

"I promised a true government-to-government relationship -- a relationship that recognizes our sometimes painful history, a relationship that respects the unique heritage of Native Americans and that includes you in the dream that we all share."

President Obama  
Address to White House Tribal Nations Conference  
December 2, 2011

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## *Together, Building on Our Trust for the Health of Our People*

### **The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2014 Budget**

Annual National U.S. Department of  
Health and Human Services Tribal  
Budget and Policy Consultation

March 2012

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"The trust responsibility is not a  
discretionary choice. It is not a line item.  
It is a solemn agreement that has been  
sustained over hundreds of years."

Jefferson Keel, President  
NCAI State of Indian Nations Address  
January 26, 2012

"Together, we have made enormous progress  
across Indian country promoting healthy people  
and healthy communities while honoring every  
Tribe's sovereign rights. And yet too many First  
Americans continue to live sicker and die  
younger than their peers."

Kathleen Sebelius, Secretary  
Department of Health and Human Services  
December 2, 2011

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## Executive Summary

American Indians and Alaska Natives have faith in the commitments made by the Federal government that will drive meaningful improvements in the health and well-being of Tribal members. Tribal communities face an unrelenting health crisis that has left thousands of First Americans without basic health care, and a national economic crisis has made life more difficult for our population. Across the nation, Indian families are doing their best just to scrape by—doing without basic health care as they struggle with day-to-day living expenses. Yet, these proud Indian men and women grew up believing that through their diligent efforts America would honor the treaties signed by our ancestors. They believe in a country where, as so eloquently stated by our President, “everyone gets a fair shake and does their fair share.” Yet, for decades now, American Indians and Alaska Natives have watched this solemn contract with the U.S. Government continually erode as politics are put ahead of trust obligations.

Over the past few years, this Administration and Congress have proven that they are willing to take steps to turn the corner on this injustice. Tribes are appreciative of the progress made in recent years due to the increases in Indian health funding. However, much more still needs to be done to finally end long-standing inequities in health status for First Americans. American Indians/Alaska Natives die at higher rates than other Americans from tuberculosis (500% higher), alcoholism (514% higher), diabetes (177% higher), unintentional injuries (140% higher), homicide (92% higher) and suicide (82% higher).” The urgency to solve this health crisis remains and is reflected in the modest budget request set forth in this document.

An investment in Tribal health programs, services and projects will benefit all Americans. Funding the Tribal budget request creates a workforce and much-needed jobs in communities. Funding health promotion initiatives is a smart long-term investment, reducing future costs by lessening the need for expensive chronic care and high acuity emergency care. Now is the time to act on opportunities made possible in the newly expanded authorities granted under the Indian Health Care Improvement Act. Now is the time to seek out creative ways to collaborate with other agencies within the HHS to utilize existing resources and target AI/AN needs. These are the foundational blocks necessary to address the true needs in Indian Country. To do anything less is to ask this country's First Americans to continue to accept a lesser future.

The National Tribal Budget Formulation Workgroup recommends the following Indian Health Service budget for FY 2014:

**Tribal Total Needs Budget Request: \$26.1 Billion**

**FY 2014 Tribal Budget Recommendation: \$5.3 Billion**

**Highlights of the Budget Recommendations:**

- No reductions to any IHS budget line item
- Full funding for Current Services and funding to address on-going fiscal obligated requirements of \$469.4 million including, Tribal and Federal Pay Act costs, medical and non-medical costs, population growth, staffing for new facilities, Contract Support Cost shortfall, and “must have” Health Care Facility Construction project costs.
- Support for Program Expansion of \$502.8 million
  - Program increases reflect modest increases over FY 2012 Enacted budget levels to provide additional support for national Tribal priorities.
  - Placeholder amounts have been included in the budget request for the Indian Health Care Improvement Fund (+\$10 million), HIT (+\$10 million) & new Long Term Care authorities (+\$10 million); these budget lines are subject to adjustments once approved funding needs projections are complete.
  - Budget requests for Health Care Facilities Construction and Sanitation Facilities Construction have been reinstated back to pre-ARRA levels of funding.
  - The request does not fully address unmet Contract Health Services needs, which the IHS Director’s Workgroup on Improving Contract Health Services is currently reviewing.

“Native Americans have demonstrated time and again their commitment to advancing our common goals, and we honor their resolve in the face of years of marginalization and broken promises. My Administration recognizes the painful chapters in our shared history, and we are fully committed to moving forward with American Indians and Alaska Natives to build a better future together.”

President Obama  
Proclamation on Native American Heritage Month  
November 1, 2011

## Introduction: The Foundation for Health - The Trust Responsibility

“This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.”

U. S. Const., art. VI, cl. 2

To American Indians and Alaska Natives (AI/ANs), the federal budget is a moral, as well as a fiscal document. The budget request for health care services, as provided by the Indian Health Service (IHS) and through other U.S. Department of Health and Human Services (HHS) programs, reflects the extent to which the United States honors its promises of justice, health and prosperity to Indian people. The provision of federal health services to AI/ANs is the direct result of treaties and executive orders that were made between the United States and Indian Tribes, and of two centuries of Supreme Court case law and Congressional action developed in the wake of those treaties. Through the cession of lands and the execution of treaties, the federal government took on a trust responsibility to provide for the health and welfare of Indian peoples. This federal trust responsibility is the foundation for the provision of federally funded health care to all enrolled members of the 566 federally recognized Indian Tribes, bands, and Alaska Native villages in the United States.

### ***National Tribal Budget Formulation***

***Workgroup (Workgroup):*** Members include Tribal representatives from each of the 12 IHS 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.

### **Foundation for National Tribal Budget Formulation Workgroup’s Recommendations**

- U.S. treaties and laws that require the U.S. government to provide health services to Indian people are grounded in the U.S. Constitution. The federal government has a constitutional obligation to fulfill this trust responsibility.
- Because of this trust responsibility, federal spending for the Indian Health Service is mandatory, not discretionary, spending. The IHS, like the Veterans Administration, should be exempt from broad-based cuts in discretionary spending, budget rescissions and sequestration.

- Although significant improvements in mortality and morbidity rates for AI/ANs have been and continue to be made by IHS, Tribal and Urban Indian health programs (I/T/Us or collectively, the “Indian health system”), serious health disparities persist between AI/ANs and the general U.S. population.
- In addition to significant health disparities, the Indian health system also faces significant funding disparities, both in per capita spending between IHS and other federal health care programs and within IHS, as reflected by differences in the Level of Need Funded (LNF) among IHS Areas and among sites within IHS Areas. (See Appendix Table A )

### ***FY 2014 Budget Priorities & Recommendations***

The National Tribal Budget Formulation Workgroup endorses the following Indian Health Service budget recommendations for FY 2014:

#### **Tribal Budget Policy Recommendations**

- Protect the prior year increases in FY 2012 and hold Indian health programs harmless from budget rollbacks, freezes, rescissions and sequestration. Indian people have just begun to benefit from the increased investments made in Indian health in Fiscal Years 2008, 2009 and 2010. In the 2011 Continuing Resolution, there was only a .4% overall increase, which from a Tribal perspective was a significant setback.

Sequestration: The Tribes are very concerned about the repercussions of the stalemate on deficit reduction measures by the Joint Select Committee on Deficit Reduction, also known as the Supercommittee, created as a part of the Budget Control Act of 2011. Unless Congress acts, the sequestration process automatically triggers across-the-board cuts, including a potential 2% cut annually in the IHS Services and Facilities accounts from FY 2013 through FY 2021, and higher cuts for other health programs and services provided by HHS. Unless critical Indian health programs are

“The federal Indian programs that we fight hardest to fund were created to fulfill the trust responsibility between this Nation and its first people. Authority to fund these programs derives from three distinct provisions of the Constitution – the Indian Commerce Clause, the Treaty Clause and the Property Clause. This is not “nice to have” spending. That is “must have” spending to fulfill the trust responsibility founded in the Constitution.”

Senator Lisa Murkowski (R-AK),  
Ranking Member  
Subcommittee on Interior and  
the Environment  
Senate Committee on  
Appropriations,  
January 27, 2011

protected from sequestration measures, the progress made in recent years to address severe and chronic health and funding disparities in Indian Country may be jeopardized.

- Make a commitment to a multi-year funding agreement to fully fund the IHS Total Need of \$26.1 billion over the next 10 years. This amount is based on current shortfalls and backlogs of unmet need and the funding needed to bring parity to the IHS per capita spending compared to other federal health programs, such as the Federal Employees Health Benefits (FEHB) program. Developing and implementing a plan to achieve funding parity is critical to the future of Indian health and to fulfilling the United States' trust responsibility to AI/AN people. (See "AI/AN Needs Based Funding Aggregate Cost Estimate" table in the Appendix B).

### **Top Tribal IHS Priority Line Items**

- Fully fund Current Services (Federal & Tribal Pay Costs, Medical & Non-Medical Inflation and Population Growth) at \$163.5 million and other obligated commitments (New Staffing for New/Replacement Facilities (+\$50 million), Contract Support Cost - Shortfall (+\$109.2 million) and Health Care Facilities Construction (+\$146.7 million) for a total of +\$469.4 million.
- Increase the IHS budget for FY 2014 by \$502.8 million for necessary program increases over the FY 2012 IHS Enacted Budget to a total of \$5.3 billion. The priority line items and increases that are critical are listed below.
- Hospitals & Clinics (H&C) - Increase funding for Hospitals & Clinics by \$196.2 million over the FY 2012 Enacted Budget. This includes a \$166.2 million increase to address outpatient and inpatient medical care needs. Tribes also request within the H&C line item:
  - Additional \$10 million increase to implement American Recovery and Reinvestment Act (ARRA) provisions related to the HITECH Act to upgrade Health Information Technology at Tribal programs
  - Additional \$10 million in FY 2014 to begin implementation of the Indian Health Care Improvement Act's Long Term Care provisions and
  - Additional \$10 million for the Indian Health Care Improvement Fund.
- Mental Health - Increase funding for Mental Health by \$45.8 million over the FY 2012 Enacted Budget to address resource deficiencies at behavioral health programs that are providing outpatient and emergency crises services and community based prevention programs. These vital programs address such issues as suicide and suicide attempts, co-occurring disorders and depression among the AI/AN population.

- Contract Health Services (CHS) - Increase funding for CHS by \$171.7 million over the FY 2012 Enacted Budget, which includes \$10 million for the Catastrophic Health Emergency Fund (CHEF). This amount is required to meet the high demand to purchase services from the private sector because most IHS and Tribal operated direct care facilities do not provide the required emergency and specialty care services.
- Health Education - Increase funding for the Health Education line item by \$7.9 million over the FY 2012 Enacted Budget to provide resources to the current Health Educators that have the enormous responsibility of providing community health, school-based health, and individual patient education in Tribal communities.

*"From my perspective, when it comes to the health and well-being of the American Indian and Alaska Native people, our responsibility at HHS extends beyond the Indian Health Service and our Office of Intergovernmental and External Affairs. It is a critical part of our work in every operating division and program office across the Department."*

*Kathleen Sebelius,  
HHS Secretary  
White House Tribal Nations  
Conference, December 2, 2011*

- Contract Support Costs (CSC) - Increase funding by \$8.3 million over the FY 2012 Enacted Budget for new and expanded programs identified in FY 2012 associated with the ongoing 329 Tribal contracts and compacts.
- Health Care Facility Construction - Increase funding by \$25 million over the FY 2012 Enacted Budget to provide funding needed for two or more Joint Venture projects and for the agency to implement the Facilities provisions of the Indian Health Care Improvement Act.
- The increases identified are needed to address funding disparities between the Indian Health Service and other federal health programs as illustrated below and in the "2011 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita" chart included in the Appendix C.



**FY 2014 National Tribal Budget Recommendation Table**

<i>Planning Base - FY 2012 Enacted</i>		<b>\$4,306,527,000</b>
<b>Current Services &amp; Binding Obligations</b>	<b>Subtotal</b>	<b>\$469,441,000</b>
<b>Current Services</b>	<b>Subtotal</b>	<b>\$163,547,000</b>
Federal Pay Costs		14,634,000
Tribal Pay Costs		17,181,000
Inflation (medical & non-medical)		73,837,000
Population Growth		57,895,000
<b>Binding Obligations</b>	<b>Subtotal</b>	<b>\$305,894,000</b>
New Staffing for New & Replacement Facilities		50,000,000
Contract Support Costs - Shortfall		109,233,000
Health Care Facilities Construction (5-yr plan)		146,661,000
<b>Program Expansion Increases - Services</b>	<b>Subtotal</b>	<b>\$455,997,000</b>
Hospitals & Health Clinics	<b>Subtotal</b>	196,198,000
Hospitals & Health Clinics - Increase Services		166,198,000
Indian Health Care Improvement Fund		10,000,000
Information Technology		10,000,000
Long Term Care		10,000,000
Dental Services		6,829,000
Mental Health		45,806,000
Alcohol and Substance Abuse		9,409,000
Contract Health Services (includes \$10M for CHEF)		171,661,000
Public Health Nursing		2,196,000
Health Education		7,920,000
Community Health Representatives		4,386,000
Alaska Immunization		6,000
Urban Indian Health		1,644,000
Indian Health Professions		459,000
Tribal Management Grants		174,000
Direct Operations		931,000
Self-Governance		35,000
Contract Support Costs - New & Expanded		8,343,000
<b>Program Expansion Increases - Facilities</b>	<b>Subtotal</b>	<b>\$46,826,000</b>
Maintenance & Improvement		2,710,000
Sanitation Facilities Construction		17,903,000
Health Care Facilities Construction Authorities		25,000,000
Facilities & Environmental Health Support		942,000
Equipment		271,000
<b>GRAND TOTAL</b>		<b>\$5,278,791,000</b>

% and \$ Change over Planning Base

22.58%

\$972,264,000

## FY 2014 Tribal Budget Priorities

“We are well aware of the budget challenges our nation faces. We live in Indian Country – we know all about doing more with less. We urge Congress to stand up for the relatively small piece of the federal budget that belongs to Tribal nations and our citizens.”

Jefferson Keel,  
NCAI State of Indian Nations Address,  
January 26, 2012

### ***Current Services & Other Obligated Fiscal Requirements***

AI/AN Tribes have long recognized 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 Cost Shortfalls, and all expected off the top mandatory assessments taken from the IHS budget. The Workgroup strongly recommends that full funding for Current Services and obligated fiscal requirements at the actual expected projected costs be funded as reflected in this section. (See “Diminished Purchasing Power” Graph in Appendix D)

***If the Current Services base is understated, program increases cannot be enacted as intended. Understating the amount necessary for Current Services creates a false expectation that a dollar increase is available to expand services when, in fact, these dollars only cover actual amounts necessary to maintain the status quo.***

### **CURRENT SERVICES: +\$163.5 million**

**Federal and Tribal Pay Costs** - The budget request includes an increase of \$31.8 million for Pay Costs based on the fixed cost projections for FY 2012 used in the FY 2014 budget formulation process, which included a 1.4% increase for both Federal, and Tribal employee pay costs. The members of the National Tribal Budget Formulation Workgroup feel strongly that not only Commissioner Corps Officers, but also all Tribal and Federal IHS employees should be exempted from any federal employee pay freeze that may be imposed in FY 2013 or 2014.

**Inflation (medical & non-medical)** - Funding for IHS programs has not kept pace with inflation, while Medicaid and Medicare have accrued annual increases of 5% - 10%. The \$73.8 million requested is needed to address the rising cost of providing health care and is based on the 1.5% non-medical inflation rate and 3.3% medical inflation rate identified by the Office of Management and Budget (OMB). However, the actual inflation rate for different components of the IHS health delivery system is much greater. As a component of the Consumer Price Index (CPI), inpatient hospital care is currently at 7% and outpatient hospital care is at 5%. The National Tribal Budget Formulation Workgroup feels that the rates of inflation applied to Hospitals & Clinics, Dental Health, Mental Health and Contract Health Services in developing the IHS budget should correspond to the appropriate components in the CPI. (See “Diminished Purchasing Power” Graph in Appendix D)

**Population Growth** - The request for \$57.9 million will address the increased service need arising from the growth in the AI/AN population, which is increasing at an average rate of 1.5%.

**Other Fiscal Obligations: +305.9 million**

**Reasons for Breaking Out Other Obligated Fiscal Requirements** - Current services estimates calculate mandatory costs increases necessary to maintain the current level of care. These “mandatories” are unavoidable and include medical and general inflation, pay costs, staff for recently constructed facilities, Contract Support Costs (CSC), and population growth. The costs associated with funding CSC and staffing for new and replacement facilities are presented as a subset of current services to emphasize the importance of funding these items. These other fiscal obligations represent commitments previously made by IHS, and must be funded in order to honor commitments made by the federal government.

**Staffing for New/Replacement Facilities** - \$50 million is recommended to fund staffing and operating costs for new facilities in FY 2014. IHS construction funds are targeted to expand service at sites experiencing 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 recommended amount is subject to adjustment based on status of actual projects completed in FY 2014.

**Health Care Facilities Construction 5-Year Plan** - \$146.7 million is requested for previously approved health facility construction projects in accordance with the IHS Health Care Facilities FY 2013 Planned Construction Budget, referred to as the 5-Year Plan, which includes the following facilities:

### Inpatient Facilities

Gila River PIMC Southeast  
Ambulatory Care Center (AZ)  
Salt River PIMC Northeast  
Ambulatory Care Center (AZ)  
PIMC Central Hospital &  
Ambulatory Care Center (AZ)  
White River Hospital (AZ)  
Gallup Hospital (NM)

### Outpatient Facilities:

Fort Yuma (CA)  
Kayenta (AZ)  
San Carlos (AZ)  
Rapid City (SD)  
Dilkon (AZ)  
Alamo (NM)  
Pueblo Pintado (NM)  
Bodaway Gap (AZ)  
Albuquerque Health System (NM)  
Sells (AZ)

**Youth Regional Treatment Centers:** Southern California YRTC & Northern California YRTC

Additional funding for new Joint Venture projects and expanded Facilities authorities has been included in the Health Care Facilities Construction budget under Program Increases.

**Contract Support Costs: Shortfall** - The National Tribal Budget Formulation Workgroup recommends a \$109.2 million increase to fund Contract Support Costs (CSC) in FY 2014. The Tribal self-determination and self-governance initiatives are widely recognized as the single greatest contributor to improved health care in American Indian and Alaska Native communities. The choice of Tribes to operate their own health care systems and their ability to be successful in this endeavor depend upon the availability of CSC funding to cover fixed costs. Absent full funding, Tribes are forced to reduce direct services in order to cover the government's CSC shortfall. Adequate CSC funding assures that Tribes, under the authority of their contracts and compacts with IHS, have the resources necessary to administer and deliver the highest quality healthcare services to their members without sacrificing program services and funding.

"It is important to remember our history and the promises we made. It is time to account for those promises, kept and unkept."

Sen. Daniel Akaka,  
Speech Commemorating Native  
American Heritage Month,  
November 16, 2011

## ***Program Increases***

Tribes request that the Administration commit to the goal of achieving full funding of the Tribal Needs base budget of \$26.2 Billion over the next 10 years. To accomplish this, the National Budget Formulation Work Group recommends the FY 2014 Budget Program Increases outlined in this section of the Budget request which will continue the significant progress made by this Administration in the past 3 years to bring AI/AN into parity with other citizens of the United States.

Included in the Hospitals & Clinics (H&C) line items are “placeholder” amounts for the Indian Health Care Improvement Fund, Health Information Technology, and Long Term Care. These “placeholder” amounts are in place as minimum funds necessary to begin to address these new programs and services and are subject to adjustment as more comprehensive program planning activities are completed.

Other program funding requests reflect what is needed to continue the progress on addressing the health disparities suffered by AI/ANs. These include substantial increases in Hospital & Clinics and Contract Health Services, and reinstatement of funding to address the pre-ARRA funding Health Care Facilities Construction and Sanitation Facilities Construction priority lists.

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

### **SERVICES: + \$ 456.0 million**

**Hospital & Clinics: + \$196.2 million** – Funding for Hospitals & Clinics (H&C) is a top Tribal budget priority in order to gradually raise the bar above the 55% average deficiency funding level for all AI/AN. More than half of the IHS H&C budget is transferred under P.L. 93-638 contracts or compacts to the Tribes, who are responsible for approximately 58% of the IHS outpatient workload and 50% of the inpatient workload. H&C funding support essential personal health medical care including inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy and other services. H&C funds also supports community health initiatives targeting health conditions disproportionately affecting AI/ANs, such as specialized programs for diabetes, maternal and child health, women’s health, elder health and disease surveillance.

Tribes support continuing to allocate H&C funding increases on a percentage of their overall funding base relative to programs nationally. This accepted funding methodology has been used

historically by the IHS. However, for funding that is dedicated to new initiatives or that may not be sufficient to be provided by this methodology, we recommend funding be allocated on a competitive grant process similar to that used in the methamphetamine/suicide and domestic violence funding initiatives

**Indian Health Care Improvement Fund: + \$10 million** – Funding for the Indian Health Care Improvement Fund (IHCIF) is a top Tribal budget priority. The purpose of IHCIF is to address deficiencies in health status and resources within the Indian health system and to promote greater equity in health services among Indian Tribes. The IHCIF directs funding through the Federal Disparity Index to the lowest funded operating units. The impact of the FY 2010 \$45 million appropriation brought all operating units within the IHS to 45% Level Need Funded (LNF). The average Federal Disparity Index level among all IHS operating units is 55%.

**Information Technology: + \$10 million** – Indian Health Service Information Technology (IT) investments include the Resource and Patient Management System (RPMS), including the RPMS Electronic Health Record (EHR), the IHS IT infrastructure, and the National Patient Information and Reporting System (NPIRS). Current national IHS Information Systems Advisory Council (ISAC) priorities include practice management, interoperability, EHR, infrastructure and architecture, clinical decision support, and meaningful use.

Health IT costs associated with the HITECH Act and new regulations will continue to increase as ICD-10 is implemented and enhanced certification, interoperability, and quality and outcome measures are required for the Medicare and Medicaid EHR incentive program. Tribal consultation about information technology is ongoing with listening sessions starting in March 2011 related to IT Shares as well as ongoing efforts to identify the true IT needs of Indian Country. ICD-10 is a complex and enterprise-wide initiative that will affect all of Indian Country. The transition from ICD-9 to ICD-10 must be completed by October 1, 2013, with consideration for possibly pushing the implementation date into FY 2014. There has been no allocation to Indian Health Service to support this transition. Furthermore, meaningful use and certification requirements will increase in the third stage of the program in 2014, requiring increased interoperability capability, significant changes to the RPMS and other EHR systems used in Indian Country, as well as interfaces among IHS and Tribal systems. Practice management applications must increase in functionality to meet HIPAA, Meaningful Use, and other CMS requirements.

**Long Term Care: + \$10 million** – Long Term Care (LTC) services in Indian Country have become increasingly important over the last decade. This is because AI/ANs are living longer and the demand for LTC services in Indian Country has increased. The improvements in the Indian health system have resulted in a population that is living longer and experiencing more age-related debilitating diseases requiring LTC services. Although only

12% of AI/ANs are age 55 and older, this group has grown by 25% over the previous 10 years and the overall life expectancy for AI/ANs has increased from 51 years in 1940 to 76.9 years in 2001. New authorities in the IHCIA have also elevated LTC services as a priority for Tribes within the IHS program. LTC has traditionally been viewed as facility-based nursing home care that consists of a wide spectrum of health and social services required to care for individuals who are limited in their capacity to care for themselves due to physical, cognitive, or mental disability. Tribes are also seeking to develop tribally and culturally based home health care services. There is very little LTC capacity or infrastructure in Indian Country and funding should be provided to address these options.

**Dental: +\$6.8 million** - Dental health is a top Tribal health priority. The IHS Dental program supports the provision of dental care through clinic-based treatment and prevention services and oral health promotion and disease prevention activities, including topical fluoride application and dental sealants. The demand for dental treatment remains high due to the high 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 provide preventive and basic dental care services as over 90% of the dental services provided by I/T/Us are basic and emergency care services. More complex rehabilitative care (root canals, crown and bridge, dentures, surgical extractions) are extremely limited, but may be provided where resources allow.

#### **Support for IHS Behavioral Health**

Tribes support collaboration and leveraging Behavioral Health resources among IHS and the Substance Abuse and Mental Health Services Administration (SAMHSA) programs. However, Tribes recommend that services and infrastructure associated with delivering Behavioral Health services be funded through the IHS appropriation. This is consistent with the obligation of providing health services through the IHS. It is also been difficult for Tribal health programs to build health infrastructure and capacity through SAMHSA grant programs that may not be sustainable. Grant programs come and go every two to three years. It is difficult to develop health care capacity in this manner.

**Mental Health: +\$45.8 million** - Behavioral Health, including Mental Health, is a top Tribal health priority. The high incidence of mental health disorders, suicide, violence, substance abuse and behavior-related chronic diseases is well documented. Each of these serious behavioral health issues has a profound impact on the health of individuals and community health, both on and off reservation. Mental Health program funding supports community-based, culturally sensitive, clinical and preventive mental health services including outpatient counseling, crisis response and triage, case management services, community-based prevention programming, outreach and health education activities. After-hours and emergency services are generally provided through local hospital emergency rooms. Inpatient services are generally purchased from



non-IHS facilities or provided by state or county mental health hospitals. Group homes, transitional living services and intensive case management are sometimes available, but generally not as IHS programs. The IHS Mental Health Program is committed to the development of evidenced-based traditional approaches within an integrated primary care and behavioral health services model, to include aggressive suicide prevention, development of culturally-appropriate child and family protection programs, implementation of tele-behavioral health, and development and use of the RPMS Behavioral Health Management Information System.

**Alcohol and Substance Abuse: +\$9.4 million** - Behavioral Health, including Alcohol and Substance Abuse, is a top Tribal health priority. The Alcohol and Substance Abuse Program (ASAP) exists as part of an integrated Behavioral Health program to reduce the incidence of alcohol and substance abuse in AI/AN communities and to address the special needs of AI/ANs dually diagnosed with both mental illness and drug dependency. The ASAP provides minimal funding to address prevention, education and some treatment services at both the clinical and community levels. Services are provided in both rural and urban community settings, with a focus on holistic and culturally based approaches. Youth Regional Treatment Center (YRTC) operations are also funded by this line item. In FY 2010, the majority of ASAP services were Tribally-managed. The IHS Alcohol and Substance Abuse Program is currently focused on the integration of primary care and behavioral health services, YRTCs, Fetal Alcohol Spectrum Disorders (FASD), the Methamphetamine and Suicide Prevention (MSPI), tele-behavioral health, development and use of the RPMS Behavioral Health Management Information System, and partnerships with consumers and their families, Tribes and Tribal organizations, and federal, state and local agencies and organizations.

**Contract Health Services: +\$171.6 million** – Contract Health Services (CHS) funding is a top Tribal budget priority. IHS purchases health care from outside providers when no IHS-funded direct care facility exists, the direct care facility cannot provide the required emergency or specialty services, or the facility has more demand for services than it can meet. CHS funds are used to purchase essential health care services, including inpatient and outpatient care, routine emergency ambulatory 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, heart disease, digestive diseases, and cancer, which are among the leading causes of death for AI/ANs. New CHS funds are distributed using a formula based on active user population, cost of purchasing health care services within a geographic area, and access to care, such as lack of availability of inpatient care. Tribes currently manage 54% of the CHS budget. At current funding levels, most IHS and tribal CHS programs are approving only medical emergent referrals (to preserve life and limb), and less urgent, routine and/or preventive care must be deferred or denied pending additional appropriations. The proposed \$171.6 million increase would



enable the purchase of an additional 7,276 inpatient services, 272,033 outpatient services, and 10,006 additional one-way transports for care.

<b>Category of Unmet Need Reported for FY 2011</b>	<b>Number of Cases Reported for FY 2011</b>	<b>Estimate Amount of CHS Unmet Need in Millions</b>
Denied	68,215	\$351,362,529
Deferred	83,740	\$431,330,241
Un Reimbursed CHEF	928	\$17,670,622
<b>TOTAL</b>	<b>152,883</b>	<b>\$800,363,392</b>

**Catastrophic Health Emergency Fund - +\$10 million** – The Contract Health Services program also includes the Catastrophic Health Emergency Fund (CHEF), which provides funding for high cost cases, such as burn victims, motor vehicle accidents, high risk obstetrics, and cardiology, after the expense associated with a case exceeds the established threshold. The top three diagnostic categories for FY 2011 CHEF cases were injuries, Circulatory, Cerebrovascular, Heart disease and Cancer. The CHEF program is centrally managed at IHS Headquarters and is available to both IHS and tribally-managed CHS programs. As in prior years, FY 2011 CHEF funds were depleted prior to the end of the fiscal year. IHS is currently considering lowering the CHEF threshold, which will make more cases eligible for CHEF support, and will likely increase the number of cases submitted.

### **Importance of the IHS Health Education**

The IHS Health Education program has reached out to all disciplines to encourage all providers to educate to AI/AN patients. Here is a local story from an IHS health education advocate.

I met Santana in the hospital last October. She was admitted after presenting to the Urgent Care with blood sugars greater than 300 (A1c 10) and a foot infection. Santana was diagnosed with diabetes four years ago. During the first couple of years after her diagnosis, she kept doctor appointments and took medicines. However, her blood sugars did not improve and so she stopped going to the doctor. When I asked why she had stopped getting medical care, she said that she got tired of being told to watch her diet, lose weight, exercise and monitor blood sugars. Santana was aware that these things were important but no one ever took the time to teach her how.

During her hospitalization, Santana and I spent time talking about how diabetes self-management could help her improve blood sugar control. An important part of self-management is learning how diabetes affects the body, and what one can do to prevent complications. Over the last 2 months, Santana followed up as an outpatient and learned more about how food, exercise and weight loss can improve blood sugar control. Spending time providing education about diabetes to Santana released her from fears about a disease she had perceived as a “death sentence”.

Last week Santana came by for a visit. She has lost 35 pounds, is walking and running 3 to 4 miles each day and her blood sugars range about 95 to 120 (A1c 6.2). She mentioned that other women in the pueblo have noticed how well she is doing. “I tell them that the dietitian taught me how to take care of my diabetes.” Santana also said, “Thank you.”

Knowledge is a powerful healer. For knowledge to take root, it requires an educator to present the information in a way that helps an individual understand and apply it. In time, it yields much fruit.

### **Public Health Nursing: +\$2.2 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 programs 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, parenting education, and screening for early diagnosis of developmental problems.

### **Health Education: +\$7.9 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 Workgroup identified several priority areas that reveal the need

for health education activities in order to empower AI/AN patients to become better informed about their own personal health and the wellness of their Tribal communities.

**Community Health Representatives: +\$4.4 million** – The Community Health Representative (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.

**Alaska Immunization Program: +\$6 thousand** – Increase for the AK immunization program; this is on top of the \$80,000 increase that is included as part of funding under current services.

**Urban Indian Health: +\$1.6 million** – The Urban Indian Health program supports contracts and grants to 34 urban Indian 501 c (3) non-profit organizations to provide services at 41 sites, including 21 full ambulatory facilities, 6 limited ambulatory programs, and 7 outreach and referral programs. Urban Indian Health Organizations provide affordable, culturally competent, primary medical care and public health case management and wrap-around services for urban AI/ANs who do not have access to the resources offered through IHS and Tribally operated health care facilities. Tribal leadership consistently demonstrates its support for funding Urban Indian Health programs to serve their members who reside away from their communities.

**Tribal Management Grant: +\$174 thousand** – The Tribal Management Grant program provides discretionary competitive grants to Tribes and Tribal organizations to establish goals and performance measures for current health programs, assess current management capacity to determine if new components are appropriate, analyze programs to determine if management by a Tribe or Tribal organization is practicable, and to develop infrastructure systems to manage and organize programs, services, functions or activities. All federally recognized Tribes and Tribal organizations are eligible to apply for Tribal management grants. Priority is given to newly recognized Tribes, and Tribes and Tribal organizations addressing audit material weaknesses.

**Direct Operations: +\$931 thousand** – The Direct Operations budget supports the leadership and overall management of the Indian Health Service. This includes oversight of financial, employees, facilities, information and support resources and systems. Funding is allocated to IHS Headquarters, Area Offices and Tribal shares.

## **FACILITIES - +\$46.8 million**

**Maintenance & Improvement: +\$2.7 million** – Maintenance and Improvement (M&I) funds are the primary source of funding to maintain, repair, and improve existing IHS facilities and Tribal health care facilities that deliver and support healthcare services. M&I funds are necessary to achieve and maintain accreditation, to meet building codes and standards, to maintain and repair the physical condition of health care facilities, to modernize existing health care facilities to meet changing health care delivery needs, and to implement mandated requirements (energy conservation, handicapped accessibility, security, etc.). The Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) serves as a measure of the condition of facilities and establishes priorities for larger M&I projects. As of October 1, 2010, the BEMAR for all IHS and reporting Tribal facilities was \$472.9 million. The \$2.8 million increase requested will help to further reduce the BEMAR.

**Sanitation Facilities Construction: +\$17.9 million** – The Sanitation Facilities Construction (SFC) program provides potable water and waste disposal facilities, and has been successful in reducing the rates of infant mortality, gastroenteritis and other environmentally-related diseases by about 80% since 1973. Due to the level of funding provided for the Sanitation Program under ARRA in 2009, the President's 2012 request proposed to cut the Sanitation Program by \$16 million. Congress followed to reduce the program by over 16% despite the fact that there continues to be over \$3 billion of documented sanitation project deficiencies, with at least \$1.45 billion of these projects considered to be economically and technically feasible. Typically, projects with exceptionally high capital costs are considered economically infeasible if their cost per home exceeds an established allowable unit cost per home for a particular geographical area. Technical feasibility relates to operability and sustainability of the proposed system. As of the end of FY 2010, there were about 230,000 or approximately 60 percent of AI/AN homes in need of sanitation facilities, including 9 percent or nearly 34,000 AI/AN homes without potable water.

The Healing Lodge of Seven Nations expanded its services in 2010 to increase the number of licensed beds from 30 to 45 beds, and increased billing capabilities for Third Party Insurance. The Center was recognized by the National Institute for Addictions Treatment (NIATx) and the State Associations of Addiction Services (SAAS) through their national iAward competition. The Center was among six organizations to be recognized across the nation for their innovative expressive arts program, which integrates music into the therapeutic environment. In January 2011, the Center released, "The Dark Road," a compilation of music and poetry readings by the program residents.

**HCFC Authorities: +\$25 million** – Program Increases are requested to support new facilities projects to be developed under the Joint Venture Construction Program and to facilitate the implementation of new authorities and program requirements under Title III of the Indian Health Care Improvement Act. Refer to page 10 for discussion of funding to support of previously approved health facilities construction priority projects included in the IHS Health Care Facilities FY 2013 Planned Construction Budget, or “Five-year Plan.”

**Facilities & Environmental Health Support: +\$942 thousand** - Facilities and Environmental Support programs provide real property, health care facilities and staff quarters construction, maintenance and operation services, community and institutional environmental health, injury prevention, and sanitation facilities construction services. Facilities Support provides funding for related Area and Service Unit operating costs, such as utilities, building operation supplies, facilities-related personal property, and biomedical equipment repair and maintenance. IHS reduced the energy related utility consumption for IHS managed facilities from 2,190,000 British Thermal Units per Square Meter (BTU/SM) in 2003 to 1,929,000 BTU/SM in 2010, which is a 10.2 percent reduction. These efforts help stem the growth in utility costs. During the period FY 2003 through FY 2010, total utility costs have increased 37 percent from \$15.5 million to \$21.1 million and total utility costs per Gross Square Meters (GSM) increased 49 percent from \$25/GSM to \$38/GSM. The IHS continues to aggressively investigate options to reduce energy costs. The Sanitation Facilities Construction (SFC) program provides management and professional engineering services to construct over 400 sanitation projects annually. Program resources also provide technical assistance, training and guidance to AI/AN families and communities regarding the operation and maintenance of essential water supply and sewage disposal facilities. The Environmental Health Services (EHS) program specializes in injury prevention and institutional environmental health, identifying hazards and risk factors in Tribal communities and proposing control measures to prevent adverse health effects. Area, district and service unit personnel train Tribal environmental health employees to provide higher levels of services to their communities and to support the provision of patient care services. The Injury Prevention Program works with Tribes to collect and analyze injury surveillance data, develop community coalitions, and build local capacity to implement proven and promising community-based strategies to prevent elder falls, motor vehicle accidents and other causes of injury.

**Equipment: +\$271 thousand** – Equipment funds are used for maintenance, replacement, and the purchase of new medical equipment at IHS and Tribal health care facilities. Equipment funds are allocated in three categories - Tribally constructed health care facilities, TRANSAM and ambulance programs, and replacement equipment. The National Tribal Budget Formulation Workgroup requests an additional \$272,000 for routine replacement of medical equipment for IHS and Tribal health care facilities to purchase new medical equipment.

## ***Hot Issues by IHS Area***

“It is a shame that when we come to these national budget meetings, the ‘have-nots’ have to fight against the ‘have-nots’ in Indian Country. When will we fully fund all our (Tribal) unmet need? We should not settle for less.”

Tribal Leader Comment

In order for IHS to respond to data requests from HHS and OMB regarding issues of concern that impact a particular Area (i.e., national emergencies, etc.), each IHS Area was asked to identify the top “hot issues” facing its regions Tribes. Any significant issues (non-budgetary, current and/or lingering) were described in brief by the IHS Areas with the intention of elevating Area concerns during the National Work Session. The IHS Areas submitted “hot issues” documents and their issue topics follow. Please refer to Appendix E for issue narratives.

### **ABERDEEN**

- User Population Definition
- Fully fund IHS facilities
- Expand ND and SD CHSDA to whole states for user pop calculations
- Fund IHCI A completely
- Contract Support Costs erode Direct Service Tribes Funding
- States Health Insurance Exchanges Plans
- Special Diabetes Projects
- Review and recommend changes to CMS expenditure policy
- Strategy to increase health revenues (move out of Interior Appropriations to HHS )
- Change budget process, more time
- ER Care
- Understand Medicare & Medicaid – educate and enroll more
- Elder Care, home health, hospice, disabilities
- CHS policy – review and make recommendations
- GAO report on funding to Direct Service vs. Self-Governance Tribes, review and make recommendations.

### **ALBUQUERQUE**

- Contract Health
- Contract Support Costs
- Information Technology
- Health Care Construction Priority System
- Hospitals and Clinics

### **ALASKA**

- Contract Support Costs
- Infrastructure Sustainability
  - Joint Venture Projects Staffing & Facility Costs
  - Energy Costs/Renewable Resources
  - Village-built Clinic Lease Deficits
  - Tele-medicine
- Behavioral Health
  - Suicide Prevention/Mental Health
  - Alcohol/Illegal Substance Abuse
  - Domestic/Intimate Partner Violence & Historical Trauma
- Information Technology: ICD-11/Electronic Health Records/Resource & Patient Management System (RPMS)
  - Implementation & Training
  - Preparation for ICD-11

#### **BEMIDJI**

- Funding Parity
- Health Disparities
- Contract Health Service
- Facilities Construction

#### **BILLINGS**

- Youth Substance Abuse and Treatment

#### **CALIFORNIA**

- Youth Regional Treatment Centers

#### **NASHVILLE**

- Funding and Implementation of the Indian Health Care Improvement Act
- Contract Support Costs
- Contract Health Services
- Health Information Technology
- Special Diabetes Program for Indians (SDPI)

#### **NAVAJO**

- Maintenance & Improvement for Facilities

#### **OKLAHOMA**

- Methamphetamine and Suicide (MSPI)
- Prescription Drug Abuse
- Unfunded Long-term Care Projects

#### **PHOENIX**

- Chronic Pain Management
- Diabetes Case Management
- Home Health Services (Elders)
- Women's Health Care
- Fort Yuma Ambulatory Care Center
- Adult Male Residential Treatment

#### **PORTLAND**

- After Care Addiction Programs for Children
- Lack of Dental Care

#### **TUCSON**

- Communicable Diseases
- Impact to Contract Health Service (CHS) Funding From Medicaid Benefit & Eligibility Cuts

### ***Implementation of the Indian Health Care Improvement Act***

The Implementation of the Indian Health Care Improvement Act (IHCIA) remains a top priority for Indian Country. IHCIA provides the authority for Indian health care but does not provide ANY funds to IHS. 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 a treatment, and coordinated mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs is now standard practice. Reflecting these improvements in the IHCIA has been 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.



All provisions of the IHCA are important in advancing the health care of American Indian and Alaska Native people and should be implemented in timely manner. Adequate funding for the implementation of these long awaited provisions is needed now.

### ***Health and Human Services Grants and Contracts***

“We have been working aggressively with the Department of Health and Human Services (HHS), OMB, the White House, and Congress to advocate for the IHS budget. I know that our Tribal partners are working hard to advocate for the budget as well. We have to do everything we can to take advantage of the immense support we have at this moment in time.”

Dr. Yvette Roubideaux Address to IHS Combined Councils Meeting January 24, 2012

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

The IHS awarded 72% of its total grant funding to Tribes and Tribal organizations and the Administration on Aging awarded 2% of its total funding to AI/AN groups. The National Institutes of Health awarded only 0.01% of total available grant funds to AI/AN groups and made only eight awards to these groups out of a total of 55,822 grants awarded.<sup>1</sup>

The barriers associated with this disparity generally fall under statutory and regulatory issues, as well as limitations on the resources of Tribes and Tribal organizations. Additionally, grant announcements may be sent to Tribal chairs or other high-level managers who are very busy and do not forward the announcement to the appropriate person in the Tribe in a timely way. These factors often result in Tribes and Tribal organizations learning about grant opportunities at a point when there is little time left to prepare a grant application.

#### **Recommendations:**

- Increase use of annual or multi-year program announcements, with multiple due dates.
- Consider reducing reliance on academic reviewers who place disproportionate emphasis on academic credentials of grant applicant staff where such credentials are not necessary for successful performance and where alternative forms of expertise are demonstrated.
- Provide orientation for grant reviewers to help them understand unique AI/AN issues and circumstances.
- Provide clear information on reasons for rejection of application.

<sup>1</sup> <http://taggs.hhs.gov/Reports/GrantsByRecipClass.cfm> (FY2004)



- Consider AI/AN "set-asides" or special grant initiatives within grant programs, including ways to address the needs of smaller/poorer Tribes and organizations.
- Increase the number of grants targeted specifically to AI/AN Tribes/organizations.
- Require evidence that states and academic institutions have support and participation of AI/AN tribes and organizations, if they are included in grant application.
- Expand Title VI authority to include grants, which are available to AI/AN tribes/organizations.

For more information and recommendations regarding HHS grants and contracts, see Appendix F.

"It would be nice to say that the work was done, but we know the truth. We have not 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. This was the moment when we began to build a strong middle class in Indian Country; the moment ... when we stopped repeating the mistakes of the past, and began building a better future together, one that honors old traditions and welcomes every Native American into the American Dream."

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

## Acknowledgements

### **National Tribal Budget Formulation Workgroup Area Representatives**

Aberdeen	Cecilia Fire Thunder, Great Plains Tribal Chairmen's Health Board Raymond Grandbois, Health Program Specialist, Turtle Mountain Band of Chippewa Indians
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Navajo	Rex Lee Jim, Vice President, Navajo Nation Jonathan Hale, Council Delegate, Navajo Nation
Oklahoma	Marshall Gover, President, Pawnee Business Council Steve Ortiz, Chairman, Prairie Band of Potawatomi
Phoenix	Amanda Barrera, Councilmember, Colorado River Indian Tribes Arlan Melendez, Chair, Reno-Sparks Indian Colony
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Tucson – Wavalene Romero

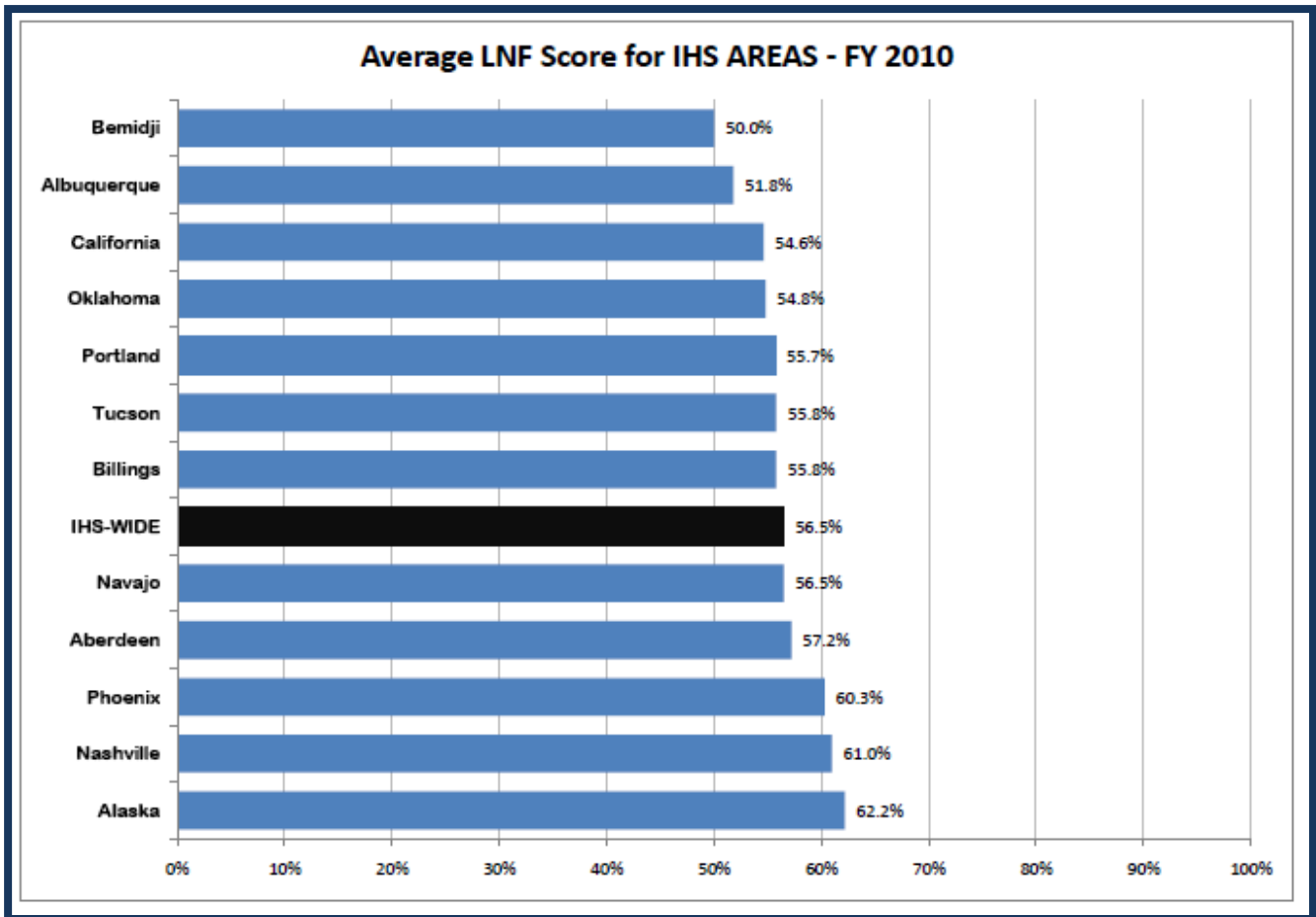
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document.

## APPENDIX

### *Appendix A: Average Level of Need Funded (LNF) for IHS Areas*



## FY 2012 AI/AN Needs Based Funding Aggregate Cost Estimate

### GROSS COST ESTIMATES

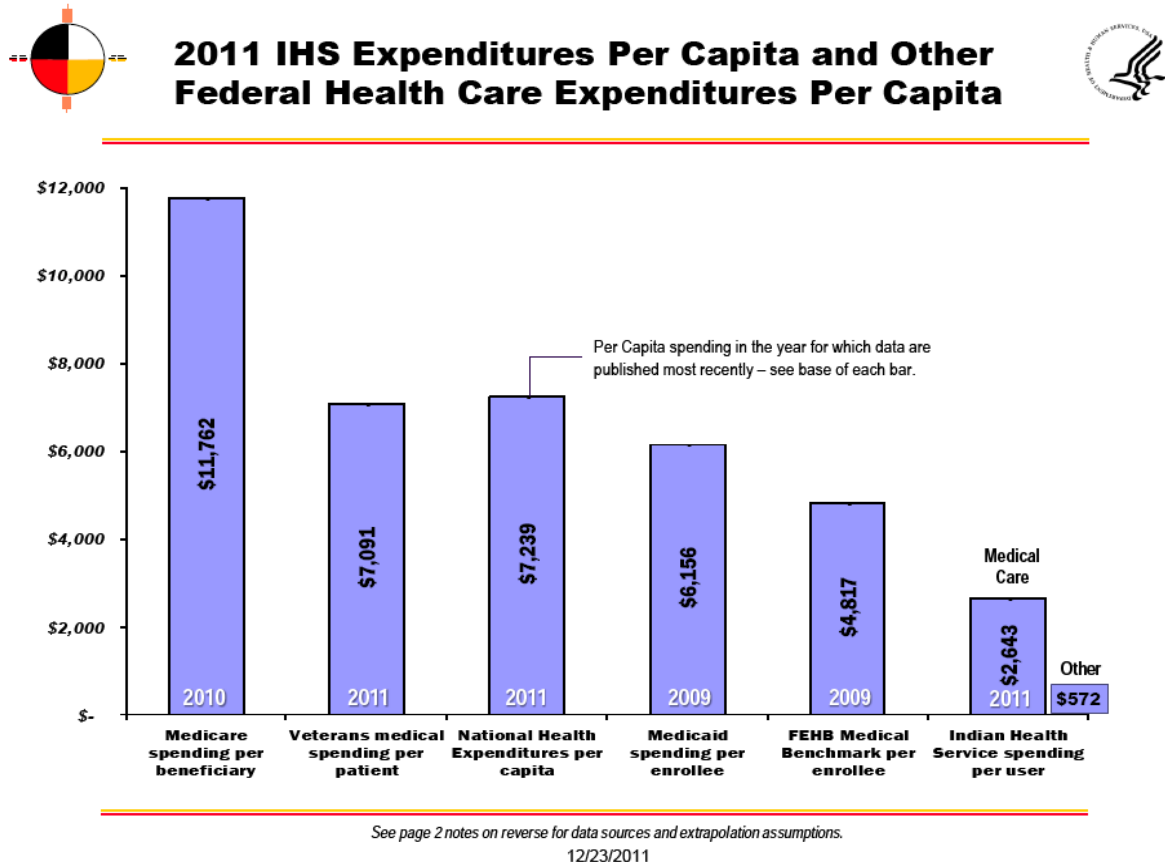
Source of Funding is not estimated

FY 2011 Need for Existing Users at I/T Sites	FY 2011 Need Expanded for Eligible AIAN at I/T/U Sites*
1,542,164	2,500,000

SERVICES	\$ Per Capita	Billions	Billions
<b>Medical Services</b>	\$5,188	<b>\$8.00</b>	<b>\$12.97</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>	\$543	<b>\$0.84</b>	<b>\$1.36</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>	\$1,217	<b>\$1.88</b>	<b>\$3.04</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, \$1,217 per capita = (.19/.81*\$5188).			
<b>Total Annualized Services</b>	<b>\$6,948</b>	<b>\$10.71</b>	<b>\$17.37</b>
<b>FACILITIES</b>	<b>\$ Per Capita</b>	<b>Billions</b>	<b>Billions</b>
<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>\$17.22</b>	<b>\$26.14</b>

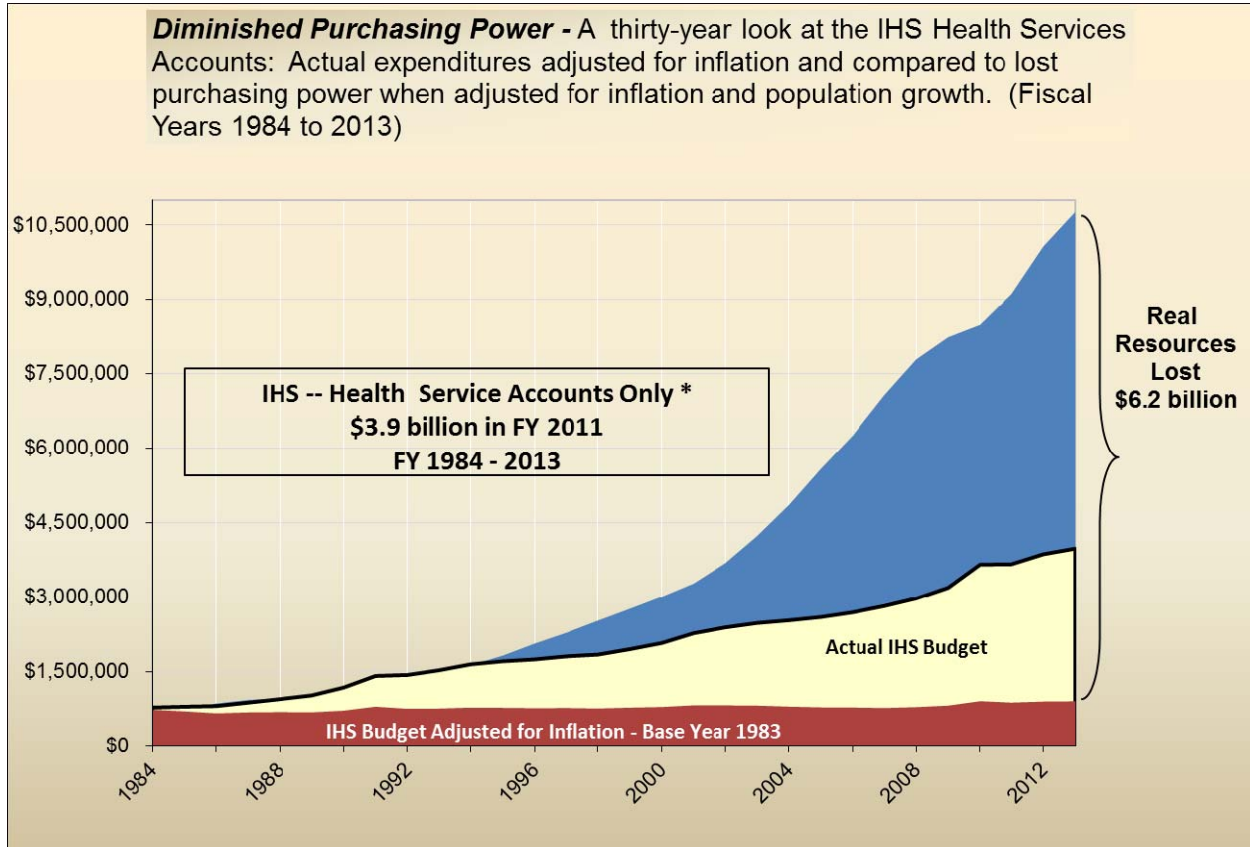
Gross costs for mainstream health care to AIAN and facilities upgrades are based on typical cost factors. The actual costs that would be experienced among I/T/U sites would vary. Gross costs are estimated expenses without specifying sources of payment. Under current law, a portion of gross costs would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

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



- ## Data Sources and Assumptions -- Health Care Expenditures Per Capita
1. 2010 AVERAGE MEDICARE BENEFIT PER ENROLLEE: Source -- 2011 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS ; available at <http://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf> in Table II.B1 Medicare Data for 2010, page 9.
  2. PROJECTED 2011 NATIONAL HEALTH CARE EXPENDITURES PER CAPITA: Source -- Table 5 Personal Health Care Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2005-2020; available at <https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf>
  3. 2011 MEDICAL CARE PER VETERANS ADMINISTRATION PATIENT: Source -- Volume II -- Medical Programs and Information Technology Programs -- Congressional Submission, available at [http://www.va.gov/budget/docs/summary/fy2012\\_Volume\\_II\\_Medical\\_Programs\\_Information\\_Technology.pdf](http://www.va.gov/budget/docs/summary/fy2012_Volume_II_Medical_Programs_Information_Technology.pdf) Per capita spending estimate is calculated by dividing 6,098,599 unique VA patients (page 1A-5 "Unique Patients") into \$43,244,000,000 medical care obligations (page 1A-6 "VA Medical Care Obligations by Program")
  4. 2009 MEDICAID PAYMENTS PER BENEFICIARY: The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS), 2009. Available at <http://www.statehealthfacts.org> Per capita spending is calculated by dividing 59,524,000 million enrollees into \$366,471,000,000 total FY2009 Medicaid Spending.
  5. 1999 MEDICAL CARE FOR FEDERAL PRISON INMATES: No longer included because data have not been updated since 1999.
  6. 2009 FEHB MEDICAL CARE BENCHMARK PER IHS USER (updated every 3<sup>rd</sup> year): Source -- Indian Health Service, Level of Need Funded Report (later renamed the Federal Disparity Index Report) by the LNF Workgroup. The LNF study used insurance premiums for the Federal Employee Health Benefits program as a benchmark for actuarial projections for costs of equivalent benefits to IHS users. The estimates for 2009 are calculated using the methods available at <http://www.ihs.gov/NonMedicalPrograms/Lnf/index.cfm> (see Assumptions, Data, Calculations for FY 2007 Cost Benchmark)
  7. 2011 IHS MEDICAL CARE EXPENDITURES PER USER: Source -- The Indian Health Service budget and appropriations tables for 2011. IHS spending from appropriations plus spending of other collections are totaled and divided by estimated 2011 user counts (FY 2010 counts plus 1% increase). The chart does not display medical care spending for IHS users by other sources because amounts are unknown. The breakout for "medical care" and "non-medical" IHS programs is based on a detailed line-item analysis of spending categories.
- 12/23/2011

## Appendix D: Diminishing Purchasing Power



## **Appendix E: “Hot Issues” Narratives by Area**

“Hot issues” Area Narratives highlight regional topics and differences between the twelve IHS Areas in need, focus, and priorities.

### **ABERDEEN**

#### **ISSUE: Expansion of Contract Health Service Delivery Area (CHSDA) to include whole states**

**BACKGROUND:** We understand that Headquarters has determined that appropriations are required to expand the CHSDA as outlined in the Indian Health Care Improvement Act. Never-the-less, what I heard in Bismarck is that the Tribes wanted the user pop calculation for the CHSDA counted immediately for the reason set forth in the second bullet.

**RECOMMENDATIONS:** In addition, the Turtle Mountain Tribe elaborated as follows: These concerns were presented by the Turtle Mountain Tribal Chairman to Dr. Roubideaux this week.

- The Aberdeen Area Office should prepare an analysis of the estimated cost to implement this provision in the Indian Health Care Improvement Act.
- The User Pop calculation process should be modified to count all users in the ND SD CHSDA. This change should be retroactive if possible. If not possible, it should be put into effect such that the estimated seven thousand (7,000) users not counted in ND and SD are included in the next fiscal year’s official user counts.
- Indian Health Service Headquarters should calculate the funding lost to North and South Dakota Tribes by not including these users in the official user pop. 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.

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

**BACKGROUND:** One of the concerns expressed by Direct Service Tribes in past conferences is that Self-governance Tribes might take resources disproportionately from Direct Service Tribes. This concern became realized when Self-governance Tribes were the first to get their own office within the Office of the Director. To address this concern, the Direct Service Tribes organization was created and representation in the Office of the Director was requested and granted. The primary concern was that with limited resources, more IHS resources may be going to Self-governance Tribes than to Direct Service Tribes. The IHS assured the Direct Service Tribes that this would not be the case.

The IHS budget however, shows a large increase each year in contract support costs. Since these costs go disproportionately to Self-governance Tribes, a larger and larger proportion of the IHS budget is supporting Self-governance Tribes largely at the expense of Direct Service Tribes. Even through the Contract Support Costs are costs designed to provide support to maintain the same level of service, they

still represent a portion of limited resources that are disproportionately allocated to Self-governance Tribes

RECOMMENDATIONS: IHS is increasingly providing grants for services. Direct Service Tribes want assurance that IHS is not disproportionately providing grants or other support to Self-governance Tribes compared to Direct Service Tribes.

## **ALBUQUERQUE**

- Hospitals and Clinics; continues to be a demand for clinics and service units to maintain current services and costs of professional staff. Often it becomes difficult to include new positions or new specialty professionals when funding is uncertain.
- Contract Health Services; most patients have to be referred out more than 50 miles for specialty care esp. when it becomes a “life or limb” situation. With an increase of uninsured patients, the referring clinics or hospitals have to prioritize patients. While third party reimbursements for Medicaid helps to cover some of the costs however it has become cumbersome with the limitations for what can be billed especially with the recent cuts. Additional funding for IHS specialist care could reduce CHS costs, as well as transportation costs.
- Contact Support Costs; continued need for additional funds is needed to not only cover for current operations but also to cover for new and expanded P.L. 93-638.
- Information Technology; this is a priority for the all service clinics and units within the Albuquerque Area. There is cost associated with the recent implementation of Resource Patient Management System (RPMS) and other IT mandates
- Transportation is constant issue and is complicated by the lack of IHS Dialysis facilities.
- All Albuquerque Area facilities fund only Priority One CHS cases. Deferred List remains unfunded indefinitely. Prevention would be cheaper than the priority one CHS costs. Lack of CHS funds also impacts patient’s personal credit.
- Exempt IHS from budget rescissions. This is consistent with the VA budget and is supported by the IHS Commissioned Corp deployments.
- Legislation for IHS budget to be an entitlement rather than discretionary
- Support implementation of proposed new Health Care Construction Priority System
- HHS to prevent state cuts from impacting Native programs including Medicaid and others



## **ALASKA**

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

**BACKGROUND:** Today, the federal government contracts with Tribes to administer over \$2.3 billion in government services. Under this legislation, Tribes and Tribal organizations are to be paid in full for the “contract support costs” (CSC) incurred in the administration of these contracts; however, Tribes are the only federal contractors not to receive their full CSC.

With the nation’s highest percentage of Tribes participating in Tribal self-governance, Alaska Tribal health programs shoulder the brunt of the national problem of inadequate CSC funding. Without full funding of reasonable and allowable CSC, Tribal health programs have for many years been forced to cannibalize funds from direct health program funds in order to pay for the reasonable and necessary costs of operating health programs, which have risen significantly over many years due to medical inflation, population increases and energy cost increases. This has greatly hurt the capacity of Tribal health programs to provide good access to quality care for Alaska Natives.

Contract Support Costs are vital to Tribal self-determination and ensure Tribes operating under contract and compacting agreements possess the resources to ensure contract compliance, as well as proper program management and administration.

**RECOMMENDATION:** Fully fund Contract Support Costs, including shortfalls.

### **ISSUE: Infrastructure Sustainability – Joint Venture Projects Staffing & Operations**

**BACKGROUND:** IHS construction funds are targeted to expand service at sites experiencing overcrowding by building new and renovating existing facilities. Additional funding is included in the budget to support staffing and operating costs for new and expanded facilities. Uncertainty regarding the level of funding for IHS Facilities projects makes it difficult to predict true staffing needs at this time and the funding request may need to be adjusted to cover the actual required staffing obligation, including any shortfalls created by a reduced apportionment for staffing in prior years.

**RECOMMENDATION:** Fully fund staffing package obligations and fully fund facility Operating Costs. Fully Fund Staffing Packages for new facilities including Jt. Venture & shortfalls from prior years; also fund operating expenses for new facilities including Facility & Environmental Health Support and related Contract Support Costs

### **ISSUE: Infrastructure Sustainability – Energy Costs/Renewable Resources**

**BACKGROUND:** With fuel prices near an all-time high, our nation is in desperate need for energy solutions. However, in rural communities, this crisis has reached epidemic proportions. In some villages, the cost of fuel oil has reached \$10 per gallon. With village homes requiring four to five 55-gallon drums of oil for heating during winter months, the choice many face is to heat their home or feed their family. Tribal health providers are reporting sick people are staying home because they cannot afford a plane ticket (again, due to fuel prices) to seek care at regional hubs. This has fostered an increasingly prevalent ‘emergent’ form of health care requiring extremely costly Medivac use. Families are doubling or tripling up in homes to save money while increasing the likelihood of getting sick and requiring care.

Fuel has become such a burden in rural areas, and clinics have had to absorb this unfair burden of costs within static budgets. The very existence of villages is in jeopardy Rural Alaska Native people cannot afford to live and work in their home towns, and basic community facilities such as clinics and school face closure or reduction of operating hours. In short, the current energy crisis threatens the very survival of our rural villages and while fuel costs are not normally associated with public health, the connection between the two is evident in rural Alaska.

**RECOMMENDATION:** Fund variable fuel and electrical costs associated with health facilities out of a national pool designed to allow for energy cost adjustments (short term) and invest in renewable energy projects which benefit community clinics, health centers and hospitals in high cost regions (long term).

**ISSUE: Infrastructure Sustainability – Village-built Clinic Lease Deficits**

**BACKGROUND:** The IHS Alaska Village Built Clinic (VBC) Lease Program is designed to fund utilities, rent, insurance, and maintenance costs of village-owned healthcare facilities in over 170 rural Alaska communities. These facilities, which are predominantly community health aide clinics, are typically the only healthcare facility in the community.

Many Village-built clinic leases were entered into several decades ago and have been maintained at static levels without consideration for the actual operating costs of operating and maintaining these clinic buildings. While many of these facilities have been replaced and upgraded, the leases do not cover the true costs of running the building. As a result, the Tribes or in some cases the Tribal organizations have had to subsidize these leases by at least 100% & in some cases, over 600%. IHS has suggested that the Tribes approach Congress for a solution to meet this shortfall of about \$6M annually; however, we are in a catch 22 because Congress is not longer able to “earmark” funds for specific projects. We need to work with the Administration to acknowledge that these leases must be funded or we will continue to see closures, which will compromise the safety and healthcare for our rural communities.

VBC lease payments cover less than 60% of the operating costs of these clinics. Since this time, energy costs have more than doubled in rural Alaska, creating additional stress on an already burdened system. Without adequate funding for the VBC Lease Program, Alaska Tribes have had no choice but to cannibalize resources from critical health programs, reduce clinic operations, defer maintenance and repairs, and lay off crucial health staff.

**RECOMMENDATION:** Fund VBC Leases deficits to bring them into par with other federal leases

**ISSUE: Infrastructure Sustainability - Telemedicine**

**BACKGROUND:** Telemedicine has the potential to improve access to health care services, decrease travel costs per the President’s executive order, and promote the efficient spending of federal health-care dollars. Our unique geography is ideal to test a pilot telemedicine technology as a natural extension of our patient care system. We cannot hire pharmacists, doctors, specialists, in all of our communities; having access to these specialties, however, is critical to the continuum of care necessary to treat our patients; expanding telemedicine capability is an intelligent solution to bring access to quality health care to our Native beneficiaries.

RECOMMENDATION: Invest in Tele-medicine

**ISSUE: Behavioral Health - Suicide Prevention/Mental Health**

**BACKGROUND:** Alaska has the highest rate of suicide per capita in the United States with Alaska Natives experiencing a higher risk of suicide than any other ethnic group. In 2007, the rate of suicide in the United States was 11.5/100,000. In Alaska, the rate was 21.8/100,000. Among Alaska Natives, the rate jumped to 35.1/100,000. Alaska Native men between the ages of 15-24 have the highest rate of suicide among any demographic in the country. There is an average of 2.6 suicides in Alaska *EVERY WEEK*. Between 2000 and 2009, at least one suicide occurred in 176 Alaskan communities. Studies have shown that youth who are exposed to suicide or suicidal behaviors are more at risk for attempting suicide themselves. However, interventions can work with proper funding. According to the American Association of Suicide, more than 90% of people who complete a suicide have a diagnosable, treatable mental or substance abuse disorder. New evidence suggests a linkage between historical trauma and adverse childhood events, such as those experienced by Alaska Natives, and the high risk behaviors associated with suicides.

**RECOMMENDATION:** Increase sustainable funding for tribal-specific, culturally sensitive Mental Health treatment & prevention solutions, including research into the historical trauma and adverse childhood events unique to Alaska Native people.

**ISSUE: Behavioral Health – Alcohol & Substance Abuse**

**BACKGROUND:** According to the State of Alaska Substance Abuse Prevention Program, Alaska has – across the board – one of the highest rates of alcohol consumption rates per capita. The rate of alcohol dependence and alcohol abuse is twice the national average. Almost thirty years of research into this issue has identified a number of key issues including the need for culturally appropriate services in Alaska Native communities. Programs that implement traditional cultural values are more successful than those that do not. Substance abuse outside of alcohol is also particularly problematic. Prescription drugs are one of the most widely abused classes of drugs with cocaine, marijuana and meth popular. In December 2011, a 14-year-old girl died after being injected with China White heroin – a far more potent form than the more common black tar heroin. The most recent National Survey on Drug Use and Health (2007-2008) indicated that 11.8% of Alaskan residents used illicit drugs in the past month with the national average being 8%. Alaska rated among the top ten states for past-month illicit drug use among persons age 12 and older; past-month illicit drug use among young adults age 18-25; and past-year cocaine use among persons 12 and older.

A total of \$267 million dollars in the IHS FY 2010 budget was allocated to support behavioral health services (which includes both mental health and substance abuse), representing only 6.7 percent of the entire IHS budget to serve the AI/AN population. AI/AN populations have major health disparities in rates of alcohol/substance abuse and addiction, but the use of alcohol and substances often go hand in hand with other mental health conditions and high-risk behaviors in Indian Country including suicide, depression, PTSD, HIV transmission, domestic violence and incarceration, among others. The National Institute on Drug Abuse estimates that 60% of all people with a substance abuse disorder also suffer from a mental illness.

**RECOMMENDATION:** Increase sustainable funding for Tribal-specific, culturally appropriate Alcohol & Substance Abuse treatment & prevention solutions, including funding for comprehensive chronic pain management and programs to prevent illegal prescriptive drug use and resale.

**ISSUE: Behavioral Health – Domestic & Intimate Partner Violence/Historical Trauma**

**BACKGROUND:** Alaska continually ranks as one of the most dangerous states for women. According to the 2010 Alaska Victimization Survey lifetime estimates, 58% of Alaskan women have experienced intimate partner or sexual violence. From 2003-2009 the average rate of reported forcible rape was 2.6 times higher in Alaska than nationally. Alaska Natives are disproportionately represented in these figures and Alaska Native females are approximately three times more likely than Alaska Native males to have been hospitalized for injuries due to assault. Perhaps the most telling figures come from the 2010 National Census of Domestic Violence Services. On one single day - September 15, 2010 - 467 victims were served by Alaskan domestic violence programs, 307 domestic violence victims found refuge in emergency shelters and transitional housing, 160 adults and children received non-residential assistance and services and 80 hotline calls were answered. Many more victims are not able to access services due to limited resources. In FY2010, the Alaska Network on Domestic Violence and Sexual Assault Pro-Bono Program received 293 applications but were only able to provide services for 90 of those individuals. In 2009, Alaska Legal Services statewide served 427 victims of domestic violence and sexual assault but were unable to serve another 550 individuals. Children are heavily impacted by violence. In cases reported to the Alaska State Troopers, approximately 43% involve a child being present during the assault. During fiscal year 2009, 41% of the cases seen in the Alaska Children's Advocacy Center were under the age of six with another 36% aged 7-12.

Alaska's child sexual assault rate is six times the national average. In Alaska State Trooper cases, 94% of sexual assault victims are 15 or younger.

- Alaska's forcible rape rate is 2.5 times the national average. Alaska Native women are victimized at a rate three times the State average and represent a disproportionately high percentage of forced prostitution and sex traffic victimization.
- Alaska leads the nation in the rate of men murdering women. In 2008, nearly 70% of homicides had a previous history of domestic or sexual violence.

Almost 30% of Alaskans were not able to access victim services or encourage others to do so because there were no services available in their area at the time.

**RECOMMENDATION:** Increase sustainable funding for Domestic & Intimate Partner Violence and to allow culturally relevant, research and community-based psychological services to improve outreach, education, appropriate intervention and treatment for unresolved childhood trauma

**ISSUE: Information Technology (IT) – ICD-11/EHR/RPMS**

**BACKGROUND:** Until FY 2009, IHS OIT has operated on an annual spend plan rather than a planned budget line item allocation. In FY 2009, OIT received a line item budget of \$2 million, well below its average annual spend plan of \$35 to \$40 million. This lack of annual operating budget has created an administrative shortfall to adequately address IT needs within the I/T/U. The lack of comparable funds for Tribal Health IT within the budgeting process further exacerbates the ability of the Indian Health

System to modernize its technology as required to meet ICD-10/11 transitions, and EHR Meaningful Use requirements. This lack of IT investment is counter to the Secretary's vision of "a truly 21<sup>st</sup> century health system where we pay for the right care, not just more care." The IHS budget should clearly reflect this funding need so Tribal health programs can begin using smarter, new technology to further our mutual mission of improve care for all AI/AN.

The OIT function, which exists today, is technologically more advanced than the IT PFSA's which were in existence when shares were first negotiated. Advances in technology have created a whole new list of expected PFSA's for OIT. The National Data Warehouse is a new function created to address data requirements outside of RPMS. Training and staffing needs have been redesigned to match current technology. In addition, new mandated requirements have expanded including security, personal health information, and EHR meaningful use. The recent opportunity afforded by the ARRA funding has significantly changed the infrastructure and capacity in a positive way, giving the agency an unprecedented ability to modernize its hardware, software and infrastructure, and providing an opportunity to address upgrades to its practice management package and deployment of Electronic Health Record package.

**RECOMMENDATION:** Increase sustainable funding and transparency for the Information Technology budget to adequately fund implementation, training and on-going costs related to conversion to ICD-10/11 , Electronic Health Records Meaningful Use, and both IHS & Tribal Health IT-solutions including RPMS & non-RPMS systems.

#### **BEMIDJI**

##### **ISSUE: Funding Parity**

**BACKGROUND:** The Bemidji Area is, and has been, the lowest funded Area in the entire Agency; Current Level of Need Funded (LNF) is 49.9% while the Agency is 56.6%.

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

##### **ISSUE: Health Disparities**

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

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

##### **ISSUE: Contract Health Services**

**BACKGROUND:** The Bemidji Area is highly dependent upon Contract Health Service (CHS) because of remote and rural locations where there is a lack of hospital access and available specialty care.

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

#### **ISSUE: Facilities Construction**

BACKGROUND: The Bemidji Area is primarily comprised of Title I and Title V Tribal programs who have limited access the federal facility construction dollars. The Bemidji Area has not been considered for federal or Tribal facilities construction funding despite some of our Federal facilities being over 50 years old and little to no support of Tribal construction efforts.

RECOMMENDATION: 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.

### **CALIFORNIA**

#### **ISSUE: Youth Regional Treatment Centers (YRTC's)**

BACKGROUND: In 1992, Congress authorized IHS to construct and operate two YRTC's in California, one to serve northern California, and one to serve the remainder of the state. On March 9th, many California Tribal leaders and IHS representatives will be celebrating a 'Dedication of the Land' as ground will be broken for California's first YRTC. This is truly a part of the dream coming true; but, the work is not finished.

RECOMMENDATION: IHS must prioritize the funding and construction of the two California Area YRTC's.

### **NASHVILLE**

#### **ISSUE: Funding and Implementation of the Indian Health Care Improvement Act**

BACKGROUND: The Team chose to make funding and the Implementation of the IHCA their top "Hot Issue" to communicate the importance of fully funding the provisions of IHCA. Although the Team chose only a select few IHCA priorities, all provisions are important in advancing the health care of American Indian and Alaska Native people and should be implemented in a timely manner.

RECOMMENDATIONS:

## Section 222: LIABILITY OF PAYMENT

A patient who receives contract health care services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.

The Secretary shall notify a contract care provider and any patient who receives contract health care services authorized by the Service that such patient is not liable for the payment of any charges or costs associated with the provision of such services not later than 5 business days after receipt of a notification of claim by a provider of contract care services.

Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 220 (b), the provider shall have no further recourse against the patient who received services.

Many Tribes within the Nashville Area have experienced difficulty and resistance from Contract Health Care providers when explaining this new provision. As discussed with the IHS Director on several occasions (i.e. face-to-face discussion, through USET letters dated March 3, 2011 and July 14, 2011 and by USET Resolution No. 2012:007) this remains a priority for Nashville Area Tribes.

A template letter was assembled by IHS and sent to Tribal contract health service departments in July 2011 for Tribal signature and in some cases has been helpful. However, in other instances it has had little to no success and patient bills are still being sent to collection agencies for payment.

Nashville Area Tribes respectfully request that a letter on IHS letterhead with the Director's signature be provided to Tribal programs to give the issue more authority.

## Section 711. BEHAVIORAL HEALTH PROGRAM

The Secretary, acting through the Service, consistent with section 702, may plan, develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

The Nashville Area Tribes support this grant program to expand community-based behavioral health services as the need and importance within the area remains a top priority. Nashville recommends allocating funding to be divided by Area for local competition of grant funding.

## Section 827. PRESCRIPTION (PDM) PROGRAM

Monitoring Establishment—The Secretary, in coordination with the Secretary of the Interior and the Attorney General, shall establish a prescription drug monitoring program, to be carried out at health care facilities of the Service, Tribal health care facilities, and urban Indian health care facilities.

Report—Not later than 18 months after the date of enactment of the IHCA, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes—

The needs of the Services, Tribal health care facilities, and urban Indian health care facilities with respect to the prescription drug monitoring program under paragraph (1);



The planned development of that program, including any relevant statutory or administrative limitations; and

The means by which the program could be carried out in coordination with any State prescription drug monitoring program.

Abuse—The Attorney General, in conjunction with the Secretary and the Secretary of the Interior, shall conduct

An assessment of the capacity of, and support required by, relevant Federal and Tribal agencies—

To carry out data collection and analysis regarding incidents of prescription drug abuse in Indian communities; and

To exchange among those agencies and Indian health programs information relating to prescription drug abuse<sup>3</sup> in Indian communities, including statutory and administrative requirements and limitations relating to that abuse; and

Training for Indian health care providers, Tribal Leaders, law enforcement officers, and school officials regarding awareness and prevention of prescription drug abuse in Indian communities.

The Nashville Area Tribes have some of the highest prescription drug abuse rates in the country so a monitoring program would greatly benefit the Tribes. In conjunction with the monitoring program, the United South and Eastern Tribes is working with Office of National Drug Control and Policy (ONDCP) to develop a tool kit geared toward Indian Country regarding Prescription Drug Abuse and Treatment. The Nashville Area Office of Public Health has also initiated a Prescription Drug Abuse Prevention initiative in 2012 to establish a baseline of drug abuse rates and to draft a prevention plan/ strategy.

Nashville Area Tribes recommend allocating funds within this IHClA section to be used to support both Area initiatives and Tribal grant opportunities.

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

**BACKGROUND:** All federally recognized Tribes and Tribal organizations are eligible to contract or compact health programs through Title I and Title V of the Indian Self-Determination and Education Assistance Act, and to receive CSC funding in addition to the amount of program funding that the Secretary would have otherwise provided for the direct operation of the program

**RECOMMENDATION:** The Nashville Area Tribes support fully funding Contract Support Costs. Contract Support Costs (CSC) are defined as reasonable costs for activities that Tribes and Tribal organizations must carry out, but that the HHS Secretary either did not carry out in her direct operation of the program or provided from resources other than those under contract. This line item request is to cover CSC requirements related to new and expanded P.L. 93-638 contracts.



#### **ISSUE: Contract Health Services**

**BACKGROUND:** CHS funds are used to purchase essential health care services, including inpatient and outpatient care, routine emergency ambulatory 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, heart disease, digestive diseases, and cancer, which are among the leading causes of death for AI/ANs.

**RECOMMENDATION:** The Nashville Area Tribes consider Contract Health Services (CHS) funding is a top Tribal budget priority and Hot Issue. IHS purchases health care from outside providers when no IHS-funded direct care facility exists, the direct care facility cannot provide the required emergency or specialty services, or the facility has more demand for services than it can meet.

#### **ISSUE: Health Information Technology**

**BACKGROUND:** The HITECH Act and new CMS regulations require AI/AN medical providers and their facilities to implement electronic health record (EHR) and demonstrate MU. In addition, HITECH also requires health information network exchange capabilities, which requires enhanced interoperability and bandwidth connectivity.

**RECOMMENDATION:** As in the previous year, Health Information Technology continues to be a priority for the Nashville Area Tribes. Additional federal funding is needed to enhance and support the IHS open source EHR (RPMS-EHR) to meet standards as required by HITECH and CMS regulations. In addition, resources are needed to assist Tribally operated facilities in the purchase of commercial EHR systems when the Tribe determines its appropriateness under Tribal sovereignty.

#### **ISSUE: Special Diabetes Program for Indians (SDPI)**

**BACKGROUND:** Results from the SDPI programs offer hope for prevention since there is still no cure for diabetes. Positive outcomes, such as improvements in control of blood glucose, blood pressure, LDL Cholesterol and triglycerides are attainable. Many important lessons have been learned that will benefit all people affected by diabetes.

**RECOMMENDATION:** Reauthorization of the SDPI remains a high priority for the Nashville Area Tribes. If the SDPI is reauthorized, it will assist the IHS, Tribal and Urban Indian health care programs continue to build a strong foundation for a diabetes-free future for Indian communities.

Loss of funding would be devastating and even more costly because all of the gains made with the current funding will be lost.

### **NAVAJO**

#### **ISSUE: Maintenance & Improvement for Facilities**

BACKGROUND: SM is the area of all of the buildings in the Indian Health Service Inventory. M&I is based on the SM of all the buildings. The rate of funding has not kept pace with the increase rate of SM.

RECOMMENDATION: The M&I funding per (SM) has decreased over the years to the point that there is only funding each fiscal year to cover regular maintenance of facilities. Regular maintenance covers preventative maintenance for facilities equipment that require service contracts to meet accreditation standards. In prior years, there has been limited funding available for unknown improvements at the facilities and/or to replace building systems (HVAC, Boilers, Chillers, etc.) if they should fail or malfunction.

The industry standard for sustainment of facilities is based on 2% of the replacement cost of a given facility for the low end and 4% of the replacement cost of the facility on the high end. As of FY2012, the Navajo Area has a shortage of M&I funding of approximately \$1,974,019, based on the low end of sustainability requirements. Essentially, that is \$56.04 per SM compared to the \$43.05 per square meter that we currently receive. This value will continue to go down as new tribal and federal facilities come on-line and the M&I funding remains at the same level. This level is comparable to all IHS facilities.

Given the fact that new facilities are not in the near future, it is imperative all area facilities maintain, improve and replace current facilities building systems. Thus, the M&I funding levels are requested to increase \$10,000,000.00 to meet the low end of sustainment requirements.

Proposed Amount: \$ 10,000,000

## **PHOENIX**

### **ISSUE: Chronic Pain Management**

BACKGROUND: Chronic pain results from the varying health problems and requires effective pain relief and other physical therapies to improve health functioning.

RECOMMENDATION: There is a major need in to address the debilitating effects of chronic pain that many patients experience on a daily basis. Patient education, medication management and adjustments to the therapies are components of Chronic Pain Management.

### **ISSUE: Diabetes Case Management**

BACKGROUND/RECOMMENDATION: While much has been accomplished through the Special Diabetes Program for Indians, instituting a Diabetes Case Management program would improve individual patient care. The types of assistance offered to patients would include information diabetes self-care, weight loss assistance and behavioral health support. Care managers would focus on prevention to reduce the health related impacts of diabetes, work with physicians, pharmacists and other staff to help the patient understand the importance of early detection and treatment of the heart disease, assist the patient access specialty cardiac and hypertension management services when needed.

### **ISSUE: Home Health Services (Elders)**

**BACKGROUND:** Many Tribes are developing plans for elder health care programs and they are seeking funds to initiate best practices for the care of their elders.

**RECOMMENDATION:** It is recommended that the IHS establish elder health care protocols within its scope of services and collaborate with Tribes to develop Tribally and culturally based home health care services that coordinate care with IHS, Tribal and urban providers.

**ISSUE: Women's Health Care**

**BACKGROUND:** Some of the needed obstetrical and gynecological services, such as mammography and other preventive screening tests are not available in many direct care settings and contract health dollars is used refer patients to the private sector.

**RECOMMENDATION:** These services need to be enhanced, especially in the Phoenix Area to meet GPRA standards. Further, it is expected that obstetrical care and gynecological services, and other preventive screening tests such as mammography will be included in the Affordable Care Act (ACA) Essential Health Benefits (EHB) package. In preparation for ACA implementation in the Indian health system, what the medical profession deems as a basic health care service and included in the EHB package must be accessible in Indian country.

**ISSUE: Fort Yuma Ambulatory Health Center**

**BACKGROUND:** The aged facility has been declared unsafe which has been substantially damaged due to seismic activity.

**SITUATION:** The Phoenix Area IHS has monitored the structure for several years, but recent earthquakes in the region have intensified concerns and it is apparent that patients and staff are at greater risk. The process to lease space and relocate services temporarily while waiting the construction funding has begun in the last few months. Both the Tribal councils of the Quechan Tribe and the Cocopah Tribe have recently conducted special sessions to address their concerns.

**ISSUE: Adult Male Residential Treatment**

**BACKGROUND/RECOMMENDATION:** There are few resources available for these adult males in need of alcohol and substance abuse treatment to obtain these services in the Phoenix Area. Treatment dollars are generally available for youth and women with children, but resources for men for needed treatment and support for family involvement in the healing process is glaringly inadequate.

**PORTLAND**

**ISSUE: After Care Addiction Programs for Children**

**BACKGROUND:** Due to State budget cuts elimination of After Care Follow up

RECOMMENDATION: Numerous Tribal Representatives in attendance speak of the need for After Care programs. Many of the children go through Alcohol and Drug Treatment Programs and there is not aftercare provided after they return to their respective Reservations, thus leading them to again abuse alcohol and drugs. The Director of the Healing Lodge of Seven Nations spoke of the success stories of the children going through treatment at the facility and then returning home to no follow up care.

**ISSUE: Lack of Dental Care**

BACKGROUND: Ms. Croker, Health Manager for the Snoqualmie Tribe

RECOMMENDATION: Ms. Crocker voices her concern about the lack of dental funding received at the Snoqualmie Tribe. She states that they receive \$15,000.00 to provide dental services to over 1,000 members. She states that additional funds are needed to properly care for their patients.

**TUCSON**

**ISSUE: Communicable Diseases**

Communicable Diseases continue to be a high priority and ongoing Public Health threat throughout Indian Country. The appropriate investigation, mitigation, surveillance, education, communication and prevention place a significant strain upon local resources as Tucson Area I/T/Us address these issues.

BACKGROUND: The Tucson Area I/T/Us in recent years have worked together in collaboration with local, County, State and Federal agencies to address the outbreak of communicable diseases. Most recently, in 2007 the Tohono O'odham Nation declared an outbreak of Sexually Transmitted Disease, which brought the necessary attention and some limited resources from multiple public health agencies to initiate a program of surveillance, treatment and ongoing education. Thereafter, in 2009 the H1N1 influenza outbreak once again drew attention to a potential epidemic, which strained Tucson Area programs to maintain ongoing efforts of mitigation and education. Finally, and most significantly as of late, the Tucson Area recently identified six (6) cases of Rocky Mountain Spotted Fever (RMSF) in an area once thought to be devoid of this threat.

RECOMMENDATION: The role of Public Health in addressing communicable diseases is to interrupt disease transmission, locate and administer prophylaxis or treatment to exposed contacts, identify and contain outbreaks, ensure effective treatment and follow-up of cases, and alert the health community through all available methods. While the Tucson Area I/T/Us consider it within their mission to identify these public health threats and assign resources through internal and external collaborations, it has proven, as in the case of RMSF, to be prohibitive given current resources. For example, a local animal control program budget requires over \$400K per year to sustain, an amount that stretches beyond current allocated resources. Resources are required to adequately address and prevent these communicable diseases not only for IHS but for collaborating local, State and Federal agencies.

Additional budget resources are required immediately and over the long term to monitor disease trends over time, identify high risk groups, allocate resources for response, treatment and prevention, develop

public policy, and design effective education programs for current and future communicable disease threats.

**ISSUE: Impact to Contract Health Service (CHS) Funding From Medicaid Benefit & Eligibility Cuts**

In October 2010, the AHCCCS program began to no longer reimburse for emergency dental services, podiatry, and well adult visits.

In addition, the State of Arizona, due to budget constraints, has implemented Medicaid – AHCCCS cuts to the over 21 years and childless adult population. These eligibility reductions were implemented in July 2011. For the Tohono O’odham Nation and the Pascua Yaqui Tribe of the Tucson Area, this will have a negative financial collection impact as well as the CHS budget for outside referrals to non-IHS or Tribal facilities.

**BACKGROUND:** On March 15th, 2011, Arizona Governor Jan Brewer announced plans to adjust the Arizona AHCCCS program and institute permanent reforms to drive down Medicaid costs. The State plan is to implement eligibility and service reductions for the Proposition 204 childless adult population.

This voter approved proposition was implemented back in 2000, which expanded Medicaid services to those over the age of 21 years and had no children. Traditional Title XIX Medicaid covers children below 19 years of age and pregnant women. Arizona is one of only six states to provide additional Medicaid services to those over 21 years. As a result, the Tucson Area has benefitted by being able to bill and receive reimbursement for these services. The state of Arizona did receive approval from CMS to implement these changes effective July 8th, 2011.

Potentially, 250,000 childless adults would be impacted, which will include 27,130 Native Americans. The financial impact to the TON and PYT Tribes in the Tucson Area would be enormous. Decreased services, positions, Medicaid (AHCCCS) revenue will be lost, and could compromise the health care delivery systems to patients.

**RECOMMENDATION:** The Tucson Area held numerous consultation meetings with the Tohono O’odham Nation, Pascua Yaqui Tribe, the State of Arizona, Department of Health & Human Services Region IX and Center for Medicare & Medicaid Services regarding the impact of the AHCCCS reductions in benefits and eligibility for the Indian Health Service and Tribal programs. These consultations with both internal and external stakeholders have resulted in a waiver request to CMS, through the state Medicaid (AHCCCS) program, to waive all services that are reimbursed at 100% FMAP (Federal Medical Assistance Percentage). This would include all services that both the Indian Health Services and Tribal programs provide to its beneficiaries.

The 100% FMAP methodology would have no financial impact on the state of Arizona, and they have agreed to exclude all AHCCCS reductions for current Native American enrollees. A waiver request was submitted to CMS on March 31st, 2011 to exempt all impacted AHCCCS Native American enrolled childless adults. As of today, no decision from CMS has been made. The Tucson Area Indian Health Service, Tohono O’odham Nation and Pascua Yaqui Tribe are anxiously awaiting a favorable response. If the waiver request is not approved, the negative impact to CHS for both Tribes will be substantial and continued/increased funding in 2014 will be necessary.

Related, the TON and PYT support the feasibility of a Medicaid “51st State” concept that would expand the traditional Title XIX Medicaid program between the federal and state government, to include Tribal governments. This concept would provide greater autonomy for Tribes regarding eligibility, benefits, reimbursements, etc. without being subject to state budget mandates. Authorization for exploratory and feasibility regarding the 51st state concept for the Navajo Nation has already been approved on March 23rd, 2010, through the Indian Health Care Improvement Act. The TON and PYT supports this concept

## ***Appendix F: Support from Health and Human Services Budget Line Items***

American Indians and Alaska Native (AI/AN) Tribes and Tribal organizations receive a disproportionately low number of HHS grant awards. Information from the HHS Tracking Accountability in Government Grants System (TAGGS) database for FY 2004 provides evidence that the AI/AN population is under-represented as a proportion of total grant funding across all HHS agencies. AI/ANs are approximately 1.5 percent of the U.S. population, but AI/AN entities serving them receive only 0.51 percent of total grant funds awarded by HHS agencies.<sup>2</sup>

The Indian Health Service awarded 72 percent of its total grant funding to Tribes and Tribal organizations in 2004 and the Administration on Aging awarded 2 percent of its total funding to AN/AI groups that year. The National Institutes of Health awarded only 0.01 percent of total available grant funds to AI/AN groups – and made only eight awards to these groups out of a total of 55,822 grants awarded.

Agencies vary in the types of grant programs they support and, to some extent, under-representation of AN/AI groups in grant awards and funding may reflect the types of grants available from specific agencies. NIH and the Agency for Health Care Research and Quality (AHRQ) focus heavily on academic research grants, and AN/AI Tribes and organizations may have limited experience and lack staff with appropriate technical expertise to conduct research. Other agencies – Health Resources and Services Administration (HRSA), Centers for Disease Control (CDC), and Substance Abuse and Mental Health Services Administration (SAMHSA) – support some research-focused grants and others that fund program development and provision of services. AN/AI groups may be more likely to apply and be funded for non-research-focused grant programs. Despite this, HRSA, CDC, and SAMHSA also fund disproportionately few grants to AN/AIs.<sup>3</sup>

The barriers identified and the strategies presented to address these barriers are generally related to statutory, regulatory, administrative, or policy issues and to resources of Tribes and Tribal organizations. Statutory barriers are legislative requirements that may define program parameters that direct funding and payment policies (e.g., requirements for matching funds, population-based formulas that determine the level of funding, and eligibility rules). Regulatory barriers include program rules, definitions, and procedures. Administrative barriers may include management requirements and standards for routine program functions. Resource barriers generally are those that involve limited infrastructure or capacity of the population groups studied that affect their ability to learn about, respond to, and manage HHS grants.

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

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<sup>2</sup> <http://taggs.hhs.gov/Reports/GrantsByRecipClass.cfm>

<sup>3</sup> Barriers to American Indian, Alaska Native, and Native American Access to HHS Programs: Final Report prepared for US DHHS Office of the Assistant Secretary for Planning and Evaluation April 2006 <http://aspe.hhs.gov/hsp/06/barriers2access/report.pdf>

A regulatory barrier is the data required to establish eligibility and meet reporting requirements are often not available at the rural and small community level. Several administrative, policy and resource barriers were include: 1) lack of resources to track and identify grant opportunities; 2) each HHS program requires unique grant application formats and have different grants management requirements; 3) program funding is inadequate for small community-based organizations to administer and provide services to special populations and to those in remote areas; 4) the inherent advantage previous HHS grantees have in the award process; and 5) lack of explicit statements about eligibility in grant announcements.

A number of barriers related to the limited resources and capacity include: 1) potential applicants may not have resources or experience to track and identify grant opportunities, prepare grants, or gain access to experienced grants writers; and 2) many community-based programs for people who are homeless, rural populations, and faith-based organizations do not have administrative or service capacity to meet program requirements or to successfully apply and compete for grants, due to limited workforce numbers, lack of computer and internet technology and experience, and transportation barriers.

Additionally, grant announcements may be sent to Tribal chairs or other high-level managers who are very busy and do not forward the announcement to the appropriate person in the Tribe in a timely way. These factors often result in Tribes and Tribal organizations learning about grant opportunities at a point when there is little time left to prepare a grant application. The usual short time period between grant announcements and their due dates is a significant barrier for those who do not have resources to learn about grant opportunities on a timely basis. A short time span does not allow adequate time for coordination with any potential partners including the state, obtaining Tribal approvals, and writing the grant proposal.

On decisions to apply for specific grants, limitations on indirect costs and requirements for matching funds often factor into the decision to apply for a specific grant. Many Tribes and organizations have very limited resources and, as a result, are unable to administer a program that is not fully funded by HHS with respect to indirect costs. Indirect costs are treated differently in some IHS and non-IHS HHS funding streams. This difference may cause confusion in the grant application process. When contracts are issued from IHS for Tribes or other organizations to provide health care, the Tribe or organization receives funds to operate the program plus additional administrative costs (in theory) beyond the projected actual cost of the health care, whereas non-IHS HHS grant fund applications must build indirect costs into the proposal budget.

Few Tribes and Tribal organizations have access to funds that could be used to provide even a relatively low level of matching funds. The requirement of some grant programs that grant applicants provide a plan to demonstrate the sustainability of the program after grant funding ended. Sustainability of some components of the program may be possible, but some grant announcements require a plan for sustainability of the full program. If Tribes had the necessary resources to sustain a program, they would already have the program in place. Tribal-specific grant options within broader grant programs could include flexibility in grant announcements by encouraging creative proposals for achieving a degree of sustainability in grant proposals.

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. Both baseline data to measure progress as well as data to monitor and report on outcomes are important. Modifying the requirements for rural and other applicants in areas for which data on need are not available could be considered, as well as increased flexibility in the type and level of detailed data that are acceptable.

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. Thus, language in the announcement needs to recognize these traditional practices and/or set up alternative standards 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.

Also, existing grant programs may not be designed to “fit” Tribal structure and needs. For example, grant programs that indicate that only health provider groups are eligible do not recognize that many Tribes receive services through the IHS and IHS cannot apply for grant funding from other federal agencies. A related issue is the requirement, in some grant announcements, that the proposed program director and/or staff have specific academic credentials. In most rural areas and on reservations there may not be a supply of people with these credentials. As a result, some Tribal staff learn “on the job” and build extensive experience in other ways, but do not meet the specific academic or credential requirements for the grant program.

Regarding the grant review process, some grant reviewers have very limited or no understanding of AN/AI history, culture, geography, and resource limitations. In addition, even when no minimum population base was specified in the eligibility criteria, some reviewers ranked AN/AI applications lower because of the small number of people that would be reached by the grant program. Those that had 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 HHS 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.

Due to limited resources and capacity, Tribes and Tribal organizations don’t necessarily have the ability to compete successfully against large urban organizations and universities. Given this disparity in resources, “set-asides” for AN/AI organizations within grant programs could be a possible strategy for increasing the number of grant awards.

Collaboration among HHS agencies and organizations involved in grant implementation was a way to build the infrastructure necessary to successfully administer programs and manage grant funds. For example, the Native American Research Center for Health (NARCH) is a cooperative program using funds from IHS and various research agencies such as NIH and AHRQ to fund research activities and training at Tribal organizations. The principal research investigator must be associated with a Tribe, but need not be American Indian. The Tribe then partners with an academic institution. Also, there can be partnerships between operating divisions; for example, if a Tribe has received a SAMHSA grant, they would then be eligible to apply for an NIH research grant/clinical trial that focused on the purpose of the SAMHSA grant. SAMHSA and NIDA currently have this type of an arrangement.

#### Recommendations: Information on Grant Opportunities, Deciding to Apply, and Preparing Grant Applications

- Increase use of annual or multi-year program announcements, with multiple due dates.
- Increase use of planning grants by HHS agencies that may provide opportunities to build capacity and infrastructure.
- Include explicit statements about minimum population base requirements in grant announcements, if applicable.
- Include explicit statements in grant announcement that experience may substitute for academic credentials of key staff
- Increase training and technical assistance on grants processes and grants preparation skills, provided by HHS and/or national and regional AN/AI organizations, including possible knowledge transfer between successful AN/AI grantees and less experienced Tribes and organizations.

#### Recommendations: Grant Review Processes

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

#### Recommendations: Grants Management Processes

- Develop standardized HHS-wide grants management requirements.
- Provide training and technical assistance on grants management requirements, particularly for new grantees.

#### Recommendations: Additional

- Consider AN/AI "set-asides" or special grant initiatives within grant programs, including ways to address the needs of smaller/poorer Tribes and organizations.
- Improve capacity for HHS to track grant submissions and awards by AN/AI Tribes and communities.
- Increase the number of grants targeted specifically to AN/AI Tribes/organizations.
- Require evidence that states and academic institutions have support and participation of AN/AI Tribes and organizations, if they are included in grant application.<sup>4</sup>

#### Federal non-IHS Funding Streams (examples):

##### SAMSHA's Uniform Block Grant Application

An agency that has made strides in providing a more efficient, Tribally-focused grant process is the Substance Abuse and Mental Health Services Administration (SAMHSA). On July 26, 2011, SAMHSA

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<sup>4</sup> Barriers to American Indian, Alaska Native....

announced a new application process for its major block grant programs the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant (MHBG). The change is designed to provide States greater flexibility to allocate resources for substance abuse and mental illness prevention, treatment and recovery services in their communities. One of the key changes to the block grant application is the expectation that States will provide a description of their Tribal consultation activities. Specifically, the new application's planning sections note that States with Federally-recognized Tribal governments or Tribal lands within their borders will be expected to show evidence of Tribal consultation as part of their Block Grant planning processes. However, Tribal governments shall not be required to waive sovereign immunity as a condition of receiving Block Grant funds or services.<sup>5</sup>

#### The Justice Department's Coordinated Tribal Assistance Solicitation

On January 23, 2012, the Justice Department announced the posting of the Coordinated Tribal Assistance Solicitation (CTAS), a comprehensive grant solicitation to support improvements to public safety, victim services and crime prevention in American Indian and Alaska Native communities. Commenting on the announcement, Associate Attorney General Tom Perrelli said:

"We are committed to helping strengthen and sustain safe and healthy American Indian and Alaska Native communities with a funding process that is responsive and coordinated. This effort to streamline the grant application process, with multiple purpose areas, offers Tribes and Tribal consortia an opportunity to develop a comprehensive and community-based approach to public safety and support for victims."

More than \$101.4 million is available through the 2012 CTAS. This year, funding can be used to conduct comprehensive planning, enhance law enforcement, bolster justice systems, support and enhance Tribal efforts to prevent and control juvenile delinquency and strengthen the juvenile justice system, prevent youth substance abuse, serve victims of crimes like domestic violence and sexual assault, as well as support other crime-fighting efforts.

CTAS is a critical part of the Justice Department's ongoing initiative to increase engagement, coordination and action on public safety in Tribal communities. This is the third year for CTAS, which provides Tribal governments and Tribal consortia with a single application to reach all of the department's grant-making components, including the Office of Justice Programs, the Office of Community Oriented Policing Services, and the Office on Violence Against Women. It allows these grant-making components to assess the totality of the public safety needs of each Tribe or Tribal consortia. The FY 2012 CTAS reflects improvements developed as a result of Tribal consultations, listening sessions, and other feedback.<sup>6</sup>

#### The Tribal Law and Order Act (TLOA)

Through the TLOA, Congress sought to engage new federal partners to build upon previous efforts in addressing alcohol and substance abuse in the AI/AN population.<sup>7</sup> As a result, the Secretary of Health and Human Services, the Secretary of the Interior, and the Attorney General, recently signed a Memorandum of Agreement (MOA) to, among other things:

<sup>5</sup> SAMHSA FY 2012 Justification of Estimates for Appropriations Committees to DHHS <http://www.samhsa.gov/Budget/FY2012/SAMHSA-FY11CJ.pdf>

<sup>6</sup> "Justice Department announces grant solicitation for funding" Native American Times January 19, 2012 <http://nativetimes.com/news/federal/6663-justice-dept-announces-grant-solicitation-for-funding>

<sup>7</sup> Testimony by Richard T. Mckeon on HOPE for the Future: Helping our People Engage to Protect our Youth before Committee on Indian Affairs in the United States Senate on October 22, 2011 <http://www.hhs.gov/asl/testify/2011/10/t20111022a.html>

1. Determine the scope of the alcohol and substance abuse problems faced by American Indians and Alaska Natives;
2. Identify the resources and programs of each agency that would be relevant to a coordinated effort to combat alcohol and substance abuse among American Indians and Alaska Natives; and
3. Coordinate existing agency programs with those established under the Act.

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

When Congress enacted The Tribal Self-Governance Amendments of 2000, P.L. 106-260, it included a provision requiring the HHS to conduct a study to determine the feasibility of extending Tribal Self-Governance to non-IHS programs within DHHS. In the final study submitted to Congress in 2003,<sup>5</sup> DHHS concluded that it was feasible to extend Tribal Self-Governance to eleven select programs within the Department, and recommended that Congress do so. Making the assumption that Self-Governance, as a practice, provides a greater benefit than federally-administered programs, supporting the expansion of this practice, via Title VI is a priority for Tribes.

Benefits of Title VI Self-Governance Amendments include:

1. Expands Tribal Self-Governance; the most successful policy in the history of Tribal-Federal relations.
2. Builds on the well-documented successes of Tribes and Tribal organizations in delivering IHS health care programs and services under Title V.
3. Determined to be feasible and desirable by DHHS in its 2003 study.
4. Allows Self-Governance in DHHS analogous to that in the Department of the Interior, where Title IV allows Tribes to compact non-Bureau of Indian Affairs programs and services.
5. Provides an integrative, holistic approach to ensuring healthy communities by providing services that enhance individual and community well-being.
6. Described by the Senate Committee on Indian Affairs as "the next evolution in Tribal self governance."<sup>8</sup>

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<sup>8</sup> National Tribal Self-Governance Strategic Plan & National Priorities 2011-2013 Self-Governance Communication and Education Tribal Consortium [http://www.Tribalselfgov.org/\\_\\_\\_NEWSGCE/\\_\\_\\_documentsdownload/Tribal%20Strategic%20Plan%20-%202011-13.pdf](http://www.Tribalselfgov.org/___NEWSGCE/___documentsdownload/Tribal%20Strategic%20Plan%20-%202011-13.pdf)  
[http://www.Tribalselfgov.org/\\_\\_\\_NEWSGCE/\\_\\_\\_documentsdownload/Tribal%20Strategic%20Plan%20-%202011-13.pdf](http://www.Tribalselfgov.org/___NEWSGCE/___documentsdownload/Tribal%20Strategic%20Plan%20-%202011-13.pdf)

Appendix G: GPRA Performance Measures

## 2011 National Dashboard (IHS/Tribal) - Final

2011 Q4 National Dashboard (IHS/Tribal)					
DIABETES	2010 Target	2010 Final	2011 Target	2011 Final	2011 Final Results
Diabetes Dx Ever	N/A	12%	N/A	12.8%	N/A
Documented A1c	N/A	82%	N/A	83.0%	N/A
Poor Glycemic Control	16%	18%	19.4%	19.1%	Met
Ideal Glycemic Control	33%	32%	30.2%	31.9%	Met
Controlled BP <130/80	40%	38%	35.9%	37.8%	Met
LDL (Cholesterol) Assessed	69%	67%	63.3%	68.7%	Met
Nephropathy Assessed	54%	55%	51.9%	56.5%	Met
Retinopathy Exam	55%	53%	50.1%	53.5%	Met
DENTAL					
Dental: General Access	27%	25%	23.0%	26.9%	Met
Sealants	257,920	275,459	257,261	276,893	Met
Topical Fluoride- Patients	136,978	145,181	135,604	161,461	Met
IMMUNIZATIONS					
Influenza 65+	60%	62%	58.5%	62.0%	Met
Pneumovax 65+	83%	84%	79.3%	85.5%	Met
Childhood IZ <sup>a</sup>	80%	79%	74.6%	75.9%	Met
PREVENTION					
(Cervical) Pap Screening	60%	59%	55.7%	58.1%	Met
Mammography Screening	47%	48%	46.9%	49.8%	Met
Colorectal Cancer Screening	36%	37%	36.7%	41.7%	Met
Tobacco Cessation	27%	25%	23.7%	29.4%	Met
Alcohol Screening (FAS Prevention)	55%	55%	51.7%	57.8%	Met
DV/IPV Screening	53%	53%	52.8%	55.3%	Met
Depression Screening	53%	52%	51.9%	56.5%	Met
CVD-Comprehensive Assessment	33%	35%	33.0%	39.8%	Met
Prenatal HIV Screening	77%	78%	73.6%	80.0%	Met
Childhood Weight Control <sup>u</sup>	24%	25%	N/A	24.1%	N/A
<sup>a</sup> 4 Pneumococcal conjugate vaccines added to Childhood Immunization series in FY 2011.					Measures Met: 21
<sup>u</sup> Long-term measure as of FY 2009, next reported in FY 2013.					Measures Not Met: 0

National 2011 and 2012 Targets; National and Area 2011 Results

9/7/2011

GPRA Clinical Measures	2012 IHS-All Target	National IHS-All 2011 Target	National 2011 Result IHS-ALL	Aberdeen Area	Alaska Area	Albuquerque Area	Bemidji Area	Billings Area	California Area	Nashville Area	Navajo Area	Oklahoma Area	Phoenix Area	Portland Area	Tucson Area
Poor Glycemic Control	18.6%	19.4%	<b>19.1%</b>	20.8%	9.6%	22.2%	15.7%	21.1%	15.2%	20.7%	23.6%	13.1%	23.4%	15.6%	31.6%
Ideal Glycemic Control	32.7%	30.2%	<b>31.9%</b>	28.5%	44.2%	30.1%	26.6%	27.5%	36.2%	28.8%	27.8%	40.0%	27.0%	35.8%	25.8%
Controlled Blood Pressure	38.7%	35.9%	<b>37.8%</b>	35.2%	40.3%	47.2%	29.6%	37.2%	33.9%	35.6%	42.3%	34.5%	40.2%	33.9%	51.4%
LDL Assessed	70.3%	63.3%	<b>68.7%</b>	63.3%	76.4%	70.7%	62.2%	67.2%	69.6%	66.0%	61.9%	77.0%	66.0%	70.8%	76.4%
Nephropathy Assessed	57.8%	51.9%	<b>56.5%</b>	65.7%	34.5%	72.9%	48.3%	57.6%	54.3%	49.2%	55.5%	59.8%	49.0%	56.2%	67.9%
Retinopathy Assessed	54.8%	50.1%	<b>53.5%</b>	43.2%	47.2%	62.2%	43.9%	55.3%	47.4%	44.6%	62.0%	56.8%	54.2%	46.4%	53.8%
Influenza 65+	63.4%	58.5%	<b>62.0%</b>	54.3%	48.2%	73.9%	55.6%	59.0%	53.3%	60.2%	69.4%	65.8%	58.3%	57.1%	75.6%
Pneumovax 65+	87.5%	79.3%	<b>85.5%</b>	84.3%	93.6%	93.9%	72.1%	88.4%	82.0%	86.4%	91.5%	80.4%	83.9%	80.1%	96.5%
Childhood Immunizations	77.8%	74.6%	<b>75.9%</b>	73.3%	79.5%	73.8%	70.6%	79.8%	70.2%	75.4%	80.3%	74.1%	77.3%	64.3%	84.4%
Pap Screening	59.5%	55.7%	<b>58.1%</b>	53.2%	73.9%	69.8%	51.1%	54.9%	49.1%	60.2%	54.4%	61.6%	53.8%	52.5%	54.5%
Mammography Screening	51.7%	46.9%	<b>49.8%</b>	43.3%	57.2%	49.6%	43.3%	48.3%	45.4%	53.7%	47.7%	58.9%	43.4%	39.3%	58.5%
Colorectal Cancer Screening	43.2%	36.7%	<b>41.7%</b>	29.8%	58.5%	35.9%	36.6%	39.3%	35.5%	46.0%	36.9%	53.4%	28.9%	41.1%	14.0%
Tobacco Cessation	30.0%	23.7%	<b>29.4%</b>	30.6%	16.7%	34.4%	34.1%	29.2%	25.1%	44.6%	9.9%	42.8%	11.4%	28.5%	31.8%
Alcohol Screening (FAS)	58.7%	51.7%	<b>57.8%</b>	66.1%	44.8%	69.3%	51.7%	58.3%	47.5%	72.1%	61.0%	62.0%	51.3%	46.0%	96.8%
Domestic (IP) Violence	55.3%	52.8%	<b>55.3%</b>	62.4%	39.7%	66.8%	53.4%	52.8%	48.1%	63.8%	59.2%	61.0%	49.2%	43.4%	97.0%
BH-Depression Screening	56.5%	51.9%	<b>56.5%</b>	66.5%	55.7%	70.6%	48.1%	57.9%	46.0%	58.1%	59.2%	60.0%	43.6%	45.6%	97.6%
CVD Prevention	40.6%	33.0%	<b>39.8%</b>	43.8%	24.5%	40.8%	39.4%	33.0%	44.7%	46.7%	35.7%	48.0%	32.6%	30.3%	18.6%