,900
Mental Health	67,495,900
Alcohol and Substance Abuse	77,600,900
Purchased / Referred Care ( <i>formerly CHS</i> )	200,000,000
Public Health Nursing	584,000
Health Education	457,000
Community Health Representatives	557,000
Alaska Immunization	3,000
Urban Indian Health	10,000,000
Indian Health Professions	564,000
Tribal Management Grants	0
Direct Operations	128,000
Self-Governance	328,000
Contract Support Costs - New & Expanded	2,799,000
<b>Program Expansion Increases - Facilities</b>	<b>\$48,514,000</b>
Maintenance & Improvement	21,589,000
Sanitation Facilities Construction	13,927,000
Health Care Facilities Construction-Other Authorities	7,560,000
Facilities & Environmental Health Support	438,000
Equipment	5,000,000
<b>GRAND TOTAL</b>	<b>\$6,225,641,700</b>
\$ Change over Planning Base	\$1,122,656,700
% Change over Planning Base	22.0%
Date	Feb 11, 2015



## INTRODUCTION

In the defining six years of his Administration, President Obama has courageously set forth policies reinforcing his stated commitment to strengthen the unique government-to-government relationship between the United States and sovereign Tribal Nations. Each year Tribes have seen moderate increases within the Indian Health Service (IHS) budget and increased access to other funding opportunities within the Department of Health and Human Services. Unlike other Administrations, President Obama has made a concerted effort to apportion increases to support Indian programs within his proposed budget to Congress. However, these increases have only been enough to cover inflation proofing and to meet existing mandated obligations; there have been few dollars, if any, to expand services necessary to bring true health parity for American Indians and Alaska Natives. Sadly, despite these positive efforts to increase the IHS budget, there still exists a huge gap when comparing per capital health spending between Indian health and other federal healthcare programs.

*"This country faces a continuing federal deficit and tight budget. The federal government also has important responsibilities to Indian people. Those responsibilities require funding."*

*-Senator John Barrasso, Chairman, Senate Committee on Indian Affairs, February 24, 2015*

### **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.

In FY 2015, for example, IHS received an increase of \$207.9 million, most of which is being used to cover inflation and binding obligations and to restore cuts from FY 2014. Similarly, in FY 2014, IHS received an increase of \$304 million over FY 2013 enacted levels. Most of this increase was required to fully fund contract support costs (CSC), as well as new staffing packages, at the direction of Congress. The joy of seeing an increase in IHS appropriations quickly dampened when the agency had no choice but to cut an additional \$10 million from Services to pay for CSC and staffing costs. No funds were available to restore sequestration cuts from FY 2013, nor to adjust for actual inflationary increases and population growth. As a provider of direct healthcare services, the IHS must be treated like other federal health provider agencies and be held harmless from future sequestration. When budgets are developed, they must minimally include enough funds to maintain current services, and must provide a meaningful increase to make an impact on chronic health disparities.

FY 2017 represents the final opportunity for this Administration to create an unprecedented legacy, which will shift the focus from the past travesties imposed upon this country's first citizens, and move towards redefining relations build on a new respect and honor of trust with sovereign Tribes. While inflation and other required appropriation priorities have hindered progress toward improved health performance outcomes, the final 2017 budget proposed by the Obama Administration can significantly reverse this trend. By preparing a budget that fully honors the federal trust responsibility, we will not only reduce, but *also eliminate* the health disparities between the Native peoples and other Americans. The target for the IHS budget of **\$29.96 billion** over twelve years contained in this request offers a lasting legacy for

President Obama and his cabinet. It will serve to rewrite a better future for deserving Native American youth and will correct an injustice suffered by our elders by giving back their dignity.

It is imperative that President Obama visibly launch a sustainable plan to achieve full funding. It must start with putting forward, in this last budget of his administration, a FY 2017 legacy proposal which will create a better future for Indian peoples to include:

1. Phased- in Full Funding of IHS - Total Tribal Needs Budget of \$29.96 Billion Over 12 Years
2. A minimum 22 % increase in the overall IHS budget over the FY 2016 President's Budget request, subject to adjustments for actual FY 2017 CSC, New Facility staffing, and New Tribes
3. A higher percentage budget increase in Hospitals & Clinics budget line to allow flexible service expansion funding which will be used by the IHS Areas to fund local budget priorities
4. \$300 million on top of the 22% to begin to implement the provisions authorized in the Indian Health Care Improvement Act (IHCA)
5. Permanent exemption from sequestration

## TURNING THE CORNER...

The federal budget for AI/AN is not just a fiscal document between sovereign Nations. It is indeed, the execution of a moral, ethical, and legal commitment. The U. S. federal government recognizes Tribal nations as “domestic dependent nations” and Congress has long recognized the sovereignty of Native Nations, citing treaties, made between sovereign nations, as the Supreme Law of the Land. These early treaties, reaffirmed by Executive Orders, Congressional actions and two centuries of Supreme Court case law, provide the basis for Congress to apportion funds for Indian Health care services for the benefit of all AI/ANs. Tribes are the only citizen group allowed to have formal consultation into the federal budget formulation process. The annual budget request reflects the extent to which the United States chooses to honor its promises of justice, health, and prosperity to Indian people. When national budget requests for Indian health care fall short of providing even the most basic level of services equitably to all Tribal members, Tribal communities suffer. It is no wonder that visitors to remote Tribal reservations or villages are moved to describe Tribal living conditions as “third world” in nature. Ironically, it is oft time easier for these same third world countries to receive foreign aid, than it is for our own “domestic dependent nations,” to receive funding for even basic health care. It is tragically still a truth that many families are forced to make tough decisions between seeking health care or to pay for food or living expenses. This is unconscionable in a country promising equality and justice for *all* its citizens.

Washington must take a stronger stand to uphold its legal trust responsibility to Tribal Nations. Congress and this Administration must turn the corner by fully honoring its treaty and trust obligations to Indian Country. It is what our Tribal forefathers agreed to when giving up lands and rights for peaceful coexistence. It is a matter of honor. It is what great Nations do.

**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 2.2 million individuals. Currently, the IHS FY 2014 budget is \$4.6 billion. That is only (on average, system wide) 59% of the level of need.



## WRITING A NEW FUTURE...

Federal trust responsibility written into negotiated treaties and agreements 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. Fulfilment of this trust responsibility can only occur if the Administration requests funds and Congress appropriates them. This Administration, more than any other, has made great strides to engage with Tribes in meaningful consultation at all levels of government about budget and other Tribal concerns. This FY 2017 budget request, as proposed and fully funded, will serve to write a new future in U.S. –Tribal relations. It will empower Tribal communities with the necessary resources to implement services and programs to make lasting improvements in the health and wellness of Tribal members. It will bring parity and hope at this critical turning point for Indian peoples who are weary of facing another decade of promises without action.

## ....FOR OUR NEXT GENERATIONS

This Administration has made it a priority to visit Indian country to see firsthand some of challenges which stand in the way health and wellness for Indian youth. Socio-economic ills and lack of resources have crippled many Tribes in their mission to take a holistic approach to solve health disparities facing members. Efforts to reform national health care will have a profoundly negative impact on Tribes, if not properly managed and funded. Indian health care services are already under-resourced; new mandates such as Electronic Health Records Meaningful Use requirements, and performance reporting requirements without equal access to sustainable systems to capture and report on performance outcomes, only serve to exacerbate this. Adequate funding must be provided so that Tribes are not left even further behind. Tribes must have the resources to hire and retain a qualified workforce, and to arm them with clinical quality data systems necessary to address chronic and urgent care needs in this new age of health reform. The hope for a healthier future lies in an abyss for our children, and our children's children, if the right action is not taken *now* to address widening funding gaps.

*“Throughout our nation’s history, the United States has made a solemn commitment to provide health care through the treaties and agreements it negotiated with the Tribes. We have to honor that commitment. Support for the Budget of the IHS helps ensure that we do that. Congress has stepped up and provided significant increases for Tribal health programs over the last several years, but we clearly have a lot of work to do.”*

*Senator Tom Udall (D-NM)  
March 11, 2015*

It will take more than just inflation proofing and funding for existing obligations, 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.

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.

HIV/STDs cases are becoming epidemic on some reservations. Indian Country is asking 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 2017 budget request.

*“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

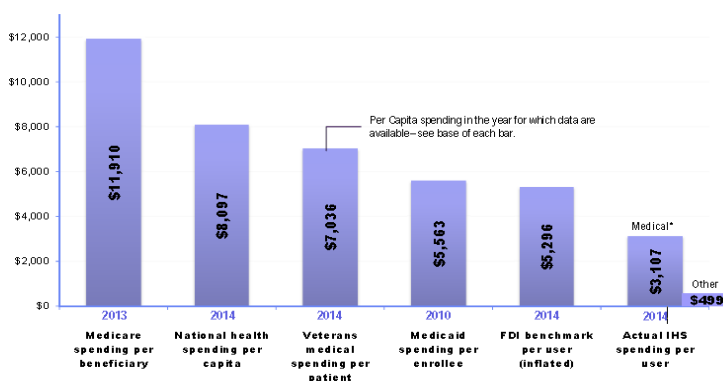
Alarming health risks attributed to historical trauma, poverty and a lack of adequate prevention and treatment resources, also continue to burden Tribal communities. According to IHS data, 39 percent of AI/AN women experience intimate partner violence, which is the highest rate of any ethnic group in 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 related to alcohol and substance abuse are widespread in many Tribal communities, leading to other health and socio-economic 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, as evidenced by the per capita spending between the IHS and other federal health care programs. In 2014, the IHS per capita expenditures for patient health services were just \$3,107, compared to \$8,097 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 2014 was only 59% of calculated full costs. The actual percentage varies widely 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 resource opportunities come with a cost for billing, collections and

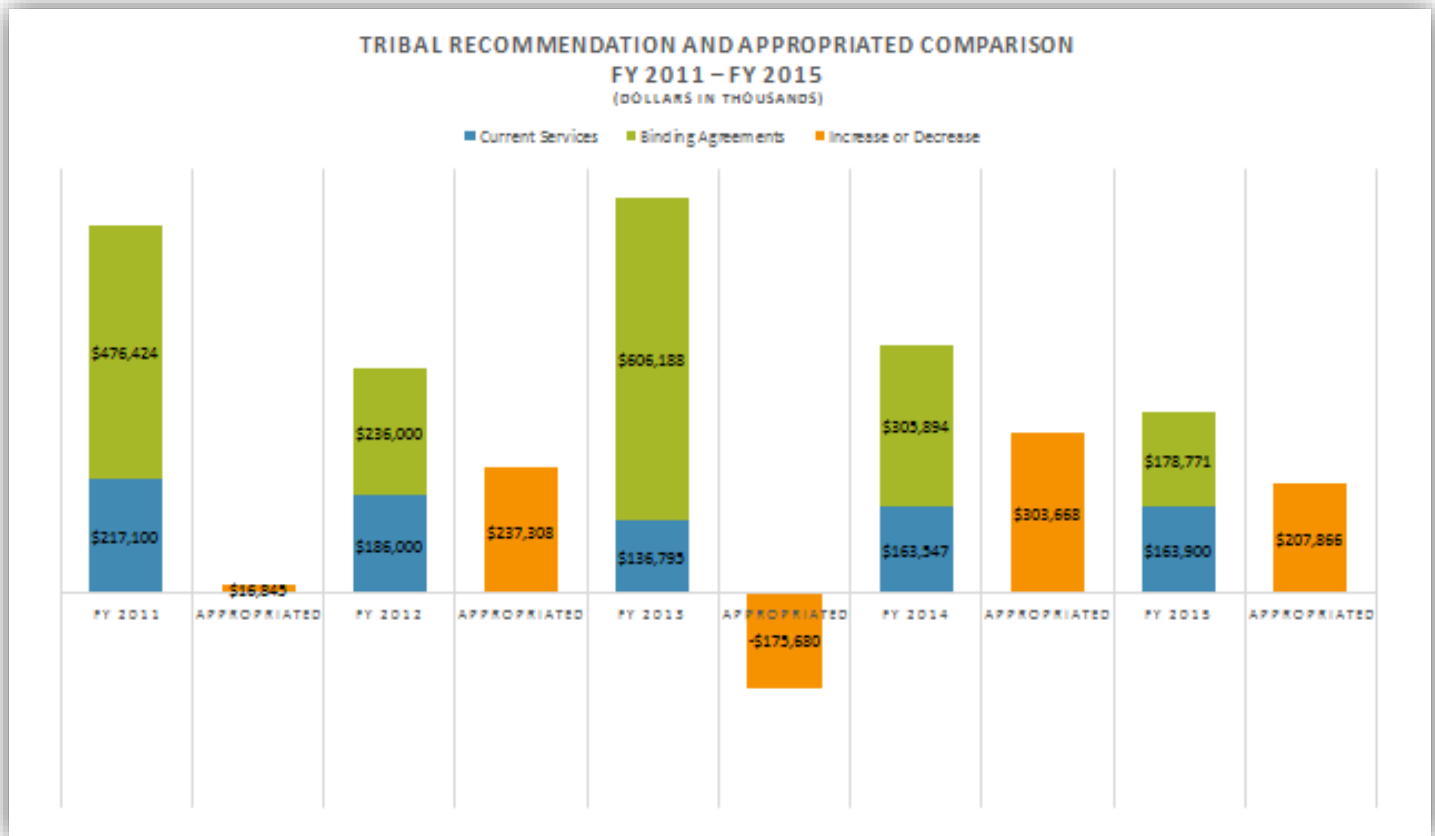
compliance and are no substitute for the fulfillment of the federal trust responsibility. With the funding gap already reaching upwards of \$25 billion, even if 100% of these were recouped and put into services, the huge budget gap and associated health disparities will remain. It will be some time before reliable data is available to determine the impact of these changes on American Indians and Alaska Natives.

**2014 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita**



See page 2 notes on reverse for data. \*The extent of payments by other sources for medical services provided to AI/ANs outside IHS is unknown.  
2/13/2015

## Five Year Trend Budget Requests Inflationary & Fixed Costs Compared with Enacted Indian Health Service Appropriations



*“One of these days we will move on to the next world some call it Heaven, our Chiefs and passed Council will ask us, “Why did you ask for only a small budget for our People when you could have asked for everything you needed?”*

Andy Joseph, Jr. Tribal Co-Chair, National Budget Formulation Work Group

*“Our need is \$29 billion, at the rate we are going we will never get there. When you look at Indian country and look at healthcare overall, it is not enough – they need to pass resolutions that will hold that the way the budget is, is an injustice and HIS must uphold their trust responsibility. As we go through priorities today and tomorrow, all the priorities are important – we get the crumbs. Everything in our community is a priority. We have to list these things: Diabetes, Cancer, facilities, all are important. I wish congress could learn how we have to budget less each year to try to meet the needs of our communities. Our average age of tribal deaths since 1990 is 50 for males and 54 for females. This is not acceptable.”*

Gary Hays, Tribal Co-Chair, National Budget Formulation Work Group

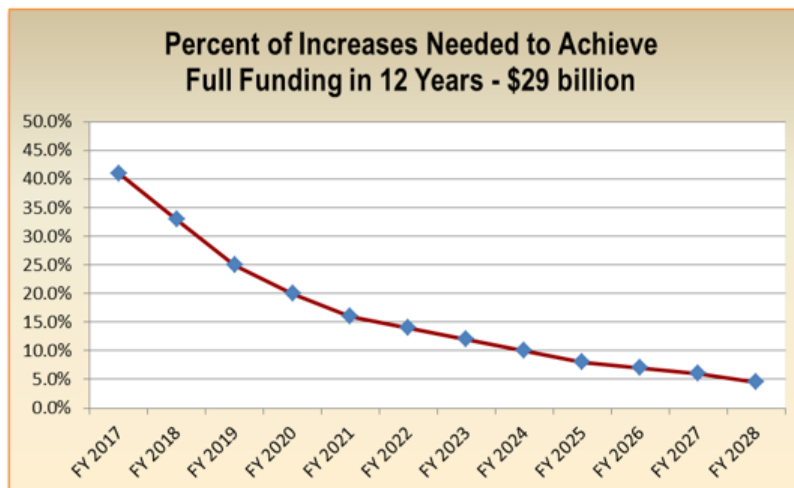
## FY 2017 TRIBAL BUDGET RECOMMENDATIONS AND PRIORITIES

### ❖ 1<sup>st</sup> Recommendation: Phase-In Full Funding of IHS- Total Needs Based Budget of \$29.96 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 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 2017* is now **\$29.96 billion**, based on the FY 2014 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 \$29.96 billion would need to occur over the next 12 years.



# FY 2017 AI/AN Needs Based Funding Aggregate Cost Estimate

## GROSS COST ESTIMATES

Source of Funding is not estimated

Need Based on FY 2014 Existing Users at I/T Sites	Need based on FY 2014 Expanded for Eligible AIAN at I/T/U Sites*
1,594,229	2,710,893

SERVICES	\$ Per Capita	Billions	Billions
<b>Medical Services</b>	\$5,836	<b>\$9.30</b>	<b>\$15.82</b>
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
<b>Dental &amp; Vision Services</b>	\$611	<b>\$0.97</b>	<b>\$1.66</b>
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		
<b>Community &amp; Public Health</b>	\$1,369	<b>\$2.18</b>	<b>\$3.71</b>
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).		
<b>Total Annualized Services</b>	\$7,816	<b>\$12.46</b>	<b>\$21.19</b>
FACILITIES	\$ Per Capita	Billions	Billions
<b>Facility Upgrades Upfront Costs</b>		<b>\$6.51</b>	<b>\$8.77</b>
<b>Annualized for 30 year useful Life</b>		<b>\$0.38</b>	<b>\$0.51</b>
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.			
<b>TOTAL</b>			
<b>Total Annualized Services + One-time Upfront Facilities Upgrades</b>		<b>\$18.97</b>	<b>\$29.96</b>

**❖ 2<sup>nd</sup> Recommendation: Present a 22% Increase in the Overall IHS Budget from the FY 2016 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 **22%** or **\$1.1 billion** over the FY 2016 President's proposed IHS Budget. This includes **\$157.4 million** for *Current Services*, **\$325 million** for *Binding Agreements* with Tribes and **\$640.2 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 **\$640.2 million** are needed to address the urgent AI/AN health disparities related to Program Expansion for Services and Facilities. In order to address obligated costs due to medical inflation, 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)*<sup>1</sup> by **\$200 million**.
- Increase funding for *H&C* by **\$200 million**.
- Increase funding for *Alcohol & Substance Abuse Services* by **\$77.6 million**.
- Increase funding for *Mental Health* by **\$67.5 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 *Dental Services* by **\$31.2 million**.

If the requested Program Expansion increases continue to be overlooked, 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. Turning the corner on health for Indian people, requires serious determination. This Administration has made this a priority for years, and we hope that the last budget proposed will be one of that truly sets a legacy for our people.

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<sup>1</sup> Formerly called Contract Health Services

**Planning Base for FY 2017**FY 2016 President's Budget of \$5,102,985,000 x 22% = **\$1,122,656,700****Current Services (Fixed cost estimates): \$157,440,000**

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

**Binding Agreements (Fixed cost estimates) \$325,000,000**

Contract Support Costs Need (estimate) \$150,000,000

Health Care Facilities Construction Projects (estimate) \$100,000,000

Staffing Costs for Newly-Constructed Facilities (estimates) \$75,000,000

**Program Expansion – Top 5 \$576,282,700**

1. Hospitals &amp; Health Clinics \$200,000,000

2. Purchased / Referred Care \$200,000,000

3. Alcohol &amp; Substance Abuse \$77,600,900

4. Mental Health \$67,495,900

5. Dental Services \$31,185,900

**Other Budget Recommendations \$63,934,000**

6. Maintenance &amp; Improvement \$21,589,000

7. Sanitation Facilities Construction \$13,927,000

8. Urban Health \$10,000,000

9. Health Care Facilities Constr./Other Authorities \$7,560,000

10. Equipment \$5,000,000

11. Contract Support Costs – New &amp; Expanded \$2,799,000

12. Public Health Nursing \$584,000

13. Indian Health Professions \$564,000

14. Community Health Representatives \$557,000

15. Health Education \$457,000

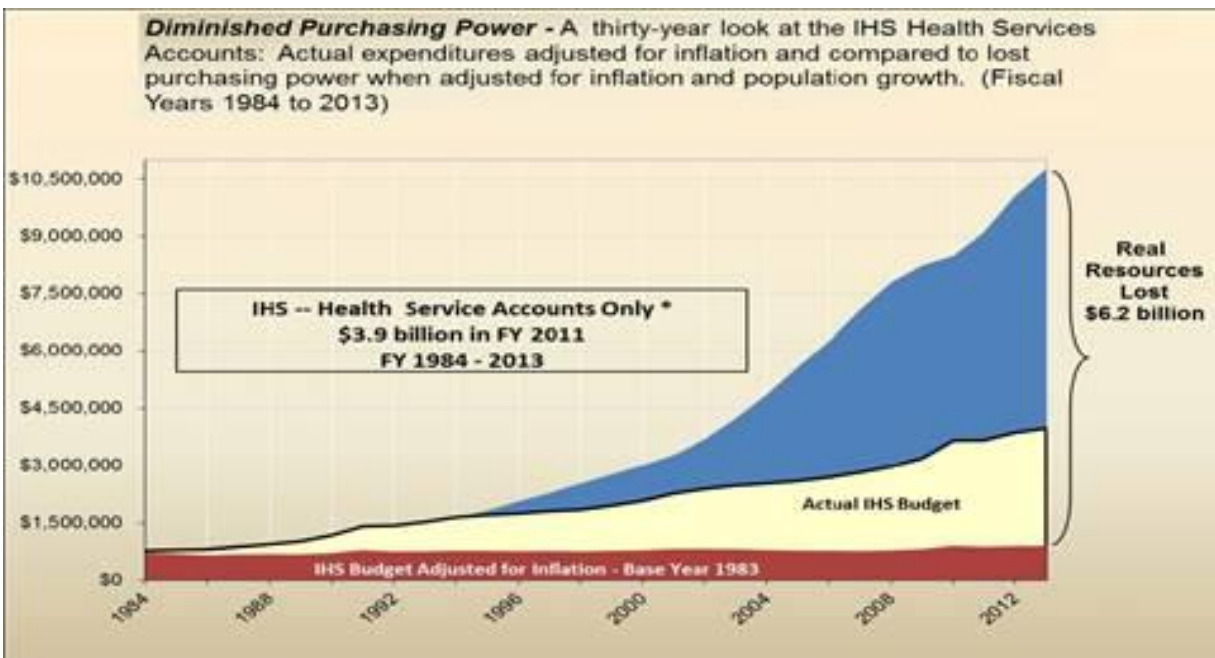
16. Facilities &amp; Environmental Health Support \$438,000

17. Self-Governance \$328,000

18. Direct Operations \$128,000

19. Alaska Immunization \$3,000

## Current Services & Binding Agreements (Fixed Costs)



AI/ANs 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. The workgroup strongly recommends that full funding for Current Services and obligated fiscal requirements at the actual projected costs be funded as reflected in this section.

### **Current Services (Fixed costs) +\$157.4 million**

The FY 2016 President’s Budget request included an increase of \$147 million for direct and tribally provided health care services to cover increased costs associated with population growth, pay cost increases for medical workers and medical inflation, and ensure continued levels of health care services. Unfortunately, the proposed \$147 million falls short of actual need, specifically in population growth, only covering \$56.7 million of the total population growth need of \$82 million. Population growth estimates are determined by a 1.5% increase.

The FY 2017 Tribal Budget Request includes an increase of \$8.2 million for Federal Pay Costs and \$10 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 2017. If Tribes and IHS are to retain quality health professionals it is critical that we honor these employees by providing a competitive wage.

The Current Services request also includes \$8.5 million for Non-Medical Inflation and \$63 million for Medical Inflation. 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 1.5% annually.

Despite historic increases since 2009, the IHS remains severely underfunded far below need. 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 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.

**Binding Agreements (Fixed costs) +\$325 million**

**New Staffing for New & Replacement Facilities +\$75 million (estimate)**

An estimated \$75 million is requested to fund new staffing and operating costs for FY 2017. IHS construction funds are targeted to expand service sites experience overcrowding by building new or renovating existing facilities. Additional funding is included in the budget to support staffing and operating costs for new and expanded facilities. This recommendation amount is subject to adjustment based on the status of actual projects completed in FY 2016, which become ready for staffing packages.

**Contract Support Costs +\$150 million (estimate)**

An estimated \$150 million is requested for reasonable costs for activities that Tribes/Tribal Organizations must carry out to support health programs and for which resources were not otherwise provided.<sup>2</sup> The Indian Self-Determination and Education Assistance Act requires that 100% of these costs be paid, and is therefore this budget line is considered to be a Binding Agreement. In FY 2014, more than \$2.5 billion of the IHS appropriation was administered by Tribes/Tribal Organizations under contracts and compacts, and the assumption of programs, services, functions and activities by Tribes/Tribal Organizations under the Act continues to grow. The FY 2016 President's Budget Request included a proposal to reclassify Contract Support Costs from discretionary to a mandatory appropriation beginning in FY 2017, which

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<sup>2</sup> After the Tribal Budget Formulation Workgroup completed its national Budget Recommendations for IHS, the President's Budget was submitted for Fiscal Year 2016, identifying CSC requirements for a three-year period, FY 2017-2019. In doing so, the IHS identified \$800 million as required to fund all CSC requirements in FY 2017. As this line item is identified as a Binding Agreement, and notwithstanding the estimated funding level by IHS, the appropriation should include such sums that are necessary to fully fund this contractual requirement, realizing that the exact amount will not be known until closer to the appropriated fiscal year.

would pair the appropriation authority with the legal requirement to pay these costs. Tribes universally support this concept.

**Health Care Facilities Construction (Planned) +\$100 million**

In FY 2017, \$100 million is requested for previously approved health facility construction projects in accordance with the IHS health care facilities 5-year plan. HCFC budget line is historically underfunded due to the demands of providing actual health care to AI/AN patients.

**New Tribes Funding \$0 (estimate)**

At the time this budget was formulated, no information was available regarding newly federally recognized Tribes requiring funding in FY 2017. However, this is subject to adjustment if newly recognized Tribes are identified in the Budget appropriations year.

**Total FY 2017 Request for Fixed Costs:**

**Current Services \$157,440,000**

- Federal Pay Costs \$8,173,000
- Tribal Pay Costs \$9,989,000
- Inflation (non-medical) \$8,510,000
- Inflation (medical) \$63,318,000
- Population Growth \$67,450,000

**Binding Agreements \$325,000,000**

- New Staffing for New & Replacement Facilities \$75,000,000 \*
- Contract Support Costs - Need \$150,000,000\*
- Health Care Facilities Construction (Planned) \$100,000,000
- Newly Recognized Tribe Funding \$ 0\*

\*these placeholders are estimates only and are subject to adjustment based on actual requirements

**Program Expansion Increases – Services Budget**

Because FY 2017 is the last Budget that Obama Administration will submit, we call upon the Administration to use this as an opportunity to draft a budget that will set a precedent for the goal of achieving full funding of the Tribal needs-based budget of **\$29.96 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: +\$343.7 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 or 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 direct care 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 ancillary 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.

### TRIBAL EPIDEMIOLOGY CENTERS

Tribal Epidemiology Centers (TECs) work in partnership with the local Tribes to improve the health and well-being of their Tribal community members by offering culturally-competent approaches to reduce health disparities faced by AI/AN populations. Epi-centers serve a critical function as the only public health authorities for Indian Country. Yet, the national average amount received to support TECs is only \$360,000 each year, far short of the \$1 million per TEC requested. This funding level, which includes indirect costs, has been flat for the past 5+ years. Essential functions that the IHCA states that Tribal Epi-Centers should fulfill are:

1. Collect data relating to, and monitor progress made toward meeting, health status objectives
2. Evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health;
3. Assist in identifying highest-priority health status objectives and the services needed to achieve those objectives, based on epidemiological data;
4. Make recommendations for the targeting of services needed by the populations served;
5. make recommendations to improve health care delivery systems for Indians and urban Indians;
6. Provide requested technical assistance in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and
7. Provide disease surveillance and assist Indian tribes, tribal organizations, and urban Indian communities to promote public health.

Clearly, \$360,000 annually is inadequate to achieve these functions. Costs, particularly personnel costs, keep increasing but funding has remained flat so the dollars buy less and less over time. Inadequate funding creates issues with hiring and retaining qualified and capable staff and uncertainty for multi-year public health project planning and implementation.

With additional funding TECs would be able to increase capacity to provide the essential public health functions, and public health infrastructure. TECs would provide critical and timely data-related support to meet tribal health priorities, as identified in the Indian Health Care Improvement Act. (e.g. funds to support adequate number of biostatisticians, EHR programmer/analysts, epidemiologists, and data visualizers)

We request that the Administration prioritize Epi-Centers in its FY 2017 Budget Request. We also request that IHS work with the Centers for Disease Control and Prevention to ensure that funds available at that agency are also reaching the Tribal Epi-Centers.

One key component of this budget line item is access to basic quality preventative care. Tribes understand the commitment at HHS to require that federal funds be used to make meaningful impact on health outcomes. This will never be achieved if we must continue to use our scarce resources to meet basic

primary and urgent care needs. Our communities suffer from significantly higher mortality rates from cancer, diabetes, heart disease, suicide, tooth decay, and substance abuse. Preventative care programs help to stop these costly burdens before they start. Yet, with funds primarily directed to cover fixed and inflationary costs at the service unit level, little is left over to make significant, long-term progress toward the health of AI/ANs. This Administration can make a difference with targeted, funding going to Tribal communities. Furthermore, we recommend that Tribes have the flexibility to develop and implement their own preventative programs. Evidence clearly shows that culturally appropriate approaches ultimately have the best chance of success.

A critical component of realizing full potential of H&C is funding of new authorities under the IHCIA. The expanded provisions in this law represent a promise made by the federal government to improve greatly the health of our people, yet five years later, most of these new programs remain unfunded. This stands as yet another broken agreement by the federal government. Meanwhile, elders continue to go without care, preventative health in Indian Country lags far behind the rest of the country, and our clinics are woefully in need of qualified medical professionals. FY 2017 should be the year where the Administration commits to funding these authorities so that we can finally begin to see the impacts of a law that was over 20 years in the making. This special initiative should *on top of* base-level H&C funding.

#### **Health Information Technology (H&C) +16 million**

As the United States medical community is now adopting certified electronic medical records and reporting clinical quality measures electronically, the IHS is now in its 17<sup>th</sup> year (*for the 2018 budget*) of reporting electronic performance results for GPRA/GPRAMA clinical measures from IHS's electronic health record, the Resource and Patient Management System (RPMS). The future of quality reporting in the IHS is twofold: centralization of national, clinical performance reporting and alignment of clinical measures with national standard measures, where appropriate. This new direction aligns with the Affordable Care Act's *National Strategy for Quality Improvement in Health Care* (National Quality Strategy) as well as the HHS Measurement Policy Council's (MPC) efforts to align core performance measures.

Beginning in FY 2017, IHS will produce aggregated, clinical performance measure results from our new centralized Integrated Data Collection System Data Mart (IDCS DM) housed within IHS's National Data Warehouse (NDW). The IDCS DM will increase national performance data collection since performance results will expand to represent the IHS direct, tribal and urban (I/T/U) User Population. The IDCS DM will use all data exported to the NDW including RPMS and non-RPMS files as well as the data supplied by the fiscal intermediary. The same exports that are used to calculate IHS's User Population will be used to calculate performance results, which will reduce the reporting burden for I/T/U facilities. Users will be able to access secure, web-based reports that contain no patient identifying information – just aggregate numerators and denominators. IDCS DM reports will be as current as the last data refresh in the NDW, which occurs on a weekly basis. The IDCS DM will be a new, more efficient way to program and report clinical performance measures in a centralized location.

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 2017, the Workgroup recommends **\$10 million** to maintain current investments and an additional **\$6 million** to continue to implement meaningful use requirements at all remaining IHS operated facilities.

Information technology is essential to effective quality health care delivery and efficient resource management in the IHS system. Health care is information-intensive and increasingly dependent on technology to ensure that appropriate information is available whenever and wherever it is needed. Deployment of EHR requires additional resources to support Tribal and IHS hospitals and clinics, Area IT offices who provide technical support, and IHS headquarters, who develop the software applications and enterprise architecture, as well as security compliance.

The IHS I/T/U IT infrastructure includes people, computers, communications, and security that support every aspect of the IHS mission. The IT infrastructure platform is an architecture that incorporates government and industry standards for the collection, processing, storage, and transmission of information. The IHS I/T/U 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 the practice management third party billing package. 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: +\$37.2 million**

Dental health is a top Tribal health priority. The \$37.2 million increase includes inflation plus \$31.2 in program increases to address this growing health disparity. 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 IMPORTANCE OF THE DENTAL HEALTH AIDE THERAPIST MODEL

### **CASE STUDY: NW Portland Area Oral Disease**

Early Childhood Caries (ECC) is the most prevalent chronic disease of childhood and is five times more prevalent than asthma. Approximately 70 percent of AI/AN children experience dental decay in their primary dentition (baby teeth). Almost half of those children have severe ECC, which causes both pain and infection and can affect a child's overall health and well-being. A Washington State Department of Health survey evaluated the oral health status and treatment needs of children in Washington State. Compared with the survey's random sample of elementary school children, 37% of AI/AN children had a history of rampant decay, as compared with 15% of all children surveyed. The findings suggest a problem with dental access that is confirmed by IHS data showing that AI/AN children are served by fewer dentists, are less likely to be served by fluoridated water systems, and have greater treatment needs than the general population. In addition to the burden of disease, there is a tremendous backlog of dental treatment needs among AI/AN dental patients in all age groups. Unfortunately, sufficient staffing and facilities are simply not available to meet all the dental needs of the AI/AN population.

### **A National Solution: The DHAT 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.

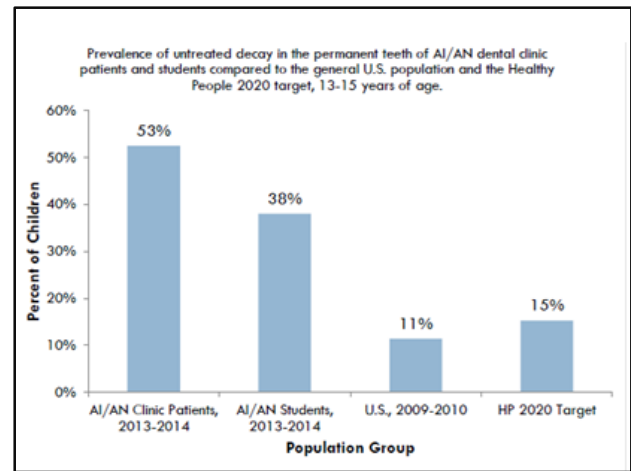
*The Workgroup strongly recommends that the IHS work to expand the use of DHATs throughout the I/T/U service delivery area by working within current law.*

According to the IHS, over 80 percent of AI/AN children ages 6-9 years suffer from dental caries, while less than 50 percent of the U.S. population ages 6-9 years have experienced cavities. AI/AN children ages 2-5 years exhibit an average of six decayed teeth, while the same age group in the U.S. population averages one decayed tooth. Furthermore, preventative care is one of the most critical aspects to ending dental disease for AI/ANs and we urge the Administration to support robustly preventative dental programming in its FY 2017 budget.

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.

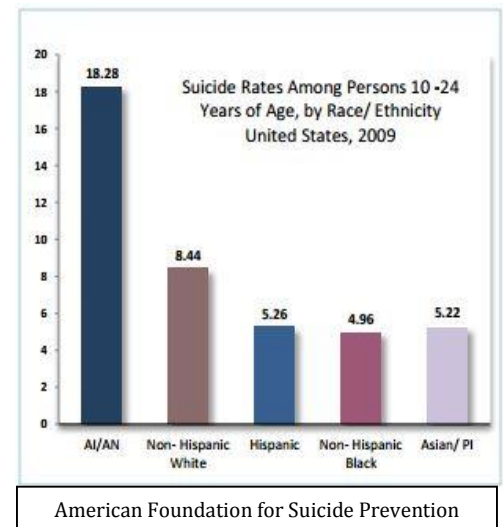
For the general U.S. population there are approximately 1,500 patients per dentist, while there are more than 2,800 AI/AN patients per dentist employed by the IHS and tribal dental clinics. It is essential that dental clinics serving the AI/AN population operate efficiently while also devoting time and dollars to the primary prevention of dental disease. Most dental professionals do not receive adequate training in terms of either clinic efficiency or community-based prevention.



**Mental Health: +\$70.4 million**

Tribal leaders identified that Mental Health is a top concern and recommended a **\$70.4 million** increase total (includes inflation and an additional \$67.5 million in program increases) above the Fiscal Year 2016 Budget Request. Without a major infusion of resources in FY 2017, 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 or outside the Tribal system.

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. AI/ANs suffer high rates of chronic exposure to stress<sup>3</sup>, which impacts the overall health and wellbeing of individuals and communities. Additionally many tribes recognize historical trauma, the cross-generational transmission of trauma from historical losses (e.g., loss of population, land, and culture), 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. New epigenetic research<sup>4</sup> provides support of physiological impact of historical trauma. These experiences, and the subsequent loss of traditional kinship systems, traditional language, spiritual practices and cultural



<sup>3</sup> R.A. Bulatao, NBe. Anderson Understanding racial and ethnic differences in health late in life: A research agenda. The National Academies Press, Washington, DC (2004)

<sup>4</sup>A. Crawford. “The trauma experienced by generations past having an effect in their descendants”: narrative and historical trauma among Inuit in Nunavut, Canada. Transcultural Psychiatry, 0 (0) (2013), pp. 1–31

## VISITING INDIAN COUNTRY

When President Obama and First Lady Michelle initially arrived on the Standing Rock Indian Reservation on June 13, 2014, they visited with a group of Lakota teenagers.

“Before we came here, Michelle and I sat with an amazing group of young people. I love these young people. I only spent an hour with them. They feel like my own. And you should be proud of them – because they’ve overcome a lot, but they’re strong and they’re still standing, and they’re moving forward. And they’re proud of their culture. But they talked about the challenges of living in two worlds and being both “Native” and “American.” And some bright young people like the ones we met today might look around and sometimes wonder if the United States really is thinking about them and caring about them, and has a place for them, too.

“There’s no denying that for some Americans the deck has been stacked against them, sometimes for generations. And that’s been the case for many Native Americans. But if we’re working together, we can make things better. We’ve got a long way to go. But if we do our part, I believe that we can turn the corner. We can break old cycles. We can give our children a better future. I know because I’ve talked to these young people. I know they can succeed. I know they’ll be leaders not just in Indian Country, but across America. And we’ve got to invest in them and believe in them and love them, and that starts from the White House all the way down here.”

President Obama also spoke to economic development, tribal sovereignty, education, justice, tribal courts and violence against women.

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.

Tribes, Tribal programs and direct service facilities are in various stages of implementing trauma informed care in their health care programs. Safety, trustworthiness, choice, collaboration, and empowerment are the core values of a trauma-informed culture of care. In 2007, the National Center for Health Statistics noted that AI/ANs experience serious psychological distress 1 ½ times more than the general population.

In 2013 (the most recent year for which data are available), 41,149 suicide deaths were reported in the United States, making suicide the tenth leading cause of death for Americans. That year, someone in the U.S. died by suicide every 12.8 minutes. At least 90 percent of all people who died by suicide were suffering from a mental illness at the time, most often depression. 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.

As an example, in Alaska, Alaska Native people were 5.1 times more likely to be hospitalized for a suicide attempts and self-harm than non-Natives statewide (2002-2010, 26.8 and 5.3 per 10,000, respectively,  $p<0.05$ ). Alaska Native people aged 20-29 years had the highest intentional injury death rate of any age group (133.4 per 100,000). The rate for this age group was 2.6 times the age-adjusted rate for all ages (51.6 per 100,000,  $p<0.05$ ). (*ANTHC epicenter*)

Unlike other groups where the suicide rate increases with age, AI/AN rates are highest among the youth and decrease with age. 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 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: +\$85.3 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 have once again identified it as a top budget priority for FY 2017. The Workgroup recommends a program increase of **\$85.3 million** over FY 2016 (for both inflation plus \$77.6 million for program expansion). 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.

From 2000 through 2013, the age-adjusted rate for drug-poisoning deaths involving heroin increased for all regions of the country, nearly quadrupled from 0.7 deaths per 100,000 in 2000 to 2.7 deaths per 100,000 in 2013. Most of the increase occurred after 2010 and the greatest increase is seen in the Midwest.<sup>5</sup>

These numbers are consistent with the reports throughout Indian Country about increases of heroin addiction. Also, with more stringent regulations around prescription opioids, more people are turning to heroin as a relatively cheap and apparently easy accessible alternative. Several hospitals in Alaska have seen an alarming increase of infants born in 2014 addicted to heroin. The growing use of heroin has spurred a resurgence of public health issues like Hepatitis.

Review of medical records from 2002 -2011

indicated that alcohol was documented as being associated with 63.2% of all intentional injury

*“I will tell you, as persuasive as I like to believe I might have been in coming up with solutions, I do not think I could match the conversation that the President and First Lady had with six Native American youth who told their stories. The things that the president is going to remember is not me yacking on about housing, I think their take away will be those six amazing youth leaders who have had life challenges that most people could only imagine. They experience things that children their age should not have to have been confronted with – whether it be experiences involving suicide, parental addiction or whatever else there was.*

*What I will really remember is a young Native American girl sitting next to Nicole Archambault the chairman’s wife who was literally shaking with excitement. When the president turned and looked at her, she burst into tears. It was a reminder to me, as the President and First Lady were spending that time there, they were demonstrating: ‘You children are valued and you are important, that is why we’re here.’ You could see that pride in the people that participated.”*

*Senator Heidi Heitkamp [D-ND]*

*Reflects on Historical Presidential Visit to North Dakota*

<sup>5</sup> Drug-poisoning Deaths Involving Heroin: United States, 2000–2013 Holly Hedegaard, M.D., M.S.P.H.; Li-Hui Chen, M.S., Ph.D.; and Margaret Warner, Ph.D

hospitalizations and 32.2% of all unintentional injury hospitalizations among AI/AN, based on blood alcohol and breathalyzer tests and other notes in the patient's medical record. Almost three out of five (57.5%) suicide attempt and self-harm hospitalizations among Alaska Native people were reported as alcohol-related.

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 in a more cultural appropriate manner. 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 programs have found successful. The Wellbriety Movement, based on the teachings of Native elders, includes a variety of holistic treatment programming for AI/ANs struggling with substance abuse. The term Wellbriety conveys both sobriety and wellness. The GONA (Gathering of Native Americans) process reflects the Native concept of the four levels of human development and responsibility, providing a structure for community gatherings addressing substance abuse. These are just 2 examples of cultural approaches that aid in healing.

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.

Domestic violence rates are alarming, with 39% of AI/AN women experiencing intimate partner violence—the highest rate in the U.S. 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. In addition to that, Section 714 of the Indian Health Care Improvement Act Provisions Passed in the *Patient Protection and Affordable Care Act* (P.L. 111-148), authorizes the establishment of a culturally appropriate program, in each IHS area, to prevent and treat Indian victims of domestic and sexual violence and perpetrators of domestic and sexual violence in Indian households.

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): +\$248.3 million**

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. For this reason the recommendation of \$248.3 million includes an inflation adjustment plus an addition \$200 million in new funding. 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.

As the national trend to attract and retain qualified healthcare providers continues to become more challenging, we see a correlation of increasing need for PRC referrals.

With current funding levels already insufficient to meet the demand, this exacerbates disparities in care and outcomes for AI/ANs. Additionally, 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 ensure that these funds to go further would be for PRC reimbursements to be paid 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.

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 appreciates the work that the Administration has done to move this issue forward through the rulemaking process and look forward to working with you as the rule moves forward. However, a statutory change would be a better option. Enacting legislation to require Medicare Like Rate payments for IHS PRC would guarantee access to care and ensure compliance with the rate.

We urge the Administration to work with Congress to see that this no-cost beneficial change is enacted.

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 meet patients' needs fully within even this one PRC service category. Many Tribes are 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: +\$3.1 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. The request includes inflation plus \$584,000 in expanded services.

**Health Education: +\$1.1 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. The request includes inflation over the FY2016 base plus \$457,000 in program expansion.

**Community Health Representatives (CHR): +3 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.

**51<sup>ST</sup> STATE FOR MEDICAID**

Access to PRC dollars also varies widely between IHS areas, due to the decision to expand Medicaid in some states and not others. For example, Albuquerque Area has noted that some facilities are now referring Priority IV cases when last year they were only referring Priority I cases, due to New Mexico's decision to enact Medicaid Expansion. Others, however, are not even meeting Priority I. AI/ANs in states like South Dakota, Oklahoma, and Alaska are held hostage by the state government's decision not to expand Medicaid.

This is a key reason why Tribes are asking for a 51<sup>st</sup> State for Medicaid for Indian Country that would be administered by the federal government. Allowing IHS or another federal agency to administer Medicaid rather than going through states would ensure that Indian People are getting the care they need. This would better articulate the federal government trust responsibility, circumvent states opting not to utilize Medicaid expansion, eliminate unnecessary pass-through expense to the states and provide all Tribes with an equitable level of service across the country.

With the opportunity provided under the IHCI, 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. The request includes inflation plus \$557,000 in expanded services.

**Alaska Immunization: +\$80,000**

*Hepatitis B Program:* Viral hepatitis, including hepatitis B, and other liver diseases continue to be a health disparity for AI/ANs in Alaska. The Alaska Native Tribal Health Consortium (ANTHC) Hepatitis B Program continues to prevent and monitor hepatitis B infection, as well as hepatitis A and hepatitis C infections, throughout the state of Alaska. In FY14, maintained high vaccine coverage was reported; hepatitis A vaccination coverage was 93% and hepatitis B vaccination coverage was 97%.

*Immunization (Hib) Program:* Immunization is a fundamental health prevention activity for Alaska Native people. In 1990, elevated rates of Haemophilus Influenzae B (*Hib*) among Alaska Native children prompted an immediate call to action for increased vaccination coverage, especially in Alaska Native communities with limited access to care. High vaccination coverage rates have resulted in a 99% reduction in *Hib* meningitis and vaccination coverage rates amongst Alaska Native children continue to be the highest in Alaska. The ANTHC Immunization Program maximizes the prevention of vaccine-preventable disease by providing directed resources, staff training, and coordination to tribes in Alaska. Support services also include site visits and consultation for the varying electronic health records (EHR) systems within each tribal health organization to facilitate immediate access to complete vaccine records. Dedicated immunization funding has ensured continued access to vaccines in Alaska Native communities and high vaccine coverage for Alaska Native children and adults. The request includes a small program increase of \$3,000 plus inflation of \$77,000.

**Urban Indian Health: +\$11.7 million**

Our request is for a program increase of \$10 million, plus inflation over the FY 2016 base, for a total of \$11.7 million. Thirty-six 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 \$43.6 million, which is less than 1% of the 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: +\$1.3 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

**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 2017 Budget.

contributes to a life expectancy of 4.2 years less for AI/AN individuals. Just over half of this request is for inflation proofing plus an additional \$564,000 to expand funding to address unmet need.

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 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.

Tribes continue to support efforts by the agency to engage in creative recruitment and retention practices for staff. However, more needs to be done. Some IHS Areas experience vacancies for medical professionals up to five years. In the long-term, this means that clinics close, thereby denying care to AI/ANs. With a nation-wide physician shortage, this problem is only likely to grow. It is vital that the Administration work with Congress to be able to offer competitive pay rates and better working environments.

### **Tribal Management Grants: +\$49,000**

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.

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 carry out effectively these PSFAs.

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 material audit weaknesses.

### **Direct Operations: +\$1.2 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. The request includes inflation plus \$128,000 for expansion of services.

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. Funds should be specifically allocated in FY 2017 to support technical advisors and meeting travel for these consultations.

### **Self-Governance: +\$421,000**

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 IHCIA, 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. The request includes inflation plus \$328,000 to expand Self-Governance support in FY 2017.

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 Budget

The Workgroup recommends a program increase of **\$48.5 million** for Indian Health Facilities over the FY 2016 President's Budget and **\$100 million** to address Binding Agreements for pending Health Care Facility Construction projects for a total increase of **\$148.5 million**.

### **Maintenance & Improvement (M&I): +\$23.5 million**

The recommended amount represents a program increase of \$23.545 million (\$2 million in current services +\$21.5 million in program increases) above the FY 2016 President's Budget request for the M&I line item of \$89 million. All Tribal Area budget formulation sessions reported the critical need for a program increase in this category. The recommended M&I funds increase are to support and enhance the delivery of health care and preventive health services and to safeguard interests in real property. M&I funds are distributed to four categories: routine maintenance, M&I projects, environmental compliance and demolition. Routine maintenance funds are used to pay for the following typical maintenance activities: emergency repairs, preventative maintenance activities, maintenance supplies and materials, building service equipment replacement, training, and local projects. This amount is also referred to as "sustainment" or the amount necessary to sustain a facility in its current condition. M&I Project Funds are for larger projects that accomplish major repairs and improvements of primary mechanical, electrical, and other building systems as well as public law compliance. Environmental compliance and demolition funds are distributed by headquarters to the Areas with approved project documents.

Maintenance and improvement funding allocated to the Areas is based on the total supportable space of eligible IHS programs. The Indian Health Service has approximately 1,371,000 square meters of supportable space, federal and tribal, eligible to receive maintenance and improvement funding. Based on the total amount of M&I available and the total amount of supportable space eligible for M&I funding IHS is at "sustainment." The IHS is only able to fund routine maintenance. There is no funding available for M&I projects. The IHS has a documented Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) for each facility eligible to receive M&I. The total amount of BEMAR for IHS is approximately \$467 million. Therefore, increased funding is needed, to continue to address routine maintenance, address environmental compliance, energy reduction projects and to start to reduce the BEMAR.

Increased maintenance and improvement funding will also allow IHS to improve infrastructure, building systems (boilers, emergency generators, chillers, etc.) of health facilities. The increased funding will allow facilities to replace aging generators, boilers, chillers, HVAC systems, electrical systems, and plumbing systems. Renovating and upgrading the existing building infrastructure will extend the useful life of existing buildings allowing health care services to continue. Keeping existing facilities in excellent condition is a number one priority since funding for new health facilities is very limited. Increased funding allows facilities the ability to renovate, expand and improve buildings and building systems to keep up with the utility requirements for state of the art medical equipment thus ensuring enhanced medical care to all Native Americans and Alaska Natives.

The mission of the IHS is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. Ensuring that the Indian Health Service has well maintained, adequate sized and current up to date infrastructure to provide health care is ensuring the physical, mental, social and spiritual health of American Indians and Alaska Natives is raised to the highest level.



### **Sanitation Facilities Construction (SFC): +\$16.3 million**

The recommended amount represents a \$16.339 million increase (\$2.4 million in current services for binding agreements + \$21.6 million in program expansion) above the FY 2016 President's Budget of \$115 million for the SFC line item. Due to the remoteness of Tribal communities and lack of infrastructure, the need for improvements and maintenance of water supply, sewer systems and solid waste facilities remain substantial. The SFC program is an important Indian health disease prevention program. It yields positive results by directly improving environmental conditions making a positive impact on the health of individuals on a day-to-day basis thereby reducing medical care costs.

IHS reported in the FY 2016 Congressional Justification that at the end of FY 2014, the list of documented sanitation project deficiencies totaled \$3.39 billion. Of these projects, \$1.93 billion is the amount needed for projects considered economically and technically feasible. It was reported that about 217,000 or approximately 56 percent of AI/AN homes need improvements and that about 6.1 percent of the homes are without potable water.

For years, the appropriation level has not been sufficient to address the backlog. A \$13.9 million increase, however, would help many families improve their lives by providing water wells or connecting their homes to community water and waste water systems and upgrading and maintaining these systems. These projects would be prioritized from the IHS Sanitation Deficiency System inventory.

The provision of sanitation facilities is an extension of primary health care delivery. The availability of essential sanitation facilities can be a major factor in breaking the chain of waterborne communicable disease episodes but by no means is their value limited to disease intervention. Safe drinking water supplies and adequate waste disposal facilities are essential preconditions for health promotion and disease prevention efforts. Efforts by other public health workers are much more effective when safe water and adequate wastewater disposal systems are in place.

Patients admitted to the hospital have longer lengths of stay due to lack of sanitation facilities at home. An example of this is an elderly patient with a broken hip who should be discharged home but has no indoor water and sewer facilities and typically uses an outhouse located a long distance from the home. Many of these patients end up being admitted to off reservation nursing homes where exposure to nosocomial infections may worsen the chance of good outcome and return home.

The provision of sanitation facilities also has other far-reaching, positive effects. The availability of such facilities is of fundamental importance to social and economic development. In turn, such development leads to an improved quality of life and an improved sense of well-being.

A recent cost benefit analysis indicated that for every dollar IHS spends on sanitation facilities to serve eligible existing homes, at least a twentyfold return in health benefits is achieved. The IHS Sanitation Facilities Construction Program has been the primary provider of these services since 1960.

The IHS Areas that Tribes reported significant need to increase the SFC line item include Alaska, California, Navajo (AZ, NM, UT), Phoenix (AZ, NV, UT), Portland (OR, WA, ID) and the Tucson Area in southern Arizona.

### **Health Care Facilities Construction (HCFC): Binding Obligations: +\$100 million & New Authorities: +\$7.56 million**

The recommended increase for the Health Care Facilities Construction line item is \$100 million above the FY 2016 President's Budget request. Tribes are keenly aware that the lack of facilities is a major barrier to access to adequate health care in Indian Country. This could easily be remedied by increasing the funds necessary to begin construction of projects listed for decades on the IHS HCFC priority list and, additionally, by advancing partnerships with Tribes to implement a new national health care facility planning and construction system. Both are required under the Indian Health Care Improvement Act. Dedicated resources for construction should be one of the highest priorities of the Administration and is necessary to improve quality of health care for AI/AN. Some of the existing facilities are very dated with an average age of 47 years and have surpassed their useful lives. The facilities are grossly undersized for the identified user populations, which has created crowded, even unsafe, conditions among staff, patients, and visitors. In many cases, the management of existing facilities has relocated ancillary services outside the main health facility; often times to modular office units, to provide additional space for primary health care services. Such displacement of programs and services creates difficulties for staff and patients, increases wait times, and create numerous inefficiencies within the health care system.

While the total amount identified currently for HCFC projects exceeds \$2.1 billion, an additional \$100 million would allow one or two additional projects to complete design and progress through construction. In addition, new IHS funded health facilities in remote and isolated areas typically must include a request to include funds to construct government quarters to provide suitable housing to support the recruitment and retention of medical professionals and ancillary staff.

Lastly, of major concern to Tribes who do not have projects on the priority list, is the number of years and the amount of funds it will take to complete these projects before they can even get on the priority. The IHS Health Facilities Construction Priority System (HFCPS) or Priority List is the assembly of "justified" projects dating back to 1994.

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 \$7.56 million is requested in FY 2017 for this purpose.

Ten of the 12 IHS Areas support this level of increase to the HCFC line item. Three Areas, Navajo, Phoenix and Tucson indicated it was a major priority. Three Areas, Billings (MT, WY), Phoenix and Portland noted that Tribes would benefit by funding New Authorities.

### **Facilities & Environmental Health Support (FEHS): +\$8 million**

A recommended increase of **\$8 million** (\$7.5 million for current services and \$438,000 in program expansion) is sought for this line item. The FEHS staff provides important levels of support to operate and maintain the real property and buildings in the Indian health care system. In addition, these professionals plan and design new and replacement facilities projects and support sanitation facilities construction and environmental health services activities.

A new health facility improves access to care and the quality of care by improving the design (functionality) and increasing the size of facilities to better support existing and new health services. When new IHS health facilities are approved for construction, the subsequent staffing packages provide additional providers and improved access to basic and expanded health care services. In addition, new IHS funded health facilities in remote and isolated areas typically include the construction of government

quarters to provide suitable housing to support the recruitment and retention of medical professionals and ancillary staff.

FEHS staff ensures that the IHS continues to demonstrate its commitment toward quality health care by maintaining their facility accreditation/certifications, undertaking quality improvement initiatives, and meeting established quality performance targets. A number of facilities seek The Joint Commission accreditation or Centers for Medicare and Medicaid Services (CMS) certification.

**Equipment: +\$6.2 million**

Tribes recommend a program increase of **\$6.2 million** (current services at \$1.2 million and program expansion of \$5 million) for Equipment above the FY 2016 President’s Request of \$23.5 million. Equipment funds are critically needed for new and routine replacement of medical equipment, to obtain new and like-new medical equipment through the Department of Defense and to procure ambulances for IHS and Tribal emergency medical services programs. 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 some of the cases to PRC providers. An important investment must be made to allow IHS and Tribal facilities to acquire telemedicine and Electronic Health Record technologies. The last significant increase to purchase equipment came through the 2009 American Reinvestment and Recovery Act (ARRA), in which a portion of ARRA funding was used for this purpose. Since then subsequent allocations have not kept pace with replacement requirements which are necessary to ensure quality care and the safety of our patients.

For example, as the existing health care facilities continue to age, the associated building equipment and components deteriorate to a point of failure and the decreasing availability of replacement parts on this aged equipment ultimately disrupt the already limited health care services. The piping systems providing potable water for health services frequently experience failures, which require the shutting down of systems for extended periods of time and patient care is disrupted until appropriate repairs can be made. The rural and often isolated conditions associated with many IHS health facilities complicates the repair of failed systems and extends the time required to make needed repairs. The constant system failures deplete designated maintenance and improvement funds and require the use of third party collections or other funding sources that would otherwise be used for direct patient care. In terms of medical and laboratory equipment, the IHS makes every attempt to keep pace with changing and updated technologies; however, as a result of limited equipment funds, IHS health facilities typically use equipment well beyond its expected useful life.

**❖ 3<sup>rd</sup> Recommendation: Higher Increase in H&C for Local Priorities**

This recommendation addresses an emerging concern expressed by Tribes that the roll-up of budget priorities at the national level, coupled with the formula-basis used to distribute appropriated funds, restricts the ability of Tribes to have access to non-formula funds to address local health issues. Local priority health issues and budget priorities are identified within the Hot Topics section of this document for each IHS Area. Congress no longer has the ability to “earmark” funds to address local health crises in their districts, and often times local health crises do not rise up to a level of a national health initiative like the Special Diabetes Program for Indians. As such, an innovative approach must be created to allow the flexibility needed to fund critical health issues identified by Tribes within each Area. This request includes

an additional increase within the Hospital & Clinics budget line, which can be used by the agency, in consultation with the Tribes, to address these local budget needs.

Examples of local priorities that never make it to the national level for funding include the village built clinic lease issue in the Alaska Area, the methamphetamine in pregnant women crisis in the Billings Area, the STD/HIV prevention and screening for Tribal jails in the Navajo Area, and the need for Detox services in the Phoenix Area, among others. The Indian Health Service does not have any flexibility in existing budget lines to address local issues. Providing an additional amount within the H&C budget line would provide resources needed to address crisis level issues, which impact the life and safety of Tribal communities.

#### A CASE STUDY: IMPROVING HEALTH THROUGH EQUITABLE FEDERAL FUNDING FOR INDIAN COUNTRY

As a means of targeting improved health for Indians, one example is the need to request special allocation of funds for Hepatitis C Virus (HCV) similar to what has been provided to the VA. Beginning at a small scale in 2014, select IHS, Tribal and Urban facilities began treating American Indian and Alaska Native (AI/AN) people for HCV with the class of Directly Acting Antivirals (DAAs) recently approved by the the Food and Drug Administration. These drugs represent a breakthrough. Prior to the introduction of the new high-cost treatment therapies in January 2014, the treatments for Hepatitis C were often ineffective and presented considerable side effects to the user. By contrast, new DAAs are more effective at curing patients with HCV, present significantly fewer side effects than earlier options, and are much simpler to administer. Cure of HCV significantly decreases the risk of progression of disease to cirrhosis, liver failure, liver cancer, and death. IHS wants to ensure all AI/AN with HCV can access treatment. The new DAAs, as with all, are expensive even with federal discounts, which is a significant barrier to initiating and scaling up treatment in proportion to the clinical needs of our patients. IHS requests similar funds to scale as what was allocated to the Veterans Administration for HCV treatment in 2014 (370 million) and what they requested for 2015-2017 (697-660 million). IHS requests 95 million in 2016, 180 million in 2017 and 170 million in 2018, projecting treatment of 1,500 people in 2016, 2,800 people in 2017 and 2,650 people in 2017.

*The Workgroup urges the Administration to begin supporting IHS as it does VA, starting with increased funding for the FY 2016 Budget and including amounts for FY 2017 and FY 2018.*

#### ❖ 4th Recommendation: Fund Indian Health Care Improvement Act New Authorities at \$300 Million

The implementation of the Indian Health Care Improvement Act (IHCIA) remains a top priority for Indian Country. IHCIA 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 IHCIA. Tribes fought for over 10 years to

renew IHCIA and the Administration and Congress should act to fulfill the promise enacted by the 2010 law.

Tribes recommend that IHS reprogram existing resources to take advantage of these new authorities that would be more beneficial for their communities, when requested and consulted. The battle for IHCIA 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, five 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 IHCIA. For example, mainstream American health care increased focus on prevention as a priority and coordinated mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs is now standard practice. Replicating these same improvements for Tribes in the IHCIA was a critical aspect of the reauthorization effort. The time and resources paid off with the permanent reauthorization of IHCIA. Highlights of what is contained in the IHCIA 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.

One key component is supporting the health professional development in Indian Country. For instance, Section 112 of the law which Authorizes the Secretary to fund demonstration programs for Indian health programs to address chronic shortages of health professionals. This could go a long way in ending the chronic lack of health professionals in Indian Country. Additionally, the law authorizes the establishment of a mental health technician program within IHS to train Indians as mental health technicians to provide community-based mental health care to include identification, prevention, education, referral, and treatment services.

An additional \$300 million will only begin to scratch the surface of implementing these new budget authorities. While we understand the tight fiscal constraints that govern the budget request, it is crucial for the Administration to begin to make these funds a priority in next year's budget. With a direct request to make this a priority from the Administration, Congress is much more likely to provide funding for these critical programs in FY 2017.

### ❖ **5<sup>th</sup> 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 a staggering \$220 million left the IHS, which already is under funded by an average of 41%. 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 direct service 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 forced others to deliver only PRC for Priority I. The Indian Health Service is one of only four federally funded services providing direct patient care; however, it was the only one of the four, not exempted from sequestration. This oversight, which created an unsafe hardship for Indian patients seeking care, must be permanently corrected.

For fiscal years 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 <sup>1</sup>
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: <sup>1</sup> 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.

**❖ Other Policy Recommendations**

*Advance Appropriations for the Indian Health Service*

For several years, Tribes across Indian Country have voiced their support for Advance Appropriations for the Indian Health Service. An advance appropriation is funding that becomes available one year or more

*“We need to ensure that the health of Indian people is not subject to the whims of political stonewalling, much like it was during the recent government shutdown and sequestration.”*

*- Senator Jon Tester (D-MT), Senate Committee on Indian Affairs, April 2, 2014*

after the year of the appropriations act in which it is contained.<sup>6</sup> This means, that IHS and Tribal health providers would not have to have funding inconsistency or disruption when managing their health care delivery. Currently, our programs must make long-term health care decisions with only short-term funding guaranteed.

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. IHS and Tribal health 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.

For example, in Alaska, short-term funding means basic operating costs are more expensive. Heating oil is a major expense in this region, but it is cheaper if you buy in bulk in September, rather than buying in bits and pieces as continuing resolutions come out from Congress. In September, health providers can buy oil that is pulled in by barge, but by November or December the oil must be flown in which dramatically increases the cost. Indian health budgets operate on the margins and delayed appropriations make this situation even worse. No private health provider would operate this way, and I/T/Us should not have to either.

The Veterans’ Administration (VA) achieved advance appropriations for its health programs in 2009. That legislative change received support from this Administration. 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.

*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 2 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,

*“Now, the care that our veterans receive should never be hindered by budget delays. I’ve shared this concern with Secretary Shinseki, and we have worked together to support advanced funding for veterans’ medical care. What that means is a timely and predictable flow of funding from year to year, but more importantly, that means better care for our veterans.”*

*- President Barack Obama, April 9 2009*

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<sup>6</sup> 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.

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 the federal government 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 2 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

This Administration has in its power the historic opportunity to write a new future for American Indians and Alaska Natives. Finding a relatively miniscule \$29.96 billion out of the annual federal budget to improve the health status of its First citizens will not only turn the corner in Indian health treaty and trust obligations but it is the *right* thing to do. The human impact on this nation's first people will be immediate and profound. Not only will monumental strides be made to honor the Trust responsibility accepted by the U. S. Government in past treaties and agreements with Tribal Chiefs and sovereign Tribes, but also President Obama and his administration will leave a legacy, which will represent an epic advancement in the traumatic history between U.S.-Tribal relations.

Like Congress, this Administration understands that 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 the power to honor these treaties by advancing a budget which meaningfully addresses gross health disparities and which offers a true promise of hope for 1.2 million Tribal members. President Obama *must* leave his legacy by *acting now* to provide a meaningful increase of *at least 22%* for the IHS in FY 2017 and to put into action a plan for future Administrations to fund 100% of our \$29.96 Billion Tribal Needs budget.

Americans, who understand the history of the U.S. and Tribal relations, strongly support the need for our government to honor the treaties made with sovereign Tribes. Those who have met with Tribal leaders are surprised that such deplorable health conditions continue to exist on reservations and in villages; many have expressed a willingness to partner with Tribes to advocate for change. They understand the injustice of continuing to disregard the health and lives of all Native Americans who have paid with their lives, their lands, and their sovereign rights. Future generations of Americans will hold our government in account for its responsibilities to American Indians and Alaska Natives. It is time to end the unnecessary death and suffering occurring every day in Indian communities – centuries of neglect are now an urgent humanitarian cry for justice and equity for our First Peoples. Our Native youth deserve a chance at a better future. Our elders deserve the rest and peace that comes with knowing their fight is over. Our country deserves the honor of living up to its morale and binding obligations to American Indians and Alaska Natives.

## **WORKING TOGETHER NOW— WRITING A NEW FUTURE FOR INDIAN HEALTH**

We urge you, as our President, to resolutely turn the corner in Indian Health Treaty and Trust obligations and write a brighter new future for all American Indians and Alaska Natives.

Together, we have the collective power to work with an informed Congress to make measurable improvements in the health status and quality of life of America's First Peoples. You have heard our people voice emotional and desperate concerns during numerous Tribal consultation sessions. You have witnessed the innocent hope in our youth contrasted against the growing weariness of our elders. You have empathized with despair felt when socio-economic conditions and lack of funding challenge the best of the best of our Tribal leaders. You can re-write the future. In this constrained environment, Congress relies on the Administration to exercise its duty to recommend a responsible budget, one which reasonably addresses the disparate healthcare needs of American Indian and Alaska Native peoples. Working within

the Budget Control Act constraints, Tribes can no longer rely solely on Congress to right size to our budget unmet needs. The Administration must work with Tribal leaders as partners to set a new path forward.

As this and future Administrations move to reform America's health care system, it is imperative that Tribes not continue to be left behind. With the right resourcing, the Tribal health system can be the model for true, low-cost sustainable health care delivery. A budget of 22% in FY 2017 with a strategy to phase-in the \$29.96 billion is necessary to achieve reform within the Indian health care system and raise health parity for all American Indian and Alaska Native citizens. We understand that this presents a fiscal challenge, but we believe in the President and our Great country's valiant commitment to justice. 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 turn the corner and write a new and better future for American Indians and Alaska Natives.***

*“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

## ACKNOWLEDGEMENTS

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**Special thanks to all IHS  
Staff, especially the IHS  
Budget Formulation staff,  
for assistance in preparation  
of this document.**

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## APPENDIX

### ❖ APPENDIX A: HOT ISSUES BY IHS SERVICE AREAS

#### ALASKA

##### **ISSUE: Village Built Clinic Lease Program Shortfalls**

The Village Built Clinic (VBC) lease program is a unique and critical component of the health care delivery system in rural Alaska. The delivery of quality health care is dependent on having a well-maintained clinic facility. Obtaining adequate and fair funding for the VBC lease program has been a priority of the Alaska Tribal Health System (ATHS) for many years. The dramatic increases in energy costs in rural Alaska have accentuated the funding crisis. We are requesting that IHS fully fund the VBC leases at \$17 million.

VBC leases, administered by the IHS, are used to fund of the costs associated with health clinics in rural Alaska. VBCs are the sole health care facilities for their communities in the vast, predominantly road-less regions of rural Alaska. Current funding levels for the VBC leases provide only a fraction of the operations costs resulting in deteriorating clinic buildings, reduced operations, deferred building maintenance, accreditation compliance problems and ultimately a threat to the provision of safe patient care in the villages. In some cases, there is no running water to the clinic. It's difficult to imagine it's a reality that there are instructions on how to provide a urine sample in an outhouse at these clinics, bearing in mind that these are in areas where temperatures are often at subzero levels, but reality it is. Even in clinics with running water they must often choose between paying for heating oil or janitorial services (or other maintenance/operation expenses as highlighted later), which adversely impacts patient/provider health and safety.

**BACKGROUND:** Community Health Aide Program (CHAP) – Alaska Native people in rural communities depend on local health clinics as their only source of primary health care. The CHAP is mandated by Congress as the instrument for providing basic health care services in remote Alaska Native villages. The CHAP is the backbone of the rural health care system and in many cases provides the only local source of health care for many Alaska Native people. Certified Community Health Aide/Practitioners, Dental Health Aide Therapists and Behavioral Health Aide/Practitioners provide ongoing services based out of the village clinic facilities. In addition, medical, dental, eye care, and behavioral health professionals itinerating to the villages from the regional hospitals use the clinics.

Alaska has about 170 VBCs, generally owned by the local city, tribal government or the regional tribal health corporation serving that community. The IHS leases the clinic facilities in order to provide clinic space for the CHAP. Unfortunately, years of underfunded lease payments have left many of the clinic facilities in disrepair, and in some cases closed. Rural Alaska was fortunate that many of the clinics were upgraded or replaced through partnership between the clinic owners and the Denali Commission. Unfortunately, continued underfunding of the VBC lease program will also jeopardize this investment in our communities.

**CHRONIC UNDERFUNDING:** Since the mid-1970s, the IHS has consistently under-funded the VBC leases. The last significant increase to the program occurred in 1989, at which time the number of clinics funded was also increased. VBC lease program has not received an increase to its base since then. In FY 2006, a study showed the lease payments to the villages covered only 55 percent of operating costs statewide. The costs of doing business in rural Alaska have increased tremendously since then. In order

to hold the system of care together, financial responsibility for the village clinics has shifted from the IHS to the village governments and/or regional health corporations.

**MAINTENANCE AND OPERATIONS:** VBC leases are “Full Service Leases” which cover most basic expenses involved with maintenance and operation of the clinic facilities. Those expenses include basic rental costs (loan amortization/depreciation, fuel, electric, water/sewer/refuse, janitorial services/ supplies, maintenance and repair services/supplies and building insurance). In 2011 the IHS developed revised Guidelines for Environmental Health Practices at Village Health Clinics to provide a tool for annual inspections of the VBC-leased Facilities. For most clinics, the IHS lease monies do not cover the actual cost of fuel, electricity, and water/sewer bill let alone provide funds sufficient to maintain a high quality healthcare environment.

## HOT TOPICS BY IHS SERVICE AREA

This crisis in funding clinic operation and maintenance costs now threatens decades of investments by the federal government, rural Alaska villages, and regional tribal health organizations.

**RECOMMENDATION:** The Alaska Tribes request an increase of recurring funding (currently at \$4.5 million/year) to the IHS in the amount of \$12.5 million (for a total of \$17.0 million/year), to adequately fund operation and maintenance of VBCs leased by the IHS in rural Alaska.

### **ISSUE: IHS Advance Appropriations**

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.

**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.

### **ISSUE: Contract Support Costs**

In the FY2016 Budget Request to Congress, the Administration has proposed that Contract Support Costs (CSC) be transitioned from the discretionary budget to the mandatory category. If the proposal were enacted, CSC would be made mandatory for three years, (FY2017-FY2019) with increases each year to account for the estimated growth in future CSC need. The funding would also be reclassified as “no year” funding and therefore available to be carried over in future years. This legislative change will guarantee legal compliance to fully pay CSC, while ensuring that these payments do not take limited funds from the other areas of the IHS services budget.

**BACKGROUND:** CSC are the funds that Tribes and Tribal organizations receive from the government to manage health and other programs that were previously operated by the federal government. The CSC funding obligation should not have been achieved at the expense of other Tribal programs.

**RECOMMENDATION:** For FY 2015 and beyond, Tribes are requesting that Congress continue to fully fund CSC without requiring cuts from other IHS programs. Furthermore Alaska tribes advocate for enacting the transition to Mandatory funding of CSC as early as FY2016; and ensure that Direct Services budgets at IHS are not impacted by this change.

### **ISSUE: Long-term Care/Eldercare**

Alaska tribal health organizations are opting for nursing rather than assisted living because the rates are cost-based in Alaska. More tribal health 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.

**BACKGROUND:** The authority for IHS to offer and fund long-term care services presents great promise for meeting the needs of our Elders and those with disabilities. 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.

**RECOMMENDATION:** Alaska tribes urge the IHS to target funds to implement LTC services as authorized under the IHCA. There is also a need to support and coordinate the efforts of IHS and the Centers for Medicare & Medicaid Services to address reimbursement and certification/regulatory issues.

## HOT TOPICS BY IHS SERVICE AREA

### **ISSUE: Behavioral Health**

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. Alaska also continually ranks as one of the most dangerous states for women with regard to victimization of intimate partner or sexual violence. Alaska has one of the highest alcohol consumption rates per capita in the nation. Evidence suggests that individuals that are addicted or abuse substances—use this as a coping mechanism to deal with a history of trauma. All of which culminate to create a cycle of violence, trauma, abuse, that perpetuates from one generation to the next and impacts the health and wellness of entire communities not in a domino fashion from one to the next, but in wave fashion extending from the center and heaving outward and all around and catching all in its wake.

Behavioral Health services provide a net that can catch the boulders before they strike. These services also build retaining walls to help protect family, friends, and communities when calamity does strike. Behavioral health directly affects physical health and is key to a holistic approach to wellness and improving the overall health of our People and our Communities. Alaska tribes have three recommendations:

#### Combine Mental Health and Alcohol & Substance Abuse Line Items

Behavioral Health is a more holistic view on caring and treating both mental health and alcohol & substance abuse. The delineation pits one area above the other in priority, which on the local level can vary greatly with the national averages. This hinders programs in ability to address one or the other. It also hinders taking an integrated approach by creating silos of care.

**BACKGROUND:** While individuals may have a mental health disorder without a substance use disorder and vice versa, a substantial number of individuals suffer co-occurring disorders and for those who don't have a co-occurring disorder, they are at higher risk of developing a co-occurring disorder.

**RECOMMENDATION:** In the interest of preventative care, and holistic approaches and granting tribes the ability to be responsive to their needs with regard to behavioral health, Alaska recommends that the two separate line items, mental health and the Alcohol & Substance Abuse line items be combined into a single line item.

#### Increase funding for Tele-Behavioral Health

**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. VTC offers promise, but some areas still require infrastructure development. In many villages digital connectivity is non-existent or rely on a satellite-based Internet system that is slow and unreliable. According to the Federal Communications Commission nearly 81% of rural Alaska residents lack access to modern broadband services with sufficient speed needed (new benchmark of 25 megabits per second for downloads) for high quality voice, data and video.

In Alaska there is real difficulty in 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. Therefore Tele-behavioral health is a significant and crucial component to the spectrum of resources within Alaska's Behavioral Health programs.

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

#### Increase funding for Behavioral Health Workforce Development (Staff Recruitment & Retention)

**BACKGROUND:** 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 trauma, substance use and mental illness.

However, traumatized individuals or those with substance use and/or mental health disorders experience difficulty trusting others, including behavioral health providers, to begin their healing processes. This is exasperated by staff turnover. 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.

## HOT TOPICS BY IHS SERVICE AREA

**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.

### **ISSUE: Special Diabetes Program for Indians**

Few programs have proven to be as effective as the Special Diabetes Program for Indians (SDPI) has proven to be. Tribes are implementing evidence-based approaches that are attesting to the improvement of quality of life, lowering treatment costs, and yielding better health outcomes for tribal members. However, the disparities still exist. The progress made as a result of the SDPI is at risk due to shorter authorization periods, flat funding and more tribes needing access to SDPI funds. As reported in the *Indian Health Service Special Diabetes Program for Indians 2011 Report to Congress*:

*SDPI not only provides the resources that enable the 404 grant programs to employ hundreds of health care professionals but also supplies the tools that help hundreds more receive training in delivering quality diabetes services. This strong network of professionals has dramatically increased access to diabetes medical care and prevention services for tens of thousands of American Indian and Alaska Native people.*

*SDPI resources put a spotlight on diabetes. These resources enable local communities to concentrate on providing essential services to prevent and treat diabetes—services that are not often reimbursable by third party payers. The spotlight on diabetes would fade quickly without SDPI funding as communities would not have the resources to deal with the diabetes epidemic.*

**BACKGROUND:** The flat funding has meant that the existing programs have already lost purchasing power. Diluting the funds further to include more tribes would adversely affect the current programs.

**RECOMMENDATION:** Alaska Tribes request for a minimum increase of \$50 million for a new total of \$200 million. Current programs should be held harmless and with the additional funds, allow for tribes not currently funded to apply.

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## ALBUQUERQUE

At the Albuquerque Area's 12/ 15/14 consultation, the tribes were concerned that only the top 5 priorities would be considered at the National Session. The tribal representatives agreed to choose the top 5 based on the number of service units that voted for the line item, but there were additional line items that received votes that weren't in the top 5. The Albuquerque tribes wanted to insure that these were also considered as priorities for the Albuquerque Area. Budget Narratives for these additional topics have also been attached. Additional priorities in order of votes for the Albuquerque Area tribes were:

- M & I
- Health Care Facilities Sanitation Facilities Urban
- Health Ed CHR
- Contract Support Costs
- Equipment
- PHN
- Self-Governance

The Ute Mountain Ute Tribe recognizes that such items as Maintenance & Improvement, Sanitation Facilities Construction, Health Care Facility Construction, and Equipment are severely underfunded. The Tribe recognizes that the current facilities are aging (most over 30 years versus the private sector which is well under 10 years of age). It is not only just the age of the facilities which require significant funds to maintain but the inefficient design which hinders efficient patient care. Please also note that the overall lack of space is preventing the hiring of additional providers.

## HOT TOPICS BY IHS SERVICE AREA

The ASU tribes agreed that the Health Care Facilities Construction Line Item has been underfunded for many years. Funding to support the construction of new facilities of the IHS is needed to support current services and the expansion of additional prevention and outreach.

Some IHS facilities are (or have) reached critical mass in age and they need to be replaced with new modern buildings. The old buildings and structures make it difficult to provide basic services. The older buildings were not designed with expansion in mind and therefore it is difficult (or too expensive) to modify older building to increase access to care; adding more exam rooms and office space. The outdated design of older buildings often times contributes to poor patient/work flow which creates bottlenecks in flow process and inefficiencies throughout the service line including high heating and cooling costs. Limited access and poor work flow not only delays care it can also prevent care. The lack of access to care also limits the ability for the Service Units to generate and collect much needed third party revenue. This revenue is needed in many cases to supplement the annual appropriations.

The need for new, modern, up to date facilities ranging from dental offices to full service hospitals is dire within service unit areas, specifically in remote and rural communities. The ASU campus was built in the early 1930s; the facility was initially created as an inpatient hospital, it is now used as an ambulatory care clinic. The design is outdated and is not conducive to easy access and clinic flow. Many of the IHS facilities are outdated and should be replaced with modern structures. Additional funding will help with providing more new construction throughout Indian Country.

The Pueblo of Laguna specifically supports the Joint Venture (JVC) program. Replacement and repair of health care facilities within tribal communities is a critical need to ensure the provision of quality health services. Many facilities on reservation are older than 40 years in age and retrofitting and renovation are not cost effective.

The Mescalero Apache Tribal community lacks adequate water & sewer services to serve about 35% of the tribal members that require the service for new homes. There is a waiting list for members to obtain services.

The To'Hajiilee community has a poor domestic water system which creates health problems and diseases due to lack of potable water and adequate sewer systems. As a result, the local people have to haul potable water from Albuquerque in water barrels for drinking, cooking and other domestic use. The Indian Health Service started to develop the domestic water system in the 1960's and over the next 40 years expanded the system to serve 375 water customers. The Canoncito water wells are very shallow and require a lot of maintenance due to the infiltrations of sand into the pumps and casings.

The water quality is also very poor and has a very bad smell. In the early 60's the IHS had the contractors use asbestos water lines as the main trunk lines for 8 miles and today these asbestos pipes are still in use. This is another reason people don't drink the water. For the 17% budget increase, Canoncito allocated \$61m for the budget line items Sanitation Facilities Construction to improve water and sewage systems.

The Zuni tribe stated that the \$325 million being recommended under the Binding Obligations is insufficient to cover all needs. The RNSB, Inc. had a water emergency situation due to their water system constantly going down. The Pine Hill Health Clinic ceased seeing patients until such time its water pressure is at an acceptable level. The Ramah Navajo community water system had been installed by Indian Health Service and the Bureau of Indian Affairs over thirty (30) years ago. The water system has lived its useful life making it difficult and expensive to operate and maintain the systems. In addition, the EPA has cited numerous violations regarding the Pine Hill water system. EPA has threatening the operations of the health center and the school system.

As for the Pueblo of Zuni, the tribe will be constructing a new elementary which will combine the enrollment of the two present schools. This enrollment will be approximately 700 students. This will bring on the need for additional faculty housing. There are also approximately 25 plus new residential home being built as indicated above. Improvement in the sewage and water system is needed on a continued basis for areas that do not meet the present health standards.

The Urban Indian Health Line Item has been underfunded for many years. Funding to support the urban operations of the IHS is needed to support current services and the expansion of additional prevention and outreach. Funding for Urban Indian Health Services within IHS should be a high priority due to the increasing urban Native population. Urban Indian communities are inter-tribal and represent over half of the Native American population in the U.S., yet they lack access to sufficient health services. Urban Indian clinics are greatly underfunded. For most urban Natives the Urban Indian Health Service is the only means of receiving health care. Most of these urban facilities are small in size and offer only limited



## HOT TOPICS BY IHS SERVICE AREA

services. Increasing funding for Urban Indian Health will allow more dollars to be spent on new positions (routine/specialty care) to meet the patient demand for increase access to care as well as improvements to our systems including expanding clinic hours and providing urgent care services.

A greater proportion or an increase in funding needs to be allocated to community-driven, culturally respectful, multi-year behavioral programs to improve the screening, diagnosis, treatment, and survival of our Native population. With most urban settings there is a large homeless population. Many of the homeless patients experience a wide range medical, dental, and behavior health issues.

Additional funding will help with providing more services, education, and prevention. Quality and access will be improved with increased funding by enabling urban Indian health programs to increase their capacity to serve more patients (thereby decreasing wait times for appointments, emergency room utilization, increasing the number of patients with a medical home etc.), improve their internal systems (e.g. ,hire more support staff, create responsive triage systems, etc.) to be more efficient and effective thereby decreasing barriers to accessing services, and increase the types of services available (e.g. ,add specialty care or ancillary services such as pharmacy, lab, etc.) to maximize patients' treatment adherence and health outcomes.

These increases also take into account those factors that impact the cost for delivering services-- inflation, population growth, staffing need, etc. Increased funding should allow for staff trainings in customer service for the requested budget increase for urban Indian health. Also, funding should allow for eligible urban Indian health programs providing direct health services to pursue accreditation including patient centered medical home accreditation which emphasizes more patient-centered services that include customer service oriented (e.g., increased access to their providers, medical records, etc. resulting in improved levels of satisfaction among their patients) . Given the changes in the health care environment including competition among health care providers, customer service is a priority for urban Indian health programs including FNCH.

IHS is a good investment because the increases will enable urban Indian programs to continue to provide and improve their culturally sensitive health delivery systems to address the holistic needs of their patients. These increases will not only improve access to direct services but also outreach and education, both critical for reaching more unserved American Indians and for maximizing health outcomes among urban Indians. IHS is a unique health care program that provides a unique service delivery system unmatched by other health care providers. In this sense, IHS is a good investment because of its holistic and culturally sensitive approach to care. There are no health care entities that address these needs at no cost to the urban Indian community. If urban Indian programs continue to be underfunded, these programs will be rendered incapable of meeting the needs of its target population. Funding in many ways dictates the volume and quality of services provided. Program must be able to address the rising health care costs associated with wrap around services.

The Denver Indian Health and Family Services, Inc. (DIHFS) proposes to use a budget increase to fund a full time Medical Director as the organizations clinical leader and to fund a part time dentist. Each of these positions is important to providing care to our American Indian/Alaska.

Native population in the Denver area. Currently DIHFS does not have a medical director. The need for a full time medical director will oversee the clinical care in the facility, work with the interdisciplinary team to ensure quality care and implement appropriate clinical policies, procedures, and programs, and work with the facility administration regarding staff management and survey issues, quality assurance activities, and education and training for providers and clinical staff. The Denver Urban dental clinic only provides clinic services 3 days a week. Adding another part time dentist will allow our clinic to open up two more service days for our community. Currently, we are booked into February 2015. Being the only AI/AN clinic in the Denver area, we have an unmet need. Expanding in this area is very essential to helping our community with their dental needs. DIHFS is the only AI/AN clinic in the Denver area. Access to healthcare is certainly a priority; therefore DIHFS would like to see IHS allocate funds in our area of need. Improving customer service is one of DIHFS highest priorities. I.H.S could provide training webinars that are culturally appropriate in customer service. Investing in healthcare is not only an investment, but a priority. Again, with DIHFS serving the AI/AN, our funds are stretched among many programs. If IHS invests more funds to our urban program, we can provide the quality care needed in serving our community.

The First Nations Community Health Source (FNCH) will use a budget increase to reduce the inequities in funding by addressing the need for increased funding among urban Indian health programs. Specifically, there is a need for additional

## HOT TOPICS BY IHS SERVICE AREA

direct medical services to support the provision of essential health services including routine and urgent ambulatory care, medical support services such as laboratory, pharmacy, behavioral health screenings, nutrition education, etc., to address the chronic health, urgent care, and preventative health care needs among the urban Indian population. This also includes specialized programs for maternal and child health, family planning, communicable diseases, youth services, women's health, men's health, elder care, pre- and post-natal care, etc.

The impact of this increase is that it will address the increased service costs arising from the growth of the urban Indian population which continues to grow each year. Funding this increase will enhance the ability of urban Indian programs including First Nations Community Health Source (FNCH) to meet the current demand for services. Urban Indian health programs provide affordable, quality, and culturally competent medical care and public health case management services as well as wrap around services for urban Indians who do not have access to the resources offered through IHS or tribally operated health care facilities. FNCH proposes to use the increased funding to expand its medical providers to include 1.0 FTE Pediatricians (\$180,000), 1.0 FTE Family Practice Physicians (\$200,000) and 2.0 FTE Medical Assistants (\$65,000). The addition of these positions will expand the provision of health services available for American Indians of all life cycles. Additionally FNCH will use the increase to fund Alcohol and Substance Abuse services to decrease the incidence and prevalence rates of alcohol and substance use rates among the urban Indian population to a level that is lower or equal to the rates for the general US population through a network of urban Indian community based emergency, inpatient, outpatient treatment and rehabilitation services. This funding will support the efforts of urban Indian programs in developing a continuum of care of services that range from substance abuse prevention education, systems navigation, outpatient and inpatient treatment, and step down levels of care. Also, the impact of this funding increase is to address the special needs of urban Indians with co-occurring disorders with both mental illness and substance dependency. FNCH proposes to use the increased funding to hire a 1.0 FTE Psychiatrist (\$220,000) who will be co-located in primary care due to increased demand for psychiatric services by clinic patients. The psychiatrist will provide psychopharmacology treatment, psychiatric assessments and consultations and clinical treatment services. Having a FTE Psychiatrist will increase access to psychiatric services, which are extremely limited in Albuquerque with unacceptable wait times for appointments. FNCH will also use the increase to fund Mental Health Services to address the mental health needs (e.g., historical trauma, depression, domestic violence, behavior-related chronic disorders, etc.) among the urban Indian population. Mental health services will include both clinical and preventative care services with a spectrum of services ranging from crisis intervention, triage, psychiatry, psychological assessments, screenings, case management, prevention programming, outreach, health education, and individual, group, family and other treatment modalities. Mental health disabilities have a profound impact on the individuals, their families and their communities.

Many urban Indians experience depression and an overwhelming sense of isolation due to their separation from their natural supports on the reservation. This is further compounded by challenges experienced with their day-to-day living (e.g., homelessness, unemployment, etc.). FNCH proposes to use the increased funding to hire a .50 FTE Child Psychiatrist (\$150,000) to provide psychiatric consultations and treatment to youth and children. FNCH also proposes to use the funding to hire a 1.0 FTE licensed behavioral health clinician (e.g., Psychologist, Social Worker or Independently Licensed Clinician) (\$65,000) to provide clinical services including group, individual, and family counseling services to all life cycles.

FNCH will also use the increase to fund Diabetes prevention services to address the disproportionately high rates of diabetes among the urban Indian population. Services will decrease the incidence and prevalence rates of diabetes among the urban Indian population to a level that is lower or equal to the rates for the general US population through a network of urban Indian community based prevention education services (e.g. healthy lifestyle education and promotion) that incorporate culturally appropriate and evidence based practices proven effective in preventing diabetes among American Indians. The onset of diabetes can result in a host of medical, dental, behavioral health and other problems including premature deaths and suffering. FNCH proposes to use the increased funding to hire a 1.0 FTE Clinical Diabetes Educator (\$75,000), 2.0 FTE Community Health Workers (\$80,000) to provide diabetes prevention education using evidence based practices to decrease diabetes risk among the urban Indian community.

FNCH will use the increase to fund Immunizations and Methamphetamine and Suicide Prevention programs to prevent premature deaths from the lack of immunizations, Methamphetamine use and Suicide. Services will decrease the incidence and prevalence rates of deaths due to the lack of immunizations, Methamphetamine use and/or suicide to a level that is below or equal to the rates for the general US population through a network of community based prevention education programs that increase access to services, incorporate culturally appropriate and evidence based practices proven effective among American Indians. FNCH proposes to use the increased funding to hire a 2.0 FTE Licensed Clinician Clinical (\$150,000) to provide mental health screenings to assess risk and mental health treatment and referrals for individuals assessed to be at

## HOT TOPICS BY IHS SERVICE AREA

risk for suicide. FNCH also proposes to hire a 1.0 FTE Public Health Nurse (\$65,000) to provide immunizations in the community with home visits, outreach activities, etc. to high risk patients with complex health care needs.

FNCH will also use an increase to fund HIV/AIDS services to provide HIV testing and counseling, case management, medical care and prevention education to decrease rates of HIV/AIDS among urban Indian communities. FNCH proposes to hire 2.0 FTE HIV Prevention Case Managers (\$90,000) to provide HIV prevention education using evidence based practices, confidential HIV testing and counseling and referrals for STD, Hepatitis C and Hepatitis B testing to high risk populations.

Finally, FNCH will use an increase to fund health promotion/disease prevention services to prevent premature and unnecessary deaths by providing activities directed to the promotion of healthy lifestyles, community partnerships, and disease prevention education to all life cycles of the urban Indian communities. This increase can support the hiring of community outreach workers/health educators with knowledge and cultural sensitivity to change community acceptance and utilization of health care resources, including decreased emergency room utilization for routine care, and use of community based networks and services to enhance health promotion and disease prevention.

FNCH proposes to hire 2.0 FTE Community Health Workers (\$75,000) to provide health education, community outreach and health screenings.

The Pueblo of Laguna stated that an increase in Health Education funds will aid in addressing the needs for behavior change, education and self-care through well-trained professionals in tribal communities. Health education is critical to case management.

### *CHR*

The Pueblo of Laguna noted that the roles of CHRs in case management and patient navigation is invaluable to patients accessing care when a health and disease issue arises. CHRs are able to provide information, interpretation and assist in accessing services by coordinating transportation or providing the services directly.

### *CSC*

The Zuni Tribe noted that there was a Congressional mandate to Indian Health Service to fund Tribal Grantees at 100% for Contract Support Cost but not allocating additional funds to the IHS budget to cover the cost. We are recommending that additional 7.6% of these funds be allocated for CSC. Funds are available to cover current services and binding obligations, but not for CSC. We understand that this will continue to affect IHS's delivery of services as more Tribes contract these services with IHS and long term solutions need to be identified to address this issue. The delivery of services will affect tribes if CSC continues to be an issue. Tribal Leaders along with support from the IHS director needs to advocate Congressional support to increase the IHS budget. Primarily Tribal Leaders need to advocate for increasing the budget for IHS.

### *PHN*

The Pueblo of Laguna specifically supported the PHN program. PHNs are critical in providing case management for patients and working as the linkage between I.H.S. providers, Tribal services, and managed care organizations and non-reservation based care systems. PHNs that are registered nurses and provide direct services generate a source of revenue for the tribal system or IHS for patient care in the homes and community. The ACA has embedded case management into health care delivery with Public Health Nurses, CHRs, Navigators and other field based providers that work in partnership with PHNs.

### **Impact of 638 Contracting on Direct Service Tribes**

In November 2011, the Indian Health Service and the Pueblo of Santo Domingo successfully completed negotiations on a \$3.2 million PL-93-638 contract. In January of 2012, Kewa Pueblo Healthcare Corporation (KPHC), the tribal entity charged with carrying out the terms of the contract, assumed control of 100% of Santo Domingo's tribal shares in Dental Services, Mental Health, Substance Abuse, and Public Health Nursing. With the contract, KPHC also assumed control of 63% of Santo Domingo's Hospitals and Clinics tribal shares, with the remainder retained within the Santa Fe Service Unit (SFSU) to support services based at the Santa Fe Indian Hospital (SFIH) such as urgent care. The Pueblo of Santo Domingo elected for 100% of their Contract Health Services (now Purchase Referred Care) shares to remain within the Santa Fe Service Unit.

In fiscal year 2011, the SFSU collected \$2 million in third party collections from services provided at the Santo Domingo Health Center. In response to the loss of \$5.2 million in operational funds, the

## HOT TOPICS BY IHS SERVICE AREA

SFSU reduced urgent care services at the SFIH from 24 hours a day to 12 hours a day, reduced staffing to support a maximum of four inpatients, and closed all surgical services. This reduction in services resulted in the elimination of more than 50 positions within the SFSU.

The SFSU's constituent tribes fully support the right of any tribal government to enter into self-governance contracts and compacts with the Indian Health Service. These same tribes also recognize that the SFSU's unique structure of having nine tribes' shares consolidated into one service unit imposes a degree of uncertainty for long-term planning. In particular, if one or several tribes within the SFSU elect to contract some or all of their tribal shares, the remaining tribes who elect to remain under direct service may find that their residual services are not comparable to those provided previously. Additionally, with the loss of the economy of scale gained from the pooled resources from many tribes, these direct service tribes may be unable to enter into meaningful self-governance contracts and compacts of their own.

Consequently, remaining direct service tribes experience frustrations such as: inability to do long-term planning with the SFSU, which cannot precisely predict from one year to the next what their operational funds will be; inability to reassure their tribal members that a self-governance agreement would lead to comparable or better health care services while at the same time inability to reassure their tribal members that the direct services in the SFSU are secure; and inability to persuade members of Congress that multi-tribe service units such as the SFSU may require special appropriations after self-governance contracts and compacts are negotiated in order to protect the access-to-care interests of the remaining direct service tribes.

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## BEMIDJI

### ISSUE

1. FUNDING PARITY
2. HEALTH DISPARITIES
3. PURCHASED/REFERRED CARE
4. FACILITY CONSTRUCTION
5. PRESCRIPTION DRUG ABUSE AND DIVERSION
6. NOTIFICATION OF CONSULTATION MEETINGS AND/OR COMMENT PERIODS
7. HEALTHCARE REFORM IMPLEMENTATION AND IMPACT

### BACKGROUND

1. Tribes noted Funding Parity as a 'hot issue' as the Area is the lowest funded in the IHS according to the Level of Need Funded/Federal Disparities Index (LNF/FDI) scores. Bemidji Area is identified as the lowest LNF score in IHS at 49.8% while the Agency's overall average is 55.6% according to 2010 data.
2. Bemidji has some very high health disparities in heart disease and cancer, accidental injuries, as well as diabetes. The last comparative data from 1999-2001 showed the Area leading the Agency in Heart Disease - #1, Malignant Neoplasms (Cancers) - #2, and Diabetes - #3. Tribes identified specific program areas where funding and attention are needed: Dental, Mental Health (MH), Alcohol & Substance Abuse (ASA), and Long Term Care (LTC). Tribes shared anecdotally that  
  
the impact of poor Dental funding results in all age groups having poor oral health leading to poor nutrition. This is especially concerning when dealing with toddlers. Tribes also recognize that issues regarding prescription or other drug abuse/use/misuse are oftentimes linked to MH. The increase in MH and ASA funding is needed to address the root of the problem with counseling while providing the appropriate treatment to address any physical addiction. Tribes in the Area already operate LTC facilities and specific funding would assist Tribes in their efforts to meet the growing need.
3. Purchased/Referred Care (PRC) is a 'hot issue' for the Area for several reasons: the geographic challenges of remoteness and therefore access to specialty care; the lack of funding parity coupled with the higher health disparities of Area users vs. the IHS as well as varied level/type of service available from a Tribe. Bemidji Area is very PRC dependent (72% eligibility overall and significant health disparities) due to a lack of hospitals and specialty care in ITU programs. Programs must use priorities.

## HOT TOPICS BY IHS SERVICE AREA

4. Bemidji Area Tribal programs have limited opportunity to receive federal funding for healthcare facilities construction. The majority of Area Tribes may only access Small Ambulatory Grants (\$2M maximum award) or apply for Joint Venture (JV). However, to date no Tribes have received JV funds in the Area. IHS Construction programs need more funding in these programs in order for Tribes to have access to facility construction dollars. In addition, IHS criteria may need revision to allow greater access/eligibility.
5. Prescription Drug Abuse and Diversion: Declared as a public health emergency on the three reservations with direct service programs and listed as a major problem by contracting and compacting Tribes at HHS Tribal consultation meetings. This is a multifaceted problem that requires involvement of Tribal Leaders, law enforcement, education, health care professionals, States, Federal Agencies and the community to solve. There is also a need for alternative resources such as physical therapy, behavioral health and buy-in to pain treatment utilizing alternatives to abused medications.
6. Tribes note concern about the notification timeframes regarding consultation meetings and/or comment periods. The Agency's 30-day response timeframe limits the opportunity for Tribal programs to assemble subject matter experts and provide a comprehensive and thoughtful response to consultation matters.
7. IHS, Tribal, and Urban (ITU) programs note challenges and concerns regarding the implementation of the Affordable Care Act on January 1, 2014. Examples of challenges include limited consultation with Tribes by States, limited information regarding the impact to urban programs, and the inconsistency of implementation of Medicaid expansion. Building on the last challenge, a concern is the anticipated increased collections, in States with Medicaid expansion which could create a greater disparity with Tribes in States that do not have Medicaid expansion. The inconsistent implementation could adversely impact Tribes in MI and WI when the Bemidji area is already the lowest funded in the Agency.

## SITUATION

1. The Area needs increased funding to meet the demand of a growing population
2. 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, substance abuse prevention and treatment and accidental deaths.
3. The Area continues to utilize PRC 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 PRC 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 PRC appropriations.
4. While some Area Tribes have received Small Ambulatory grants, none have 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 to promote equity and advancement for Bemidji Tribes.
5. Area-wide collaboration between HHS Region V/IHS and ITU is on-going. Monthly teleconference calls, coordinated by HHS Region V and IHS, have been held for 2.5 years and are transitioning to Tribally-lead calls with planning for next steps underway.
6. Additional time during the comment period would allow Tribes the opportunity to participate and provide input to important Agency decisions.
7. The Area hosted various trainings in FY2013 for the ITU programs to identify challenges, improve knowledge, and explore opportunities to maximize the ACA authorities/implementation. Trainings will continue to evolve in FY2014 to meet the changing needs and concerns of ITU programs.

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## BILLINGS

ISSUE: Contract Support Cost (CSC)

## HOT TOPICS BY IHS SERVICE AREA

**BACKGROUND:** The Billings Area FY 2014 Recurring Base budget for CSC was \$10,750,680. In IHS's plan to fully fund the CSC need, identified reductions from Headquarters, IHS, reconciliations, and adjustments were made to fully fund CSC to each individual tribe in FY 2014. The Billings Area is comprised primarily of seven (7) Direct Service Tribes and two (2) Self Governance Tribes.

**SITUATION:** As discussed at the Billings Area 2017 Budget Formulation meeting, after reconciliation the Billings Area IHS was required to reprogram from Hospitals and Clinics (HC) \$90,000.

The Billing Area Office absorbed \$45,000 and each Service Unit absorbed their percentage of the remaining \$45,000. This percentage was based on the Billings Area Federal Recurring Base and each individual Service Unit's portion of Federal Recurring Base. Although the respective tribes were not affected fiscally, the local Service Unit budget was decreased by:

Blackfeet Service Unit	\$ 9,914
Crow	\$ 13,925
Ft. Belknap	\$ 4,943
Ft. Peck	\$ 5,137
Northern Cheyenne	\$ 6,055
Wind River	\$ 4,669
Flathead (PRC staff)	\$ 358
Billings Area Office	\$ 45,000
TOTAL	\$ 90,000

Provided this status, the Billings Area Tribes comments centered primarily on Congress providing 100% funding for Contract Support Costs in future fiscal years. This would alleviate the fact that, although \$90,000 is relatively small, HC has been decreased which has a negative impact on provided to their respective Indian communities. The tribes expressed concern that if not fully funded in FY 15, this could also have a negative impact on current services as well as the upcoming years.

Upon receipt of the FY 2015 Budget, the Billings Area will coordinate and communicate with the tribes on final P.L. 93-638 Annual Funding Agreement amounts. Also, if any, amounts to be absorbed by the individual Service Units this will be communicated to the tribes as well.

### ISSUE: PURCHASED/REFERRED CARE

**BACKGROUND:** Insufficient funding levels

**SITUATION:** At the beginning of the fiscal year current base funding for Billings Area supports all Priority levels, depending on the funding and needs of each specific Service Unit. However, it is common that as the Service Unit PRC programs advance through the year only Priority I (loss of life and limb) will be referred. This action is taken to ensure the programs stays within available funds.

With additional funding we'd be able to better meet the overall and ongoing health care needs of our patients.

In FY2014 the Billings Area's unmet need for medical priority 1 was \$10,664,549 = (9,668 cases). Deferred was \$4,243,038 = (2,852 cases) and unfunded Contract Health Care Catastrophic Fund cases were 185 equivalent to \$1,344,353.

Service Units have been forced to use any available 3rd Party resources (Medicare, Medicaid, and Private Insurance) to pay for care when PRC funds have been exhausted. In FY 2014, \$2.2 million dollars of 3rd Party revenue had to be used for PRC.

Although there have been increases from FY2009 -FY2014, the impact of the rescission and sequester in FY2013 (\$2.9 million) was devastating to an already underfunded program. For example, FY 2009 Billings Area total unmet need was \$49,254,691. FY 2009-FY2014 program increases were \$16,653,097 which represents 33% of FY2009 total need. With medical inflation and population growth for these years estimated at \$11,232,846, the Billings Area net increase for all these years was only \$5,420,251.

## HOT TOPICS BY IHS SERVICE AREA

### ISSUE: ALCOHOL AND SUBSTANCE ABUSE

BACKGROUND: Increased Alcohol and Substance Abuse.

SITUATION: According to the P.L. 93-638 Contracted Tribal Substance Abuse Programs AccuCare 's Aggregate Report Generation System (ARGS) report, all substance abuse patients assessed by the Billings Area Tribal Substance Abuse Programs indicate that the Primary Alcohol/Drug of Choice is:

- Alcohol 60.09%,
- Heroin 0.02%,
- Methadone 0.026%,
- Opiates/Analgesics 0.73%,
- Barbiturates 0.06%,
- Other Sedative/hypnotic/tranquilizer I 0.06%, Cocaine 0.03%,
- Amphetamine/Meth. 3.49%,
- Cannabis 5.12%,
- Inhalants 0.15%,
- Alcohol and multiple drugs addictions 11.65%.

Methamphetamine use has continued to increase in the State of Montana and Wyoming and this increase has also been seen in pregnant women. Alcohol and methamphetamine abuse in utero is a significant issue in the Billings Area. Mother's ability to participate in treatment programs is limited because treatment centers who will take prenatal patients and her children are limited. At one of the Service Units in 2012, 44% of the babies born had In utero Drug Exposure (IUDE) (15% to methamphetamine, 6% to alcohol). Additional funding for the Alcohol and Substance Abuse Program would provide the tribes a mechanism to help their community members and schools, hire additional professional staff, treatment opportunities, etc.

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## GREAT PLAINS

### Area Hot Issues – Budget Related

Medicare Like Rates - Enacting Medicare Like Rates for referred non-hospital services could save the IHS millions per year for the purchased/referred care program. Given the Great Plains Region strong dependence on contracted care not only for hospitalizations but for also for specialty care office visits, Medicare Like rates could significantly alleviate the tremendous burden on the PRC budget.

### Purchased / Referred Care – Provider payment delays & Patient transportation:

As mentioned in above priorities, underfunding for PRC in addition to antiquated information echnology systems result in consequences that affect quality of care. An emerging issue in the Great Plains is the growing burden of uncompensated care on the major contracted providers.

The administrative process used by the IHS is uniform throughout the entire nation when administering PRC. Following all of these requirements is a significant administrative burden on private sector providers and the IHS, as the process is manual, paper-driven susceptible to errors and slow. As currently administered the process is slow and susceptible to errors. Finally, the payment process is delivered through a national fiscal intermediary who is required to issue payment via paper checks and remittance advices, adding substantial reconciliation efforts for providers.

Along with the administrative costs there are undesirable consequences through the existing IHS PRC process. Payments for private sector care are often denied due to appropriation or budget limits and medical priority determinations. When payments are denied, it is possible an individual tribal member will be responsible for the payment of provided services, which generates a financial burden for the individual and the provider.

The tables below reflect the top 10 providers for purchased and referred care, and the billed services outpatient services and what was paid by the IHS.

**HOT TOPICS BY IHS SERVICE AREA**

<b>Top Ten Providers of Outpatient Services Fiscal Year 2013</b>		
Facility Name	Total Billed Charges	IHS Payment
<b>Rapid City Regional Hospital</b>	\$ 9,443,851	\$ 1,727,952
<b>Black Hills Dialysis</b>	\$ 6,533,225	\$ 1,555,426
<b>Coteau Des Prairies Hospital</b>	\$ 3,213,526	\$ 1,442,169
<b>Trinity Hospital (Minot)</b>	\$ 5,290,543	\$ 1,029,712
<b>Sanford Chamberlain</b>	\$ 2,387,348	\$ 835,079
<b>Mercy Hospital, Devils Lake</b>	\$ 2,139,823	\$ 725,929
<b>Sanford Bismarck</b>	\$ 3,247,522	\$ 674,980
<b>Altru Hospital, Grand Forks</b>	\$ 2,820,102	\$ 518,325
<b>Black Hills Surgical Hospital</b>	\$ 1,580,765	\$ 488,671
<b>St Mary's Hospital, Pierre, SD</b>	\$ 1,903,401	\$ 367,548

One of the primary reasons provided in South Dakota for the lack of support for the Medicare Like Rates legislation is attributed to unsettled PRC claims.

SD/ND CHSDA - Sec. 192. Of the IHCIA permanently establishes a single contract health services delivery area consisting of the states of North Dakota and South Dakota for the purposes of providing purchased and referred care. IHS Headquarters has indicated that appropriations are required to expand the CHSDAs to include all counties in ND and SD, as required in the IHCIA.

As with previous year's requests, the Great Plains Tribal Chairman's Health Board, Board of Directors reiterates its request to IHS Headquarters for the following:

- The Aberdeen Area Office or Headquarters should prepare an analysis of the estimated cost to implement this provision in the IHCIA.
- Modify the User Population calculation process to count all users in the ND and SD CHSDA. This change should be retroactive if possible. If not possible, it should be put into effect such that the estimated users who receive services, but are not currently counted in ND and SD user populations, are included in the next fiscal year's official user counts.
- IHS Headquarters should calculate the funding lost to ND and SD Tribes by not including these users in the user population. The dollar amount of these funds should be provided to ND and SD Tribes in proportion to their adjusted user counts. The funds should be taken off the top of the next appropriation.
- A report should be provided to ND and SD Tribes showing how the adjustments have been made prior to the following year's appropriation.

IHS Budget appropriations Formula – the Great Plains Leadership would like a detailed review of the current IHS budget formula used to determine appropriations.



**HOT TOPICS BY IHS SERVICE AREA**

**NASHVILLE**

#	ISSUE	BACKGROUND	RECOMMENDATION/ STATUS
1	<b>Budget Representation for Urban Programs</b>		
	<p>The IHS Urban Indian Health Program supports contracts and grants to 34 urban health programs funded under Title V of the Indian Health Care Improvement Act. The Urban Indian Health Program line item is distributed through contracts and grants to the individual Urban Indian Health programs. The distribution is based upon the historical base funding of these programs. The funding level is estimated at 22% of the projected need for primary care services. Eighteen (18) additional cities have been identified as having an urban population large enough to support an Urban Indian Health Program. 2010 Census data shows that 71% of all American Indians and Alaska Natives live in urban centers. The President’s FY2014 budget marked the third straight year that funding for urban Indian health fell below 1% of total Indian Health Service funding.</p>		<p>It is important to bear in mind that urban Indian health programs are funded from a single IHS line item, and do not have access to funding appropriated to other areas of the IHS budget. Thus, any increase the Administration has proposed for the broader Indian Health Service budget will not benefit urban Indian health programs or the Native communities they serve. It is critical that Congress direct resources to the urban Indian health line item in order to provide health care services to urban Indian patients. Additional recommendations are the inclusion of urban programs in:</p> <p>100% federal match for Medicaid services – a protection already enjoyed by IHS and tribal facilities (100% FMAP would provide states with 100% of the cost of payments made to urban Indian health providers for services provided to American Indian Medicaid patients, rather than requiring the states to assume a percentage of the cost of Indian health care).</p> <p>Federal Tort Claims Act - unlike IHS and tribal health programs, urban Indian health programs are required to spend thousands of program dollars each year to purchase malpractice insurance for their providers. Given the extremely sparse funding that is appropriated to serve American Indians in urban centers, urban Indian health programs should not be required to spend these precious resources on insurance coverage – especially since IHS and tribal programs have long been exempted from this burden.</p>
2	<b>Fully Fund Contract Support Costs</b>		
	<p>There has been a long history of contract support costs being underfunded and shortfalls. According to NCAI, "In amending the 1975 Indian Self Determination Act Congress in 1988 recognized that failure of BIA and IHS to fully fund contract support costs often resulted in program reductions".</p>		<p>1."Direct appropriation of funds for CSC would be critical to ensure that CSC remains fully funded".</p> <p>2."Empower the IHS Director to request reprogramming of funds direct to the comptroller".</p>
3	<b>Medicare Like Rates for Nonhospital Services</b>		
	<p>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.</p>		<p>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.</p> <p>*This is a reoccurring hot issue for the Nashville Area</p>
4	<b>Advance Appropriations for the Indian Health Service (IHS)</b>		

## HOT TOPICS BY IHS SERVICE AREA

	<p>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 <i>after</i> the year of the appropriations act in which it is contained, allowing for increased certainty and continuity in the provision of services.</p>	<p>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, <i>The Indian Health Service Advance Appropriations Act of 2013</i>, have been introduced in the House and Senate, respectively.</p> <p>*This is a reoccurring hot issue for the Nashville Area</p>
5	The Special Diabetes Program for Indians (SDPI)	
	<p>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 has been given a one year extension for FY 2015 and not permanent reauthorization. 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.</p>	<p>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.</p> <p>From 2014 Impact Statements/Testimony: The Special Diabetes Program for Indians has been of great benefit to the Tribe in addressing some of the most significant factors contributing to these complications that our citizens have endured. Without this program our patients will suffer from the lack of educational training, prevention activities, and we go back to treating the disease only.</p> <p>*This is a reoccurring hot issue for the Nashville Area</p>
6	Alcohol and Substance Abuse Treatment Facilities in Nashville Area	
	<p>The high rates of alcohol and substance abuse, mental health disorders, suicide, violence, and behavior-related chronic diseases in American Indian and Alaska Native (AI/AN) communities are well documented. Each of these serious behavioral health issues has a profound impact on the health of individuals, families, and communities. For example, AI/ANs are significantly more likely to report past-year alcohol and substance use disorders than any other race, and suicide rates for AI/AN</p>	<p>New facilities or program dollars to address alcohol and substance abuse treatment.</p> <p>No additional funds have been earmarked for new treatment facilities in the Nashville area. There are currently two treatment facilities serving the Nashville area including Unity Healing Center, an adolescent drug treatment center located in Cherokee, NC and the Partridge House, an inpatient addiction program for adults located in Akwesasne, NY.</p>

## HOT TOPICS BY IHS SERVICE AREA

	<p>people are 1.7 times higher than the U.S. all-races rate. The documented connections between behavioral health issues and chronic diseases underscore the need for holistic and integrated solutions. Access to culturally competent alcohol and substance abuse treatment programs in the Nashville Area is limited by the number of facilities available and the cost per patient (currently \$10,000 for a 90 day program and more for Intensive Outpatient Treatment).</p>	<p>Additionally, including funding to implement section 827 of the Indian Health Care Improve would be of benefit. Prescription Drug Monitoring (PDM) Program. Nashville recommends allocating funds to develop a PDM program that are carried out by Tribes, IHS and/or Urban programs.</p>
7	<p>Pilot project for Premiums</p> <p>Beginning in 2014, the Affordable Care Act provides an opportunity for an estimated 579,000 uninsured American Indians and Alaska Natives to get affordable health insurance coverage. Exchanges may permit Indian tribes, tribal organizations, and urban Indian organizations to pay the QHP premiums for qualified individuals, subject to terms and conditions set by the Exchange. As more tribal members are participating in state and federal marketplaces, 48,103 plan selections indicated membership in a federally recognized tribe in April 2014, there is interest in the analysis of the cost of premiums and the use of tribal resources to cover those premiums for individuals.</p>	<p>The proposed pilot project for tribal premium sponsorship would answer, what is most cost effective for tribes?</p> <ul style="list-style-type: none"> <li>-Tribes reimburse members individually for the cost of premiums</li> <li>-Tribe pays for premiums from resources other than contract dollars</li> </ul> <p>There are several resources available for tribal premium sponsorship including:</p> <p><u>Edward Fox – Tribal Premium Sponsorship</u> *sample policies and procedures are available</p> <p><u>Tribal Premium Sponsorship Programs</u></p> <p>USET’s collaboration with other Area Health Boards, Tribal Education and Outreach Consortium developed several tribal sponsorship tools that can be located on at <a href="http://www.nativeexchange.org">www.nativeexchange.org</a></p>

## NAVAJO

### Correctional Health Services ISSUE

Inmate behaviors pose a significantly high risk to HIV acquisition and are least likely to seek health care services.

### BACKGROUND

Incarcerated American Indians experience extremely high rates of STDs and health disparities. Tribal Jails are unable to meet health care needs due to limited resources and lack of awareness of health care needs of inmates, lack of collaboration between Department of Corrections and health care providers. Tribal jails are small, lack of infrastructure, lack of staffing, and respond only to urgent medical conditions. Inmates are at higher risk for STDs, substance abuse problems (i.e. alcohol related offenses, Domestic Violence), and sexual risk-taking.

### SITUATION

Tribal jails offer a unique opportunity for STD education, screening, and testing for a population that might be hard to reach and to control STDs and HIV in high risk populations. Tribal jails are small which may hold up to 10-24 detainees or mid-level 25-49 and a selected few may more than 49 inmates at one time.

Health Education will increase awareness of STD and HIV risk factors, transmission, symptoms, benefits of regular screening by understanding the test/rapid screening, and health check-ups, emphasize safer sex knowledge & complications of STDs, provide safer sex skill training, and encourage safe sexual and drug use behaviors.

## HOT TOPICS BY IHS SERVICE AREA

With Resolution C0-50-14 establishing the Navajo Nation Health Department is in a position to establish correctional HIV screening policies as determined by tribal or federal statutes. Less than half of State prison systems (21) reported testing all inmates for HIV at admission, while in custody, or upon release (Source: CDC HIV testing Implementation Guidance for Correctional Settings, January 2009).

### Emerging Infectious Disease

The term "emerging infectious disease" refers to diseases of infectious origin whose incidence in humans has either increased within the past two decades or threatens to increase in the near future. Environmental influences on human health can severely impact the Navajo people if we are not prepared. Diseases can be transmitted from animal species to humans through viruses. HIV, bird flu, ebola, enterovirus D68, as well as Giardia and Cryptosporidia are such diseases that impact human health. There are three main pathogens (Escherichia coli or E.coli, Giardia, and Cryptosporidium ) that are contributing factors to Waterborne illness. Twenty seven percent of the Navajo homes do not have access to safe water with the majority in the western portion of the NN.

### SITUATION

Water hauling is essential and due to distance, lack of funds to drill wells, and build water infrastructure, risks to individuals' health is high. Water hauling containers including polyethylene tanks (plastic tanks) 300-500 gallon tanks may eventually develop fungus and algae growths because individuals haul water from unregulated livestock wells. Water from these sources is of unknown quality. Over 3,000 livestock wells were built for livestock use only, according to the Navajo Nation Water Resources Department. The livestock wells pump water into uncovered storage tanks. The water is subject to contamination by dead birds and other dead animals. Some storage tanks contain soiled diapers and trash. Most contamination occurs during the summer monsoon months with floods that seep into the water wells due to low water well casings. Hand pump wells are also used by some residents for domestic use. These hand pump wells were built in the 1950s by I.H.S./P.H.S. as evidenced by the cement base of the pump, have been subjected to animal excreta, debris, freon, asbestos from vehicle brakes dumped in the ditches, as well as anti-freeze, and oil. Home septic tanks are not managed by home owners that can overflow and create a health hazard as potential exposure to Hepatitis and Cholera, for example.

### Modular Dental Facilities and Staffing

#### ISSUE

Modular dental units to be placed at various service units, including the requisite staff

Background: The Navajo Area dental program is able to see less than 29% (the current GPRA objective) of the user population each year. Also, the dental program is unable to meet the Early Childhood Caries objective for dental access for children aged 0-2. This has resulted in 60.0% of children aged 0-5 needing additional dental treatment.

#### RECOMMENDATION

The American Dental Association standard for the dentist to population ratio is 1:1200. Most service units across Navajo have a ratio off from 1:3600 to 1:4200, when fully staffed. Simply creating additional FTEs will not suffice. The industry standard for efficiency is to have at least two dental chairs per dentist. Hence, bringing on additional dentists without building infrastructure may actually reduce the access to dental care.

Modular dental units are pre-fabricated units which can be placed in smaller communities, allowing less travel costs to seek dental care. They are a standalone facility, which can provide a full range of general dental services. A five chair clinic will require two dentists, five assistants, and one clerk. Initial costs would include \$15,000 for site preparation, \$676,000 for the modular building including set up, \$416,000 for equipment and instruments. Annual costs include \$550,000 per annum for staff salaries and benefits and \$50,000 for supplies.

Given that new facilities are not in the future of all Navajo service units, modular facilities can fulfill the need for additional access to dental care.

Proposed Amount: \$6,900,000 for four units, with annual amount of \$240,000 for 10 years.

### Uranium Exposure

#### ISSUE

Abandoned Uranium mine waste continues to pose public health threats to Navajo communities and residents through water, air and land contamination. There is dire need to escalate public health education that will decrease exposure risks and increase prevention.

### BACKGROUND

## HOT TOPICS BY IHS SERVICE AREA

According to the Indian Health Service Regional Differences in Indian Health 2002-2003 Edition, the infant death rate among the Navajo people is 8.5 deaths per 1000 live births, compared to 6.9 deaths per 1000 live births among all races. Only 61% of Navajo mothers with live births received prenatal care in the first trimester as compared to 83% of all U.S. mothers. The Navajo Birth Cohort Study has found that many Navajo families are not aware of the health threats; cancer, asthma, birth defects and learning disabilities.

### SITUATION

Navajo Nation land base is host to 1,100 uranium mine waste tailings and 531 of those are now identified for cleanup. 70% of the Navajo Chapters exposed to the uranium tailings. However, the costs for adequate remediation are not attainable. Therefore, the congressional mandated Navajo Birth Cohort Study will be ending August 2016. We highly recommend that (8) Public Health Educators to work with the Navajo Birth Cohort Study program under the Navajo Community Health Program/Navajo Department of Health. This will cost \$2.5 for (4) years.

### Memorandum of Understanding Between VA and IHS

The health care reimbursement rate of \$342 per patient visit does not cover the actual cost of the health care provided to Native American Veterans.

Proposed Change: Reimbursement health care service to AI/AN Veterans should be based on line-item billing. Medications should be billed at cost.

### BACKGROUND

The Indian Health Services was given approval on May 1, 2013 to bill the VA for all our Native Veterans.

The Memorandum of Understanding sets forth mutually agreed upon goals:

- Increase access, improve quality of health and leverage strengths.
- Patient-centered collaboration, communication.
- Effective partnerships and sharing agreements in consultation with Tribes.
- Ensure appropriate resources of services for AI/AN Veterans.
- Health-promotion & disease-prevention for AI/AN Veterans to address community - based wellness.

### SITUATION

- Services are generally billed by line-item for each patient. A patient bill typically exceeds the \$342 reimbursement rate. For an example, Emergency Services for a patient could be \$1,258.50 yet only \$342.00 would be reimbursed by the VA. Line-item billing would be better because it would then cover the cost providing the best possible health care to AI/AN Veterans while achieving the goals of the MOU.
- Similarly, VA patients receiving care typically have prescriptions for medications associated with concerns addressed in the office visit. Currently, only medications with a cost of \$20.00 or more are considered for payment. Ideally, all medications would be billed at cost.

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## OKLAHOMA CITY

### 1. Expanded Authority

Maximize the authority given by the IHCA to provide facilities and services, such as, medical rehabilitation, long-term care, elder care and behavioral health/substance abuse. The OCA recommends the development of a pilot project that addresses these types of facilities.

### 2. Medicaid Expansion

Lack of expansion in Oklahoma has directly affected the opportunity to collect additional third party revenue. Patients that may have been covered under this expansion will continue to be covered by PRC. The tragic result is limited access of care for the patient population that would have been covered by a Medicaid expansion.

In addition, there is inconsistency between the scope of services between States creating a disparity for AI/AN patients. The OCA recommends that IHS explore a direct relationship with CMS for the Medicaid program. In addition, the OCA recommends that IHS funding formulas be evaluated to adjust for Tribes in States that do not have Medicaid expansion.

## HOT TOPICS BY IHS SERVICE AREA

### 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 IHCA, 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 IHCA (or ACA) remains

Ensure IHCA survives any congressional or judicial 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.

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## PHOENIX

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

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

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 sufficient to hire needed staff or to sustain the infrastructure to expedite billing and reimbursement in order to enhance resources. Rural and frontier locations have these issues to contend with along with the struggles to attract professionals to these locations.

Dental Health: Tribes and urban Indian programs identified dental services as a significant need across the Phoenix Area. Dental decay among children requires significant attention. Adults, in most states are restricted from obtaining alternative resources to cover dental services. Medicaid coverage is largely limited to emergency dental services as an optional benefit. It is hoped that this may be remedied as Health Insurance Marketplace and state based Marketplaces have begun to offer information about affordable dental plans.

Crises & 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 on many reservations is detox services. These services aid individuals in serious situations. Further injury or death can be prevented if a safe detoxification environment can be provided.

## HOT TOPICS BY IHS SERVICE AREA

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

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

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## PORTLAND

### ISSUE: Autism

**BACKGROUND:** Autism is a developmental disability significantly that affects verbal and nonverbal communication and social interaction. Other characteristics of autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences. Autism adversely affects a child's educational performance and ability to learn. A recent report issued by the State of Oregon indicates that 84,707 kids are in special education as a consequence of autism. The report shows that since 2008-09, the number has risen by 2,727 kids -- a 3.3 percent growth rate, which is faster than Oregon's population growth of 2.6 percent in that period.<sup>7</sup> Systems will soon be stretched to capacity to respond to the growing population who may require additional support services. Tribal leadership has reported that the effects of autism are starting to impact Tribal communities. While autism has been present in the Tribal system, it more recently is starting to become a greater concern, and also having a financial impact on Tribal education and health budgets.

**RECOMMENDATION:** IHS and BIA need to collaborate to provide resources to screen on all AI/AN children for Autism Spectrum Disorder (ASD) by their second birthday, and use consistent process for the identification evaluation. Promote the training of personnel throughout I/T/U agencies. Support increased funding for Early Intervention/Early Childhood Special Educations by providing additional resource for the BIE and state agencies need to do more to assist Tribes.

### ISSUE: Uranium contamination on reservations

**BACKGROUND:** The Midnite Mine, located on the Spokane Tribe of Indians Reservation in Eastern Washington State was operated by the Dawn Mining Company under a lease from the Spokane Tribe of Indians from 1954 until 1981. In addition to radioactive contamination from uranium, heavy metals such as arsenic, cadmium, and manganese have been identified in local surface and groundwater (ATSDR, 2007, 2009). In addition to the Midnite Mine, another mine located on the reservation, Sherwood, and a uranium ore mill site just across the reservation boundary, the Ford Mill, both employed a large number of tribal members, potentially contributing both direct occupational exposure as well as secondary exposure of employees' family members and community members. Trucks hauled ore from the mines to the mill using roads that passed through the most populated areas of the reservation. The Spokane Tribal leadership continues to be concerned about the health effects of this mine on its tribal population and wants IHS to do more about it.

**RECOMMENDATION:** IHS and CDC should use health data to determine the impact and address this health issues with other federal agencies (i.e. EPA, CDC, IHS, BIA, etc.). The Spokane Tribe of Indians has long been interested in pursuing funding for a RESEP clinic in the Northwest. The IHS and other federal agencies should fund a RESEP clinic that is central accessible by patients from Northwest Tribes most affected by uranium mining-related exposure including the Nez Perce Tribe and the Coeur d'Alene Tribe (ID), Confederated Tribes of the Umatilla Indian Reservation and Confederated Tribes of

Warm Springs (OR) and Confederated Tribes and Bands of the Yakama Nation and The Confederated Tribes of the Colville Reservation (WA).

### ISSUE: Public Health Emergencies

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<sup>7</sup> Oregon Statewide Report Card, An Annual Report to the Legislature on Oregon Public Schools 2013-14, Oregon Department of Education, p.78, [www.ode.state.or.us](http://www.ode.state.or.us)

## HOT TOPICS BY IHS SERVICE AREA

**BACKGROUND:** While Tribal health programs have public health and medical care infrastructure it is often underfunded and may lack the capacity to respond effectively to health, natural, and manmade disasters. Too often population density is often a primary consideration in the allocation of emergency preparedness resources, it is important to recognize that public health emergencies and disasters can and do occur on Indian reservations and in rural areas in proximity to Tribes, and that the impact of these emergencies can be felt on all Americans regardless of geography. One need only consider the far reaching impacts of natural disasters, agricultural blight, and infectious diseases to realize the interconnectedness of our reservation, rural and urban citizens.

The recent public health emergencies dealing with the Ebola outbreak in the United States is yet another example. Tribes expressed concerns regarding the cost of deployment of IHS Commissioned Corp officers to combat Ebola, protecting AI/AN communities from exposure to the Ebola virus, and communications with Tribal leadership. While IHS facilities may have established infection control procedures IHS facilities are not equipped to deal with the Ebola virus. IHS and Tribal facilities in most cases do not have isolation rooms, full body protective gear, and other things necessary to contain the Ebola virus.

**RECOMMENDATION:** In order to ensure the readiness of the Tribal governments in times of crisis, an important consideration is that, while the Federal and state governments need to be financial partners in this endeavor, resources and implementation must also occur at the local Tribal level.

### ISSUE: Heroin use

**BACKGROUND:** Opioids are a class of drugs chemically similar to alkaloids found in opium poppies. Historically they have been used as painkillers, but they also have great potential for misuse. Repeated use of opioids greatly increases the risk of developing an opioid use disorder. The use of illegal opiate drugs such as heroin and the misuse of legally available pain relievers such as oxycodone and hydrocodone can have serious negative health effects. Nearly 17,000 overdose deaths in 2011 were related to prescription opioid medications. In 2013, among persons aged 12 or older, the rate of current illicit drug use was 3.1 percent among Asians, 8.8 percent among Hispanics, 9.5 percent among whites, 10.5 percent among blacks, 12.3 percent among American Indians or Alaska Natives, 14.0 percent among Native Hawaiians or Other Pacific Islanders, and 17.4 percent among persons reporting two or more races.<sup>8</sup>

**RECOMMENDATION:** Portland Area tribal leaders have noticed that heroin use is on the rise in their communities and stress the importance of prevention and treatment funding to address this growing issue. There is a tremendous need to increase culturally competent treatment and supportive services by providing additional funding to Youth Regional Treatment Centers.

### ISSUE: Providers limiting/refusing Medicaid patients

**BACKGROUND:** With an increased enrollment of individuals now eligible for Medicaid, Indian health providers have noticed an increase demand for services. With respect to specialty care and dental care Tribal health programs have also noticed an increase in providers refusing to serve Indian patients because they are at capacity or do not take Medicaid (dentists). One program in Washington has surveyed dentists within a 60 mile radius and could only find two dentists that took Medicaid and one of those programs was the tribe itself.

**RECOMMENDATION:** Portland Area Tribes recommend that CMS require states to pursue options with Medicaid managed care providers to ensure that they must offer contracts to Tribal health programs using a Indian addendum similar to the Part D and QHP addenda. This will assist to make referrals for specialty care. Portland Area Tribes also recommend that IHS support and pilot alternate approaches for providing oral health delivery similar to the Alaska DHAT model.

### ISSUE: Hepatitis C drugs

**BACKGROUND:** Hepatitis C Virus (HCV) affects an estimated 150 million persons worldwide, and about 5 million in the United States. In the US, an estimated 75% of HCV occurs among persons. Born between 1945 and 1965, most of whom do not know they are infected. Recent data from The Department of Veteran Affairs (VA) showed that 10% of veterans born 1945-1965 were confirmed positive with HCV, a rate that was seen among American Indian and Alaska Native (AI/AN) veterans as well.<sup>9</sup> Based on these and other national data, there are many tens of thousands of HVC patients in Indian Country with a high proportion of them undiagnosed. Most persons exposed to HVC will develop a chronic form of the infection, which can have

<sup>8</sup> Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, U.S Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality <http://www.samhsa.gov/atod/opioids>

<sup>9</sup> Backus, Lisa I., et al. (2013). Hepatitis C Virus screening and prevalence among US veterans in Department of Veterans Affairs Care. *Journal of the American Medical Association, Internal Medicine, 173.16:* 1549---1552.



## HOT TOPICS BY IHS SERVICE AREA

no symptoms for decades. HCV leads to highly elevated risk of death from liver disease, including cirrhosis, liver cancer, end-stage liver disease, chronic liver disease (CLD) and other complications. AI/AN have much higher rates of deaths from Chronic Liver CLD, including premature cirrhosis and liver cancer. The CLD death rate among AI/AN was 3.5 times higher, cirrhosis as 4 time higher, and hepatocellular cancer was 2.5 times higher than that of Whites.<sup>10</sup> HCV is the leading cause of liver transplants in the US.

### HCV Treatment

Past treatment for HCV lasted several months, presented severe side effects, required consistent injections, and had high failure rates. Within the last year, treatment for the four HCV genotypes found in the United States has improved dramatically – with three new treatments regimens being recommended. The new regimens can be taken orally, have few side effects for contraindications, and have treatment times shortened to a range of 8 to 12 weeks for almost all patients. Sustained virology response (SVR; patient effectively ‘cured’) has consistently improved with new treatments, and the latest regimens are resulting in SVR rates of > 90% according to current data. Obtaining HCV SVR has been cited as reducing liver failure by 90% and liver cancer by 70%<sup>11,12</sup>

New Drugs called Direct Acting Agents (DAAs) including harvoni, sofosbuvir, simeprevir, and ledipasvir, are approved – with more DAAs expected in the near future. These drug regimens represent a revolution in treatment that is shorter, more effective and less toxic than the previous generation of HCV treatment options. These regimens are oral-only, last 8-24 weeks, have few side effects, and have shown cure rates of 76 percent to 99 percent. The shorter treatment times, low toxicity, and high success rates of these drugs make HCV largely manageable at the primary care level for many HCV patients if there is specialist support available at key junctures such as intake and determination of treatment regimen.

### The Cost Barrier

The new treatment regimens are extremely expensive. Of note, two of the new HCV medicines cost over \$1,000 per pill, making a 12-week regimen over \$100,000. Insurance companies, state Medicaid programs, the VA and Indian Health Service (IHS) cannot afford the high cost of treatment for large numbers of patients, which has resulted in only those patients with the most severe liver disease qualifying for HCV treatment, although earlier treatments would have prevented fibrosis and cirrhosis. So far, IHS has successfully accessed various pharmaceutical companies’ patient assistance programs (PAPs). Although PAPs carry a heavy paperwork burden for both the patient and the provider, they obtain some or all of the needed HCV drugs for free.

The national response to HCV has begun with an emphasis for scaled up screening and treatment. Currently only a handful of IHS, Tribal, or Urban Indian health (I/T/U) sites are treating HCV patients. Relying upon PAPs does not represent a scalable or sustainable solution to meeting outstanding HCV treatment needs in Indian Country. The high costs of the new regimens and the perceived cost barriers are serving as a strong disincentive for I/T/U sites to initiate broader screen and treatment programs.

### Potential Budget Impact

In the last 12 months, IHS has spent \$1.2 Million on HCV medications through the Pharmaceutical Prime Vendor. Of this total, \$1 million was spent on Sofosbuvir alone. The cost for treatment averages approximately \$72,000 per patient. The cost for treating 25,000 patients would be \$1.8 billion.

Separately, Human Resources impacts and costs are projected but have not be formally assessed. These include:

- Clinical training/lab burden.
- Paperwork burden to secure medications via patient assistance programs.
- Routine appointment to monitor patients.

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<sup>10</sup> Suryaprasad, Anil, et al. (2014). Mortality caused by chronic liver disease among American Indians and Alaska Natives In the United States, 1999–2009. *American Journal of Public Health*, 104.S3: S350---S358

<sup>11</sup> Lok, Anna S., et al. (2012). Preliminary study of two antiviral agents for hepatitis C genotype 1. *New England Journal Of Medicine*, 366.3: 216---224,

<sup>11</sup> Ghany, Marc G., et al. (2009). Diagnosis, management, and treatment of hepatitis C: An update. *Hepatology* 49.4: 1335---1374.

<sup>12</sup> Van der Meer, Adriaan J., et al. (2012). Association between sustained virological response and all---cause mortality Among patients with chronic Hepatitis C and advanced hepatic fibrosis. *Journal of the American Medical Association*, 308.24: 2584---2593.

## HOT TOPICS BY IHS SERVICE AREA

**RECOMMENDATION:** Portland Area Tribes recommend that I/T/U sites receive the clinical and administrative support related to diagnosis and treatment for HCV patients. Even if a clinic treats only a small cohort of patients at a time, many lives will be saved. While it is difficult to project the current and future rate of HCV-related deaths and complications, available data shows the impact of HCV is high, and growing. A recent IHS study showed that HCV hospitalizations more than tripled in recent years.<sup>13</sup> CLD mortality has been significantly increasing from 1999-2009. One prominent study estimated CLD to be the 4<sup>th</sup> leading cause of death among AI/ANs, a rate that is nearly three times higher than the Ai/AN mortality rate for diabetes.

### ISSUE: Tulalip shooting

**BACKGROUND:** Youth violence refers to harmful behaviors that can start early and continue into young adulthood. The young person can be a victim, an offender, or a witness to the violence.

Youth violence includes various behaviors. Some violent acts—such as bullying, slapping, or hitting—can cause more emotional harm than physical harm. Others, such as robbery and assault (with or without weapons), can lead to serious injury or even death.

Deaths resulting from youth violence are only part of the problem. Many young people need medical care for violence-related injuries. These injuries can include cuts, bruises, broken bones, and gunshot wounds. Some injuries, like gunshot wounds, can lead to lasting disabilities.

Violence can also affect the health of communities. It can increase health care costs, decrease property values, and disrupt social services.<sup>14</sup> A number of factors can increase the risk of a youth engaging in violence. However, the presence of these factors does not always mean that a young person will become an offender.

Risk factors for youth violence include: Prior history of violence; Drug, alcohol, or tobacco use; Association with delinquent peers; Poor family functioning; Poor grades in school; Poverty in the community.

Among 10 to 24 year-olds, homicide is the leading cause of death for African Americans; the second leading cause of death for Hispanics; and the third leading cause of death American Indians and Alaska Natives.<sup>15</sup> ([http://www.cdc.gov/violenceprevention/youthviolence/schoolviolence/data\\_stats.html](http://www.cdc.gov/violenceprevention/youthviolence/schoolviolence/data_stats.html))

**RECOMMENDATION:** IHS should develop better internal systems to develop crisis plans and supply mental health providers in emergency situations like the shootings at Tulalip and Red Lake. Often Tribes do not know that such plans may even exist (if they do), or what the protocols are for seeking IHS assistance. IHS should also conduct training and technical assistance to IHS and Tribal health programs about these plans and protocols so that Tribes are better equipped to respond to emergency situations.

### ISSUE: Human Trafficking

**BACKGROUND:** Human trafficking is a serious federal crime with penalties of up to imprisonment for life. Human trafficking involves a person to perform commercial sex related acts, labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. In comparison to other racial and ethnic groups, Native women remain the most frequent victims of physical and sexual violence in the U.S. and in Canada. In the U.S., their rate for sexual assault and rape in 2000 was 7.7 per 1,000 women versus 1.1 for White women, 1.5 for African American women, 0.2 for Asian women, and 0.6 for Hispanic women. Over 30% of Native women have experienced an attempted or completed rape in their lifetimes, versus 17.9 % of Whites, 18.8% of African Americans, and 6.8% of Asians (Tjaden & Thoennes, 2006)."

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<sup>13</sup> Byrd, K. K., et al. (2011). Changing trends in viral hepatitis--associated hospitalizations in the American Indian/Alaska Native population, 1995–2007. *Public Health Reports*, 126.6: 816.

<sup>14</sup> Centers for Disease Control and Prevention. Youth risk behavior surveillance—United States, 2011. *MMWR, Surveillance Summaries* 2012;61(no. SS-4)

Behaviors that Contribute to Violence on School Property Fact Sheet, CDC

<sup>15</sup> Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). [cited 2012 Oct 19] Available from [www.cdc.gov/injury](http://www.cdc.gov/injury).

Understanding Youth Violence Factsheet, CDC

## HOT TOPICS BY IHS SERVICE AREA

There are several common risk factors among victim's poverty, young age, limited education, lack of employment opportunities, homelessness, run-away, history of substance abuse. Native women and children are often target because they are desperate to meet their survival needs. In many case Tribal communities are not prepared to recognize or provide services for those individuals who are being trafficking. The following recommendations are from the Alaska Native Task Force on Sex Trafficking:

**RECOMMENDATION:** Tribes need assistance to begin to address this issue. IHS should coordinate with other federal agencies that have jurisdictional responsibilities for dealing with the effects of human trafficking (i.e. SAMHSA, DOJ, BIA, FBI, etc.) so that responsibilities are more clearly defined. Resources are also need to implement prevention and prosecution activities.

**ISSUE:** Cost for Outreach and enrollment into ACA

**BACKGROUND:** Portland Area Tribes are concerned that they had to perform many administrative activities related to education, outreach and enrollment for Medicaid and the Insurance Exchanges. In most instances in the private sector, these costs were accommodated by funding organizations to conduct such services or performed by the State itself. Tribes were funded very little if at all to conduct such activities yet had their tribal personnel carry out this work. This disrupted patient care as tribes had to shift resources away from carrying out direct health care and other associated administrative activities. Often the state outreach and education assistance is inadequate to address or respond to the questions and needs of Indian people. Tribal health programs are in best position to do this however they lack the necessary capacity to do the jobs they are financed to do (provide direct health care) and also carry out the responsibilities of the state and federal government.

**RECOMMENDATION:** IHS and CMS need to find a mechanism to directly fund these administrative costs for Tribes. The states get reimbursed for such activities and Tribes should too, as to not infringe on patient care.

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## TUCSON

### Diabetes prevalence

The Tohono O'odham Nation is the 2<sup>nd</sup> largest tribe, and is aware we have the highest prevalence rate of 20.1%. Although much has been accomplished by the SDPI program to provide real returns, one is the development of a comprehensive diabetes management program that would improve patient care. Services would include diabetes education, oral health, foot care, eye care and through the curriculum components, which includes behavioral health that focuses on the patient. Efforts to continue the collaborate and communicate between the Tohono O'odham Department of Health and Human Services and Indian Health Service is beneficial to the outcome of the patients overall care to treat and prevent diabetes in ways that significantly reduce this disease By efforts with both entities.

### SITUATION

The Tohono O'odham Nation Health Department, SDPI program offers diabetes education and prevention that will improve patient care for all tribal members. To improve overall patient care the Indian Health Services and the Tohono O'odham Nation Department of Health and Human Services are working to establish an electronic health record system; to assist in capturing the diabetes education and prevention services information is documented, thus would have an impact on improving patient care.

### Equipment Replacement

### ISSUE

Equipment Replacement, lack of funds to replace medical equipment.

### BACKGROUND

The Pascua Yaqui Tribe is in need of new medical equipment and the distribution formula for equipment dollars is based on square footage which creates a challenging situation for the Pascua Yaqui Tribe.

### SITUATION

## **HOT TOPICS BY IHS SERVICE AREA**

For the Pascua Yaqui Tribe there are no Indian Health Service facilities, medical services are rendered directly and indirectly through a non-traditional system of subcontracts and 90% of the funding received is Purchased/Referred Care (PRC). The equipment funding Pascua Yaqui Tribes receives only supports a small clinic space.

### **Urban Health Funding**

#### **ISSUE**

Title V Contract Funds, request additional funding for Urban Indian population increases.

#### **BACKGROUND**

The Tucson Indian Center serves the Urban Native American Population of Metropolitan Tucson, providing health promotion, preventative services, education, outreach, and referral services to a population of 44,817. Since 2012, the active client population has increased 21.9% and there have been no corresponding Budget Increases to the Urban Health Funding.

#### **SITUATION**

The Tucson Indian Center request additional Title V Contract Funds for the population growth \$111,690 and \$16,164 for medical inflation which was 2.6% at June 2014 (2.6% of \$621,690).

### Introduction

Tribes and Tribal organizations receive a disproportionately low number of Department of Health and Human Services (HHS) grant awards. While IHS is the primary agency providing health care delivery for AI/ANs, the federal trust responsibility is the responsibility of all government agencies, including other departments within HHS. During the last several years, Tribes have developed a strong working relationship with HHS leadership and its agencies. While these conversations are frequently productive, much remains to be done as Tribes are consistently left-out of key funding opportunities. Across HHS, agency leadership often understands and supports the unique situation of Tribal governments but bureaucratic processes that score grant applications are stacked so that Tribes often miss out on critical opportunities.

The reasons for this are multi-faceted and involve statutory, regulatory, administrative or policy issues. For instance, many Tribal communities do not meet stringent eligibility criteria for certain federal grants or do not have the staff or capacity to write grant applications that are competitive with state agencies or large universities. Other barriers involve matching fund requirements or lack of knowledge about traditional healing practices among grant reviewers.

The Tribal Budget formulation Workgroup recommends that HHS use its administrative authority to overcome some of these barriers and advocate for statutory change when necessary. The following report will address some of these concerns and ask the HHS to clearly look at this information.

### EXPANSION OF SELF GOVERNANCE AT HHS

Expansion of Tribal Self-Governance at HHS also supports Tribal requests to expand Tribal Self-Governance to agencies at HHS beyond the IHS. A 2003 study done by HHS determined this was feasible. The Obama Administration reopened this dialogue with Tribes and convened a workgroup to discuss this further. The workgroup determined self-governance expansion was feasible but that legislation would be needed to move forward with expanding self-governance at HHS. Tribes are eager to work with HHS on the development of a legislative proposal that would expand self-governance. For many Tribes, the choice to self-govern ensures efficiency, accountability and best practices in managing and operating Tribal programs and administering federal funds at the local level. We reiterate the request of the Secretary's Tribal Advisory Committee to renew a Tribal Federal workgroup be established to continue the work left undone (Pilot Title VI of ISDEA) at the cessation of the Self Governance Tribal Federal Workgroup (SGTFW) two years ago.

### Statutory Barriers to Accessing Grants at HHS

It is no secret that Tribal communities experience some of the worst health disparities in the country. The average life-expectancy for AI/ANs is 4.2 years less than the national average, but on some reservations, it is as low as 48. That's actually *14 years less* than the lifespan in Haiti – the poorest country in the Western Hemisphere. Our population suffers disproportionately from cancer, diabetes, heart disease, substance abuse and suicide. Clearly, more must be done to ensure that our people are not living sicker and dying younger.

Tribal governments enjoy a government-to-government relationship with the United States but often do

### HIV PREVENTION AND OUTREACH

The Centers for Disease Control and Prevention (CDC) has funded organizations in the past specifically to work with American Indian and Alaska Native communities on HIV prevention, and this funding has helped to establish and reaffirm national leaders in HIV prevention, care and treatment in Indian Country. However, during the last round of funding for five-year grants, CDC did not fund *any* AI/AN-specific organization to provide support or capacity building. This failure to fund Tribal organizations is especially troubling when considering the rates of HIV incidence in American Indian and Alaska Native communities has continued to rise over the past decade while the rates have fallen in other communities.

*See: PS14-1403, "Capacity Building Assistance for High-Impact HIV Prevention."*

not have the same status as state governments when it comes to accessing grants. Out of the 10 block grants that HHS administers,<sup>16</sup> four do not allow Tribes to access them directly. To access those funds, Tribal governments must go through the states, which have a very mixed record of ensuring money ever reaches the Tribes. Of those block grants where tribes *can* access them directly, few of the block grants have robust participation by tribes who receive these funds directly. It is likely that many Tribes do not even know that direct funding is available in these cases.

Other statutory barriers involve requirements for matching funds that may be prohibitive for underserved groups that lack resources for the match. Tribes are often at a disadvantage for 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. While statutory requirements are often necessary to design programs that meet the need identified by Congress, it is critical that the Administration identify these barriers and work with Congress to make concessions on some of these factors.

#### Regulatory / Administrative Barriers

Tribal governments and Tribal organizations often experience barriers to accessing grants at the Administrative and Regulatory level as well. These include:

- Lack of resources to track and identify grant opportunities;
- Unique grant application and management requirements for programs across agencies;
- The inherent advantage previous HHS grantees have in the award process;
- Lack of explicit statements about eligibility in grant announcements; and
- Implementation requirements designed for projects targeted at state governments vs. Tribal governments.

Many of the Tribal communities who are most in need of HHS grant funding are those with limited capacity and resources to employ a robust grant writing team that could compete with a state government or university. Few of these Tribes have the ability to sift through all federal opportunities, let alone, apply.

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<sup>16</sup> Child Care and Development Block Grant; Community Mental Health Services Block Grant; Community Services Block Grant; Low Income Home Energy Assistance Block Grant; Maternal and Child Health Services Block Grant Preventive Health and Health Services Block Grant; Social Services Block Grant; Substance Abuse Prevention and Treatment Block Grant; Temporary Assistance to Needy Families; Title V Abstinence Education Block Grant

## DHHS GRANTS SUMMARY

The federal government should be targeting Tribal communities when it writes grant announcements and reviews applications.

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.

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 HHS 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

Tribes recommend several policy changes at the agency level to ensure that Tribal communities are receiving access to grant funding at HHS:

- Advocate in Congress for direct access to Tribes for federal grant programs
- Provide Grant opportunities directly to Tribes instead of funneling through state governments, and work with Congress to change statute when necessary.
- Provide specific, targeted, outreach to Tribal communities when grant funding becomes available. This should target *all* Tribal governments, but especially those in areas with great need.
- Explicitly honor traditional health methods in drafting grant announcements and in reviewing grant applications
- Recruit grant reviewers who are experienced in working with Tribal governments. If not available, HHS should provide cultural competency training for each grant reviewer at the department
- Fund additional capacity building grants so that smaller or less resourced Tribes may be able to access the grant funds more consistently



Photo Credit: James Cook, 1990  
The Centennial Ride to Wounded Knee

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On December 29, 1990, photographer James Cook caught sight in the distance of the more than 350 horseback riders who were recreating the ride to Wounded Knee, South Dakota, as part of a centennial memorial of the massacre that occurred there in 1890. The riders were near the end of their 7-day, 300-mile journey.

Since 1986, the descendants of those killed at Wounded Knee Creek have recreated the ride to the site. More than 350 men, women and children were to be escorted by US troops so they could be transported to Omaha, Nebraska, to be resettled on Indian reservations. When a medicine man and others failed to comply, a shoot-out ensued. In less than an hour, 150 Lakota and 25 soldiers were dead. A three-day blizzard followed the battle, freezing the dead bodies and killing the wounded.

The weather Cook experienced as he tried to document the ride mirrored the blizzard of 1890. Temperatures hovered around -54 degrees and harsh winds blew across the arid landscape. He learned early on to rewind the film slowly, or, stiffened by the cold, it would shatter. If he exhaled when his face was too close to the camera, his breath would freeze his face to the viewfinder.

Cook began photographing native peoples in the late 1980s because, as he says, the richness of the culture fascinated him. Cook is of European descent, but says he doesn't know much about his own cultural heritage. "I started realizing that the Native Americans had a lot going with their cultural roots and preserving their heritage," he says. "I admire that; I envy that."

To Cook, photographing Native Americans is about documenting a specific point in history. "It's all evolving, and I think it's important to document things as they are in our day and age," he says. The passage of time is evident in his "The Ride To Wounded Knee" image as well. "We got the headdresses and horses, but one of the riders is wearing a snowmobile outfit as well," he says.